Harris Review Meeting 5

13:45 – 16:00, 26 June 2014, Room 7.29B
102 Petty France, London SW1H 9AJ

Present
Chair: Lord Toby Harris (TH)

Panel Members: Philip Leach (PL), Deborah Coles (DC), Meng Aw Yong (MAY), Graham Towl (GT), Dinesh Maganty (DM), Richard Shepherd (RS)

The Harris Review Secretariat:
Deborah Browne (DB), Robyn Malan de Merindol (RM)

Apologies: Matilda MacAttram (MM), Stephen Cragg (SC)

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1. DC updated the panel on a meeting she held with Barrow Cadbury Trust, who are funding work by Inquest, following the Fatally Flawed Report. Barrow Cadbury Trust raised concerns about an inconsistency between Harris Review Call for Submission questions on the website and on Citizen Space.

Action 54: Secretariat to ensure same version of call for submissions on all websites.

Item 3: Minutes of meeting 05.06.2014

2. Minutes accepted as true record.

Item 4: Action Log

3. The meeting reviewed the actions and updates were recorded. Panel members were reminded to continue to encourage submissions to the *Call for Submissions.*

Action 55: Secretariat to draft letter from TH to Inquest Lawyers Group suggesting a meeting with the panel.

Action 56: Secretariat to request details of Safer Custody Audit in Official Questions for NOMS.

Item 5: Case Summaries

4. It was agreed that legal advice will be sought on how much detail from each of the summaries should be published. Options discussed included listing all of the deaths in scope in an annex to the final report, and included more detailed case histories within the text to illustrate key points. Legal and data protection issues will need to be considered.

5. The content of the Case Summaries was discussed and it was agreed that consideration needed to be given to include, where possible, details of previous relevant deaths at the prison, cross reference with rule 43 recommendations, consideration of whether the prisoner is on an IPP sentence, IEP status at time of death, dates of publication of the PPO report and the date of the inquest, and any press interest.

6. It was felt that ideally leadership issues in the prison should be captured if raised.

Action 57: Secretariat to ask NOMS and NHS England if they make any early internal report following a death in custody and if the Review can have these.

Action 58: Secretariat to check that the 'baby-barristers' (BBs) summarising the deaths have no conflict of interest.

7. It was felt it would be useful if some feed back could be given to the panel after the trainee barristers had completed around 20 cases, depending on scheduling of meetings etc.

Item 6: Discussion on Findings so far

8. It was agreed that this was a useful exercise and it was confirmed that the intention was to repeat it at regular intervals.

9. In summary, the key points of discussion focused on the following:

- It was agreed that where multiple stakeholders are repeating the same messages, this needs to be noted.

Context of 18 – 24 year olds:

- Context / nature / maturity are all significant
- Academic references concerning issues of maturity should be sourced and included
- It was felt worthy to note that during the hearings from the IMB and HC they told the Review that staff no longer feel safe around young adults
- Capture gender issues around safety and self-harm
- Diversion prior to sentencing for this age group was considered worth looking at.

Action 59: Find out what mechanisms prisons use to communicate to prisoners the risks of harming themselves.

Prison Management and Policy:

- The importance of covering mental health services in prisons, their availability and how they were accessed were important
- Clarity on whether support for certain conditions was ring-fenced would need to be looked at.
- Should health and mental health assessment happening at an earlier stage, for example in police cells, be considered as a viable option. This could help facilitate better liaison and diversion and would also be available to the court. It would need to be considered where the funding would be drawn from.
- It would be interesting to look at how effective NOMS thinks IEP is – where/what is their evidence for this having a positive effect on behaviour?
- Would population pressures impact on space otherwise given over to early days and induction?
- How do NOMS monitor whether the policies concerning safety in custody are being done? Are there relevant KPTs and KPIs?

Staff Training:

- More details were needed on details around how and who delivers training on safety, ACCT and mental health awareness and the extent of this training.