IAP paper on embedding recommendations to prevent deaths in custody

Theme: Levers to improve performance

Related Dame Elish Angiolini Recommendations: Chapter 17 of Dame Elish's *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* addresses the importance of learning lessons and embedding recommendations. It makes several recommendations including the creation of an Office for Article 2 Compliance. This was rejected by the Government in its initial response to the report - this is a position the IAP would like to see kept under review. However, the Government has acknowledged the need for greater focus to be given to embedding recommendations successfully in order to prevent future deaths and meet its human rights obligations to protect life.

Task:

- Address repeat recommendations by identifying those with most impact to reduce deaths in custody and embedding them

Recommendations

Board members are invited to:

i. review the paper and:
ii. consider how best to circulate and, if minded, endorse the paper among the custodial services
iii. consider the IAP's plan to:
    - embark on a discrete consultation exercise with custodial services at selected establishments/places of detention to clarify and, where possible, help managers and staff to deal with barriers to embedding recommendations as well as identifying barriers outside of the control of establishments and advising accordingly on ways to improve compliance and accountability
    - undertake further discussions with members of the Ministerial Board and, subject to their views, review the rollout and outcomes of this work before October 2019

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Successfully embedding recommendations to prevent deaths in custody

Introduction

The role of recommendations

1. The custodial investigatory, monitoring and regulatory bodies, henceforward referred to as scrutiny bodies – such as the Prisons and Probation Ombudsman, HM Inspectorates of Prisons and Policing and Probation, Independent Office of Police Conduct, Care Quality Commission – perform a vital role. As part of this, they make hundreds of recommendations each year to the custodial services. Coroners' Reports to Prevent Future Deaths must be taken into account. Add to these reports issued by the National Preventive Mechanism, Independent Monitoring Boards, Lay Visitors, Custody Visitors, NGOs (particularly, INQUEST) and individual health trusts and the number of recommendations increases exponentially.

2. The multiplicity of recommendations reflects both the web of organisations involved in scrutinising the state's responsibilities and the importance that these organisations place on preventing deaths in custody. The recommendations made by such scrutiny are wide-ranging, with a focus both on matters of national responsibility and policy and specific issues in individual establishments/places of detention. They can require consideration and implementation by managers and staff through to Ministers as part of their human rights obligation to take positive steps to protect life.

3. Recommendations, and the associated action plans that follow them, are tried and tested techniques for driving improvement and focussing attention on the things that require improvement. Many members of the Ministerial Board on Deaths in Custody will be aware of particular reports, recommendations and actions that have improved prisons, hospitals, approved premises, immigration centres and police custody and helped to safeguard lives.

The issue of repeated recommendations

4. Notwithstanding the value offered by the current scrutiny system, the Ministerial Board on Deaths in Custody has discussed many times the problem of the same recommendations being made repeatedly over the years – sometimes to the same establishments. The Board's frustration with services and establishments seemingly unable to embed some recommendations, and concern about the context in which they are trying to operate, has become a recurring theme at Board meetings.

5. Dame Elish referred to this concern in her report[1]:

> *"Recommendations from past reports have not always been followed up in a coherent or joined-up way. There is no single national body that can monitor progress and maintain the momentum and pressure for institutional change. As a result, progress tends to be piecemeal.* ***The same failings, and the same issues, appear to manifest themselves time and again****."* (Emphasis added).

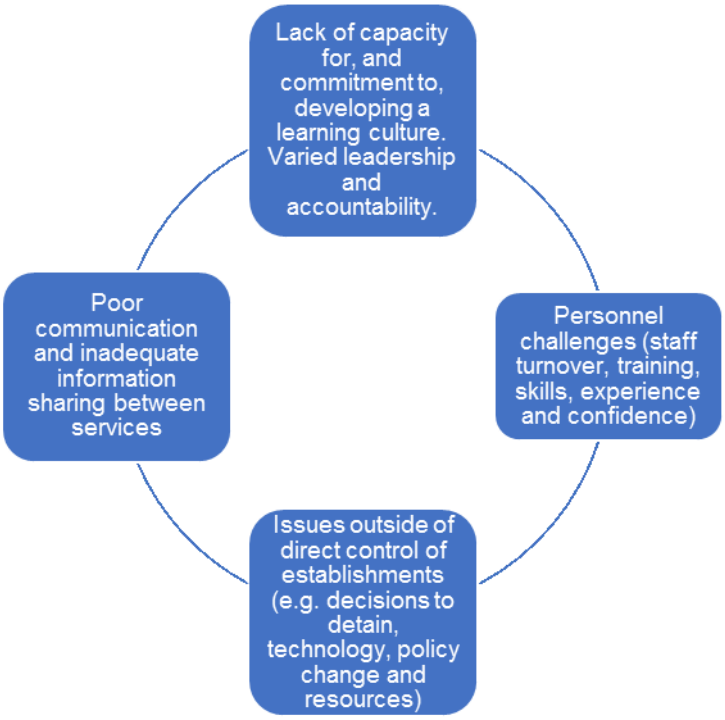
6. Understandably, there is widespread appetite for some remedy to the seeming cycle of *recommendation – implementation – failure – recommendation*. Dame Elish's recommendation for an Office for Article 2 compliance was rejected initially by the Government, in favour of a more collaborative approach involving the members of the Ministerial Board. The IAP is prepared to contribute to these efforts, and this paper aims to set out a constructive structure for those involved in responding to recommendations taking into account the context in which they are working. The IAP would like however to see the recommendation for an office of Article 2 compliance kept under review.

What has inhibited the successful embedding of recommendations to date?

7. Staff and heads of scrutiny bodies were asked to consider what has prevented the successful embedding of recommendations to date. They cited the following areas as the main fetters on progress:

Figure 1: The main barriers preventing successful implementation of recommendations – identified by the IAP in discussion with stakeholders.

[1]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf



Overall aims of addressing repeat recommendations

8. The overall aim of this piece of work is to reduce deaths in custody by:

(a) collating the core recommendations (in discussion with scrutiny bodies) that, if successfully implemented, would have the most impact in preventing such deaths,
(b) identifying effective methods of embedding recommendations in practice,
(c) consulting organisations and individuals and helping them to prioritise when faced with a raft of recommendations,
(d) providing the Ministerial Board with collected recommendations and methods for embedding them that can be discussed and added to over time
(e) identifying recommendations that fall outside the control of managers of custodial settings and formulating advice to Ministers.

Process undertaken to date

9. The IAP has been exercised by the problem of repeated recommendations for a number of years and, under Lord Harris' chairmanship, undertook some initial work to scope out the main issues in this area. The IAP ran a workshop in May 2015 with a range of stakeholders to discuss both the barriers to learning and what has worked well. Attendees raised the lack of supportive learning cultures, failure to learn from near misses and the need for appropriate professional judgement. Lord Harris reported to the Ministerial Board in June 2015 that the main barrier was a lack of an environment of openness, and reflected that other sectors must have better methods which the public sector can learn from. The Ministerial Board welcomed the work, and suggested that the IAP undertake a literature review of relevant

organisational learning – which was not carried out until the IAP re-engaged with the issue in 2016 (see below).

10. The Harris review published in 2015 recommended establishing a requirement on the part of the State to respond to all families after an inquest into a death in custody as to the action that has been taken and the lessons learned to prevent future deaths. The potential impact of such a measure and the wider scope to learn from bereaved families merits further discussion by the Board.

11. Since the appointment of a new, permanent chair in September 2016, the IAP has focussed on how to solve the problem of repeat recommendations. In discussion the former Prisons Minister, Sam Gyimah MP encouraged the IAP as follows:

> *"I would welcome a different piece of work that focuses on drawing out the 'top ten lessons' and more specifically to understand better how these can be embedded in practice across the estate. … I hope that this approach will then form a key part of your focus going forward…."*

12. The synergies between this work and the issues raised by Dame Elish have led this work stream to be included in the Ministerial Board's work programme established in response to the Angiolini review. It should be noted that this work is designed to be complementary to other work on improving learning; the IAP does not have the resources or remit to address learning from recommendations on its own and looks forward to working collaboratively with members of the Ministerial Board.

13. The IAP's recent work on this subject has included:
    - Reviewing the work, the Panel undertook in 2015 to address this issue.
    - Drawing relevant material on the key recommendations to safeguard life from consultations with people in prison: 'Preventing the deaths of women in custody' March 2017 with contributions from 60 women prisoners and 40 health and justice professionals. 'Keeping Safe – preventing suicide and self-harm in custody' December 2017 produced in partnership with Inside Time, Prison Radio and the Samaritans with contributions/solutions from 120 men across 60 prisons set in the context of recommendations made by scrutiny bodies.
    - Developing an initial list of 'top ten' recommendations to test with the Panel, departmental officials and wider stakeholders.
    - Holding a workshop on 17 January 2018 with scrutiny bodies to focus on the central recommendations that need addressing and to examine implementation – what helps, what hinders?
    - Producing a research paper on organisational learning for the February Board.
    - Developing a draft model following the Board and testing this again with scrutiny bodies.
    - Setting out a revised model in an outline paper for June Ministerial Board
    - Completing this paper following discussion at the Board and comments made by newly appointed expert members of the Panel.

A cross-cutting list of core recommendations

14. The IAP has reviewed scrutiny reports, held discussions with stakeholders across the custodial system and hosted a workshop with representatives from scrutiny bodies to consider the most relevant recommendations that cut across all custodial sectors. Following these discussions and subsequent consideration at the Ministerial Board, the IAP believes that the thematic recommendations listed below are central for organisations concerned with preventing all types of death in all custodial sectors.

- **Effective leadership and accountability** at all levels, including by Ministers personally, is vital in order to:
  - Ensure staff in custodial organisations see safety as an overarching priority and are clear about their responsibilities in this regard.
  - Ensure custodial organisations develop healthy learning cultures which include listening to, and learning from, people held in custody and their families
  - Drive change and improvement in all levels of the organisation.

- **End the use of police or prison custody as a place of safety** – people should only be held in police or prison custody because of a relevant criminal justice issue, not because it is deemed to be a safe environment for them. If people are experiencing a mental health crisis, this should be treated as a medical emergency.

- **A focus on the quality of care should be prioritised**, going beyond just saving lives/keeping people alive – for long-term improvements in custody attention to safety needs to be directed at holistic care and support, not the minimum to keep people alive.

- **Appropriate levels and skills of staffing should be established** – custodial services and establishments require sufficient trained, experienced and kind multi-disciplinary staff to keep their populations safe.

- **Clear, effective and open information sharing should be developed** between all the services involved in custody – this should include an emphasis on sharing information where relevant to safeguarding lives and working to include a single, shareable medical record system.

- **Health commissioning and provision must address the complexities of the population entering custody** – this should include effective drug and alcohol treatment and care, specific response to NPS and timely transfer to mental health facilities with an adequate number, and efficient use of, in-patient beds and continuity of care.

- **Effective and consistent emergency response** procedures and actions must be in place in all custodial settings.

- **The identification of risk factors** when an individual arrives in custody - this implies sufficient training, time and support is given to reception and early days' periods and that there is planned management of transitions including transfer and release or discharge from hospital.

- **Meaningful activities, time out of room or cell, peer support and contact with family** must be prioritised as direct supports to safety.

- **Effective implementation of existing procedures** (particularly suicide and self-harm prevention procedures) should be undertaken as a priority, monitored regularly and assurance given.

Organisational learning

15. Given the number of reports, recommendations and action plans made across England and Wales each year, simply developing further recommendations or advice in isolation will not be conducive to establishing and maintaining high performance over the long-term and keeping people safe. Therefore, having identified which current recommendations have the most impact, the IAP is concerned with considering how organisations can best be enabled to embed learning more effectively.

16. Underpinning all of the identified recommendations is the need to encourage a better organisational learning culture in each custodial sector, and their individual units. Organisations in which managers and staff set out to develop a learning culture are inherently better placed to implement recommendations and embed learning successfully, as they go through the process of understanding how and why something has happened, and are then able to act upon this understanding. These organisations will be prepared to listen to, and take on board the views of people detained in custody and of bereaved family members. The IAP is conscious that some custodial sectors and establishments are likely to be more advanced learning organisations than others, and would encourage those that are to share their expertise and good practice more widely.

17. Over the course of the IAP's discussions with stakeholders, the importance of organisational learning was raised several times. It was also flagged by the stakeholders who attended the Panel's earlier workshop in 2015. During the 2018 meeting with scrutiny bodies, the following comment was made by an attendee:

> *" it is clear the lessons are all out there but the key is to encourage organisations to become effective learning organisations."*

Embedding the recommendations

18. The IAP is conscious that, while it may help with prioritisation, simply collating the recommendations outlined above, is not sufficient to address the problem

of repeated recommendations. Paragraph 7 discusses the factors the IAP has been made aware of that inhibit the successful implementation of recommendations. These are generic barriers which affect all services and establishments – to greater or lesser degrees – when they come to try to implement recommendations.

19. Addressing these barriers should make it easier to implement whichever recommendations the custodial organisations are facing at that particular time. In essence, the IAP aims to understand and help remove the barriers to implementation – rather than telling services how to implement any one specific recommendation.

Barriers

Lack of capacity for, and commitment to, developing a learning culture

20. Clear leadership and accountability and a commitment to developing a learning culture were highlighted by stakeholders as an essential basis for learning hard lessons and implementing recommendations. The IAP's paper on organisational learning was submitted to the February Ministerial Board, and the main points are summarised below:

- Effective organisational learning is not simply problem solving – it is learning about learning.
- Organisations under pressure – or faced with failure – can become defensive, block out criticism and ascribe blame to others. Scrutiny bodies referred to 'implementation fatigue' and 'unhelpful resistance to multiple recommendations'. This reaction, while understandable, limits the ability of the organisation to address openly the problems it faces, prevents it seeking help and risks failings being perpetuated.
- Even where organisations do seek to develop better learning practices, they can resort to rationalising effective learning as simply a function of motivation and access – essentially assuming that effective learning will result from giving people the opportunity to learn (e.g. through reviews or training). This leads to the development of organisational structures and formal reviews which, without changing how the organisation and people within it think and learn, will not be successful.
- The internal reasoning processes in individuals are resilient but defensive – with the primary motivation of most people being error-avoidance. Focussed, objective discussions are needed to bring out the premises, inferences and conclusions that have driven behaviour, if the organisations are determined to change behaviour in the long-term.

21. Although the potential benefits of an effective learning culture are encouraging, the steps to inculcate this in busy, sometimes beleaguered, demand-led environments will be complicated by the day-to-day pressures services experience. The IAP is aware that the NHS has made strides towards a different culture with a focus on learning rather than blame, and the IAP would encourage the Board to learn from the members with advice and examples of Trusts that have engaged in reflective learning rather than damage limitation.

Personnel challenges

22. The need for sufficient, good and trained staff to work in custodial settings is a prerequisite for safe and secure establishments. The IAP would endorse work undertaken across all departments and services to ensure that this takes place.

23. The importance of getting staff/prisoner relationships right was cited in the Keeping Safe consultation more than any other factor in preventing suicide and self-harm. One prisoner wrote:

> *"..you get the odd officer who really takes care and really wants to do something but there should be an officer on every landing who spends at least ten to twenty minutes with one prisoner at a time through the time he is there and understand him and get to know him rather than him being just a number and him just open the cells and unlocking it and then it might be easier for the prisoner to approach him and the officer can see if the prisoner's down or not by getting to know him."*

24. The IAP would also recommend that custodial establishments consider where avoidable pressures on staffing exist, and what actions could be taken to address them. For example, managers in the criminal justice system could consider the amount of times detainees are moved around the estate – reducing transfers potentially reduces risk, as well limiting the amount of time staff are involved in such activities.

25. However, noting that systems change, service funding and macro-staffing decisions are beyond the scope of individual establishment heads (which is where the responsibility for implementing many of the recommendations lies), the IAP will continue to offer support and advice to those who carry overall accountability to meet human rights obligations to protect lives.

26. Services within establishments need to make the best use of the staff they have. This means both maximising the amount of time they are in work (i.e. minimising sick absence) and maximising the impact they have while at work. In terms of the first point, a report produced for the Department for Business, Innovation and Skills[2] explained that if the average employer is able to raise their employees' subjective wellbeing (SWB), the theory and available evidence suggest that they are likely to see improvements in the performance of their workplace:

> *"The empirical literature indicates three causal mechanisms through which higher levels of SWB can bring about higher job performance. The first is by affecting employees' cognitive abilities and processes*

[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/366637/bis-14-1120-does-worker-wellbeing-affect-workplace-performance-final.pdf

− enabling them to think more creatively and to be more effective at problem-solving. The second is by affecting employees' attitudes to work − raising their propensity to be co-operative and collaborative. The third is by improving employees' physiology and general health − improving their cardiovascular health and their immunity and enabling speedier recovery from illness."

27. Specific features that could help improve SWB include autonomy, supportive supervision, clarity on objectives and opportunities to develop their skills.

28. In terms of the second point – maximising the impact of staff decisions – there are a wide range of ideas that exist in fields such as psychology, behavioural economics and management that leaders could explore to see if any have applicability to the challenges they are currently facing. Examples of these include:

- Using behavioural nudges[3] to encourage the right actions:
  - **Report that others are doing the desired behaviour**: pointing out that a beneficial behaviour is more prevalent than expected can increase levels of that behaviour. What options does this finding present within, and between, sectors and establishments?
  - **Make the desired behaviour easy**: for instance, if pension enrolment is automatic, more people will contribute to their pension. Even very small barriers can have a big impact on behaviour; reducing the number of painkillers that shops could sell is estimated to have reduced the number of deaths by suicide. Are there elements of behaviour in the workplace that are currently 'opt in' that could be changed to 'opt out'?
- Giving those in custody a voice[4]:
  - **Taking information and ideas from people in custody** is a helpful way of gaining knowledge on concerns from those directly experiencing them. This can help ensure that staff time and resources are directed towards the areas that are of most concern to those in custody.
  - Furthermore, giving people in custody an opportunity to speak and influence the way a custodial establishment is run provides a useful safeguarding function in itself. Feedback from prisoners to the Keeping Safe consultation included:

    "It would be really nice for me to know that I have helped and contribute to the solutions, as opposed to complaining about things and getting down"

    and

[3] More information on nudges can be found at the Behavioural Insights Team (BIT) (a social purpose company jointly owned by the UK Government; Nesta and the employees)

[4] *Exit, Voice and Loyalty* by A, Hirschmann, 1970 explains that allowing 'voice' in a system can prevent 'exit' (in the case of custody, this could mean isolation, self-harm or suicide).

"I would be willing to help no matter what it takes because dieing in a cell lonely, angry, bitter and upset is no way for anyone to leave this earth."

- **Learning from bereaved families.** The Harris, Farmer and Angiolini reviews all recommended learning from, and responding respectfully to, bereaved families as a way in which hard lessons can, and must, be learned. In terms of positive impact, the IAP maintains that this could do more than many other measures to prevent future deaths in custody.

Inadequate information sharing between services

29. Information sharing between, and within, services is a perennial concern of those working in, reporting on or working with custodial services. The Royal College of Nursing stated in its response to the 'Preventing the Deaths of Women in Custody consultation*: "IT systems are still not sufficiently robust to ensure safe transfer of critical information to keep people safe from harm."* While improvements have been made in numerous areas, it remains a source of frustration to those working with individuals in custody that they are often asked to make highly significant decisions with incomplete information. This feeling is often exacerbated by the knowledge that relevant information could be made available with better coordination or confidence on the part of the different services involved.

30. The IAP produced an Information Sharing Statement in 2011 which reminded custodial staff of the need to share information on a detainee's risk of self-harm or suicide. This statement - which outlines the risks of not sharing information and how the Data Protection Act, subject to concomitant parameters, does not prohibit the sharing of information – was supported by the Information Commissioner and the General Medical Council. The statement was endorsed by the Ministerial Board, and the Panel subsequently wrote to service leaders to ask them to disseminate the statement using their usual communication channels. Other examples of information sharing statements[5] could also be considered for further use in this area.

31. The continuing salience of this issue – added to the potential uncertainty caused by more recent legislation[6] - suggests that this is a matter that the Ministerial Board should address as a key theme of its next work programme.

Issues outside of direct control of establishments (e.g. decisions to detain, technology, policy change, resources)

32. Issues outside of the direct control of establishments are those that need addressing either with leaders of the relevant services or, if they have cross-departmental dimensions or are systemic, at the Ministerial Board. The IAP

[5] *Consensus Statement on Sharing Information on suicide risk:* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

[6] Relevant legislation could include the EU General Data Protection Regulation and UK Data Protection Act 2018

would advocate identifying such concerns, which can then be added to the next work programme of the Ministerial Board.

Conclusion and next steps

33. The IAP hopes that, as organisations work to implement recommendations and embed learning from deaths in custody, all those with a responsibility to meet human rights obligations and take active steps to protect life will find this paper helpful. In particular, the IAP is keen that such an approach helps to reduce the risk of a series or cluster of deaths following a self-inflicted death in custody. We would encourage organisations to share learning and best practice with peers and with the Ministerial Board.

34. As the paper makes clear, many of the barriers to implementation cannot be addressed in a simple or easy manner – or by ideas from the IAP alone. They need careful thought from a range of partners, and a commitment to addressing them in a cooperative and sustained manner. This can be managed through the Ministerial Board. The IAP recommends that the prevalent concerns that it has uncovered through this work should form part of the Ministerial Board's future work programme. This should include at a minimum:

- Improving organisational learning
- Making greater use of Coroners' reports to prevent future deaths
- Learning from bereaved families and people detained in custody
- Improving staff capacity and ability to make appropriate decisions
- Improving information sharing
- Strengthening measures to ensure compliance with recommendations
- Further cross-cutting issues to be identified by services and Board members.

35. The IAP is committed to working with the Ministerial Board to address these barriers, and help protect lives in custody. Subject to the views of the Board, as a next step in this process the IAP intends to embark on a discrete consultation exercise with custodial services at a few selected establishments/places of detention to identify and, where possible, help staff to consider how best to overcome barriers to embedding recommendations. Learning from this exercise will inform the IAP's further advice to the Board.