

**Minutes of the twenty-second meeting of the Ministerial Board on
Deaths in Custody
28 June 2016
Richmond House, Whitehall (Department of Health)**

Attendees:

Andrew Selous	- Minister for Prisons, Probation and Rehabilitation, (Chair) MoJ
Anne McDonald	- Deputy Director, Offender Health & Mental Health Legislation, DH
Mark Taylor	- Deputy Director, Equality Rights and Decency Group, NOMS
Clare Checksfield	- Director, Immigration Enforcement, Home Office
Miv Elimelech	- Deputy Director, Police Integrity and Powers Unit, Home Office
Digby Griffith	- Director of National Operational Services, NOMS
Nigel Newcomen	- Prisons and Probation Ombudsman
Deborah Coles	- Co-Director, INQUEST
Kim Forrester	- Care Quality Commission (CQC)
Juliet Lyon	- Director, Prison Reform Trust
Kate Lampard	- Chair, Independent Advisory Panel on Deaths in Custody
Nick Ephgrave	- Acting Chief Constable – Surrey, National Policing Lead -Custody
Kate Davies	- NHS England
Claire Slade	-Independent Police Complaints Commission
Mike Durkin	- National Director of Patient Safety, NHS England,
Peter Clarke	- HM Chief Inspector of Prisons
Lord McNally	- Chair, Youth Justice Board
Mark Cooper	- HM Inspectorate of Constabulary
Fiona Malcolm	- Executive Director of Operations, Samaritans
Katie Kempen	- Chief Executive, Independent Custody Visiting Association
Frances Crook	- Chief Executive, Howard League for Penal Reform
Andrew Fraser	- Head of Secretariat to Ministerial Council
Kishwar Hyde	- Deputy Head of Secretariat to Ministerial Council (minutes)
Angie Hinksman	- Secretariat Support

Apologies

Mike Penning	- Minister for Policing, Crime and Criminal Justice, Home Office
Ben Gummer	- Minister for Care Quality, DH
Peter Thornton QC	- Chief Coroner
Andrew Tweddle	- Senior Coroner County Durham and Darlington, and President of the Coroners' Society for England & Wales
Dame Anne Owers	- Chair of Independent Police Complaints Commission (IPCC)
Victoria Bleazard	- Head of Mental Health Policy, CQC
Christine Kelly	- NHS England
Fiona Grossick	- Medical Directorate, NHS England
Dru Sharpling	- Lead Inspector, HM Inspectorate of Constabulary

Item 1: Welcome and apologies

1.1 The Chair welcomed everybody to the meeting of the Ministerial Board on deaths in custody. He explained that the agenda would be re-arranged slightly as Kate Lampard had to leave early so her items would be taken first, and that Juliet Lyon would be joining the Board later.

Item 2: Independent Advisory Panel (IAP) Update

2.1 Kate Lampard reminded the Board that she was the interim Chair of the IAP and that her term had been dominated by the review of the Council. She explained that she felt it inappropriate for the Panel to start any new workstreams during this period and instead focussed on essential and uncontentious work. The truncated work programme consisted of:

- Planning for the 2016 Statistics Report (based on data from 2000-2015). Commissions to the respective services were made in early June, with a deadline of the end of June. This year's report was hoped to be released earlier (to be published before November 2016 Ministerial Board); to feature greater statistical analysis and would consider the practicability of including comparisons with international data
- The Panel had undertaken some planning on a number of thematic enquiries:
 - SIDs of those detained under the Mental Health Act
 - SIDs of IPP prisoners
 - risk factors of older prisoners, and
 - comparisons with international custodial data).
- Ongoing liaison with the services on operational practices, such as:
 - Police Approved Professional Practice consultation
 - Consider contributing to PER improvement project
 - Remote vital signs monitoring technology
- The Panel planned to consider monitoring compliance of:
 - The Family Liaison Common Principles
 - Restraint Common Principles
 - Information Sharing Statement

2.2 Deborah Coles was concerned that older pieces of work such as deaths of patients in mental health settings and liaison with families should not be lost. Kate Lampard assured her that work on these strands was still taking place in the background and that she was simply detailing new substantial work streams here. The new Chair would decide what work would be taken forward.

Item 3: Role and focus of the Board and IAP

3.1 IAP Stocktake

3.1.1 In autumn 2015 Kate Lampard was asked to undertake a "light-touch" stocktake of the IAP. In preparing for the stocktake she consulted a wide range of

interested parties and stakeholders as well as past and present panel members and members of the Ministerial Board. A common theme was that the IAP and Board were not working as effectively as they could or should. Kate had submitted a paper to the Secretary of State for Justice advising that:

- Departments should have strategies for combatting deaths in custody
- IAP needed to closely advise the Ministerial Board in its role of holding those strategies to account. The IAP and the Board needed to work together more effectively. For this to happen, the structure of the Board would need to be different and all members of the IAP should attend.

3.1.2 Frances Crook suggested that there should be more accountability for those in the judiciary for the sentencing decisions they made, and that magistrates should be part of the Board. It was noted that it was likely that the Magistrates Association would be willing to engage with the Board on these issues. Nick Ephgrave said that there was a review process in Surrey which could, in principle, be adopted more widely. The Liaison and Diversion programme was also working towards prevention for vulnerable children and young adults and were working well at intervention level with magistrates' courts.

3.2 Future Direction of IAP

3.2.1 The Chair explained that he had met with Ben Gummer MP about the future direction of the IAP but still had to speak to the Rt Hon Mike Penning MP. He was keen that all information should be data driven and welcomed the idea of a comparator. Ministers wanted more value and accountability from the IAP and would liaise with each other over the summer with the aim of having a new, sharper, focussed and targeted structure by the autumn. Deaths in custody was an issue important to all three departments. The Chair thanked Kate Lampard for her presentation and her leadership of the IAP.

3.3 Board members' responses to the Chief Coroner's paper (MBDC papers a-d)

3.3.1 The Chair thanked the four organisations who had responded to the request for their ideas and the Chief Coroner for his original suggestion about potential future work streams for the Board. He advised that these recommendations would be fed into the new work programme once the changes to the format and structure of the Ministerial Board had been implemented.

<p>Item 4: Approval of minutes of the last meeting and update on action points (MBDC 162 and 163)</p>
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4.1 The minutes of the previous meeting were approved, with one amendment noted. The Chair reminded Board members that these minutes, and all future minutes of Board meetings, would be published.

4.2 The Chair noted that all actions were complete or were on the agenda for substantive discussion. Actions he highlighted were:

Action 21/1: DoH to circulate to Board Members the draft memorandum of understanding between police and Health relating to incidence of police call outs to secure mental health settings, when available.

Anne McDonald explained that the MOU was not finalised as discussions were still ongoing over some legal issues. She will circulate when it is ready.

Action 21/2: Home Office to provide written feedback on the PACE strategy board discussion on the issue of individuals being held in police cells for their own safety. Miv Elimelech explained that the PACE strategy board had not discussed this at the last meeting. The next meeting is in two weeks and this item is on the agenda; Miv will report back at the next meeting. The Home Secretary had also given the go-ahead for the concordat; several authorities had already signed up and it was hoped it will be released before the summer recess.

Action 21/3: Immigration Enforcement to circulate their response to the PPO recommendations.

Recommendations made in PPO fatal incident investigation reports referred to the need to improve emergency medical response times within the immigration detention estate. Immigration Enforcement wrote to the PPO in February 2016 and circulated this note to the Board in March 2016.

Action 21/4: MOJ to provide an update on the status of Legal Aid funding for families at inquests at the next meeting.

The MOJ Legal Aid team provided an update for the Board stating that officials and Ministers were currently considering the existing arrangements; they were taking into account points raised by INQUEST at a meeting in June 2015 and previously considered by the Ministerial Board, as well as further issues raised in some recent cases. The Chair asked for a member of the Legal Aid team to attend the next meeting for a detailed update.

Action 1: MOJ Legal Aid team to attend the meeting in November to provide a detailed update on funding for families at inquests.

Item 5: Short report on in-year statistics, issues and capturing learning from each department (MBDC 174 –177)

5.1 Prisons

NOMS update

5.1.1 A paper was circulated prior to the meeting. Digby Griffith stated that the death in custody figures in prisons continued to be high and that NOMS were dealing with the same group of factors reported previously. Recruitment of operational staff was good but the service was dealing with high levels of sick absence, which was linked to the increased levels of volatility. Reducing deaths in custody was the highest priority for MOJ ministers; an additional £10 million allocation of funding had been made and would be spread across 50-60 prisons, primarily to provide more staff.

5.1.2 Regional Custody Leads had been established to spread good practice and advise governors; this was going to be particularly important for early adopter prisons of autonomy. The plan for autonomy meant that the centre would need to agree which policies need to be maintained centrally. One big success story was the closure of Holloway prison; there had been concerns that it would lead to greater violence and self-harm among the population but good local and central management meant this had not happened.

5.1.3 Board members commented that:

- The same issues were raised repeatedly by PPO, Inspectorates and inquests and there was a need to make better use of this evidence.
- Services had not been as good at follow-up and learning as they could be.
- Learning from near-misses was also very important
- Information sharing at every stage was vital and did not always happen

5.1.4 Digby noted that getting consistency across the estate was very difficult; one prison could learn from a death in their own establishment but the challenge is spreading that learning to other prisons. The Chair stated that officials and staff need to ensure that all prisons are putting good practice into use. He asked all departments to report on how they are improving their learning lessons processes for the next meeting.

Action 2: Departmental leads to report on how they ensured better learning in their updates for the next report.

5.1.5 Members asked what happened when recommendations relating to deaths in custody did not get implemented or were ignored. Digby Griffith said that prisons should implement the recommendations and Deputy Directors of Custody should ensure this is done effectively. Mark Cooper offered to share with NOMS the approach HMIC use to encourage constabularies to adopt recommendations.

Action 3: NOMS and HMIC to provide an overview of how Inspectorate recommendations which were not implemented were dealt with.

5.1.6 Mike Durkin stated that comparisons with Health were pertinent as they were now adopting a different approach after struggling to effectively learn lessons. He was grateful to Kate Lampard and Deborah Coles for their input in the Reference Group in building an investigatory model and making the lessons stick. Mike noted that they had recently appointed a new Chief Investigator formerly from the Air Accidents Investigations Branch. Mike noted that in the airlines industry (which the NHS is using as a model for investigation of incidents) accidents had decreased significantly. The Chair asked that NOMS and DoH work together to share their experience and expertise.

5.1.7 Kate Davies noted that staff in Yorkshire & the Humber had undertaken work to develop a database to log, monitor and analyse deaths in custody across the region using Clinical Review reports. She agreed to send details on the work to the Chair.

Action 4: NHS England to circulate details of Yorkshire and Humber project to develop a database for capturing information in Clinical Review reports.

(Secretary's note: Juliet Lyon joined the meeting.)

5.1.8 The Chair welcomed Juliet Lyon and announced that she had recently been confirmed as the new Chair of the IAP. Juliet stated that she was looking forward to joining the IAP, focussing on deaths in custody and felt that there was a need to engage families and the Samaritans more in processes.

5.1.9 Fiona Malcolm stated that the Samaritans had just completed their statistics for 2015/16; Prison Listeners had offered their support on 84,852 occasions and there were now 1700 trained Listeners. The Chair thanked the Samaritans for all the work they do in prisons. The Chair noted that he also wanted to see more informal support amongst prisoners outside of such institutional structures.

5.2 Immigration Enforcement

5.2.1 A paper was circulated prior to the meeting. Clare Checksfield advised that there had been significant developments since Stephen Shaw's report "*Review into the Welfare in Detention of Vulnerable Persons*" earlier in the year. A new Adults at Risk policy was making sure vulnerable people were being identified early and Immigration Enforcement were also identifying risk factors that needed further research.

5.3 Health

5.3.1 A paper was circulated prior to the meeting. Anne McDonald advised that the most recent figures contained a high number of deaths from unknown causes so it was difficult to draw definitive conclusions. The CQC were undertaking a thematic review looking at how NHS acute, community healthcare and mental health trusts investigated deaths and learnt from their investigations. NHS Improvement (established in April 2016) was the new body to start delivering interventions and would offer support on mental health patient safety through sharing learning and safety advice.

5.3.2 Deborah Coles raised concerns about children who died in mental health settings; it was noted that they were not included in the statistics because they entered the system voluntarily. The Chair requested this data for the next meeting.

5.4 Police

Home Office Independent Review of deaths and serious incidents in police custody – update

5.4.1 A paper was circulated prior to the meeting. Miv Elimelech advised that the latest deaths in custody statistics by the IPCC would not be released until summer 2016. The Dame Angiolini Review of Deaths and Serious Incidents in Police Custody would be concluded in July 2016; the structure of the report broadly followed the offender journey. The report would be published in summer and discussed at the Ministerial Board in November. The Chair asked for a full update on police data for the next meeting.

Action 5: Home Office to provide a full update on police data for the next meeting.

5.5.1 Lord McNally noted that U-18s were usually not separated out in any of the statistical reports so it was not possible to assess the issues relevant to this group. The Chair asked the departmental leads to provide this information in their next update for the Board in November.

Action 6: all departments to provide statistics for deaths of U-18s at the next meeting.

Item 6: Updates from members

6. 1 PPO publications on prisoner mental health and early days

6.1.1 The Ombudsman explained that these two documents were his 20th and 21st publications, but the findings repeated familiar messages from previous reports. The Chair thanked the Ombudsman for his efforts in continuing to share the learning from his investigations, and urged the services to utilise his findings.

6.1.2 Early days: this was a relatively short report which commended the good work already being done by staff during early days in custody but expressed the need to encourage staff to share information and continue to keep vulnerable prisoners under close scrutiny.

6.1.3 Prisoner mental health: this was a much bigger report and featured few surprises in the findings. The PPO listed 25 areas of learning across a range of issues. The scale of need was great and prisons should be using the list as checks to make improvements.

6.1.4 Kate Davies raised NHS concerns regarding the problems prisoners were having at HMP High Down in being able to access both on-site healthcare and community based acute services. She noted that many appointments for prisoners were being missed, and said that the NHS had written to the Governor regarding the issues. The Chair asked to see a copy of the letter.

Action 7: NHS England to forward letter between NHS and Governor of HMP High Down to the Minister's office.

6.2 Howard League paper on *Preventing Prison Suicide; perspectives from the inside*

6.2.1 The report was published on 24 May 2016. Frances Crook explained that there was little new in the report but that radical change was needed if prisons were to combat suicides. Staff experience and understanding was key and more support for staff was needed. The Chair noted that the service had been recruiting a very high quality of prison officers and that the POELT training for new officers had been extended by two weeks. Frances said that good governors empowered their staff to take control and prisons should be enabling environments.

6.2.2 The Chair stated that he had been pleased to see the good work in Aylesbury and Drake Hall with regards to their enabling environments. Drake Hall had achieved Enabling Environments (EE) accreditation from the Royal College of Psychiatrists. All Approved Premises in the National Probation Service (NPS), along with a number of individual units across the prison estate, were working towards 'EE' Accreditation – but Drake Hall was the first prison to gain accreditation for the whole establishment.

Item 7: Any Other Business

7.1 The Chair noted that the Dame Eilish Angiolini review and the Harris Review would be discussed in detail at the November meeting and felt that it was important that all Ministers should be in attendance.

7.2 Juliet Lyon announced the publication of the Prison Reform Trust's *Prison: the facts*. She also wanted to talk more substantively at the next meeting about IPP prisoners who were at greater risk of self-harm, although Digby Griffith noted the difference between self-harm and self-inflicted deaths

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

8.1 The next meeting will be held on 8 November 2016 at the Home Office in Marsham Street.