Ministry of Justice | Home Office | Department of Health

Independent Advisory Panel on Deaths in Custody

Minutes of the Independent Advisory Panel meeting
Wednesday 10 Sept 2014
102 Petty France, London

Attendees: Lord Toby Harris (TH) of Haringey (Chair),
Professor Philip Leach (PL)
Professor Richard Shepherd (RS)
Stephen Cragg QC (SC)
Matilda McAttram (MM)
Dinesh Maganty (DM)
Dr Meng Aw-Yong (MA-Y)
Professor Graham Towl (GT)
Professor Darrick Jolliffe (DJ), Research Team (University of Greenwich)
Laura McCaughan (LM), Secretariat
Kishwar Hyde (KH), Secretariat
Alice Balaquidan (AB), Secretariat
Kim Shepherd (KS) (CQC), for item 7
Kim Patience (KP) (CQC), for item 7

Apologies: Deborah Coles (DC)

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1. Welcome and introductions

1.1 TH welcomed the members to the meeting of the Independent Advisory Panel. DC had sent apologies for her absence.

2. Minutes from last meeting (IAP 10.9.14-1) and update on actions

2.1 Minutes of the previous meeting were agreed.

2.2 LM updated the Panel on actions from previous meetings:

- *Secretariat to invite a representative from the Wish Centre to the equalities stakeholder meeting*. The Secretariat had contacted Nicky Simpson at WISH and invited her to join the practitioner and stakeholder group.

- *Secretariat to set up a meeting between Philip Leach and the NHS England Project Manager.* PL, DC, and MM met with the NHS England project manager and Head of Patient Safety Policy in June. NHS England explained that they would not have sufficient funding or the correct governance to establish an independent body to

- *Secretariat to ask Immigration about the status of the Panel on the non-compliance management report.* LM and KH had met Immigration Enforcement officials in August, and this was followed by a bilateral meeting between Lord Harris and Clare Checksfield (Director). The IAP on Non-Compliance Management had reported to Ministers and their training package was currently being rolled out for all escort staff. The training was due to be completed in November 2014 and all staff would then be subject to 6-monthly refresher courses. The focus of the training, called HOMES training, was on de-escalation but new methods, such as a waist restraint belt (approved as a safe method of restraint for those on aircraft if required) had been introduced. MM and MA-Y expressed interest in observing HOMES training.
  Action 1: Secretariat to arrange for MM and MA-Y to attend/observe HOMES training.

- *Secretariat to ask Alan Greene (ACPO) how it is intended that restraint records would then be available for analysis in data.* The Secretariat was arranging a meeting between Lord Harris and Alex Marshal of College of Policing. *[Secretary's note: TH had a telephone meeting with Alex Marshall on 19 September. Alex stated that the College was currently considering comments on the APP consultation and it would then go to their Professional Practice Committee for sign off. Developments were under consideration for collation of data at a national level.]*

- *Secretariat to follow up on progress to expand PPO terms of reference to cover any death in a secure children's home and also chase an update on improvement to clinical reviews.* LM had a number of discussions with YJB, MoJ and DfE about the reasons for delay to implementing this recommendation. Guidance and discussions with SCH managers went well in 2012/13. However, DfE had had difficulties with drafting a memorandum of understanding that would require SCHs to comply with a PPO investigation because they had no direct governance relationship with the homes. However, YJB were commissioners of justice beds in these homes and would change their contracts with SCHs to ensure they complied with PPO investigations. MoJ are currently working with DfE to complete a MOU to acknowledge the department's role in producing guidance if there were any lessons to be disseminated around the sector. MOJ would be providing an update paper for the next Ministerial Board meeting on 21 October.

- *Lord Harris to meet with organisations to encourage use of information sharing statement to improve practice.* TH and the Secretariat had had a series of meetings with the sectors who updated as follows:

  - the Director of National Operational Services at NOMS agreed to incorporate the statement into existing policy at the next review and would ensure regional safer custody leads drew attention to this issue at a local level.

  - Immigration had produced operational instructions setting out the need to comply with the ISS.

- NHS England had built in the need to share information as part of operation of SystmONE. However, more work was needed to understand whether health practitioners were aware of this issue as a priority.

- The College of Policing had incorporated the ISS into the draft Authorised Professional Practice on custody/ detention for police.

- *Secretariat to discuss provision of most recent data with NOMS:* NOMS had advised that although the Panel could have informal access to unpublished information about deaths in prison, it would not be possible to update the spreadsheet for the most immediate quarter's data.

- TH advised that he had written to Sue Hemming and Malcolm McHaffie at the CPS Special Crime Division inviting them to attend the Panel meeting and to give a presentation on their work on deaths in custody. Sue Hemming had declined to meet but provided a great deal of information, including a very useful flowchart, on the work of the CPS. TH asked Panel members for comments on the letter: The Panel raised concerns that the CPS took too long to update families about decisions to prosecute; that the Panel should ask for an update on the progress of the forum for families about deaths in custody, and also to request timescales against CPS actions and figures on performance and outcomes in relation to investigations and convictions on death in custody cases.
  Action 2: Secretariat to draft letter to CPS requesting further information.
  [Secretary's note: letter to CPS was sent 1 October 2014.]

3. Feed back from co-sponsor meeting on 8 September

3.1 TH provided a summary of the co-sponsor meeting held earlier in the week. This was essentially an accountability meeting with the main point of discussion being the work of the Panel. TH had gained assurance from co-sponsors that the Panel could continue to deliver on the workplan as it existed at the moment. There would be opportunity later in the meeting to discuss the plan in detail and including any amendments needed.

3.2 Co-sponsors also discussed terms of reference for the Panel and Board – this was tied in with the Triennial Review which was due to start in April 2015. TH stated that in his opinion it was not worth amending the TOR a few months ahead of the Review as it would look at these aspects anyway.

4. Panel work programme

Developing a strategy to guide future IAP projects
4.1. TH explained that the Panel was pursuing several disparate pieces of work and that GT had given some thoughts to how the work could be delivered alongside a strategic description of what the Panel was trying to achieve. GT stated that he had looked over the workplan and recommendations. One of the main themes to emerge was a lack of resources in custodial organisations to take action forward. GT also noted that some projects rightly focused on improvements to the processes around safer custody rather than seeking outcomes from organisations and this may change over time. He proposed that the Panel could take a more strategic overview of their work, which would help guide priorities and to set objectives in areas where they can make

most difference. The Panel discussed the process and how they would show the effectiveness of their work. The Panel also felt that although there had been some successes the work of the Panel was not recognised widely and that perhaps they needed to publicise or raise their profile in order to be more effective. LM suggested that she would draft a strategy document in liaison with GT to inform discussion for the next Panel meeting. This would also be a useful tool to feed into the Triennial Review.
Action 3: Secretariat to work with GT on strategy document for next Panel meeting.

4.2 TH advised that the Panel would need to look at next year's plan at the meeting in December. There were areas of the plan which currently needed to be developed. One of these areas was equalities; MM stated this was an important area and she would help to fortify the workplan. Although it should cover all protected characteristics, MM thought race was particularly important as, a decade on from some high profile deaths in custody, the situation did not appear to have improved. There continued to be disproportionate representation of black males in rates of mental health detention and the use of restraint. LM recommended the need to identify what could be achieved this year and agree to organise a meeting between the Secretariat with MM and DC to prepare a paper for the Ministerial Board meeting in February. PL asked whether there was a need to conduct a literature review, which would be discussed at the meeting. .
Action 4: Secretariat to set up meeting with MM and DC to prepare a paper on equalities for Ministerial Board in February.

Review of progress on existing projects
4.3 Ensure common principles reflected in custodial organisation guidance and understand impact on safer restraint: RS advised that there was little to be gained in pursuing organisations for their implementation outcomes of the Common Principles. Organisations had already stated that they would comply with the principles and it was therefore time for the Panel to focus its efforts elsewhere. They may come back to a review of the principles as practices in this area develop.

4.4 Develop proposal on use of Taser data: the Secretariat had circulated a data capture form designed by the Met Taser Reference Group. This led to a discussion about the use of tasers in hospital wards by the police, and Panel members' experience of their increased use. TH expressed concern that although they were currently used only as a last resort and in exceptional circumstances, there was a danger that continued use could lead to them becoming normalised, which would be particularly concerning in hospitals. It was agreed that the Panel needed more statistics on the use of tasers in hospital settings.
Action 5: Secretariat to obtain data on the use of tasers in mental health hospital wards.
(*Secretary's note: CQC responded on 6 Oct – in their annual report 2012/13 tasers were reported to have been used six times that year. On three further occasions (all on non-secure wards) the Taser was presented but not fired. A paper will be circulated to the Panel.)*

4.5 Mental Health Literature Review: University of Greenwich had produced a literature review on mental health and deaths in custody although they had been unable to find sufficient literature to enable the Panel to draw definitive conclusions about the next steps in this area. TH stated that although the review was helpful in confirming the Panel's views they would now need to consider priorities for this project. LM explained that there was a small body of evidence to show that mental health training for staff would be beneficial for detainee wellbeing as well as for staff and that it may be a

possible future workstream for the Panel to promote organisations' efforts to support the mental wellbeing of their own staff.

4.6 Information Flow through the CJS: The Panel had followed up the University of Greenwich study by contacting individual organisations, including NOMS, NHS England and Immigration, to discuss the next steps for ensuring staff act upon the information sharing statement.

4.7 Cross Sector Learning: The Office of the Chief Coroner had now developed a fully searchable, publicly accessible, record of coroners' preventing future deaths (PFD) reports. This would be discussed in more detail under agenda item 7.

4.8 Article 2 Compliant Investigations: PL, MM, DC and LM had met with the Patient Safety Directorate at NHS England about their draft serious incidents framework. The Panel had raised concerns that it was not rigorous enough and did not reflect current law on Article 2. Additionally, there was still no move to set up an independent body to investigate deaths of detained patients and the guidance as to when to commission such investigations was still unclear. PL would be responding to the consultation in detail, setting out these and other concerns he had already shared with the Panel.

4.9 ACCT – summary of activity: The Secretariat had drafted a paper on activity which had taken place around ACCT including a summary of the University of Greenwich research report and NOMS' review of the ACCT process. LM stated that the paper included some projects that were ongoing and that the Panel would be discussing ACCT in more detail at the December meeting in order to agree next year's plan.

4.10 Panel contributions to reference groups: TH acknowledged that all Panel members also sat on a variety of other groups and forums. He asked all members to notify the Secretariat about such memberships and advised that they should also note them in their Declaration of Interests forms.

4.11 Quarterly data updates: LM asked whether these were still of value to the Panel. After discussion it was agreed that the Secretariat would still collect and circulate the data but it would not be placed on the agenda for discussion unless there was something exceptional to report.

5. Mental health and policing

5.1 LM had circulated a paper summarising a range of work that was being conducted in this area to ensure the Panel were aware of relevant projects, including Liaison and Diversion; Street Triage and the HMIC thematic inspection of vulnerable people in police custody. A range of projects were due to complete or report in early 2015 and this was an important area for the Panel to be aware of.

5.2 MM advised that TH would also be speaking at a summit on Mental Health and Policing that Black Mental Health UK was organising with the Home Office, later in the month.

6. Update on Research Projects - Statistical Publication for 2013 data

6.1 DJ advised that a roundtable was held in June. This had brought all the contributing organisations together to clarify and explain the rationale for their data collection and the classifications. It had been a very positive meeting in terms of sharing understanding. A useful conversation had taken place about comparing rates of deaths

and it had been decided that this was not necessarily useful information to compare across all sectors.

6.2 DJ explained that the University had started putting together the release and now had a skeleton structure in place. They were proposing to do a more in-depth analysis at chapter two than they had done previously. He advised that there was a slight discrepancy in the NOMS data which provided different age bands than previously used but the Secretariat were liaising with NOMS about this issue. The timescale for publication of the final report was planned for end of October 2014 although this would probably slip to November given demands from other Panel projects.

6.3 GT would lead on behalf of the panel for the statistical publication. Discussion took place about concerns with the data and particular tables that should form part of the final report. TH asked all panel members to feedback further comments to the Secretariat.
Action 6: Panel members to feedback to Secretariat about content for the statistical publication.

7. Role of Panel in receiving and disseminating learning in future - Preventing Future Death Reports

7.1 The Chief Coroner's Office had started to publish Preventing Future Death (PFD) reports on their website for the first time. Some responses had also been published but this was on a discretionary basis. The Chief Coroner's Office did not have the resources, however, to conduct an analysis of common themes arising from the PFD reports. The Office had agreed to mark up cases where it was known that the individual had been detained under the Mental Health Act because there was currently a broad 'mental health' heading.

7.2 TH stated that individual organisations would be responsible for implementing learning from reports written specifically but that the Panel could have a role to play in drawing out cross sector learning. Panel and Secretariat resources were also limited but a possible alternative model may be to commission a body to undertake the analysis on behalf of the Panel. TH stated that he intended to acknowledge the progress the Chief Coroner's office had made but would argue that there was a need to publish *all* responses in order to show transparency and to enable follow up on implementation of lessons learned. Locating responsibility for picking up on themes from PFD reports and feeding back to Inspectorates would be a discussion for the panel meeting in December.
Action 7: Secretariat to prepare a paper for Panel on options for analysis of PFD reports and to follow up with Office of Chief Coroner regarding their plans for publishing responses to reports on their website.

8. The Mental Capacity Act – CQC input

8.1 TH welcomed Kim Patience and Kim Shepherd from CQC. They had been invited to speak to the Panel about the CQC role in monitoring the Mental Capacity Act (MCA).

8.2 KM gave a summary of the role and responsibilities of the CQC. KS explained that they had just published *Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards* annual report for 2012/13. The Deprivation of Liberty Safeguards were introduced in 2009 and were part of the Mental Capacity Act 2005. They are used to protect the rights of people who lack the ability/mental capacity to make certain decisions for themselves.

8.3 The report looked at the legislation for the Deprivation of Liberty Safeguards and inspections the CQC had carried out against the Safeguards. Deprivation of

Liberty Safeguards applied to all settings in which individuals were being provided with care by a registered Health and Social Care provider. However, most of the information available to CQC came from care homes and hospitals. KS advised that the CQC was informed when a death occurred of a patient under the Mental Health Act, and that although this should happen when a patient was subject to the Deprivation of Liberty Safeguards, the process was less clear because there was no legislative requirement for providers to report the deaths. The House of Lords review of the MCA had shown that Deprivation of Liberty Safeguards were not widely understood and as a result applications were patchy and data about deaths of patients subject to Deprivation of Liberty Safeguards was unreliable. For this year's report the CQC had been gathering information from a wide range of sources. CQC Inspectors were also checking, during the course of their usual activity, to see if anyone had been deprived of their liberty illegally. Following the Supreme Court judgment, (*P v Cheshire West and Chester Council* and *P and Q v Surrey County Council)* they had seen a 10% increase in applications and were hoping that there would also be an improvement in the notifications about deaths. The CQC did not have a right to enter a patient's home to undertake an inspection; in these cases the inspectors would check the systems and processes of the provider by examining office files and arrangements for staff training.

8.4 TH thanked KP and KS for attending the meeting and stated that this presentation had highlighted the need for a better framework for enabling CQC to have access to data on patients subject to DOLs, including death notifications. The Panel would consider whether it would be helpful to make a recommendation to the Ministerial Board to enable improvements on data collection.

9. Any other business

9.1 There was no other business to report.

10. Date of next meeting

10.1 Wednesday 10 December 2014 at 10am – 1.30pm

Action points

1: Secretariat to arrange for MM and MA-Y to attend/observe HOMES training.

2: Secretariat to draft letter to CPS requesting further information.

3: Secretariat to work with GT on a strategy document for next Panel meeting.

4. Secretariat to set up meeting with MM and DC to prepare a paper on equalities for Ministerial Board in February.

5: Secretariat to obtain data on the use of tasers in mental health hospital wards.

6: All panel members to feedback to Secretariat about content for the statistical publication.

7: Secretariat to prepare a paper for Panel on options for analysis of PFD reports and to follow up with Office of CC again regarding their plans for publishing responses on their website