Welcome to the fourth E-bulletin from the Independent Advisory Panel (IAP) on Deaths in Custody. This extended E-bulletin provides an overview of our National Stakeholder Consultation Event, which was held in March 2011 and also gives an update on the work that has been taken forward by the Panel since November 2010.

The IAP held its first National Stakeholder Consultation Event on Tuesday 1st March 2011, which was attended by over 100 delegates. I am pleased to say that we have received very positive feedback about the day. During the event, attendees had the opportunity to hear from Crispin Blunt MP, Minister of State for Prisons and Probation who delivered the keynote speech.

A family member, whose brother died whilst at HMP Brixton in 2006, provided an overview of the experiences faced by families following the death of a relative in prison. His story served as a powerful reminder to both the Panel and to attendees about the importance of what we are all working to achieve, a reduction in the number of deaths in state custody, so that other families do not have to go through the same experience. I know that attendees greatly appreciated the chance to hear his personal account and many felt that it provided an important context to the day. After the event, the Chief Executive of the National Offender Management Service (NOMS) met with officials to discuss current approaches to family liaison services within NOMS. He has asked officials to reiterate the importance of Governors offering personal condolences to families affected by the death of a relative whilst in prison custody and asked officials to write to families following receipt of the report into the death by the Prisons and Probation Ombudsman’s (PPO) and again at the conclusion of the Coroner’s Inquest to inform them of action is being taken to address any recommendations made by the PPO or the Coroner.

The Panel welcomes these developments in ensuring that effective family liaison mechanisms are in place.

The event provided an excellent opportunity for the Panel to discuss and explore potential recommendations with stakeholders to ensure they were operationally viable. It also provided a valuable forum for the sharing of learning and best practice between agencies and organisations. Over the next few months, the IAP will be incorporating the discussions from the day into our six workstreams. I would just like to add, that we all found the day to be of incredible value and to thank all of those that were able to attend and contribute to the success of the event.

More generally, this E-bulletin provides details on the publication of the IAP’s mid term report, which provides an overview of our key achievements in the first 18 months and work priorities for the future, as well as an update on the progress of the six IAP workstreams.

Finally, I would just like to take this opportunity to offer my thanks to Jane Boys, the Head of Secretariat to the Ministerial Council on Deaths in Custody who has started her maternity leave. Jane has given the IAP enormous support during her time in the Secretariat and I know I can speak on behalf of the six Panel members in wishing her well for the future. Laura McCaughan took up the post of Head of Secretariat on 1st April 2011.

I hope that you find the issues covered in this E-bulletin interesting. As always, should you wish to comment on any of the issues raised or have any questions, please feel free to contact the Secretariat who will ensure that any comments are passed onto me and the other members of the Panel.

Thank you,
The IAP’s First National Stakeholder Consultation Event

On Tuesday 1st March 2011, the IAP held its inaugural National Stakeholder Consultation Event, which was the first time that the IAP had brought members of its virtual Practitioner and Stakeholder Group together. The event was very well attended with a wide range of stakeholders from the police, prison service, government departments and agencies, third sector organisations and legal and medical experts, to ensure that a broad spectrum of views were captured.

On Tuesday 1st March 2011, the IAP held its inaugural National Stakeholder Consultation Event, which was the first time that the IAP had brought members of its virtual Practitioner and Stakeholder Group together. The event was very well attended with a wide range of stakeholders from the police, prison service, government departments and agencies, third sector organisations and legal and medical experts, to ensure that a broad spectrum of views were captured.

The event was an important signal of the IAP’s commitment to consult and engage with our stakeholders in order to collect, analyse and disseminate relevant learning about deaths in custody. The IAP was keen to ensure that delegates participated fully and they were invited to attend two of six workshops running on the day. Each workshop was led by a member of the Panel to cover their workstream. The aim of the workshops was to:

- Introduce the work of the IAP and present stakeholders with an opportunity to influence the direction of the IAP’s six working groups
- Provide the IAP with an opportunity to discuss and explore potential recommendations with stakeholders to ensure they are grounded in operational reality and identify additional areas where the IAP’s focus could be effective
- Offer an opportunity to share best practice and any lessons, which may have cross sector applicability and provide a networking opportunity for attendees

Below is an overview of the key issues and themes, which arose in the workshops. The workshops were subject to Chatham House rules so the discussions do not necessarily reflect official departmental positions, but they are reflective of real concerns and issues raised by those present:

Use of Physical Restraint Workshops

These workshops, led by Professor Richard Shepherd, examined the effectiveness of restraint training and practice available to operational staff. Key themes and issues from these workshops were:

- A holistic approach to restraint needs to be adopted to ensure that all necessary approaches to controlling a violent situation have been exhausted before the use of physical restraint. The importance of de-escalation during these situations needed to be highlighted.
- There was a perceived disconnect between what was taught in the classroom and the deployment of restraint within an operational environment. There was concern that training taught in the relatively sanitised environment of a classroom did not adequately prepare staff for real life situations and that the quantity and frequency of training needed increasing.
- An investigation into restraint incidents resulting in the near death of individual would benefit from greater focus, given the potential for learning that could be extrapolated from these incidents. The importance of learning from these ‘near misses’ was crucial to gain an understanding of why the application of restraint in these cases did not result in death.
- Concerns that learning from restraint deaths was not disseminated quickly after a death. Delays in the PPO investigations and coroner’s inquests meant there was a real danger that learning was not captured and shared quickly.
Cross Sector Learning Workshops

These workshops, led by Deborah Coles, examined the effectiveness of existing investigation mechanisms in ensuring that cross sector learning was disseminated quickly following a death in custody. Key issues from these workshops were:

- Some attendees thought there was real value in the collation of the recommendations contained in coroner's Rule 43 reports and narrative verdicts and the IAP’s efforts in collating these were welcomed. However, it was critical to identify whether the recommendations contained in these reports had been implemented by the organisations in question.
- There would be value in establishing a formalised process for sharing lessons and learning. This could take the form of an annual report, which brings together the key learning points from investigations, coroner’s Rule 43 reports and inquest hearings.
- There was concern that criminal justice agencies did not have an effective way of translating any learning gleaned from a death in custody into operational instructions, which could be monitored and audited by inspection agencies.
- Delays to coroner’s inquests were seen as a major barrier preventing the quick and effective sharing of learning.
- There was concern that there were no structures in place to promote any learning from clinical reviews into deaths in prison custody, which feed into the development of the PPO investigation reports.

Deaths of Patients Detained under the Mental Health Act Workshops

These workshops, led by Simon Armson, examined the specific issues relating to the deaths of patients detained under the Mental Health Act (MHA) and in particular, the deaths of patients that occurred as a result of natural causes. Key issues from these workshops were:

- There were concerns over the lack of purposeful activity for patients in secure mental health settings, which could be problematic in allowing patients to ‘stagnate’ and how this could potentially cause further health problems. A programme of activity could help reduce poor health and stress levels in patients.
- There would be value in exploring further work on the obesity and metabolic syndromes present in patients detained under the MHA.
- There needed to be a better mechanism to promote the swift dissemination of learning following an unnatural cause death. Of additional concern were whether the reviews following these deaths were compliant with Article 2 of the ECHR.
- For natural cause deaths, there were four key areas to consider: prevention, intervention, emergency response and continuity of care. Attendees believed that there were a small number of natural cause deaths, which could be preventable.
- There was some concern over the ineffective information exchange of a patients medical history files when they are transferred between mental health trusts.
Information Flow through the Criminal Justice System Workshops

This workshop, which was led by Professor Stephen Shute, examined how information about an individual’s health needs and their risk of suicide / self-harm could be more effectively shared during their journey through the Criminal Justice System. Key issues from these workshops were:

- There was a poor understanding of medical confidentiality throughout primary care trusts and criminal justice agencies. Attendees believed that clarity needed to be provided as to what information could be shared with whom. There was concern that medical confidentiality provided some staff with a ‘shield’ to hide behind, justifying their decisions not to share risk information.
- Joint clinical supervision between clinical and discipline staff has attracted some success and was highlighted as an example of good practice.
- SystmOne, which is a national clinical IT system in prisons, was highlighted as an example of good practice. However, some attendees thought that there needed to be greater clarification for staff on how to enter risk information on the system. Currently, some Primary Care Trusts (PCTs) and prisons were entering the same risk information differently on SystmOne, which created inconsistent and contradictory records.
- Issues were raised about the sharing of information with escort contract agencies. There was concern that they often received very limited information, which had impact on their risk management strategies.
- Attendees were of the opinion that the creation of a clear and concise national protocol for sharing information, supported by training, would help provide clarity for custodial and healthcare staff on how to share information between agencies.

Risks Relating to the Transfer and Escorting of Detainees Workshop

These workshops, led by Dr Peter Dean, explored the particular risks relating to the transfer and escorting of detainees and the training provided to staff. Key issues from these workshops were:

- There was concern that there were cultural barriers in existence between criminal justice agencies, which prevented the effective sharing of information. This lack of information could in turn lead to difficulties in preparing effective risk management strategies for the detainee.
- Attendees believed there was confusion over the disclosure of information that is considered medically confidential during the transfer process. Staff needed simple guidance on their duties and obligations when sharing information.
- A narrative on the Person Escort Record (PER) form would be of benefit in drawing escort staff’s attention to any imminent risk of self-harm or suicide. Some Attendees thought that this could be more readily understood and interpreted by escort staff.
- There were concerns about police budget reductions, which meant that resources sometimes only allowed for one police officer to transfer a detainee in a caged vehicle, rather than the Centrex recommendation that there should be an officer specifically there to monitor the detainee during transfer.
- A lack of oversight during the transportation of juveniles to local authority accommodation was highlighted. If a young person is remanded to local authority care, there is no regulation on the suitability of vehicles to use. Usually, a standard, unmodified car is used, which can cause problems should the juvenile need to be restrained during transfer, given the interior space restrictions.

The discussions were of real value to Panel members in helping them to identify any further issues, several of which had cross-cutting relevance, which needed to be taken into consideration for each of their workstreams. Where there are cross-cutting issues, Panel members will work together to explore the development of potential recommendations to address these. Some of the issues listed above are already being explored by the IAP and these are referenced later in the E-bulletin. At the next IAP meeting in May 2011, the Panel will discuss its work plan for 2011/12 and will seek to identify suitable approaches to focus on the remaining issues where possible in this work plan.

IAP Publish Mid-term Report

The IAP has been in operation since 1 April 2009 and is now over 18 months into its initial three-year term. The Panel thought this was an opportune moment to publish its
mid term report, which reflects on the achievements of the Panel over the last eighteen months, as well as committing to work that will be taken forward in the remainder of its term. The report provides an overview of the creation of the Ministerial Council on Deaths in Custody and the IAP, a statistical overview of all recorded deaths in state custody between 1st January 1999 and the 30th September 2010, progress made by the IAP and future areas of work the IAP would like to focus on throughout 2011/12.

The report is available to download here and if you have any comments about the contents of the report, please feel free to contact the Secretariat via the contact page on the website. It is the intention of the IAP to publish an end of first term report in February 2012, which will provide an evaluation of our key successes during our first term.

Update on the IAP Working Groups

Below is a summary of the progress made by each of the IAP’s six working groups since the last E-bulletin:

Cross Sector Learning

A procurement exercise is underway to commission an analysis of Rule 43 Reports and narrative verdicts relating to deaths in state custody in order to identify how the existing systems in place for sharing the learning could be strengthened and any key learning points for cross sector dissemination.

This work will commence in April 2011 and a report with findings and recommendations will be available in October 2011.

The Secretariat has also been collating the responses from the coroners’ questionnaire, which was issued in conjunction with the Coroners Society in August 2010 to obtain accurate data on the numbers of outstanding inquests into deaths in custody and the reasons for any particular delays. The returns are currently being analysed. The IAP are planning to work with the Coroners Society in 2011/12 to develop a series of recommendations to address these delays.

Deaths of Patients Detained under the Mental Health Act (MHA)

In March 2011, the workstream led by Simon Armson presented a paper to the Ministerial Board on Deaths in Custody, which summarised the emerging findings and recommendations to the Department of Health. The IAP recognised that a large amount of work has already been undertaken in an attempt to reduce suicide and other types of unnatural cause deaths amongst those detained under the Mental Health Act (MHA) and this workstream will explore further ways of reducing deaths arising from unnatural causes. However, the IAP believed that it was also important to consider deaths that occur as a result of natural causes particularly those that could be considered as premature. This workstream will explore the work being undertaken to improve the physical health of detained patients and identify any particular areas where further work is required.

The IAP recognised that further analysis of the data held by the Care Quality Commission (CQC) on the natural cause deaths of those detained under the MHA would be beneficial in order to identify the most common causes of death and commissioned Offender Health to undertake this work. The analysis found that for all age groups, the most frequent natural cause deaths were due to pneumonia (23%), myocardial infarction (20%) and pulmonary embolism (8%). The results also suggest that there were a small number of deaths (on average 15 per year) due to medical or surgical emergencies, which could be considered as potentially avoidable. The IAP have developed a number of recommendations to address these specific issues and more generally to improve the physical health of detained patients and will work with the Department of Health to explore options for progressing these over the next few months.

Article 2 Compliant Investigations

In October 2010, Professor Philip Leach met with officials from the Prisons and Probation Ombudsman (PPO) to discuss the work being taken forward with Offender Health (DH) to assess the clinical quality of a sample of clinical reviews into deaths in prison custody. The IAP believes that further work is required to consider whether the quality, timescales for completion and level of independence of clinical reviews into deaths in prison custody are adequate and will be undertaking further meetings in April 2011 to explore how to take forward joint work with the PPO and Offender Health throughout 2011/12.
Deaths in Custody

The timing of this work is opportune given the potential implications of the NHS reforms, being introduced as part of the Health and Social Care Bill 2011, on commissioning arrangements for these reviews.

The IAP believes that the National Patient Safety Agency (NPSA) good practice guidance on the ‘Independent Investigation of Serious Patient Safety Incidents in Mental Health’ should be revised in order to strengthen its focus around Article 2 investigations and will be discussing this suggestion with the Department of Health. Further consultation will also be undertaken with stakeholders in 2011 to determine whether the production of cross sector guidance on the principles of Article 2 compliance would be helpful for the custody sectors. Finally, Professor Leach is currently exploring options to undertake joint research with Deborah Coles and Simon Armson’s workstreams into the investigation of deaths in the secure mental health settings. The findings and recommendations from this group will be presented to the Ministerial Board in June 2011.

Use of Physical Restraint

In January 2011, the Chair of the IAP wrote formally to the Co-sponsors of the Ministerial Council, the Youth Justice Board (YJB) and the Restraint Accreditation Board (RAB) to request confirmation of their official position on the viability of implementing the specific recommendations contained in the IAP’s cross sector restraint report that related to their work (click here to download report with recommendations). The IAP has received a number of responses so far, and will continue to work with these departments to progress the recommendations further.

Following an open procurement exercise undertaken in January 2011, Caring Solutions (UK) Ltd, a mental health and learning disability consultancy company was commissioned to undertake a review of the medical theories and research relating to restraint related deaths. It is hoped that the findings of this review will be used to improve consistency and practice across custodial sectors in relation to the use of physical restraint and feed into the development of a set of common principles covering its use, which the IAP hope all custodial sectors will adhere to as a minimum. An interim report will be presented to the Board in June 2011, with the final report due in October 2011.

The Secretariat has also undertaken an initial analysis of the recommendations contained in 13 Rule 43 reports, narrative verdicts, investigation reports and Mental Health Act Commission Post Inquest Reports relating to those deaths where restraint was identified as either a direct cause or a contributory factor. Additionally, an analysis was conducted by the IPCC of 22 cases where the use of restraint was either directly linked, or may have contributed to the death of an individual has been used to inform this work. Emerging issues from this work to date have highlighted:

- Concerns around the prolonged application of prone restraint techniques on individuals;
- Lack of staff awareness of the medical dangers associated with the use of restraint;
- In nine of the IPCC cases, drugs and alcohol were listed as factors in the death with all drug factors connected to illicit drug use and;
- From the IPCC cases, there were 13 where the individual was displaying mental health issues at the time of their death, with eight of these individuals diagnosed with paranoid schizophrenia.

A paper summarising the results of this work will be presented to the Board in June 2011.

The Risks Relating to the Transfer and Escorting of Detainees

In December 2010, Dr Peter Dean met with officials from the Metropolitan Police Service (MPS). At this meeting, a number of specific issues were highlighted in relation to the restrictions on movement in the back of police vans, which can potentially cause problems in road traffic accidents or when a detainee needs to be restrained. Concern was also raised about the lack of specific guidance on risk assessment procedures for the transfer of detainees in police response vehicles. The IAP are considering the benefits of issuing a questionnaire to individual police forces in 2011/12 to identify whether the vehicle safety issues encountered by the MPS are replicated across other forces and any further design issues for consideration.

In February 2011, an additional meeting was held with officials from the MPS, London Ambulance Service and the Association of Chief Police Officers (ACPO) to discuss issues around the transfer of detainees subject to Section 136 of the Mental Health Act (MHA). A key issue highlighted was the difficulty faced by the MPS in acquiring medical clearance from health staff to detain individuals at a designated place of safety, as healthcare staff would not admit anyone without first receiving a second medical opinion. It was argued that these delays could lead to the prolonged transportation of a detainee by the police in a vehicle that was unsuitable for the provision of medical services, which could increase the level of risk for the individual involved. This workstream is due to present its emerging findings and recommendations to the Ministerial Board in June 2011.

www.independent.gov.uk/iapdeathsincustody
Information Flow through the Criminal Justice System (CJS)

In March 2011, Professor Stephen Shute’s workstream presented a paper to the Ministerial Board. The paper, which contained three recommendations, provided a summary of the main mechanisms for collecting and sharing information about an individual’s health needs and risk of suicide/self harm and an assessment of the effectiveness of these mechanisms.

One of the main concerns highlighted in the paper was the difficulties encountered by custodial staff when trying to make sense of the many different sources of guidance on information sharing protocols, which have contributed to an air of uncertainty as to what kind of information can be shared, with whom and when. Misunderstandings about the duty of confidentiality and data protection have also proved to be major barriers to effective information sharing. Further concerns in the paper drew attention to the existence of cultural barriers between agencies, which prevented the timely sharing of information when an individual is transferred into the custody of another criminal justice agency. The paper also suggests that the risk questions included on the Person Escort Record (PER) could benefit from further refinement in order to identify those individuals at very high risk of self-harm/suicide more effectively.

The IAP will work with the Ministerial Council’s Co-sponsors and partner agencies to explore opportunities to take the recommendations contained in the report forward in the next few months.

Contributing to the IAP’s Website

The IAP’s intention is that everyone with an interest in preventing deaths in custody should have the opportunity to contribute to the IAP’s work. If you have a relevant news story or research article that you feel may be of particular interest to stakeholders, please feel free to contact the Secretariat at: iapdeathsincustody@noms.gsi.gov.uk.

News

IAP Publish their Mid-Term Report

In March, the IAP published their mid term report, which provides an overview of the key achievements made by the IAP since its creation in April 2009, along with proposed next steps the IAP wish to take in the next 18 months: http://iapdeathsincustody.independent.gov.uk/news/iap-publish-their-mid-term-report/

IAP Meeting

The ninth meeting of the Independent Advisory Panel (IAP) on Deaths in Custody took place on the 7th March 2011. At this meeting, the IAP discussed preparations for the sixth Ministerial Board on Deaths in Custody, feedback on the IAP’s first national stakeholder consultation event, the roles and responsibilities of private sector custodial providers and family liaison work. The Panel were joined by Dr. Jason Payne-James, a forensic physician who provided an overview of his work. The minutes of this meeting will be placed on the website, once they have been approved at the next IAP meeting in May 2011.

INQUEST Publish Guidance for Bereaved Families

INQUEST have published an online version of ‘The Inquest Handbook – A Guide for Bereaved Families, Friends and their Advisors’. To read the guidance, please visit their website, under the Help and Advice section: http://www.inquest.org.uk/

Learning the Lessons Committee Publish latest Bulletin

In February, the Learning the Lessons Committee produced its latest bulletin on lessons drawn from reports and information on investigations which the Committee receives from the Independent Police Complaints Commission (IPCC) on a regular basis. In this bulletin, several of the cases are custody related including learning on detention under section 136 of the Mental Health Act: http://www.learningthelessons.org.uk/Pages/Bulletin12.aspx

NOMS Publish Response to ‘AA’ Investigation

UK NPM Publish their First Annual Report
In February, the UK National Prevention Mechanism (UK NPM) published their first annual report on the 8th February 2011. The NPM was established following the UK’s ratification of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT):
http://www.justice.gov.uk/inspectorgates/hmi-prisons/2536.htm

Mental Health Guide for Criminal Justice Staff Published
In January, a new mental health guide to help frontline criminal justice staff was produced after practitioners at a mental health charity joined forces with criminal and justice health agencies.

IAP Publish their Report of the Cross Sector Restraint Workshop
In January, the IAP published their report of the cross sector restraint workshop, which was held in May 2010. The report provides a summary of the key discussions from the day, along with the resulting recommendations:

Death in Prison Custody 2010 Statistics Published
In January, the Ministry of Justice published their annual statistics on the number of deaths in prison custody:

IPCC Publish Death in Custody Statistics for 2009/10
In December 2010, the Independent Police Complaints Commission (IPCC) published their annual death in custody statistics for 2009/10. You can also access previous year’s statistics by visiting the IPCC website via this link:
http://www.ipcc.gov.uk/Pages/reports_polcustody.aspx

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IAP Publish Deaths in Custody Parliamentary Log
In December 2010, the IAP published a parliamentary log, which contains details of all parliamentary business concerning deaths in state custody from Parliament and the devolved assemblies. The log will be updated on a monthly basis:

IPCC Publish their Deaths in Police Custody Research Study
In December 2010, the Independent Police Complaints Commission (IPCC) published a major study of 333 deaths in police custody between 1998/99 and 2008/09:
http://www.ipcc.gov.uk/Pages/deathscustodystudy.aspx

NHS Publish Statistics on Patients Detained under the Mental Health Act
In November 2010, the NHS published a report which summarises information about uses of the Mental Health Act Of 1983 (MHA). It includes information from high security psychiatric hospitals as well as from other NHS service providers and independent hospitals:

PPO Publish Report on Learning from Circulatory Diseases
In November 2010, the Prisons and Probation Ombudsman (PPO) has published a new report today entitled ‘Learning from PPO Investigations: Deaths from Circulatory Diseases’. The report summarises 115 investigations into prisoner deaths due to heart-related conditions that occurred between January 2007 and December 2009:

Home Office approves Appointment of Interim Chair of the IPCC
In November 2010, Len Jackson was approved as the Interim Chair of the IPCC. He replaces Nick Hardwick who became Her Majesty’s Chief Inspector of Prisons:
http://www.ipcc.gov.uk/news/Pages/pr_081110_lenjacksonappointment.aspx

Next Issue
The next issue of the e-Bulletin will be published in July 2011.