Minutes of the twentieth Ministerial Board on Deaths in Custody
21 October 2015
Home Office, 2 Marsham Street, London SW1P 4DF

Attendees:

Mike Penning	**- Minister for Policing, Crime and Criminal Justice (Chair), HO**
Ben Gummer	- Minister for Care Quality, DH
Andrew Selous	- Minister for Prisons, Probation and Rehabilitation, MoJ
Anne McDonald	- Deputy Director, Offender Health & Mental Health Legislation, DH
Deborah Coles	- Co-Director, INQUEST
Dame Anne Owers	- Chair of Independent Police Complaints Commission (IPCC)
Victoria Bleazard	- Care Quality Commission (CQC)
Juliet Lyon	- Prison Reform Trust
Miv Elimelech	- Home Office (for Head of Police Integrity and Powers Unit)
Graham Towl	- Independent Advisory Panel on Deaths in Custody
Nick Ephgrave	- National Policing Lead, Custody
Kate Davies	- NHS England
Fiona Grossick	- NHS England, (by telephone)
Mike Durkin	- NHS England, Director of Patient Safety
Catherine Shaw	- HM Inspectorate of Prisons (for Nick Hardwick)
Clare Checksfield	- Immigration Enforcement, Home Office
Lorraine Atkinson	- Howard League for Penal Reform
Digby Griffith	- Director of National Operational Services, NOMS
Rachel Atkinson	- Deputy Director Reducing Reoffending, MoJ
Lord McNally	- Chair, Youth Justice Board
Nigel Newcomen	- Prisons and Probation Ombudsman
Peter Thornton QC	- Chief Coroner
Heather Hurford	- HM Inspectorate of Constabulary
Christine Kelly	- NHS England
Rosie Hanna	- Equality Rights and Decency Group, NOMS
Louis Appleby	- Manchester University
George Barrow	- Head of Secretariat to Ministerial Council
Kishwar Hyde	- Deputy Head of Secretariat to Ministerial Council (minutes)
Angie Hinksman	- Secretariat Support

Apologies

Andrew Tweddle	- Coroners' Society for England & Wales
Fiona Malcolm	- Executive Director of Operations, Samaritans
Katie Kempen	- Chief Exec, Independent Custody Visiting Association

Agenda Item 1: Welcome and apologies

1. The Chair welcomed everybody to the twentieth meeting of the Ministerial Board on deaths in custody. He advised the Board that there would be a Ministerial Statement by the Home Office that morning announcing the Chair of the Home Office Independent Review of deaths and serious incidents in police custody.

Agenda Item 2: Approval of minutes of the last meeting and update on action points (MBDC 153 and 154)

2. With one amendment the minutes the previous meeting held in June 2015 were approved. The Minister noted that all actions were complete or were on the agenda for substantive discussion.

Recommendations on Person Escort Record (PER):

4. An update paper had been circulated prior to the meeting. There were no comments regarding the update.

Independent investigations into deaths of detained patients – Update

5. INQUEST and other bodies had previously raised several issues with investigations into the deaths of detained patients. Many of these had recently been addressed by the NHS England Serious Incident Framework which set out a more robust and transparent approach to managing investigations.

6. NHSE had circulated a paper prior to the Board setting out the frame and scope of the work. An Expert Advisory Group was looking at issues of independence and rigour in investigations, and five sub-groups were looking at aspects such as quality, scale and scope, learning and support for families. The groups who were most affected were patients; family members, and staff.

7. INQUEST remained concerned about the independence feature of the investigations as the majority were still conducted locally within the same organisations. Members noted that the Expert Advisory Group had advisors on race issues and young people and that there were now independent guardians to protect whistle-blowers. Learning lessons and disseminating them to the right people was at the core of the outcome for the new group and it was important to find the right models to enable learning, with primary care being a greater challenge than hospitals (with staff on site).

10. The Chair raised the issue of call-outs to police to secure hospitals and A&E facilities and asked that this should be flagged for discussion at another board meeting.

    Action 1: DoH to make proposals on how the incidence of police call outs to secure mental health settings can be considered further by the board.

11. The College of Policing had a working group looking at this very issue and they would be invited to a future meeting.

12. DoH would welcome views from the Ministerial Board through a number of stakeholder events over the coming months including opportunities for

organisations/individuals to present evidence to the Expert Advisory Group directly.

Agenda Item 3: Short report on in-year statistics and issues from each department. (MBDC 156, 157, 158 and 159)

Deaths in Police Custody

14. The number of deaths had increased to 17 in 2014/15, similar to levels seen in the previous five years. It was unclear at this stage whether this was a trend but there was a connection between mental health and vulnerability; nearly half the people had mental health issues and over a third had problems with drugs and alcohol. Included in the recording was the number of suicides within 48 hours of release. Members raised the issue of sex offenders' suicide post-arrest may usefully be linked with circles of support.
Action 2: Secretariat/police to establish what links there are with support services for sexual offenders in the community, such as Circles of Support.

15. Better reporting may have contributed to the rise in numbers. There was an issue of police custody officers detaining people in custody suites who may be a risk but when there were no powers to keep them under PACE.
Action 3: Home Office to raise the issue of individuals being held in police cells for their own safety at the PACE strategy board.

Deaths in Immigration Detention

17. Deaths in immigration figures were generally low; since 2010 there had been 13 deaths in immigration detention, and there had been two deaths so far in 2015. Due to the low numbers it was difficult to identify any trends.

18. Immigration Service were now in the first year of NHS commissioned health services and now needed to improve screening, which was complex, as well as responses to emergencies.
Action 4: Immigration Enforcement to provide a short paper for circulation to board members, including responses to PPO recommendations.

Deaths in Prison Custody

19. The number of deaths had gone up slightly, the rise being accounted for mainly as death by natural causes - 148 deaths from natural causes in the 12 months ending June 2015.

20. There had been 56 self inflicted deaths in this half of the financial year. Extensive work had been undertaken to analyse the self-inflicted deaths since 2013 to identify whether there are discernible patterns or trends but very few had been found. NOMS were looking at self-inflicted deaths in the context of the whole prison environment and the general increase in violence. New Psychoactive Substances (NPS) were also having an impact causing individuals to be more violent towards themselves and others but it was leading to high levels of debts and intimidation.

21. The reform agenda in prison would make a significant contribution to reducing the number of deaths; the focus was on education and rehabilitation, work and

purposeful activity, keeping family relationships strong etc. Information sharing between prisons and sectors to enable better professional judgement by staff was important. There was concern about the upward trend in natural cause deaths and the relationship between the mortality rate within prisons and the general public. PPO found the rise in SIDS this year troubling, particularly as the issues were same as previous reports.

22. Natural cause deaths in prison were comparable to those in the NHS. Cancer screening was improving in prison and within prison was often the first opportunity that some people had to gain access to a doctor as a result of their chaotic lifestyles.

Deaths of detained patients

26. There were many similarities between prisoners and people detained under the Mental Health Act. Detained patients were an ageing population; people were most likely to be detained in mental health facilities from the age of 40 onwards. There was awareness that people with severe mental illness died approximately 16 years before the average; the service was working on improving the quality of life. There had been more self-inflicted deaths in 2015 than the previous year.

Agenda Item 4: Independent Review of deaths and serious incidents in police custody

30. Deaths and serious incidents in police custody have been a priority issue for the Home Office. Dialogue with the families of Sean Rigg and Olaseni Lewis had led to Ministers calling for an independent review to deliver recommendations that led to meaningful and sustained change.

31. The Independent Review of Deaths and Serious Incidents in Police Custody would examine the procedures and processes surrounding deaths and serious incidents, including lead-up, the aftermath and conclusion of official investigations. It would include a particular focus on the family liaison and support experience at all stages. It would identify areas for improvement and develop recommendations seeking to ensure appropriate, humane institutional treatment when such incidents occurred.

32. The Review would be setting up a website to invite submissions and comments from stakeholders and board members were encouraged to submit their remarks. The review would conclude in summer 2016.

Agenda Item 5: Welfare of vulnerable people in police custody - HMIC thematic inspection (MBDC 160)

33. The Home Secretary had commissioned a thematic inspection on the welfare of vulnerable people in custody in January 2014 and the report had been published in March 2015. The Home Secretary had especially wanted the scope to include, although not be limited to:
    - those with mental health problems,
    - those from black and minority ethnic backgrounds
    - children

35. The key findings from the report were that the majority of people detained by the police were treated respectfully and were reasonably well cared for. However, there were also inconsistencies in practice and procedures which led, on occasion, to some poor treatment of individuals. Poor data significantly hindered the ability of the police to identify how vulnerable people were treated in custody; and frontline police officers and custody officers were spending significant time caring for mentally unwell people. Further findings were that, despite the best efforts of staff, children and mentally unwell people were still held in custody because no alternative provision from other care services was identified.

37. The Inspectorate looked at 322 custody case records which showed high rates of repeat detentions, 254 people were released to their home address (suggesting they were not arrested for serious offences) and 11 were released direct to hospital for mental health treatment. Data collection from forces had shown that:
    - total custody throughput was reduced by 14% in the three years prior to the inspections
    - the average length of detention across all forces was around 11hrs
    - African Caribbean groups represent 3% general population but were 9% of total detained population in police custody and were 17 % of those strip-searched (in forces inspected)
    - 636 children were charged and refused bail
    - use of custody as a place of safety to detain individuals under section 136 had reduced significantly since 2013, across the forces inspected it was still ranged from 5% to as high as 52 %.

38. Recommendations were:
    - Improving accountability and transparency through better and more systematic monitoring
    - Improving vulnerability and risk assessments
    - Integrating services to support vulnerable people
    - Making better use of equality monitoring and impact assessments
    - Doing more to keep children and people who are mentally unwell out of custody

39. The police needed all the sectors to work in conjunction to make the recommendations work.
    Action 5: HMIC would report back to the Board on publication of the PEEL assessment of vulnerability.

Agenda Item 6: Suicides:Current trends (MBDC 161)

40. Professor Appleby had been invited to speak to the Board because they wanted to understand the wider trends in self-inflicted deaths and what bearing this had on the trends for self inflicted deaths in custody.

42. There were four possible explanations for the rise in prison suicides:
    - The increasing male suicide rate in the general population; although the rate in prisons was six times higher. Age groups were also significant; there was no rise among young men (those under the age of 40) but a rise amongst those aged 40-50.

- More high risk people in prison;
- Experience of imprisonment; 19% of prisoners died within 7 days of reception, 39% within a month. Prisoners reported feeling isolation, remorse, boredom etc. although these were not unique experiences to early days.
- Loss of protective factors e.g. services, staff, family. Although fewer staff was an issue, it was not simply a matter of numbers rather the relational security.

43. The Chair asked that Professor Appleby attend the next Board meeting so that current trends in suicide could be discussed in greater detail.

Agenda Item 7: Updates

45. A short update on the IAP and its leadership was due to be discussed but due to time constraints this was dealt with by a letter from the Chair to board members.

46. Secretary's note: the letter, sent 27 October 2015, stated that the Board had expected the IAP to be included in the MoJ's Triennial Review programme as an arm's length body; however the Triennial Review had been delayed to a much later date and it had been thus decided that a "light touch" review, in the form of a stocktake of the Panel's work, would be appropriate.

47. The Minister recorded the debt owed to Lord Harris, who had stepped down from the panel on 30 September, for his leadership of the panel and contribution to the Ministerial Board. He was especially grateful to Lord Harris for extending his term in 2014 to lead the review on Self-Inflicted Deaths of Young People in Custody. The Minister also recorded this gratitude to the three outgoing IA Panel members Richard Shepherd, Philip Leach and Deborah Coles.

Agenda Item 8: Date of next Ministerial Board on Deaths in Custody

49. The next meeting has been confirmed as 1 March 2016 and will be chaired by the Ministry of Justice Minister, **Andrew Selous.**