Independent Advisory Panel on Deaths in Custody submission to the 'Reforming the Mental Health Act' White Paper – April 2021

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 (MBDC)
- Independent Advisory Panel (IAPDC)
- Practitioner and Stakeholder Group

The remit of the IAPDC (and overall of the Council) covers deaths, both 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 those detained under the Mental Health Act (MHA) in hospital. 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 IAP'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.

Members of the IAP appointed in July 2018 are:

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

Further information on the IAP can be found on its website: www.iapondeathsincustody.org

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Introduction

1. The role of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to advise Ministers and officials on how they can meet their human rights obligations, prevent deaths and keep those under the care of the state safe.[1] Our remit covers deaths, both 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 those detained under the Mental Health Act 1983 (MHA) in hospital. 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.

2. The IAPDC's interest in the *Reforming the Mental Health Act* White Paper is focused on the issues raised concerning deaths in custody and steps that can be taken to ensure the safety of people who are detained. We welcome the Government's commitment to ensure those detained under the MHA are treated with care, dignity and respect.

3. The IAPDC is pleased that the majority of recommendations made by Sir Simon Wessely in his landmark Independent Review of the Mental Health Act have been accepted and that the steps needed to take them forward are outlined in this White Paper.

4. We welcome Government's commitment to consult widely as policies are developed, including through the Ministerial Board on Deaths in Custody. The specific recommendations in the Review about reducing deaths in custody, engaging with the families of the deceased, and using prison as a place of safety have been raised and discussed at previous meetings of the Ministerial Board, and its members have considerable knowledge and expertise to bring to tackling the difficult issues outlined in the White Paper.

5. We value and appreciate the four guiding principles developed by people with lived experience which underpin the proposed reforms.

6. The fight against COVID-19 has, understandably, diverted attention and resources from the important areas outlined in this White Paper. The IAPDC urges the Department of Health and Social Care (DHSC), the Ministry of Justice and other relevant departments and agencies to now move quickly to put the right services in place and dedicate sufficient resource to developing robust measures to protect lives.

Police custody as a place of safety

White Paper comment: *By 2023/24 investment in mental health services, health-based places of safety and ambulances should allow for the removal of police cells as a place of safety in the Act and ensure that the majority of people detained under police powers should be conveyed to places of safety by ambulance. This is subject to satisfactory and safe alternative health based places of safety being in place.*

7. The IAPDC are pleased to note the Government's commitment to end the use of police cells as a place of safety and to remove them from the definition of a 'place of

[1] Advisory Panel on Deaths in Custody, *About the IAPDC*. Available at: https://www.iapondeathsincustody.org/about-us-1 [Accessed: 25/03/2021]

safety' under the Act by 2023/24. We endorse progress made towards this objective to date.

8. Meeting this commitment will require mental health services to be given the appropriate funding to respond effectively. We appreciate that the use of s.136 is often a resourcing issue, and that police officers would almost never choose to use a police cell as a place of safety if suitable alternatives were available. The Government must now commit to a level of funding sufficient to ensure that there are satisfactory and safe alternative health-based places of safety available across England, if possible, ahead of, and certainly within the 2023/24 target period. We note that separate arrangements are being made in Wales and that, under the Mental Health (Wales) Measure 2010, care plans for people subject to detention have been placed on a statutory footing.

9. Many vulnerable members of the public find themselves in contact with the police during or following a mental health crisis and such situations present a cliff-edge moment, potentially fatal, for their immediate wellbeing. The Independent Office for Police Conduct 2019/2020 annual report indicates that, of the 18 people who died in or following police custody, 11 were identified as having mental health concerns and two of these individuals had been detained under s.136.[2] Efforts to improve the availability of mental health services and emergency response, and consistency in how these are rolled out between forces, should be paramount.

10. The IAPDC notes that Sir Simon Wessely's independent review was commissioned by government because of the profound inequalities that exist for people from ethnic minority groups in terms of access to treatment, experience of care and quality of outcomes. Black people are over four times more likely to be detained under the Act and over ten times more likely to be subject to a CTO. In David Lammy's *Independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System*[3], he examined disproportionality and evidence of racism within the criminal justice system. Of particular relevance here is the treatment by police of black men in distress at the point of arrest and use of force with tragic outcomes as in the case of Kevin Clarke and recent others.

11. In February the IAPDC, along with the Minister Kit Malthouse MP, Minister for Crime and Policing, sent a joint letter to the Police and Crime Commissioners (PCCs) as part of a wider leadership initiative to prevent deaths related to policing contact. Amongst other points, the letter asked for examples of good practice and gaps in provision in relation to mental health and substance misuse approaches and measures adopted by the force for whom the PCC is responsible. An IAPDC briefing will be produced and submitted to officials as a supplementary paper as soon as possible.

12. We were encouraged to read some instances of proactive and conscientious initiatives, and some responses, such as those from Durham and Essex PCCs, which highlighted a low number of cases where an individual had been detained under

[2] Independent Officer for Police Conduct (2020) *Deaths during or following police contact: Statistics for England and Wales 2019/20.* Available at https://www.policeconduct.gov.uk/sites/default/files/Documents/statistics/deaths_during_following_police_contact_201920.pdf [Accessed:21/04/2021]

[3] The Lammy Review (2017) An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf [Accessed: 21/04/2021]

s.136 (four since 2017 in Durham and one during the last year in Essex). However, our concern around the appropriate funding of alternative services is reinforced by the response from North Yorkshire which informed us that, since the responsibility for health care to provide a place of safety is not set in statute, detainees often have to be transported significant distances to access care. The response suggests that this is often done via a caged police vehicle should an ambulance not be obtained.

13. The IAPDC would advocate for a complete legal ban on the use of Police stations being used for detention for a mental health assessment under S136 of the Mental Health Act. The environment of a custody suite, particularly during busy periods, is not suitable for those with mental health conditions and in some cases the experience is wholly traumatising. We have concerns that in certain situations, when existing mental health needs are exacerbated, some individuals will react in such a manner which is then met by a criminal justice, rather than health-based, approach and are criminalised further.

14. While we praise the commitment elsewhere in the White Paper to support community mental health as a preventative approach, we would highlight the potential impact of the pandemic on mental health and urge commissioned healthcare providers to mitigate against this.

15. We support the need for a time limit to be placed for individuals to be kept in a place of safety. Often concerning behaviour is a result of alcohol or drug abuse which acts as a catalyst for a mental health issue which might not be serious enough for longer detention.

Prison as place of safety

White Paper comment: *We will work with sentencers, health service commissioners and clinicians to ensure that there is a clear, timely pathway in which sentencers have confidence to transfer people directly from court to a healthcare setting where a mental health assessment and treatment can be provided, under the relevant section of the act.*

16. We are pleased the Government agrees with this recommendation and call for greater urgency in developing solutions and delivering the proposed course of action. Prisons are not a safe environment and inherently damaging to an individual's mental health as detailed by the National Audit Office[4] amongst others. They are never an adequate place of safety for a person requiring mental health treatment. Abolition of the use of prison in these circumstances as 'a place of safety' should be considered, alongside the removal of prison for a person's 'own protection' (Bail Act 1976)[5].

17. The focus on transfers from court to healthcare settings when required is essential if we are to reduce the risk of deaths in custody.

[4] The National Audit Office: Mental Health in Prisons (June 2017) Accessible on https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf [Accessed on 21/04/2021]
[5] Bail Act 1976 (section 4; paragraph 3): *The defendant need not be granted bail if the court is satisfied that the defendant should be kept in custody for his own protection or, if he is a child or young person, for his own welfare.*

18. Numerous reports, including Lord Bradley's Review[6] and the Joint Committee on Human Rights Third Report[7], have raised concerns about the misuse of prisons as 'a place of safety'. The investigation and subsequent findings of the Prisons and Probation Ombudsman of the death of Dean Saunders highlight how too often people who are acutely mentally unwell are inappropriately sent to prison as 'a place of safety'.[8] The father of Dean Saunders, Mark Saunders, commented on how his son was placed in prison custody as a "holding pen" as no beds in secure health could be sourced for him.[9] To resolve this, there is an urgent need to resource, and make better use of, community alternatives to prison for offenders with mental health conditions. The IAPDC's ongoing work in collaboration with the Magistrates Association on the take-up and availability of community sentence treatment requirements (CSTRs) and alternatives to detention supports the removal of prisons as 'a place of safety'.

19. In our 'Keeping Safe' consultations[10] with prisoners and health and justice practitioners and policy makers. One man in prison said: 'Jail is not a mental hospital. Well it shouldn't be. But it is at present'. And a clinical director wrote: 'Stop using prisons as a place of safety for patients with acute mental health problems. They are not therapeutic environments. We cannot enforce treatment. Sending acutely psychiatrically unwell patients to prison does not improve their health and it is extremely difficult to manage patients in this condition in prison. The wait for transfer to a secure psychiatric hospital can be long and patients often worsen while waiting.'

20. It is unclear exactly how many times prison is used as 'a place of safety' or for a person's 'own protection' as the data is not routinely collected at either a local or national level. Early (as yet unpublished) findings appear to suggest there are relatively few occurrences. Consequently, it is not an onerous or unreasonable request to ensure adequate provision of hospital beds for those who currently would require 'a place of safety' or are required to be detained for their 'own protection'. This is particularly true when the high risk of harm that prison can inflict on people in need of specialist healthcare and support is considered. This lack of data must be resolved to understand the true scale of the problem.

21. Prisons used as 'a place of safety' also poses significant risk to operational and healthcare staff within prisons. Quite often people waiting for transfers from prison to healthcare settings become violent towards themselves or staff members usually out of either frustration or a deterioration in their mental health. This frequently leads to the person being placed into segregation as the only way to manage their behaviour. The detrimental impact segregation has upon mental heal is recognised and placing a person in need into such an environment can create a vicious cycle where their mental health deteriorates further.

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[6] The Bradley Report (April 2009) Available at https://lx.iriss.org.uk/sites/default/files/resources/The%20Bradley%20report.pdf [Accessed 21/04/2021]

[7] Joint Committee on Human Rights – Third Report (December 2004). Available at https://publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1502.htm [Accessed 21/04/2021]

[8] The Prisons and Probation Ombudsman: Independent investigation into the death of Mr Dean Saunders a prisoner at HMP Chelmsford on 4 January 2016 (September 2016). Available at http://www.ppo.gov.uk/app/uploads/2017/01/L246-16-Death-of-Mr-Dean-Saunders-Chelmsford-04-01-2016-SID-22-30.pdf#view=FitH [Accessed on 16/04/2021]

[9] The IAPDC Keeping Safe Conference (February 2020) Available at https://www.iapondeathsincustody.org/keeping-safe [Accessed on 21/04/2021]

[10] The IAPDC Preventing the Deaths of Women in Prison – initial results of a rapid information gathering exercise by the Independent Advisory Panel on Deaths in Custody. Available on https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ed66b03e920b329e6d2fdc3/1591110409188/Women+evidence+collection+v+0.3.pdf. [Accessed on 21/04/2021]

22. The time spent waiting for a transfer is necessarily linked to the time spent waiting for a hospital bed to become available. Due to the designation of prisons as 'a place of safety', prisoners are not considered to be a priority for beds that do become available. It is therefore essential to the timely transfers of people into hospital spaces, that prisons are removed as 'a place of safety' to allow beds to become available sooner to those in need.

23. The IAPDC will continue to raise concerns with urgency and work with DHSC, MoJ and HMPPS to identify solutions.

Data

White Paper comment: *The Home Office therefore considers that the disadvantages of the administrative efforts involved would outweigh any potential benefits of a more frequent collection, and does not propose, routinely, to increase the current frequency of police data reporting.*

24. We continue to support Sir Simon Wessely's recommendation that "Data on police use of detention powers under the MHA (sections 135 and 136) should be published on a quarterly basis as close to real time as possible and include new data on delays" and refute the claim by the Home Office that **'**the disadvantages of the administrative efforts involved would outweigh any potential benefits of a more frequent collection.'

25. Accurate, timely and disaggregated data is crucial to transparency and the identification of emerging trends. We draw comparison to the quarterly data on safety and deaths in custody published by HMPPS allowing more real-time identification of issues and themes. Accurate and complete data is essential for transparency and frequent data is important to uncover in-year issues and make timely improvements. Quarterly publication of data, as opposed to annual, is necessary to progress the removal of police cells as a place of safety (see above), monitor progress made and share examples of good and poor practice from which learning can be derived.

NHS commissioning of services

White Paper comment: *We are considering two options; transfer to NHSEI or adding health specialist support to the police commissioning process. These options have also been consulted on with the National Police Chiefs Council, and the Association of Police and Crime Commissioners.*

26. The arguments for transferring commissioning and budgetary responsibility from the police to NHS England are clear and well-documented. It is over ten years since this proposal was first made in the Bradley Report on people with mental health problems

or learning disabilities in the criminal justice system and repeated in 2017 by Dame Elish Angiolini's review on deaths and serious incidents in police custody[11].

27. The issue has also been raised at the Ministerial Board on Deaths in Custody, where members have noted varying satisfaction with the custody healthcare services provided across police force areas, and that forces place a premium on having qualified clinical expertise input to the commissioning and monitoring of such services. The Board consulted individuals and specific organisations, including Police and Crime Commissioners (PCCs) and Chief Constables, on practical and technical issues, and sought their perspectives on health care provision in custody. It concluded that transferring commissioning responsibility to NHS England should ensure appropriate expert clinical input and a more consistent approach to commissioning, and the quality of service provision in police custody, over time.

28. The IAPDC understands that there are practical and financial issues that need to be resolved to ensure a satisfactory transfer takes place. These issues are not insurmountable. We strongly urge that NHS England take over the commissioning of health services in police custody at the earliest opportunity, and that budgetary considerations to enable transfer are addressed by the 2022 Spending Review.

The role of the Care Quality Commission and the need for independent investigation of deaths

29. There is a stark contrast between the investigation of deaths in mental health settings and other places of detention. Such settings lack an independent system of pre-inquest investigation similar to that carried out by the Independent Office of Police Complaints (IOPC) for deaths in police custody or following police contact, or by the Prisons and Probation Ombudsman (PPO) for deaths in prison or immigration removal centres.

30. Instead, the inquest is largely reliant on the internal reviews and investigations conducted by the same trust responsible for the patient's care. It does not inspire confidence when an organisation investigates itself over a death that may have been caused or contributed to by failures of its staff and systems.

31. This comparative absence of scrutiny restricts opportunities for the NHS and healthcare organisations to learn and respond with changes to policy and practice and prevent further fatalities.

32. The role of the CQC does not extend to a full investigatory purpose following the deaths of detained patients, instead reviewing a sample of cases each year to identify emerging issues.[12]

Transfers

33. We welcome commitments to improve the process surrounding transfers for prisoners who require care under the Mental Health Act. Reviews, prisoner testimony

[11] The Angiolini Review: Report of the Independent Review of Deaths and Serious Incidents in Police Custody (January 2017). Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf [Accessed on 21/04/2021]

[12] INQUEST (February 2015), Deaths in Mental Health Detention: An investigation framework fit for purpose? Available at https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=92fa356f-8335-4c6a-a273-62aad802284c. [Accessed on 15/04/2021]

and inspectorate reports repeatedly highlight concerns relating to processes concerning assessment and transfers.

34. We welcome the proposal to introduce a statutory time limit for secure transfers. Lengthy waiting times ahead of transfer can lead to people in prison being segregated and placed on constant watch. This can lead to further deterioration of their mental wellbeing.

35. The IAPDC recommends a single competent assessment, for example provided by prisoner forensic psychiatrists, to identify the need for transfer and the appropriate security level.

36. Safeguards for women and children, minority groups within the prison estate, should also be considered. These groups are often held far away from their original home which creates additional complications during the application for specialist beds.

37. The IAPDC supports the call made by the Prison Reform Trust for community parity for people in the criminal justice system and people in the community. For example, for individuals in a community setting, s.140 MHA allows CCGs to commission emergency beds when a person is deemed to require an admission under S2/S3 MHA, but where no formal admission bed space is identified. An equivalent process should be available for NHS England, enabling them to commission emergency beds for patients in the criminal justice system in need of assessment and/or treatment, to prevent their being imprisoned due to a lack of mental health resources.

38. We support the need for a stronger monitoring system to provide greater transparency around this process.

The use of non-means-tested legal aid for bereaved families

White Paper comment: *In February 2019, the Ministry of Justice (MoJ) published its Review of Legal Aid for Inquests. This concluded not to introduce non-means tested legal aid for bereaved families to attend inquest hearings. The evidence gathered as part of this review on financial eligibility will be considered as part of our wider Means Test Review, looking at the thresholds and criteria for legal aid entitlement. It was initially intended that this review would conclude in summer 2020, but it has been delayed due to the COVID-19 outbreak. The intention is that this review will now conclude in Spring 2021. We will then publish a full consultation paper setting out future policy proposals in this area and will seek to implement any final recommendations as soon as practicable.*

39. The IAP supports the call, made in the Harris Review and a range of other independent reviews such as Dame Elish Angiolini's report into deaths and serious incidents in police custody, for the introduction of non-means tested legal aid for bereaved families where someone has died in the care of the state.[13] This would ensure meaningful participation and 'parity of arms'.

Family liaison following a death

[13] Dame Elish Angiolini, Review Report of the independent review of deaths and serious incidents in police custody', https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf.

White paper comment: *We agree in principle with this recommendation, but we are exploring a different approach. The government agrees that there is a need to better support families and carers of those who are bereaved, and that a family liaison service is a good way to do this.*

40. The IAPDC believes that there is a problem with the lack of specialist advice and support provided to a bereaved family following a death in a secure health setting.

41. We believe that any new approach should be co-produced between bereaved people and those that support them. Like information leaflets used by the Police, any material should include information on their legal rights in any process which follows a death.

Environment

White paper comment: *The review highlighted how decisions focused solely on safety can be at the expense of therapeutic environments and good quality care and can contribute to cold and unwelcoming environments. This is something that we wish to avoid, and we will work with Arm's Length Bodies (ALBs) and stakeholders to consider how best to ensure that the implementation of new patient safety interventions and programmes have positive contributions to the therapeutic environment.*

42. The IAPDC welcome the commitment to provide a greater level of dignity for detainees through improved facilities. This includes the eradication of dormitory provision and the promise that all those who are admitted to a mental health hospital have access to their own personal space.

43. There is a close link between the standard of estates, self-harm and suicide. Cramped conditions, opportunities for self-harm from structural design and a lack of basic or clean provisions can all impact emotional wellbeing and the IAPDC welcomes any promise to address the standard of space where individuals are detained.