Ministry of Justice | Home Office | Department of Health

Independent Advisory Panel on Deaths in Custody

Minutes of the Independent Advisory Panel meeting
Monday 9 December 2013
Millbank House, London

Attendees: Lord Harris of Haringey (Chair),
Simon Armson,
Deborah Coles,
Professor Philip Leach,
Professor Richard Shepherd,
Professor Stephen Shute,
Darrick Jolliffe, Research Team (University of Greenwich)
Zubaida Haque, Research Team (Runnymede Trust)
Michael Fiddler, Research Team (London Metropolitan University)
Laura McCaughan, Secretariat
Kishwar Hyde, Secretariat
Alice Balaquidan, Secretariat
Peter Thornton, Chief Coroner (joined at 2pm)
James Parker, MOJ (joined at 2pm)

Apologies: Dr Peter Dean
Claire Johnson (Head of Secretariat)

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1. Welcome and minutes of the last meeting

Lord Harris welcomed everybody to the twentieth meeting of the Independent Advisory Panel on Deaths in Custody. Apologies had been received from Peter Dean and Claire Johnson. Lord Harris welcomed Laura McCaughan who was returning to the Secretariat in April 2014 and would be attending for the morning section of the meeting. Lord Harris also welcomed the research team from the University of Greenwich and Runnymede Trust consortium; it would be useful to get their insight into the Panel's proposed work for 2014.

Deborah Coles had several amendments to make to the minutes of the previous meeting. She would forward the changes to the secretariat and the minutes could then be re-circulated and signed off.
Action: Deborah to provide amendments to the previous minutes to the Secretariat.

2. Action log

(i) Mechanisms for capturing information on near deaths and near misses
This work had been put off previously due to the Secretariat not being fully staffed and until recently, the secretariat had been in a similar position again. Deborah Coles asked that the Panel do not lose sight of this work.

(ii) Use of Taser
Lord Harris referred to figures on Taser Use relating to Mental Health prior to the meeting. He had also been approached to sit on the Taser Reference Group which he had declined although he had informed the Metropolitan Police that he would be happy to continue to receive papers. Deborah Coles expressed her concern at the figures in the recent paper and wanted to raise the issue of the use of tasers against children.

(iii) Lord Adebowale's report on the independent commission on mental health and policing
Lord Harris advised that the Metropolitan Police Service (MPS) response to the report was expected later in the month. A number of Panel Members had been at a presentation given by Christine Jones of the MPS which had been very positive. Deborah Coles asked whether the mental health Concordat was out for consultation. It was agreed that this should be circulated to the IAP for comment.
Action point: Secretariat to contact Department of Health (DH) for mental health concordat and circulate to Panel members. *(Secretary's note: draft Concordat circulated Jan 2014.)*

All other Action Points from the previous meeting were substantive agenda items.

PER (Prison Escort Record) Paper

Stephen Shute reiterated that the Panel had been looking at the effectiveness of PER for some time now. It had asked Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Prisons (HMIP) if they would inspect this area. That had been done and the Inspectorates' report was now published. Stephen was now looking at how to ensure that the proposed changes were embedded across the sector. Unfortunately, there was still a long way to go before an electronic version of the form could be achieved but the emphasis for the moment was on getting the paper-based system to work more effectively.

Stephen Shute met with Her Majesty's Inspectorate of Prison (HMIP) on 9 October 2013; all their recommendations for prisons had been accepted by NOMS. Now all that was needed was an update from the Association of Chief Police Officers (ACPO) on how PER proposals would be included in police processes. HMIC and HMIP had agreed to look at linking this issue to the criteria for inspections. There was a need to keep up to date with progress. Deborah Coles suggested that every time there was a death in custody, the impact of PER should be considered. Stephen agreed that monitoring information flow was important.

Conferences and Meetings
Lord Harris proposed that these should be dealt with later in the agenda when updating on workstreams.

IAP member recruitment
Lord Harris advised that there had been 64 applicants for the role of Panel member, significantly more than had been anticipated. The sift had been held and the sift panel had decided on the final 12 candidates; subject to Ministerial approval, these individuals would be invited to interview in early January. The successful candidates would be expected to take up post in April 2014.

Lord Harris would provide an update at the next meeting.

3. University of Greenwich (UoG) update

Darrick Jolliffe referred to his paper – "*update for IAP meeting"* – which had been circulated before the meeting. The paper is attached at Annex A.

Additional points for the Panel to note were:

Project 1: Review of the Role of Mental Health in Deaths in Custody

- The report would be submitted by the end of the week
- Following sight and agreement by the Panel, the report would be published
- There was a need to widen the research to look at mental health across the whole estate; this would be useful in pushing the agenda forward

Project 2: Evaluating the Impact of the Information Sharing Statement

- Individuals in the organisations had said that they felt the information was desirable but that they would not be able to obtain it or incorporate it into their daily work
- There were 2 ways to disseminate information: either across the whole organisation and hope that it reached the right people or concentrate on channelling it through particular groups such as custody sergeants.

Project 3: Update of Annual Report on Deaths in Custody

- Custody population figures were incomplete so the review would have to compare statistics within the total population
- Darrick stated that he would make recommendations for what data should be collected and the difference the information would make.

Project 4: Evaluating the use of Assessment Care and Custody Teamwork (ACCT)

- The Prison and Probation Ombudsman (PPO) were currently carrying out a study of children under ACCT although they were looking only at incidents of death, not near-deaths.
- There were questions about the effectiveness of ACCT.
- Deborah Coles suggested the University also look at R43 reports where ACCT had featured.

Project 5: Information Sharing at the Point of Custody for Youth

- Darrick had met with Poppy Harrison from the Youth Justice Board (YJB) and talked about the need to bring stakeholders together into a focus group
- The University would like to follow a small number of young people through the system with the aim of working out the weak points in the information flow.

Project 6: Scoping NOMS Data on Suicide, Self-Harm and the 'Custodial Career' (Pending)

- The UoG had lots of figures on deaths in custody but not on near deaths, which would be useful.

3. Update on workstreams

Use of Physical restraint

Lord Harris explained that many different organisations were working on this – ACPO, NHS England etc, and that there was a need to keep these coordinated while keeping up the momentum. Excited Delirium remained an area of concern and it was agreed that a workshop was needed on this issue. Lord Harris stated that all bodies now believed that use of restraint should be reported on.

He concluded that the following areas should be picked up and taken forward:

- recording and reporting
- pressing NHS on restraint guidance
- looking at the issue of Excited Delirium.

Information Flow through the CJS

Work had been successfully progressed in this area. Lord Harris asked whether there was anything else to be taken forward. Stephen highlighted that the information flow information from YOTs custody (also reported in the HMIP interim report as indicated on the PER update) suggested that further research was needed on this area as there was gap in knowledge. So following on to that recommendation this was entered into the work strand. Some of this work would be completed within the next 2-3 months.

Cross Sector learning

Deborah Coles had a useful meeting with the Chief Coroner. She asked whether the Panel should be taking up a thematic review of what issues were arising from inquests and jury conclusions. An analysis of coroner reports, jury findings and responses would be really helpful and could be a useful resource for organisations if it was on the website. It would also enable a more coordinated response to inquests into deaths in custody and enable a review of how the learning was taken forward and acted upon.

Lord Harris suggested that the review did not require detailed analysis and wondered if University of Greenwich could incorporate this – it would be around 100 reports per annum. This would need scoping on how far back the analysis should go and what the themes should be. The Panel had conducted some work in this area 2 years ago which could be updated. Lord Harris asked UofG to scope and come back.
Action: UoG to scope work on analysing coroner reports, jury findings and responses.

Article 2 Compliant Investigations

Philip stated that the guidance was due to be published by the end of the month. Once the guidance was out, the panel needed to consider how it could be properly monitored – this could be quite a challenge. Also access to investigation reports was still an issue to consider. Philip added that he thought the Panel should consider again in the new year how best to take this work forward.

The IPCC Article 2 report would be coming out in January 2014 and should also be a focus for the Panel.

Deaths of Patients Detained under the Mental Health Act (MHA)
Lord Harris explained that the panel were still hoping for NPS data. Simon Armson suggested a wider review of natural cause deaths; Mary Piper had given a presentation to the Ministerial Board about work being carried out but there was a need to press on the analysis. Richard had concerns about the investigation as many of the findings were "easy findings".

Deborah flagged up issues on (i) restraint, and (ii) SI deaths and the need to have access to adequate data.

Family Liaison Work
The panel had published work on the use of common principles; was there now a need to revisit and ascertain what was happening. Lord Harris recommended that the panel **ask for progress from each Agency at a future Ministerial Board.**

Equalities
It was noted that Damien Green had recently taken interest in this subject. Lord Harris stated that the UoG were doing some data analysis which may inform this work. The Panel were keen to move on this and asked UoG if they could look at the paper and tease out the BME figures. UoG stated that they could have problems with natural cause deaths as there were so many. There was another issue with learning disability but there was a real lack of data in this area.

Lord Harris suggested discussing the scoping paper with the secretariat.
Action: UoG and Secretariat to liaise regarding scoping paper for Equalities.

Commissioning and custody providers
Lord Harris explained that these would increasingly factor in the work of the panel. Richard commented that training providers would be a consideration.

Near Deaths
Lord Harris commented that while this was important he was unsure that there was any capacity to carry out the work. The new panel members may enable the work to progress. Darrick asked whether there was any value in writing up the findings.
Action: Secretariat to share 2009 near-deaths paper with University.

Suggested Future Workstreams
There was discussion of future workstreams which had been suggested by the panel members. Lord Harris stated that enough work had been identified for the next six months and beyond. When new members joined they could be engaged on some of the work streams. He also stated that there was a need to be mindful of secretariat resources and the support it can offer.

4. Planning for 2014/15
Lord Harris advised that in order to start planning for the future it was important to look at where the Panel were currently. Progress had been made in some areas but it had been slow and Lord Harris wondered whether there was a need to step back and look at areas where the Panel needed to apply pressure. Deborah asked if there should be a review of the impact the Panel has made in some sectors and if there was a need for the Panel to promote itself better.

Simon Armson stated that the evidence suggested that mental health had become the most central issue.

Lord Harris was also concerned that transparency had slipped; the website had become more difficult to navigate. One of the issues was that the Secretariat were still waiting to find out whether the IAP was exempt from Gov.uk. This would need to be reviewed over the next few months.

Other issues were the change in officials since the inception of the Panel and the bureaucratic hurdles including those of staff recruitment.

Discussion took place about the need to have a champion in each of the departments but it was agreed that this was the role of the co-sponsors. Lord Harris advised that he met with the co-sponsors every quarter and that he would use these as an opportunity to engage them as champions.

It was noted that during 2014 there would be the departmental triennial review of the Panel.

Stephen asked how the Panel could be effective given its limitations; independence was not an issue but the time allocated to Panel members for work was. Deborah considered that the Panel were spreading themselves too thin over too many workstreams. She wondered if perhaps two or more members working on the same project could be more effective, although this issue was now better since the engagement of the University of Greenwich. Lord Harris added that the recruitment of five new Panel members, rather than the current three, may help. He suggested that these issues be picked up by the next meeting and taken forward.
Action: Panel workloads to be placed on agenda for next IAP meeting.

5. IAP Stakeholder Consultation Event – Thursday 27 March 2014

The Prisons' Minister had been engaged to give the keynote speech at the event. The contract was also now in place for the theatre company Clean Break who would present a 20 minute play through which they would explore the themes for the day. The actors would remain in character throughout the day and engage the audience in the afternoon workshops. Deborah advised that she would liaise with the theatre company to work through the details for the day. Further questions put up for discussion were:

- What should the event be called?
- What should be the theme for the day – mental health, staff attitudes?
- Who should facilitate the workshops?

It was agreed that all Panel members would participate in the workshops. Deborah and Lord Harris would consider these further with support from the Secretariat.
Action: Deborah Coles and Lord Harris to liaise with Clean Break about the event.

Lord Harris also suggested that preliminary invitations should go out to the stakeholders for the event before the Christmas break to ensure they had enough notice. Full details could then be sent in the New Year once they were finalised.
Action: Secretariat to send preliminary invitations to stakeholders. *(Secretary's note: invitations to primary stakeholders sent mid-December 2013.)*

6. Update on developments in the coronial system and response to IAP recommendations

Lord Harris introduced Peter Thornton, QC, the Chief Coroner, and invited him to give a brief summary of his time in the role. Peter Thornton explained that he took up post in September 2012 and that there had been much action since then. He had worked with the MOJ on the new rules and regulations for the Coroners Act which came into force in July 2013. The Act set out the procedures for a new, modern and more effective Coroners' Court in which reports would be quicker, all relevant information would be recorded and the court process would be more transparent. The current structure was that there were 96 Coroners' areas which would need to be reduced, over time, to approximately 75; each of these would be led by a Senior Coroner with a deputy and perhaps 4-5 Assistant Coroners under him/her. This team would work in conjunction with the Local Authority.

In addition, the Chief Coroner had been revising the appointment procedures; now all appointments had to be approved by the Chief Coroner and the process would be transparent and open. There were new training procedures; all coroners and their officers were trained by the Chief Coroner and the Judicial College. Training was given on the new Act, induction for new coroners and assistant coroners, continuation training for coroners and their officers as well as a day's training in military deaths.

The Chief Coroner had also produced guidance for lawyers and coroners, one of which was regarding Reports to Prevent Future Deaths (formerly Rule 43 reports). There was a new format for report writing, and all reports were filed in the Chief Coroner's office and on the judiciary website. All reports and responses had to go through the Chief Coroner who would take up particularly important, difficult or high profile issues that were raised.

Lord Harris explained that the Panel had made several recommendations to the Chief Coroners office since its inception. Peter Thornton commented on the recommendations as below:

Recommendation 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 resources. This could include supporting coroners to make submissions to the relevant local authorities where funding is an issue.

Recommendation 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.

Taken at face value, this was already happening. The Chief Coroner had identified the top ten slowest areas and taken up the issue with them on how to improve their services. The rules and regulations stated that, where possible, inquests should be heard within six months (although this did not specifically relate to deaths in custody). Other actions being taken were training of coroners and discussions about

timescales, setting dates etc. Lord Harris raised the issue of natural cause deaths and expressed concerns about how, in mental health, to safeguard against concentrating on simply the death itself rather than the whole circumstances. The Chief Coroner stated that it was already part of the training to look at other factors. Discussion then took place about whether there was a need to develop a protocol for coroners to look at all related aspects such as, for instance, toxicology, and whether that protocol should include the timing and quality of investigation reports as well. The Chief Coroner explained that he had already pursued the issue of report timeliness with the PPO and that he could deal with the question of quality if the report had been produced by Coroners' offices but that it was difficult to ensure quality from reports produced by other organisations.

Recommendation 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.

Guidance on pre inquest hearings would be given soon. The Chief Coroner advised that the induction course for coroners included a great deal of information on the case management of the hearings and Coroners had a checklist which they could use. Both of these also emphasised the importance of communication as the majority of complaints were about unanswered correspondence. The MOJ were making headway with getting up to date with correspondence but as yet the timescale was unclear.

Recommendation 42. The Chief Coroner's office should develop a fully searchable, publicly accessible, database of all death in custody Rule 43 reports, which includes sufficient information to identify themes and trends for inclusion in the annual report to Parliament. The information should also be accessible to custodial organisations and other relevant organisations for the purposes of learning and research. Processes need to be put in place to ensure that all reports and responses are recorded on the database.

Recommendation 43. Training for coroners should include guidance about when Rule 43 reports should be made to promote greater consistency in their approach to deaths in custody inquests.

The Chief Coroner advised that reports would be uploaded onto the website alongside the responses. He was planning to have a regular review of responses alongside their reports, every six months. The reports would be published; initially redacted then viewed by the Chief Coroner before publication on the Judiciary website.

Recommendation 45 NHS England – with input from CQC and the Chief Coroner - should produce guidance for mental health trusts, which provides clear and consistent guidance on how trusts should undertake investigations following the death of a detained patient (which should include guidance on how to ensure investigations are Article 2 –compliant, where relevant).

Lord Harris advised that NHS England would be producing the guidance later in the month. The Chief Coroner advised that there were not enough experienced Coroners currently to deal with complicated inquests but that he would be looking at training up Assistant Coroners to help with these in the near future.

Lord Harris asked for a similar update of progress in a year's time.
Action: Chief Coroner to be invited to attend IAP meeting in Dec 2014.

7. Next steps and AOB

Lord Harris stated that enough work for the Panel had been identified for the next six months and beyond.

8. Date, time and venue of next meeting

The next meeting of the Panel will be on 10 March 2014. Details will be sent out nearer the time.

Actions from meeting

- **Deborah to provide amendments to the previous minutes to the Secretariat.**
- **Secretariat to contact Department of Health (DH) for mental health concordat and circulate to Panel members.**
- **UoG to scope work on analysing coroner reports, jury findings and responses**.
- **UoG and Secretariat to liaise regarding scoping paper for Equalities**.
- **Secretariat to share 2009 near-deaths paper with University.**
- **Panel workloads to be placed on agenda for next IAP meeting**.
- **Deborah Coles and Lord Harris to liaise with Clean Break about the event**.
- **Secretariat to send preliminary invitations to stakeholders**
- **Chief Coroner to be invited to attend IAP meeting in Dec 2014.**