Ministry of Justice | Home Office | Department of Health & Social Care

Independent Advisory Panel on Deaths in Custody

Work programme

August 2021 – August 2022

About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel on Deaths in Custody (IAPDC)
- Practitioner and Stakeholder Group

The remit of the IAPDC (and overall of the Council) covers deaths, natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of people detained under the Mental Health Act (MHA) in hospital and in secure health settings. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAPDC, a non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAPDC's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE chairs the IAPDC. The other members are:

- John Wadham, Chair, National Preventive Mechanism
- Jenny Talbot OBE, Prison Reform Trust
- Professor Jenny Shaw, professor of Forensic Psychiatry, University of Manchester
- Professor Seena Fazel, professor of Forensic Psychiatry, University of Oxford
- Deborah Coles, Director, INQUEST

Further information on the IAPDC can be found on its website:
https://www.iapondeathsincustody.org/

For more information on this paper – or on the IAPDC more generally – please contact: **Kishwar Hyde, Deputy Head of Secretariat, Kishwar.Hyde1@justice.gov.uk.**

Terms of reference

The Terms of the Reference for the Independent Advisory Panel on Deaths in Custody (IAPDC) are set out in Robert Fulton's *Review of the Forum for Preventing Deaths in Custody*.[1] It stated that the IAPDC will:

- Act as the primary source of independent advice to Ministers and service leaders (both through the Ministerial Board and where appropriate directly) on measures to reduce the number and rate of deaths in custody
- Consult and engage with partners in order to collect, analyse and disseminate relevant information about deaths in custody and the lessons that can be learned from them
- Commission relevant research
- Carry out thematic enquiries into areas of concern, in co-operation as appropriate with the relevant oversight and investigative bodies
- Issue formal guidance (and where appropriate set common standards) on best practice for reducing deaths in custody and state detention, both on its own authority and where appropriate under the authority of the Ministerial Board
- Monitor compliance with such guidance and standards
- Where appropriate, make recommendations to Ministers for changes in policy or operational practice, which would help to reduce the incidence of death in custody.

Strategic principles for the IAPDC's work programme

In order to prevent deaths within its remit, the IAPDC will:

Approach to advice
- seek to enable Ministers to meet their human rights obligations to protect life
- provide specific, tangible advice that can be considered and implemented by recipients
- promote the adoption and implementation of its advice

Working practices
- draw on sound research evidence to underpin its work, and identify gaps in knowledge
- build on prior work and avoid duplicating work being undertaken elsewhere
- recognise that – as a small independent non-departmental public body with limited resources – it should work strategically

Guiding principles
- consult people in custody and detention and where possible their families/significant others, and bereaved families when developing recommendations and advice.
- pay due regard to equality and diversity in its work
- work within and draw upon a human rights framework

Relationship to co-sponsoring departments and wider stakeholders
- embrace the cross-departmental nature of its remit and seek involvement at an early stage with departmental initiatives
- use representation on other Boards/groups to further influence/advise
- develop strategic partnerships and work with stakeholders to share information and knowledge, work collaboratively and appoint a lead panel member for each department/service.

[1] Robert Fulton, *Review of the Forum for Preventing Deaths in Custody*, 2008. Link: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5fc7d6fe98e12849e074b762/1606932228855/The-Fulton-Report-2008.pdf.

IAPDC's work programme for 2021/2022

The programme below outlines key IAPDC work to be delivered between August 2021 and August 2022. It includes some work ongoing from the 2020/2021 workplan.

The work is grouped under the three priority areas for the Ministerial Board for Deaths in Custody (MBDC) for the 2021/22 period, agreed by Board members in June 2021.[2] As part of a revised working model for the Board, the panel will align part of its workplan with these three priority areas, in order to provide challenge and expert advice. These three priority areas are:

1. Mental health and substance misuse
2. Embedding learning
3. Physical health and COVID-19

The panel identified the following three themes that, due to their centrality, should inform each priority area. Agreed by Board members in June 2021, these are:

a. The evidence base including collation and publication of disaggregated data according to protected characteristics.
b. Race and the impact of disproportionality.
c. The perspectives of – and learning from – people with lived experience and bereaved families.

The IAPDC workplan contains 15 projects. Seven cover multiple places of detention, while three relate specifically to prisons, two to police custody, two to immigration removal centres and one to deaths under the Mental Health Act. Progress against this workplan will be monitored monthly by the secretariat, with regular updates provided to co-sponsors.

Mental health and substance misuse

1. As part of a police leadership initiative to prevent deaths in police custody in partnership with the Minister for Crime and Policing, work with, amongst others, Police and Crime Commissioners (PCCs), health organisations, the National Police Chiefs Council (NPCC), the Independent Office of Police Conduct (IOPC) and the College of Policing to collate, disseminate and make recommendations to forces and providers on supporting people in mental health crisis and those at risk of self-inflicted death following release from police custody. **[Police]**

2. Support the Home Office to implement its action plan for preventing deaths in Immigration Removal Centres published in response to the IAPDC's report to take forward recommendations in Stephen Shaw's review of vulnerable people in immigration detention. This includes providing advice on the impact of, and response to cultural background, mental health and trauma on self-inflicted deaths and improving transfer of information across the Home Office and between Government departments. Provide advice on how to protect the lives of those held in short-term holding facilities (STHFs). **[Immigration Removal Centres]**

3. Drawing upon a range of cross-discipline expertise, publish a report from a joint IAPDC and Royal College of General Practitioners (RCGPs) initiative on substance misuse-related deaths in the criminal justice system to recommend steps to reduce such deaths

[2] Ministerial Board on Deaths in Custody, 9 June 2021, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/6102801cb3c13f3deeaa43b0/1627553820494/June+2021+MBDC+minutes+FINAL.pdf.

and improve subsequent investigations. Support services to develop enhanced data relating to such deaths in prisons and in the recently released prisoner cohort. **[Cross-sector]**

4. Provide advice to officials and ministers on the safe easing of COVID-19 restrictions in custody, with particular focus on mitigating the impact of lockdown on mental health and involving consultation with people in prison where possible. Make recommendations about the implications of 'Long COVID' on mental and physical health. **[Cross-sector]**

5. Monitor commitments made in the Mental Health Act White Paper to terminate the use of prison as a 'place of safety'. In partnership with the Prison Governors' and Magistrates' Association respectively, devise, conduct and analyse surveys of governors and magistrates to examine the misuse of prison as a place of safety, and work with the Magistrates Association and Association of Directors of Adult Social Services to examine accommodation options for vulnerable adults, including those with mental health conditions, at court. **[Cross-sector]**

6. Gather and analyse data for self-inflicted deaths and self-harm for those on remand, made particularly relevant due to the increased use of remand time during the pandemic, and for people recalled to custody. Track this data over time and present recommendations to support these particular groups in the prison population. **[Prisons]**

Embedding learning

7. Build a clear understanding of issues and trends concerning data on deaths of people detained under the Mental Health Act, including through scoping gaps in collation across relevant organisations and building understanding of demographic or causational trends to inform future work. **[Deaths under MHA]**

8. Through a sampling exercise and partner roundtables, assess trends and make recommendations for departments, services, coroners and wider partners on how coroners' Prevention of Future Deaths (PFDs) reports should be produced, collated and responded to in order to prevent deaths. **[Cross-sector]**

9. As part of the police leadership initiative, make recommendations on best practice for ensuring that learning after a death takes place is disseminated and collated - both within and across individual police forces and wider policing organisations. **[Police]**

10. Develop guidance and best practice for facilitating independent facilitation of/ involvement in lessons learned exercises following a death in the immigration detention estate, and make recommendations on how such an approach could be applied across all custodial settings. **[Immigration Removal Centres]**

11. Develop wider understanding and dissemination of 'near miss' cases across all places of detention, including Article 2 investigations commissioned by the Lord Chancellor into serious incidents in prison[3], and, working with services, independent reviewers and scrutiny bodies, make recommendations on how best to embed learning derived from such cases. **[Cross-sector]**

12. Recommend processes for, and develop guidance on, how custodial and detention services should communicate with bereaved families on action taken following a death in custody and engage them respectfully in embedding learning from such a tragic event. **[Cross-sector]**

[3] See Article 2 — Independent Advisory Panel on Deaths in Custody (iapondeathsincustody.org).

Physical health and COVID-19

13. Building on the findings of the IAPDC's report with the Royal College of Nursing (RCN) on avoiding deaths from 'natural causes' in prison, develop recommendations for reform to compassionate release policy and practice and support for those with long-term health conditions, including early diagnosis and information sharing. **[Prisons]**

14. Provide advice on the impact of the Imprisonment for Public Protection (IPP) sentence on the physical and mental health of those serving it. **[Prisons]**

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15. Work with MoJ and HMPPS to develop legislation, policy and practice guidance on a Safety Impact Assessment to be undertaken and, if necessary, steps in mitigation introduced, before any major policy decisions affecting the safety of staff and people in custody. Explore the use of this measure to protect lives across all areas of state custody **[Cross-sector]**.

Ongoing priorities

- Draw on the experience and knowledge of the stakeholder and practitioner group – the third tier of the Ministerial Council on Deaths in custody comprised of inspectorate and investigate bodies, lawyers, third sector organisations, families, academic and practitioners from custodial sectors – to inform briefings to Ministers and officials.

- Continue to develop the IAPDC website as a source of information on deaths in custody for a range of relevant groups and individuals.

- Provide evidence and advice to Parliamentary, governmental and related inquiries where relevant to deaths in custody and detention.

- Ensure that wider use is made of international data and research for all panel projects.

- Where appropriate, represent the IAPDC on relevant advisory groups and contribute to wider evidence gathering and strategy sessions across departments.

- Monitor progress against landmark reports on the prevention of deaths in custody, including the Angiolini, Harris and Shaw reviews.

- Monitor commitments made to, and recommendations in, IAPDC reports, including '*Preventing the deaths of women in prison*', and commitments made by ministers and service leads at the 2020 Keeping Safe conference convened by IAPDC, the Samaritans, Inside Time and Prison Radio.

- Monitor implementation of, and seek to further embed, recommendations made by IAPDC and the Magistrates Association regarding liaison and diversion services and use of Community Sentence Treatment Requirements (CSTRs).

Chair's overview

Since my reappointment as chair in September 2019, I am proud of the clear, independent expert advice that the panel has provided to ministers, departments and agencies on how they can meet their duty to protect the lives of people in their care. In the face of unprecedented challenges, the panel recognises and supports the considerable work that is done to prevent deaths in custody. The burden of responsibility for the safety of those in custody during COVID-19 will have weighed particularly heavily. However, we believe more can, and must, be done to keep people safe and to avoid the devastation and cost, in every sense, of each loss of life.

The panel, and those we advise, have benefitted substantially from close collaboration with partners who share our dedication to prevent avoidable deaths. In September 2020 we published our review of natural deaths in prison, led by Professor Jenny Shaw in collaboration with the Royal College of Nursing (RCN), which also incorporated insights from a wide field of experts. Among other changes, our report prompted former prisons minister Alex Chalk MP to launch work to streamline and improve compassionate release policy and practice. Elsewhere, the panel has this year published work in collaboration with the Royal College of GPs (RCGP) on substance misuse-related deaths, outlining how welcome government work on substance misuse must feature the prevention of avoidable deaths at its heart. This work has already helped inform the priorities of a forthcoming Ministry of Justice and HMPPS substance misuse strategy. Led by Jenny Talbot, the panel continues to work with the Magistrates Association to call for accelerated plans for increased provision and availability of Community Sentences with Treatment Requirements (CSTRs) in order to improve health and save lives.

The panel works closely with ministers, co-sponsoring departments and agencies to provide expert advice on how they can meet their human rights obligations to protect life. Our guidelines on how to prevent deaths in immigration removal centres, led by John Wadham and developed in response to Stephen Shaw's review into vulnerability, drew on cross-sector good practice and have been accepted for implementation by the Home Office. I have welcomed collaboration with policing minister Kit Malthouse MP on how the Home Office and IAPDC can work with key figures in police leadership to drive a reduction in the number of deaths in police custody. The panel continues to advocate for the introduction of safety impact assessments to ensure that all policy proposals affecting custodial institutions include assessment of their likely impact on the health and safety of prisoners and the staff charged with their care. We are grateful for progress made in incorporating such assessments into existing decision-making processes within HMPPS and the MoJ, and will continue to advocate for wider implementation. The new IAPDC agreement with HMPPS will ensure the panel's expert insight is drawn upon during the development of relevant new policy and practice.

The panel has delivered on our strategic principle – to consult people in custody – through partnerships with Inside Time and National Prison Radio (NPR), which built on strong relationships established through the Keeping Safe conference in 2020. The voices of people in prison during the arduous COVID-19 period have been brought to the attention of ministers and decision makers through *Keep Talking, Stay Safe*, which examined prisoner experiences during the initial outbreak of COVID-19, and *Just One Thing: prison safety and Covid-19*, which analysed how to make prison safer, both during COVID-19 and in the longer-term. We also worked with NPR and The Samaritans to broadcast Safe, a series of interviews addressing the emergence from lockdown. Listening to – and communicating with – people in detention and their families is vital to understanding the steps required to keep everyone safe.
"I'm sure there is a lot of prisoners suffering from severe anxiety, isolating in their cells not knowing when they're going to be unlocked." This statement from a prisoner guides our drive to

secure increased mental healthcare for people held in severely restricted conditions in a prison within a prison throughout the pandemic.

The panel maintains an informed influence in Parliament, the media and online. We have continued to provide expert written evidence to select committees, as well as oral contributions to the Justice Select Committee's important inquiries into both mental health and women in prison this year. Our evidence to the JSC on the Coroner Service and legal aid supported the call, now accepted by government, for exceptional case funding for bereaved families at inquests to be non-means tested. Our advice on how government should be protecting the lives of those held in closed institutions during COVID-19 – including around vaccine provision, testing, health checks, and the use of a streamlined early release scheme – was highlighted prominently in national newspapers, radio and podcasts. We regret, though, that this advice, supported by clinical, scientific and operational knowledge and experience, was not accepted by government. We have agreed to submit documents and information to the forthcoming public enquiry. The new, modernised IAPDC website is proving useful information for practitioners, policy makers and all interested parties, especially through the COVID-19 Information Hub.

We have taken clear steps to enhance the impact of the two other tiers of the Ministerial Council on Deaths in Custody, and therefore help to prevent deaths, in accordance with the principles set out in Robert Fulton's 2008 review. We have worked with the Ministerial Board on Deaths in Custody to inform plans to review its effectiveness, and it has been reaffirming to witness the high levels of commitment present within its diverse membership to drive down deaths. You will note that the panel's workplan for 2021/22 shares its focus on the three priorities agreed by the Ministerial Board for this 12-month cycle: mental health and substance misuse; embedding learning; and physical health and COVID-19. Elsewhere the panel has taken effective steps to engage and extend its Practitioner and Stakeholder Group, the third tier of the Council made up of experts from inspectorate and investigative bodies, lawyers, third sector organisations, families, academics, former detainees and practitioners from the custodial sectors. It is a panel priority to make the most of this group's expertise and shared ambition to prevent avoidable deaths.

There is still much to embed, progress and achieve before my time as chair concludes in 2022. In particular, the panel has a role to play in supporting partners to prevent and learn from the high number of deaths in secure health settings. The urgency for this work is made clear by the panel's latest statistical bulletin, produced by Professor Seena Fazel, which used new methodology to demonstrate that while most deaths took place in prisons, the highest rate of deaths is found in people detained under the Mental Health Act. Through our work to improve the impact of coroner Prevention of Future Deaths reports led by Deborah Coles, which we will complete early in 2022 in collaboration with the Chief Coroner, we aim to bring about lasting and tangible improvements to the quality, impact and take-up of matters of concern raised in these, previously underused but essential, reports. We anticipate that the police leadership initiative will encourage all police force areas to prioritise the prevention of deaths involving police contact, improve their shared response to people in mental health crisis, and accelerate the exchange of good practice. The panel will work closely with partners and draw widely from recognised expertise to prompt firm improvements in these areas.

I am grateful to my expert panel member colleagues for the drive, rigour and energy with which they have responded to the COVID-19 outbreak, especially within the context of frequent changes of ministers and lead departmental co-sponsors. I also wish to recognise John Wadham's substantial contribution to the work of the panel. John has demonstrated clear dedication to the prevention of deaths in custody during his time with the IAPDC and drawn generously on his legal knowledge and experience. A new panel member will be appointed in

2022 to work alongside other panel colleagues, who were reappointed for a further two years in July 2021. Our firm and overarching aim remains to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE
Chair, Independent Advisory Panel on Deaths in Custody
January 2022

IAPDC members

- **Juliet Lyon CBE** is chair of the panel and took up post on 1 September 2016. She is a visiting professor in the School of Law at Birkbeck, University of London and a member of the Churchill Fellowship Advisory Council. Previously Juliet was director of the Prison Reform Trust, secretary general of Penal Reform International and a Women's National Commissioner.

- **Deborah Coles** is the Executive Director of the influential human rights charity INQUEST that works on state related deaths. Deborah undertakes policy, research, media and consultancy work on the strategic issues raised by contentious deaths, in particular those in state care or raising concerns about state or corporate accountability. She is an advisor to Women in Prison and a trustee of Clean Break Theatre Company.

- **John Wadham** is a human rights lawyer and currently chair of the National Preventive Mechanism (NPM) set up by the United Nations Optional Protocol to the Convention against Torture, which brings together 21 statutory bodies monitoring detention in all forms of state custody in the UK. He is also the Human Rights Advisor to the Northern Ireland Policing Board.

- **Jenny Talbot OBE** has worked extensively to improve outcomes for people with learning disabilities and neurodiversity within the criminal justice system, including with the Prison Reform Trust, where she directed the innovative 'Care not Custody' programme. Under the auspices of the Open Society Foundations, Jenny coordinates a small international group of disability advocates working to promote fair access to justice for people with disabilities. In January 2021 she was appointed Independent Chair of the National Women's Prison Health and Social Care Review, a partnership between HMPPS and NHSE/I.

- **Professor Jennifer Shaw** is Professor of Forensic Psychiatry, University of Manchester and Honorary Consultant Psychiatrist Greater Manchester Mental Health NHS Foundation Trust. Her research interests include suicide primarily within the criminal justice system, homicide and the mental health of prisoners. She has over thirty years' experience working clinically in the NHS.

- **Professor Seena Fazel** is a Professor of Forensic Psychiatry at the University of Oxford, a Wellcome Trust Senior Research Fellow in Clinical Science, and honorary consultant forensic psychiatrist for Oxford Health NHS Foundation Trust. He works clinically in a local prison. His main research interests are on suicidal behaviour in prisoners, mental health of prisoners, and risk assessment in criminal justice and mental health.