Independent Advisory Panel on Deaths in Custody

Minutes of the Independent Advisory Panel (IAP) meeting held on Wednesday 8 May 2013 in Conference Room 8, Clive House, 70 Petty France, London SW1H 9EX between 10.00am - 1:30 pm

Attendees: Lord Harris of Haringey (Chair), Deborah Coles, Professor Richard Shepherd, Professor Philip Leach, Professor Stephen Shute, Matt Leng (Deputy Head of Secretariat - minutes) and Alice Balaquidan.

Apologies: Simon Armson, Dr Peter Dean.

1. Welcome and minutes of the last meeting

The Chair welcomed Panel members to the eighteenth meeting of the Independent Advisory Panel (IAP) on Deaths in Custody. The Panel agreed the minutes of the previous meeting were an accurate record. Matt Leng reported that the Chief Coroner was unable to attend the meeting due to matters arising with coroner training. Matt said the Chief Coroner would like to meet the Panel to discuss their specific recommendations, once his support team was in place. Deborah Coles said that it would be helpful if the meeting could be organised prior to July 2013, when the implementation of reforms to the coroner system contained within Part 1 of the Coroners & Justice Act 2009 would come into force. **Action 1 / 8.5.13: Matt Leng to organise meeting between the IAP and the Chief Coroner.**

2. Action log

(i) Use of force working group

Matt Leng said that he would be attending a scoping meeting with members of the Association of Chief Police Officers (ACPO) Self Defence, Arrest and Restraint Group and the Independent Police Complaints Commission (IPCC) on 15 March 2013 to explore the issues in this area and to discuss an approach to developing a national justification for the use of force data collation by police forces. Attendees reported how they used the data to change use of force policies and procedures to lead to safer restraint practices. The data was also used to determine whether current restraint equipment was effective and represented value for money.

A meeting is now being organised for June 2013 involving more senior practitioners and the Panel. Invites have been sent to Dame Anne Owers, Chair of the IPCC; Chief Constable Alex Marshall, Chief Executive of the College of Policing; Nick Hardwick, Her Majesty's Chief Inspector of Prisons; Commander David Martin; ACPO restraint lead and Superintendent Paul Davies, Lead Staff Officer at HMI Constabulary. The meeting will be a chance for attendees to discuss the benefits identified at the March meeting; identify additional benefits and potential risks to developing the justification and to agree an approach to re-submitting the recommendation to the Ministerial Board later in 2013.

The Chair said that whilst the original recommendation was made to the Home Office, there may be scope for other bodies to mandate this requirement, for example, the College of

Policing or the Association of Chief Police Officers (ACPO). This would be explored at the use of force meeting in June 2013. Deborah Coles said it was important that such a requirement was mandated to allow for greater transparency with use of force policies and procedures employed by police forces in England and Wales. The Chair said that as a first step, it was important to secure agreement that the date be submitted for central analysis. Follow up work could then be conducted to determine what type of data was publicly available.

The Chair added this was an area which Police and Crime Commissioners (PCC) could take an active interest in. He had written to Tony Lloyd PCC, Chair of the Association of Police and Crime Commissioners on 8 May 2013 to request a meeting and would highlight this work then. Professor Stephen Shute said that if the requirement was accepted, the organisation with responsibility for collating the data should request this data to enable a standardised analysis. He also thought this data would be subject to Freedom of Information requests. The Panel agreed that it would be important to ensure that ACPO, Her Majesty's Inspectorate of Constabulary (HMIC) and PCCs were supportive of this work.

The Chair said that Lord Victor Adebowale's independent commission into mental health and policing - which focused on how the Metropolitan Police Service (MPS) responded to people with mental health issues – highlighted how the tactics used by MPS in restraining individuals with mental health issues was of concern. The report also called for greater mental health training for MPS officers, given that dealing with individuals with mental health issues represented a core aspect of their work. *[Secretary's Note: Lord Adebowale's report can be found **here**].*

(ii) Use of Taser data

Matt reported that the Home Office Public Order Unit had responsibility for publishing Taser data. They were currently quality assuring their data, with the aim of publishing the first dataset in May 2013 *{Secretary's Note: as of 25 June 2013, the Home Office are still undertaking a data validation exercise prior to publication]*. They would be collating a wide range of data including age, ethnicity, whether the suspect had ingested drugs or alcohol and whether there were any mental health issues. Officers would have to record whether they have been specially trained on Taser or whether they are an authorised firearms officer. However, they would only be publishing data on the number of times Taser is either drawn, aimed or discharged per force. The Chair said that once the data had been published, the Panel could take a view on what data extrapolations they would like the Home Office to undertake. **Action 2 / 8.5.13: IAP to consider what data they would like extrapolating from the Home Office Taser database, once the first dataset had been published.**

Deborah was concerned at a recent article in *The Independent* newspaper, which highlighted that police had deployed Taser on patients with mental health issues in hospitals and care homes 52 times over a three year period. She was also concerned at the statement from ACPO which stated that Tasers were often "less injurious" than alternatives such as physical restraint or the use of batons or sprays *[Secretary's Note: the article can be found **here**].* The Chair referred to Lord Adebowale's report, which highlighted that in several of the cases the independent commission reviewed, Tasers were used. The MPS survey on mental health and the police reported that in 2011/12, the deployment of Tasers in 34% of the cases was linked with mental health.

(iii) Meeting with Care Quality Commission (CQC) to explore data on deaths of detained patients

Matt reported that the Chair, Professor Philip Leach, Deborah Coles and Simon Armson had met with the CQC on 4 April 2013 to discuss findings from the IAP's statistical analysis of recorded deaths between 1 January 2000 and 31 December 2011, which was published in

November 2012. Deborah said CQC referred to the development of their new review process, following the death of a patient detained under the MHA, however she was concerned at the length of time it was taking to progress this work. The Chair said he would be meeting with David Prior, Chair of CQC on 10 June 2013 and would discuss this with him.

At the meeting, CQC confirmed that currently, they were not retrospectively re-classifying those deaths where the cause of death was 'unknown' once a cause of death had become apparent following an inquest verdict. Work was underway to link the Mental Health Minimum Dataset, which includes details of all detained patients with hospital episode statistics, which detail all deaths in health and social care settings to improve the recording of causes of death. CQC also confirmed that they were not aware of any particular vulnerabilities and risks for detained female patients. CQC did have the resources to undertake a thematic review in this area, if concerns were raised by providers.

CQC also raised concerns about the lack of national accredited guidance on the use of restraint in health and social care settings, which made it difficult for service providers to develop a consistent and safe approach to the use of restraint and to train staff accordingly. There was therefore no single set of standards in place around the use of restraint against which regulatory judgments can be made. The Chair said he would raise this with Dr Mike Durkin, Director of Patient Safety at NHS England at their meeting on 24 May 2013.

CQC are in the process of developing a series of risk indicators to assure their governance processes. This work has yet to be started, but they would consider including natural cause deaths and female detained deaths as potential indicators to flag greater focus from CQC. Anne McDonald confirmed at her meeting with Laura McCaughan on 11 March that Department of Health (DH) would reconsider the re-analysis, once a resource became available within DH.

(iv) Exemption request for GOV.UK

The Digital Services Team in the Ministry of Justice (MoJ) rejected the Panel's request to be exempt from its website migrating to GOV.UK. The Chair requested the Secretariat to draft a letter to the MoJ challenging the decision. **Action 3 / 8.5.13: Secretariat to draft a letter to the Digital Services Team in the Ministry of Justice challenging the decision to transfer the IAP website to GOV.UK.** *[Secretary's Note: The Chair of the IAP will be meeting with the Digital Services Team on 11 July to discuss this decision].*

(v) Assessment, Care in Custody and Teamwork (ACCT)

Matt reported that he had met with the Head of Safer Head of Safer Custody and Litigation in NOMS to ascertain their plans for reviewing the ACCT process. The Panel would ensure that any planned work would complement underway activity.

(vi) IAP consultation event – procuring Cleanbreak Theatre Company

The Secretariat had explored procurement routes to commission Cleanbreak Theatre Company and Matt confirmed that a single tender bid could be submitted to commission their services. A discussion on whether the event should go ahead can be found in agenda item six.

3. Secretariat resourcing

The Chair reported that the recruitment process for the Head of Secretariat was still underway. Three candidates from the MoJ and National Offender Management Service (NOMS) redeployment pool and one from the Home Office had been interviewed but they had not been suitable due to lack of experience with deaths in custody. There was a

potential candidate from Women's and Equalities Group (WEG) in NOMS who had appropriate background knowledge, however Digby Griffith, Director of National Operational Services did not want her moved from WEG, given the recent increased Ministerial focus on women prisoners.

He said that the recruitment process would now move to open competition across Whitehall. He reported that this process could take up to three months to complete as sifts, interviews and completion of notice period's all had to be completed for the successful applicant. *[Secretary's Note: Claire Johnson took up post as Head of Secretariat on 3 June 2013].*

4. Update on IAP research tender

Matt Leng reported that the Secretariat received four bids from University of Central Lancashire in conjunction with Caring Solutions; University of York; University of Greenwich in conjunction with The Runnymede Trust and joint consortia of University of Oxford and University of Middlesex. These were evaluated on 29 April and clarification requests have been issued to all four regarding pricing. Depending on the clarification responses, invitations would be issued to the bidders to present their proposals on 16 May 2013. He added that successful and unsuccessful bidders would be notified soon after the presentation date and he was aiming to award the contract by the first week of June with contract commencement expected late June / early July *[Secretary's Note: The University of Greenwich and Runnymede Trust have been awarded the research contract].*

5. Update on IAP projects and preparation for the Ministerial Board on 20 June 2013

(i) Serious Untoward Incidents (SUI) reports – analysis and next steps.

Deborah Coles said it was important for the paper to highlight the lack of independence with the current investigative process for deaths of detained patients. It would be helpful if the paper compared this process, with established independent investigative processes, such as the PPO and IPCC investigations which were systematic; had clear terms of reference; were transparent and had substantial family involvement.

The Panel agreed that the sample of 18 redacted reports was sufficient to highlight areas for improvement – particularly in relation to the involvement of external investigator's and expertise; and ensuring learning from reports is implemented and shared to prevent similar deaths in future.

The Panel also agreed that the status quo for detained patient death investigations did meet Article 2 expectations. Professor Philip Leach said that whilst the IAP agreed that inquest are the primary means by which the state discharges its duties to investigate deaths in custody, it was important to emphasise that the nature and extent of the investigations carried out before the inquest are also of critical importance, as the findings from this will influence the direction of the inquest. **Action 4 / 8.5.13: Secretariat to amend the paper in light of discussions at the IAP meeting.**

The Panel thought the variable quality of the reviews conducted by Trusts suggested that guidance should be developed to promote greater consistency and to provide guidance on how to ensure investigations are Article 2-compliant where relevant. The Panel agreed that NHS England should lead on this with input from CQC given their significant experience of undertaking regulatory visits to health and social care establishments and of reviewing Serious Untoward Incident reports. Furthermore, the Coroners & Justice Act 2009 promotes the importance of Rule 43 reports reflecting the capability of these reports to have an impact on preventing similar deaths in future. The Chief Coroner - who will oversee reforms in the Act - should also provide input to the development of the guidance to ensure that the importance of learning from deaths is embedded in the guidance. Matt said he would include the recommendation and circulate the draft paper for consultation with NHS England, CQC

and the Chief Coroner. **Action 5 / 8.5.13: Secretariat to include the Panel's recommendation in the paper and consult with NHS England, CQC and the Chief Coroner.**

(ii) Revised common principles on the use of restraint – update and next steps.

The Panel discussed the revised draft of the common principles for the safer use of restraint. Deborah Coles thought it was important for the principles to emphasise that restraint could lead to the death of an individual and that whilst the principles referenced the dangers of using restraint on individuals with underlying physical health conditions, restraining individuals with mental health issues posed similar risks. The Chair thought it was important to emphasise that the vital signs of the individual being restrained (that is airways, breathing and circulation) should be assessed as soon as possible after the incident has started and monitored throughout. Professor Stephen Shute added that more clarity with the principles could be achieved if they were divided into sections, which would allow them to be referred to by staff more readily. Professor Richard Shepherd agreed to produce an amended version of the principles for circulation to Panel members prior to the Ministerial Board. **Action 6 / 8.5.13: Professor Richard Shepherd to produce an amended draft of the principles for circulation to Panel members.**

Deborah added that it would be important to determine an engagement strategy for the principles. Matt Leng said that there would be an accompanying communications plan for the principles. The principles, once approved, would be published on the IAP website and proactively communicated to the practitioner & stakeholder group. Custodial organisations and investigatory bodies will be asked to implement use of the standards using their own communications channels and policy approval methods. The principles would also be communicated to third sector organisations and monitoring bodies.

(iii) Summary of Rule 43 recommendations

Matt Leng reported that the Rule 43 summary table had been discussed by the Panel at their meeting in September 2012. Deborah Coles said the number of repeated recommendations made during inquests highlighted a lack of impact from organisations in addressing persistent deaths in custody issues, for example, problems with information sharing. Professor Stephen Shute agreed and said it would be helpful to discuss this at the next Panel meeting to determine how the Panel should communicate their concerns about the lack of impact Rule 43 recommendations were having in leading to positive change. **Action 7 / 8.5.13: Secretariat to include an agenda item on Rule 43 recommendations for September 2013.**

Matt added that the Secretariat would organise a meeting with the Chief Coroner, once his office was fully staffed, to discuss the IAP's recommendations relevant to his remit. One of which was made to the Board in October 2012 and was for the IAP, in conjunction with the Chief Coroner (and Board members) to identify organisations that should be routinely copied in to Rule 43 reports in order to monitor implementation of learning. Furthermore, the Chief Coroner was assuming responsibility for collating all Rule 43 recommendations from the MoJ. A dedicated resource was in the process of being recruited to conduct thematic analysis of the recommendations. Matt said the Panel could explore the progress of this work when they met with the Chief Coroner and ascertain whether his office could focus on an analysis of responses from organisations to Rule 43 reports concerning death in custody cases. **Action 8 / 8.5.13: IAP to ascertain whether the Chief Coroner could conduct an analysis of organisations responses to Rule 43 reports from death in custody cases.**

(iv) Quarterly deaths in custody data

The Panel discussed the quarterly death in custody statistics between 1 January 2013 and 31 March 2013 and Rule 43 recommendations and narrative verdicts that had been made in the same time period.

(v) Preparation for Ministerial Board meeting – 20 June 2013

Matt Leng reported that Damian Green, Minister of State for Policing and Criminal Justice was chairing the Board on 20 June. He added that Dr Mike Durkin, Director of Patient Safety; Ann Sutton, Director of Commissioning and Christine Kelly, Assistant Head of Offender Health at NHS England would be attending and had agreed to provide an overview of how the work of NHS England interfaced with the Ministerial Board. The Chair would be having an introductory meeting with Dr Durkin on 24 May to highlight areas of the Panel's work with relevance to the Patient Safety Directorate at NHS England.

Furthermore, at the Ministerial Board in February 2013, Frances Crook from the Howard League for Penal Reform raised an issue about learning from near deaths. Richard Bradshaw, Director of Offender Health, thought the IAP could consider how learning from near deaths could be dealt with systematically across the custodial organisations. The Panel agreed that they would consider this, once the Secretariat was fully resourced. **Action 9 / 8.5.13: IAP to consider the issue of learning from near deaths once the Secretariat was fully resourced.** The Panel would also be presenting their common principles on the safer use of restraint for Board endorsement and their SUI analysis. Professor Philip Leach and Professor Richard Shepherd agreed to attend the Board to present their work.

6. Discussion of IAP national stakeholder conference

The Panel agreed that given the current reduction in the Secretariat's capacity, it would not be feasible to proceed with the national stakeholder event on 17 October 2013. *[Secretary's Note: This event has been postponed until February / March 2014. An exact date will be circulated in due course].*

Deborah highlighted her concerns at the way in which the Ministerial Board and in particular, the IAP is presented by the co-sponsoring departments as a body with significant resources and powers to undertake significant pieces of work. Professor Stephen Shute agreed and said this could cause mismanaged expectations

7. Any other business

Deborah Coles reported that Dr Silvia Casele's independent external review of the IPCC's investigation into the death of Mr Sean Rigg, who died in August 2008, was due to be published on 17 May 2013. She added that there had been a number of Rule 43 reports in recent weeks concerning people with mental health issues who had died following police contact. She reported to the Panel that the inquest into the death of Mr Jimmy Mubenga was also due to start week commencing 13 May and was expected to take eight weeks.

8. Date, time and venue of next meeting

The Chair confirmed that the next IAP meeting would be held on Tuesday 10 September 2013 between 10.00am and 1.30pm in Clive House, 70 Petty France, London, SW1H 9EX.