THE HARRIS REVIEW
Independent review into self-inflicted deaths in custody of 18-24 year olds

Harris Review Panel Meeting 17
10:30 – 16.30, 5th February 2015
5.68B, 5th Floor, 102 Petty France, London, SW1H 9AJ

Present: Lord Toby Harris (TH), Dinesh Maganty (DM), Graham Towl (GT), Stephen Cragg (SC), Philip Leach (PL), Meng Aw Yong (MAY), , Richard Shepherd (RS), Matilda MacAttram (MM), Deborah Coles (DC), Deborah Browne (DB), Robyn Malan de Merindol (RM) Graham MacKenzie (GM)

For Item 5: Dr Matthew Tovey, Dr Sunil Routhu and Dr Ambreen Aslam

Item 1: Minutes of meeting 29 January 2015

1. The minutes were agreed as a true record.

Item 2: Action log

2. DB updated the meeting on progress against actions. She brought the panel's attention to Action 96, concerning the need to get further information on Safer Cells. The answer provided in the NOMS submission does not provide all the information that was asked for, but it was agreed that it was now clear that there was no useful purpose in pressing any further for this information as NOMS do not have it. The situation could be reflected in the report with appropriate recommendations.

Action 119: Panel to respond to the revised request for their declaration of interest statements as soon as it is circulated.

Item 3: Testing of Key Themes

3. The meeting discussed potential headings and sub-headings for each section, and it was noted that some sections would need to look at pre- and post-custody aspects as well as during custody. Where appropriate, a policy context will be provided.

(Secretary's note MM joined the meeting)

4. The voices of young adults, case studies and families will run through the report along with quotes from other stakeholders where appropriate.

Action 120: Panel to identify any quotes that they consider particularly powerful. Key themes will be assigned to individual panel members to focus on.

Action 121: Secretariat to speak to BBs to request that they ensure that the key issues from the jury and the coroner are included in the case summaries.

(Secretary's note RS and DM joined the meeting)

5. Changes and additions to the proposed themes were discussed.

Action 122: Secretariat to provide revised sections on regime, culture, etc.

Action 123: PL to provide material to describe the legal context for the report.

9. It was agreed that further thought will need to be given to the size, tone and language of the report as it is developed.

Action 124: DC to provide information on the National Preventative Mechanism.

Action 125: Secretariat to email panel with details of how they should input to the respective sections by midnight 12 February.

11. TH said that he is prepared to meet with individual stakeholders to sense and fact check as necessary.

12. The panel will need to consider who they will want to speak to again to test and sense check recommendations.

Item 4: Consideration of NOMS further response

13. TH said that he was impressed by what NOMS had achieved in two weeks and that the Review will accept this as the NOMS submission when it is referred to in the report.

Action 126: Secretariat to find out about the research commissioned into the increase in male self-harm being conducted by the NOMS Commissioning Strategies Group.

Item 5: Final report on Clinical Reviews

14. TH thanked the Clinical Review (CR) team for the work that they had done for the Review and for coming to present their research.

15. The team talked to their report which consisted of an audit of the quality of the Clinical Reviews against the National Patient Safety Agency Standard (NPSA 2010) and NHS England's Serious Incident Framework (March 2013), and a thematic review of the Clinical Reviews.

16. Additional points in discussion:

- Families were not involved in any of the CRs, which apart from being in breach of the Standard affects their overall quality;
- The team did not look at whether there was any change in the quality of the CRs over time but had noted that some issues were bad throughout;
- The Serious Incident Framework was not designed for use in prisons;
- Some of the CRs were only a page or two long and one was a post mortem report;
- Some of the people who carried out the CRs were not qualified to do so;
- Meaningful engagement with the prisoner has to continue beyond the closure of the ACCT document;
- There should be a protocol for closing an ACCT;
- ACCT needs to be re-framed so that it is not just about self-harm but also about vulnerability;
- The appropriate professionals need to identify what should be included in the ACCT Care Plan and then to support the prisoner.

Action 127: Researchers to provide the BAME breakdown for prisoners with bi-polar disorder, which cases they identified as 'violent and an additional table on latency from self-harm to self-inflicted death.