Independent Advisory Panel on Deaths in Custody

Chair’s end of term report

(September 2019 – January 2023)

February 2023

Chair's foreword

Loss of liberty should never result in loss of life. There is no such thing as an acceptable death toll in places of detention. This is the case despite significantly higher levels of risk and vulnerability amongst people who are held in prison or police custody or detained under immigration powers or Mental Health Act legislation compared to those in the general population of England and Wales. Instead, there is a clear and specific human rights obligation for government to keep people safe in custody and for ministers and their officials to take active steps to protect lives. This is combined with a duty independently to investigate all deaths in custody in order to prevent future such deaths.

The sole objective of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to help to prevent all deaths, natural, self-inflicted and by homicide, in all forms of state custody. The panel is co-sponsored by the Ministry of Justice, the Home Office and the Department for Health and Social Care. We are pleased that the IAPDC has been able to establish agreements for collaboration across departments and agencies and measures for consultation with people who are, or have been, detained and their families.

During this period, the panel has produced new guidelines, accepted and largely implemented, by the Home Office, on preventing deaths in immigration removal centres. Our report with the Royal College of Nursing on avoidable natural deaths in prison custody has led to a review and overhaul of compassionate release policy and process. It should also prompt earlier diagnosis of life-threatening conditions. The IAPDC police leadership report, supported by policing and health ministers and policing bodies, has the potential to prevent deaths at the point of arrest and following release from custody by profiling strong mental healthcare and policing partnerships, already in place in some forces.

The IAPDC has produced ground-breaking data on rates as well as numbers of deaths in all places of detention and prompted a review of unsatisfactory data collection and publication of deaths of people detained under the Mental Health Act. During Covid-19 the panel's operational guidance was accepted by, and proved useful to, the prison service. It is a matter of regret that our advice on universal vaccination of all detainees and staff in closed institutions, although consistent with that of the World Health Organisation (WHO), Public Health England and SAGE, government's own scientific committee, was rejected. And that the negative impact of isolation and extremely restricted regimes lingers to this day.

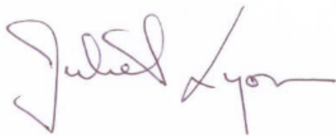
The IAPDC welcomes the developing interest in the use of its safety impact assessments to identify risks posed by proposed new policies, and major resource and operational changes, to the safety of detainees and staff and the requirement to take steps to mitigate these risks prior to ministerial sign-off. The panel looks forward to publishing its report on ways to improve impact of coroners' prevention of future deaths reports and to making a substantial contribution to the government's new ten-year suicide prevention plan.

Our advice to ministers and reports draw not only on current international research and data but also on the knowledge and experience of our Practitioner and Stakeholder Group. They reflect the collaboration we value with, amongst others, investigatory, regulatory and monitoring bodies; Royal medical colleges; voluntary organisations; staff associations and bodies representing the views and experience of people in detention.

Preventing deaths in custody is everybody's concern. It is a yardstick for humanity and decency. The Ministerial Board on Deaths in Custody is co-chaired by the ministers for prisons and probation; policing, in this instance also representing immigration; and health. Rightly the emphasis is on cross-departmental solutions and multi-disciplinary working. The panel appreciates working more closely with the board and the many opportunities to present advice directly to ministers. Latterly the panel has increased its parliamentary work and the number of submissions made to select committees. This allows for concerns to be raised including occasions where political considerations appear to be superseding clinical or ethical guidance.

At the close of an extended tenure, it remains for me to thank panel colleagues for drawing so generously on their knowledge and professional skills; our secretariat and co-sponsors for their sound support and help with navigation of systems; ministerial board and practitioner and stakeholder group colleagues for their hard work and shared determination to prevent deaths in custody; and the very many individuals who contacted the IAPDC to share their insights and experience. It has been a privilege to serve as chair of the panel.

As ever,



Juliet Lyon
Chair of the Independent Advisory Panel on Deaths in Custody

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We are very grateful for permission from Koestler Arts for the use of all images in this report.

Our purpose and remit

In its current form, the Ministerial Council on Deaths in Custody formally commenced operation in April 2009 and is jointly sponsored by the Ministry of Justice (MoJ), the Department of Health and Social Care (DHSC) and the Home Office (HO). The Council consists of three tiers:

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

The IAPDC forms the second tier of the Ministerial Council. The remit of the Council covers deaths 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, an advisory non-departmental public body, is to provide independent advice and expertise to the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. 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.

The panel's Terms of Reference originated in Robert Fulton's Review of the Forum for Preventing Deaths in Custody (2008):

- 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 Ministers and the Ministerial Board to identify the key areas of advice and research to enable the operational services to reduce the number and rate of deaths in custody.
- Consult and engage with relevant stakeholders 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, 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.

Key achievements (2019-2023)

Pioneering the introduction of a **Safety Impact Assessment** at operational policy boards within MoJ and HMPPS, meaning longer term change programmes must have safety impact actively considered and, where risks to prisoners or staff are identified, steps in mitigation should be introduced before proceeding.	*Championing, in collaboration with the policing minister, a* ***zero-tolerance approach to deaths at the point of arrest, during and following police custody or contact****, bringing together, for the first time, examples of good practice from Police and Crime Commissioners to improve partnership working and prevent deaths.*	Developing **guidelines for immigration removal centres** on the prevention of deaths in detention. The guidelines focussed on improving response to mental and physical health needs, cultural diversity and family contact. These were accepted and implemented by the Home Office.
Securing, through recommendations in a report on natural deaths in prison, reforms to the ***compassionate release*** *process, and establishing arrangements for independent monitoring of compassionate release decisions.*	Analysing how more can be made of the preventative potential of coroner-written **prevention of future deaths reports**. Working with the Chief Coroner and colleagues leading to increased focus on improving and drawing out themes and learning from these reports.	*Identifying serious gaps in* ***data on deaths of those detained under the Mental Health Act*** *and working with NHS England, DHSC and the CQC to find ways of improving data quality and usage, contributing to DHSC ministers launching a rapid review on mental health inpatient data.*
Encouraging, through recommendations in an expert report on **substance misuse-related deaths in prison**, a data exercise between the Office for National Statistics and HMPPS to understand greater detail on such deaths. Feeding into wider national work on substance misuse in the criminal justice system.	***Influencing policy and practice****, for example securing commitment by HMPPS to establish 290 ligature resistant cells in prisons and helping to introduce a ban on the use of prison custody and police cells as 'places of safety' for those in mental health crisis through the Draft Mental Health Bill.*	Producing **innovative statistical reporting** which for the first time reveals rates of deaths across all areas of custody, including the particularly high rate of deaths of people detained under the Mental Health Act.
Providing a clear, expert voice calling for Government to prioritise the prevention of deaths in custody through ***parliamentary inquiries and pre-legislative scrutiny****.*	Providing firm expert guidance to departments and agencies during the **response to COVID-19 in detention** and developing a Covid information hub to provide access to international research, policy and practice**.**	*Providing expert input, advocacy and liaison with the judiciary to inform the extended* ***provision of Community Sentence Treatment Requirements*** *to support vulnerable people, with rollout of these sentences now due to be accelerated.*

Our work

The Independent Advisory Panel on Deaths in Custody's sole purpose 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. To do this we work closely with ministers, co-sponsoring departments and agencies to provide expert advice on how they can meet their human rights obligations to protect life.

The panel has published two workplans in this period, for 2020-21 and 2021-22. For 2021-22, the panel's workplan priorities mirrored the three priority areas of the Ministerial Board on Deaths in Custody: mental health and substance misuse; embedding learning; and physical health and COVID-19.

Cross-cutting across places of detention

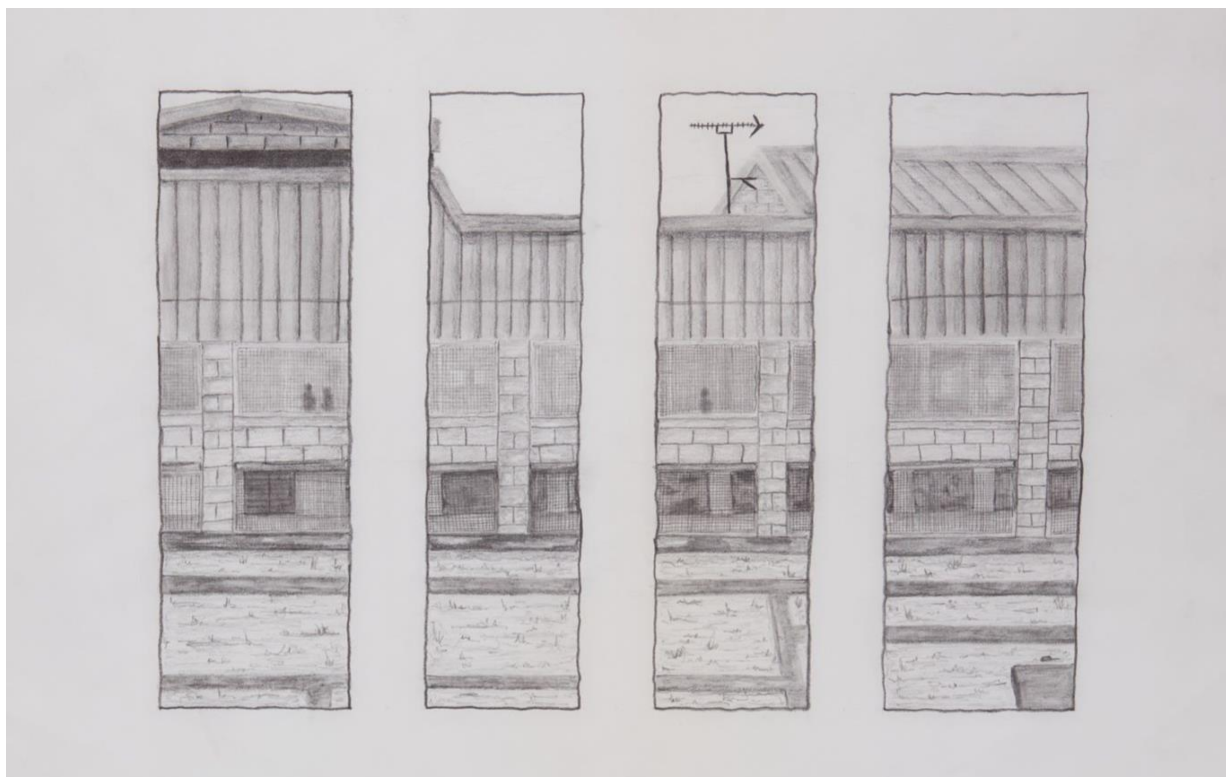
The panel has a unique role in working across custodial settings and department and agency boundaries. During this period the panel has demonstrated this approach through work to enhance the preventative potential of coroner-written prevention of future deaths reports, led on the DHSC's updated suicide prevention strategy from the perspective of custody, and produced an innovative data publication which for the first time calculated rates of deaths across all forms of custody.

IAPDC statistical report on rates of deaths in custody

> *"Accurate data on deaths in custody must be publicly available. It should not be difficult to obtain full information, but it is. It is imperative to improve data collection and publication. Missing data distorts information and hampers efforts to prevent deaths in custody."*
>
> **Juliet Lyon, *Statistical analysis of recorded deaths in custody between 2016 and 2019***

In November 2021 the panel the IAPDC published an innovative statistical bulletin on deaths in custody between 2016 and 2019. For the first time, this report analyses mortality rates in different custodial settings, allowing for further interpretation of the data than is permitted by simple comparisons of total numbers. It highlights the high mortality rate for those detained in custody compared with the general population, demonstrates that one in five deaths in custody are self-inflicted, and shows that while most deaths in custody occur in prisons, when rates are considered, people detained under the Mental Health Act have the highest mortality rate.

Worryingly, not all data was available for our report. For instance, there was missing data on the ethnicity of people detained under the Mental Health Act. Improvements overall must still be made in the collection and recording of the self-reported data on race and ethnicity and the panel will be working with DHSC, CQC and the NHS to explore ways to address gaps.



Enhancing the impact of Coroners' Prevention of Future Deaths Reports

> *"The only thing that makes sense of the loss of your loved one is that maybe lessons will be learned and the same thing will not happen to someone else."*
> **Andrew McCulloch, a bereaved parent**

Coroners produce a Prevention of Future Deaths (PFD) report when they believe action should be taken on operational or policy practice by an individual or agency to protect future lives. The panel and others have raised repeated concerns that practice around the production and receipt of, and action in response to, PFDs is inconsistent or insufficient. The panel's submission to the Justice Select Committee in September 2020 called for a strengthening of the coroner's role by making full use of coroners' reports to learn lessons about how future deaths can be prevented. In its May 2021 report of its inquiry into the coroner service, the Committee described the "absence of follow up" to PFD reports as a "missed" opportunity" and called for it to be remedied.

Following a discussion on the use of PFDs at the November 2020 meeting of the Ministerial Board on Deaths in Custody, the IAPDC launched a sampling exercise looking at a selection of PFDs detailing deaths across all places of state detention. With the support of the Chief Coroner, in Summer 2022 the panel hosted two roundtables with a representative group of coroners from England and Wales. The roundtables explored coroners' thoughts on the purpose of PFD reports, how the drafting, publication, and distribution of reports can be improved, and how learning from reports can be maximised.

The panel presented some of the early findings to the Ministerial Board in November 2022:

- Coroners will make a report if they have a concern, regardless of whether one has been written already, but expressed frustration at writing repeated PFDs following similar incidents.
- Agencies and services should treat PFD reports as opportunities for local and national learning, rather than as criticism to be avoided.
- A regular review of reports, especially for deaths which occur in state detention, should be produced to present analysis of the main matters of concern.
- Reports should be shared and disseminated as widely as possible as part of training and learning. They should always be shared with bereaved families.

The panel will now use findings from these roundtables, combined with evidence from the sampling exercise and forthcoming engagement with bereaved families and representatives from custodial settings, to finalise a report on this issue. Recommendations will focus on ensuring PFD reports are better utilised to meet their primary objective of preventing further deaths.

The panel welcomes the Chief Coroner's stated commitment to bring a renewed focus to PFDs in the coming year, including by including focus on PFDs as part of mandatory coroner judicial training and considering development of an annual digest of key themes.

Prevention of suicide in custody as part of the new ten-year suicide prevention strategy

> *"It is really difficult for men and women not to be with their families. It causes a lot of distress, plays in your mind, and can have such an impact that you can lose the will to live."*
> **Prisoner, HMP Frankland**

To inform the Department of Health and Social Care's (DHSC) new suicide prevention strategy, the panel led work to distil current research and gather expert insight from Practitioner and Stakeholder Group (PSG) members, partner organisations, and experts by experience on ways to prevent suicide across detention settings.

A consultation on suicide prevention with prisoners through Inside Time highlighted the importance of family involvement, access to meaningful activities, and peer-support initiatives such as the Samaritans' Listener scheme. A prisoner at HMP Parc told the panel: *"as men we always want to be*

seen strong but to be honest, we are not and often suffer in silence". The panel also issued a call for written evidence and convened a roundtable event attended by 60 PSG members. The panel heard from regulatory and investigatory bodies, independent monitors, academics, lawyers, third sector organisations, operational staff and bereaved family members.

In December 2022, the panel submitted an outline of prevalence data and a summary of emerging themes to DHSC to ensure the prevention of suicide in detention is featured prominently in the early scoping of the new strategy. A full report, with clear, practical recommendations for inclusion in the strategy, will be submitted later this year.

Community Sentences with Treatment Requirements

> *"For many people who offend, treatment is best undertaken in the community where … men and women can address their offending behaviour, improve their health and rebuild lives."*
>
> **John Bache, National Chair, Magistrates Association, and Juliet Lyon, letter to Chief Secretary to the Treasury.**

The IAPDC has sought to accelerate plans for increased provision and availability of Community Sentences with Treatment Requirements (CSTRs) to improve health outcomes, reduce crime and save lives. Building on the findings of a joint report in partnership with the Magistrates' Association (MA), in 2020 the IAPDC published articles in MAGISTRATE and Probation Quarterly, and in October of that year sent advisory letters to the Chief Secretary to the Treasury and the Secretary of State of the Department of Health and Social Care calling for increased provision of community sentences as part of the 2020 Spending Review.

The Mental Health Treatment Requirement (MHTR) Programme, a local integrated service which provides treatment as part of a court community or suspended sentence order, is now on course to cover 100% of England's Criminal Courts and population by early 2024. Taking steps to reduce the number of vulnerable people in prison is likely to have a positive impact on reducing custody deaths.

Immigration detention

The panel were pleased to develop guidelines for immigration removal centres on the prevention of deaths in detention, which have been accepted and implemented by the Home Office. While deaths in immigration removal centres are rare – there were none in 2022 – we remain concerned about risks to life posed by immigration detention estate, particularly in regard to the safety of people detained in temporary facilities and the selection of individuals to be transported for processing in Rwanda.

Guidelines for the prevention of deaths in immigration removal centres

> *"… people detained in IRCs have characteristics … that differ from other custodial populations and are unique to the immigration estate."*
> **IAPDC report, *Priorities for a prevention of deaths strategy in Immigration Removal Centres***

In 2018 the Home Office asked the IAPDC to provide advice on issues pertaining to deaths, 'near misses', and incidents of serious self-harm in immigration detention. The request was made in support of three recommendations relating to deaths in detention made by Stephen Shaw in his 2016 *Review into the Welfare in Detention of Vulnerable Persons*. Drawing on extensive research and consultations, the IAPDC published a report, *Priorities for a prevention of deaths strategy in Immigration Removal Centres*, in October 2020 containing recommendations for a Home Office strategy grouped into the following six themes:

- Transform the transparency of policy, data and other information around deaths in the immigration estate to improve accountability and lessons learned.
- Dedicate resource and focus on building a greater understanding of those at risk and scope for support from family and friends.
- Reconsider the immigration population in the context of the impact of detention on the mental health of detainees
- Take steps to ensure adequate healthcare provision to suit the needs and circumstances of the immigration population.

- Provide staff with appropriate training, tools, and supervision to support detainees and identify signs of physical and mental health risk.
- Improve learning processes and ensure public, independent, transparent investigation.

The panel presented the report to the Home Office Detention Reform Board in October 2020, where its recommendations were accepted, including the panel's recommendation for changes to published deaths in detention data. The Home Office response, and an associated Action Plan, was published March 2021. Over half of the deliverables on the action plan are now complete, with a further number expected to be addressed or completed in early 2023.

Preventing deaths in Short-Term Holding Facilities

> *"… Manston is not a residential facility but has been misused as such. Repeated warnings about the deterioration of conditions…have called into serious question the Home Office's ability to keep people safe and prevent the loss of life."*
> **IAPDC correspondence to the Immigration Minister, November 2022**

The panel has raised serious concerns about the risk to life posed at the residential short-term holding facility at Manston in Kent. Drawing on findings from a panel observation visit in May 2022, as well as recent evidence provided by the Independent Chief Inspector of Borders and Immigration, among others, the IAPDC wrote in October 2022, and again in November 2022, to the Immigration Minister regarding the "drastic deterioration in conditions" at Manston and the risk to life they pose.

Conditions at Manston have since become a matter of national concern following the death of an Iraqi man to diphtheria while being held at the facility. The panel still requires reassurance about measures in place to observe public health protocols, limit the spread of disease, reduce the risk of death, identify and support vulnerable people and meet Article 2 obligations. The panel has since raised these concerns in a submission (not yet published) to Parliament's Joint Committee on Human Rights' inquiry into the human rights of asylum-seekers in the UK.

Asylum processing in Rwanda and protecting lives

In light of Home Office announcements, the panel has sought clarification on accountability for safety and the steps that will be taken to protect the lives of people detained in state custody in the UK, in the period from arrival and first detention, during transit, and on arrival in Rwanda. The Home Secretary responded to an IAPDC letter sent on 10 June about the plan. We followed this with further correspondence on 14 October outlining continued concerns, to which the Home Secretary responded on 17 January. The panel has since raised these concerns in a submission to Parliament's Joint Committee on Human Rights' inquiry into the human rights of asylum-seekers in the UK.

Other key progress areas

- The panel has contributed expert facilitation of Home Office-led lessons learned reviews following a death in detention. These reviews are important and the panel is in discussion with the Home Office about how they could be developed and the role the panel should take.
- The Home Office is making use of the Safety Impact Assessment, as proposed and developed by the IAPDC (see page 13) in the development of the immigration estate at Haslar and Campsfield House.

Prisons

COVID-19 saw a substantial increase in deaths in prison – though it is important to understand that the pandemic does not explain the consistently high total. In the 12 months to December 2022, there were 301 deaths in prison custody. The panel has focused work on key areas of concern: including self-inflicted deaths, deaths from so-called 'natural causes', deaths caused by substance misuse, and deaths of specific cohorts such as women and people on remand. The panel has also focused on prevention, including through developing, promoting and embedding the Safety Impact Assessment tool.

Safety Impact Assessment

The panel has advocated for the introduction of a Safety Impact Assessment (SIA) to ensure all major policy and operational decisions are considered according to their impact on safety. If risks to the safety of prisoners or staff are identified, then mitigation needs to be introduced prior to ministerial sign-off. This proposal has been supported by the Prison Officers Association (POA) and the Prison Governors Association, which in October 2019 published a formal resolution to that effect. Our belief is that the use of such a tool will help encourage senior decision makers to view any potential changes through a safety lens and ensure that a degree of accountability is held for those decisions.

The panel has consistently recommended that the SIA be put on a statutory footing. **While this option has yet to be taken up by Government, the SIA has been incorporated into the governance process at the senior MoJ and HMPPS boards which consider new, and updates to existing, policy frameworks. These changes are having an important impact on policy and operational decisions from the perspective of safety.**

Natural deaths and compassionate release

> *"Incarceration, and associated loss of liberty, is the punishment for crimes committed. Denying the same health and care services that any of us may need is not."*
> **Juliet Lyon CBE's foreword to *Dying Behind Bars*, a report by Hospice UK**

In 2019 the IAPDC and the Royal College of Nursing (RCN) examined the rising numbers of so-called 'natural cause' deaths in prison (deaths which are not self-inflicted or homicide) to ask whether they are avoidable and what can be done to prevent them, and identify how end of life care can be managed with dignity and compassion. This initiative included a roundtable event with experts from across health and justice, gathering views from those in prison and additional research.

In September 2020, the IAPDC published *Avoidable Natural deaths in custody: Putting things right*, which made 15 recommendations grouped into the following categories:

- Improve join-up and information sharing across services and departments
- Implement improvements to primary and secondary care
- Take steps to improve provision and care for specific vulnerable groups
- Improve end of life care across the prison estate
- Enhance the profile of prison healthcare as a career
- Improve learning and investigations

The IAPDC and RCN discussed the report with Ministers, presented it at the Royal College of General Practitioners (RCGP) quarterly meeting and discussed it with senior leaders within the NHS. **The report, particularly relevant after the outbreak of COVID-19, shifted ministerial focus onto these often-neglected deaths and contributed to the Ministry of Justice's scoping of a dedicated strategy for older prisoners, which the Ministerial Board on Deaths in Custody considered in May 2022. The work also prompted significant reform to the Ministry of**

Justice's compassionate release policy and practice, streamlining the process and updating the policy to cover a wider range of medical conditions, such as Alzheimer's disease and dementia, that could lead to permission for release being granted. The IAPDC continue to monitor data on compassionate release to determine how well the changes are working.

Substance misuse-related deaths in the criminal justice system

> *"Too many people with addictions are cycling in and out of prison, without achieving rehabilitation or recovery."*
>
> **Dame Carol Black,**
> **Review of Drugs part two: prevention, treatment and recovery**

The scale of drug and alcohol misuse in the criminal justice system is significant and both directly and indirectly leads to deaths in custody. In early 2021, the IAPDC was asked by HMPPS to help inform the review of the HMPPS' drug and alcohol strategy from the specific perspective of reducing deaths in custody.

The IAPDC, in partnership with the Royal College of GPs Secure Environments Group (RCGP SEG), jointly hosted an online roundtable event bringing together a range of cross-discipline experts and professionals in the area of substance misuse in the criminal justice system. Following this and further consultations and research last year, in January 2022 the panel published a new report 'Protecting lives: a cross-system approach to addressing alcohol and drug-related deaths within the criminal justice system' following publication of the Government's ten-year drugs plan and the Prisons Strategy White Paper, both of which outline steps to reduce supply and improve treatment around substance misuse.

Recommendations in the report include:

- Better resourcing of community drug and alcohol services that divert individuals with substance misuse problems away from short custodial sentences into treatment in the community.
- Promotion of wider collaboration between prison and community staff to encourage continuity of treatment, particularly during the transitional period when released from prison.
- Increased use of newly available opioid substitution therapy to help improve continuity of treatment and as a form of harm-reduction for opioid abuse.

The panel has discussed findings from the report with officials in MoJ, HMPPS and NHS England, and presented this work at the Addictions Professionals RCGP Conference in March 2022. **We welcome the creation of a cross-governmental Joint Combatting Drugs Group and that, as recommended by the IAPDC, the Office of National Statistics has agreed to collaborate with HMPPS on a bespoke data publication on drug deaths in prison.**

Preventing the deaths of women in prison

> *"…health and justice outcomes for women sent to prison are significantly worse than for those given community orders."*
>
> **IAPDC submission to Justice Committee inquiry into women in prison**

In March 2017 the IAPDC published *Preventing the Deaths of Women in Prisons* in response to a series of recent tragic deaths in women's prisons. The panel has since continued to provide expert advice and challenge on the wellbeing of women in detention.

- In December 2020 the IAPDC provided a response to HM Inspectorate of Prison's open consultation on their *Expectations: Criteria for assessing the treatment of and conditions for women in prison*, and presented a paper summarising expert input from the panel on preventing self-harm in the women's estate to the HMPPS Independent Advisory Forum.

- In March 2021 the IAPDC chair provided oral evidence on deaths in women's prisons to the launch of the All-Party Parliamentary Group on Women in the Penal System's inquiry into 'Women's health and well-being in prisons'.
- The panel continued to monitor progress against the recommendations of the panel's report, which were accepted as part of the Female Offenders Strategy upon its original publication. Prisons Minister Alex Chalk MP provided an update on progress in response to an IAPDC request in May 2021.
- In June 2021 the IAPDC provided a written response to the Justice Select Committee's call for evidence on Women in Prisons.
- In January 2022 we presented written evidence to the Public Accounts Committee on improving outcomes for women in prisons, outlining how significant work is still required to complete the implementation of MoJ's Female Offender Strategy.
- In July 2022, the IAPDC contributed both oral and written evidence to the Justice Select Committee on issues affecting women in prison, highlighting the severe disruption caused by short sentences to continuity of care and calling for investment in preventative work and improved access to community sentences.

Keeping Safe conference

> *"How much better to be wise before the event and keep people safe, than have to promise yet again to learn lessons after a tragic death in a bleak prison cell."*
> **Juliet Lyon, the Keeping Safe Conference**

In 2017 the IAPDC published *Keeping safe: Preventing suicide and self-harm in custody*, a report identifying practical steps that prisons could take to prevent suicide in custody. In February 2020 the panel and our partners delivered the inaugural 'Keeping Safe' conference, attended by over 200 delegates who heard from speakers including the Lord Chancellor, Ministers, practitioners, policy makers, Samaritan Listeners and prisoners' families.

The panel took the points raised and changes proposed by speakers and delegates to put forward the following recommendations:

- Involve families, whenever possible, as advisors at every stage in the criminal justice process and ensure that the helpline for families and friends works in every prison.
- Support and strengthen the work done by Samaritans and Listeners in all prisons.
- Make more effective use of reports and recommendations made by Coroners, regulators and independent monitors and supporting the development of a national oversight mechanism to ensure compliance.
- Develop a risk assessment tool to examine and report on prisoner and staff safety before major policy and operational changes are made.
- Apply research to practice as part of efforts to reduce self-harm.

- Respond properly to people with mental health needs by strengthening liaison and diversion services and increasing court use of community sentences with mental health treatment requirements, and work with partners to call a halt to the use of prison as a place of safety.

Full background to the Keeping Safe initiative, including a podcast from the event, is available on the IAPDC website.

Other key progress areas

- In May 2021 the IAPDC submitted written evidence to **the Justice Select Committee on mental health in prisons**, which emphasised how inspectorate reports, investigation findings and PFD reports issued by coroners regularly reference unmet mental health need as the most significant factor in prison suicides.
- In 2022, the IAPDC signed an **agreement with HMPPS** in which both committed to increased data sharing and an open and transparent relationship.
- In a response to the **Prisons Strategy White Paper** in February 2022 the panel made clear that the prevention of deaths must be at the heart of all proposals set out by Government and any strategy for the future of prisons. The panel welcome HMPPS' commitment to establish 290 ligature resistant cells in accordance with the panel's advice, though a full review of ligature points is still required.
- In April 2022, the panel responded to the Justice Select Committee's call for evidence on the **role of adult custodial remand in the criminal justice system.** In the context of increasing remand lengths and data suggesting this cohort is at greater risk of self-inflicted death, the panel called for government to make greater effort in providing comprehensive early days support, identifying early signs of risk, and increasing available information for those facing extreme uncertainty while held on remand.
- In 2022 the panel started work with Director of Public Prosecutions Max Hill KC and the **Crown Prosecution Service** to bring together HMPPS, police, the Prisons and Probation Ombudsman and partners across the prison service to discuss processes following a death in prison custody and how such deaths can be reduced. With further engagement, and the crucial involvement of bereaved families supported by the charity INQUEST, planned for later in 2023, the panel hopes that this work will assist HMPPS, CPS, and other bodies to improve processes and better share learning and experience to prevent future deaths.
- In July 2022, following a **severe heat warning** the panel wrote to the Chancellor of the Duchy of Lancaster to urge ministers to take account of safety and the poorly ventilated environments in custodial settings. The panel has consistently advised that the prison service address, as a matter of urgency, fire safety risks in prison which pose a significant risk to life. Our advice stands that severe population pressures and overcrowding in a number of establishments must not be allowed to jeopardise essential fire safety works.
- The Prison Service is experiencing critical **recruitment and retention challenges and capacity challenges** – all of which increase the risk of death. In November 2022, the MoJ announced the commencement of Operation Safeguard – the planned use of police cells to act as overspill sites of detention for prisoners. We were clear in our response that this crisis was not unexpected and that due warning has come from the prisons inspectorate, independent monitors, unions and staff associations and the prison service itself. It is vital to be wise before the event in considering how to manage prison population pressures.
- In January 2023 the panel submitted evidence to the Justice Select Committee's inquiry into the **prison operational workforce**. It focused on the vital impact of an experienced, capable workforce on reducing deaths in prison custody. It also explored the significant impact of deaths in custody on staffing and retention and the importance of providing staff with meaningful support after a death.

Policing

Deaths in or following police custody have fallen from 19 in 2020/21 to 11 in 2021/22. The panel's work in this area has focused on a police leadership initiative, initially spearheaded by the former policing minister, the Rt Hon Kit Malthouse MP, which championed a zero-tolerance approach to deaths in custody across forces and key policing bodies.

Police leadership initiative on preventing policing deaths

> *"…practice is not uniform across England and Wales, with limited evidence that forces are sharing findings after a death, involving bereaved families in driving change or working with healthcare partners to provide effective support for vulnerable individuals following release."*
>
> **Emily Spurrell, Merseyside Police and Crime Commissioner**

The number of deaths during and following police custody has remained at similar levels for the last decade, while deaths within custody itself have fallen. However, the findings from inquests into the deaths of Kevin Clarke and Kelly Hartigan Burns, amongst others, have provided a stark reminder of matters of concern which have yet to be rectified. The deaths of people in mental health crisis and black men following the use of force by police officers have generated significant community concern.

Responding to these concerns, the panel has taken forward a police leadership initiative originally driven by the previous Minister of State for Crime and Policing to communicate a zero-tolerance approach to deaths in or following police custody. This work was focused on three key areas: mental health and risk, reducing apparent post-custody suicides, and embedding learning.

in December 2022 the panel published *Preventing deaths at the point of arrest, during, and after police custody*, a report bringing together, for the first time, a wide range of policing practice across England and Wales to prevent deaths at the point of arrest, during and after custody. The report demonstrates how many forces have forged partnerships with allied health and justice services to play to professional strengths, work with health professionals as first-responders to a mental health crisis, reduce inappropriate use of police time, and prevent deaths in custody. However, practice is not uniform across England and Wales, with limited evidence that forces are sharing findings after a death, involving bereaved families in driving change, or working sufficiently with healthcare partners to provide effective support for vulnerable individuals in crisis or following release.

> *"Valuable learning for police leaders and other agencies - especially given the additional pressures on police custody suites coming their way from prison population surge @PoliceChiefs @CollegeofPolice"*
>
> **Tweet by Andy Keen-Downs, 2 December 2022**

The report, drawn from responses received from 28 Police and Crime commissioners (PCCs), as well as chief constables and representative policing organisations, highlights relevant examples of police practice. Recommendations include:

- Greater collaboration across agencies, particularly healthcare, to support people experiencing a mental health crisis.
- Improved support for vulnerable individuals who are released.
- Better sharing and embedding of learning, particularly learning from bereaved families, the Home Office, coroners, and investigatory bodies.

The panel is now engaging with the Policing Minister, the Rt Hon Chris Philp MP, and relevant partners to take forward these recommendations. The report was welcomed by the Association of Police and Crime Commissioners, with their lead on deaths in custody, PCC Emily Spurrell, committing to continuing to work with the panel "*to help achieve zero deaths in custody".*

Other key progress areas

- The panel submitted evidence to the **Home Affairs Select Committee's inquiry into policing priorities**, arguing that in a modern police service fit for the 2020s, it is vital that police continue to discharge their fundamental duty to protect the lives of the public, including meeting the specific human rights obligation to safeguard the lives of people held in their custody.
- The panel has continued to work with Independent Office for Police Conduct (IOPC) on **restraint-related deaths data and deaths in the 'Other' category**, some of which are representative of failings in the areas of mental health response and use of restraint.

People detained under the Mental Health Act

Deaths in secure health settings remain high. In 2020/21 there were 363 deaths of people detained under the Mental Health Act and 270 in 2021/22, a period which saw a concerning increase from 33 to 50 unnatural deaths. There remains a significant lack of fundamental information about these deaths which has stymied focus on this area. The panel has resolved to focus on two main areas – securing accurate, timely data on deaths in detention and independent investigation of deaths which do occur – to begin to rectify this gap.

Data on deaths in detention

> *"Improvements could be made in the collection and recording of self-report data on race and ethnicity. Prison, immigration and police data are largely complete in this regard. Significant gaps remain in secure health figures. To give a stark example: half of the women detained under the Mental Health Act who died in 2019 did not have their ethnicity recorded."*
>
> **IAPDC, Statistical analysis of recorded deaths in custody between 2016 and 2019**

The panel has been taking forward work with key organisations to improve the recording and reporting of data on deaths of those detained under the Mental Health Act. Concerns about the accuracy, coverage and integrity of data in this area are longstanding and range from incomplete information on which deaths are captured to disparities in the data collected by different organisations. Gaining a clear understanding of precisely who is dying and how is an urgent prerequisite to inform future, much-needed work on deaths in these settings.

The panel welcomes the announcement of a national review of inpatient services by the Under Secretary of State for Mental Health, Maria Caulfield MP in response to some of these concerns. The panel has written to the independent chair of this rapid review, Dr Geraldine Strathdee, with an offer to share expertise and to ensure the vital issue of deaths data forms a central element of the review.

Preventing MHA deaths through provisions in the Draft Mental Health Bill

Following the Independent Review of the Mental Health Act, the Government published its Draft Mental Health Bill. While the Bill contains some welcome measures, the panel has recommended several changes to ensure its intention to speed up transfers from prison to hospital is achieved and a ban on the use of prison and police custody as a 'place of safety' is successfully implemented.

The panel also recommended the introduction of a statutory duty to produce high-quality data relating to those who die in detention and the creation of an independent body to investigate such deaths. Measures such as these are urgently needed to ensure that we learn from tragic deaths in detention, such as the high-profile cases that took place in Tees, Esk and Wear Valleys NHS Trust. The panel submitted evidence on these issues in September 2022 and the IAPDC chair gave oral evidence to the Committee in November. The panel submitted supplementary evidence later that same month. **The Committee recently issued the report of its inquiry in January 2023 which recognised a number of the panel's focus areas and recommendations.**

Response to COVID-19

The outbreak of COVID-19 in February 2020 required the panel to turn its attention to providing advice on the preservation of life in places of detention during the pandemic.

Advice to ministers and officials

The panel wrote to ministers on protecting vulnerable people detained in closed, poorly ventilated institutions, maintaining and strengthening family contact, improving communication and providing clear, accurate information, and making proportionate and necessary use of imprisonment. We held briefing sessions with scrutiny bodies, inspectors and regulators, and lead officials across the secure estate to identify steps taken to prevent deaths in all places of state custody during this period. The panel contributed to the Exceptional Delivery Models used to shape the HMPPS response to the pandemic, while the Chair attended the HMPPS Independent Advisory Forum, presenting particular items on reducing risk of self-harm and improving the safety of women.

End of Custody Temporary Release

In April 2020 the End of Custody Temporary Release scheme was announced by the Lord Chancellor and could have led, on his estimation, to the temporary release of up to 4,000 vulnerable people and those serving short sentences. Reducing overcrowding and risk in this way would have enabled the prison service to ease some of the severe restrictions it had imposed. The panel supported the introduction of the scheme and regretted that, mired in bureaucracy, it faltered and failed. Just 262 people were released by the time the scheme was paused on 19 August 2020.

The panel consistently drew attention to the merits of an early release scheme as a method of saving lives through correspondence throughout 2020 and 2021 to the Lord Chancellor, the Prisons and Probation Minister, the Minister for Crime and Policing, as well as the Minster of State for Mental Health, Suicide Prevention and Patient Safety.

> *"The Independent Advisory Panel on Deaths in Custody report on the government's covid-19 early release scheme: "... mired in complexity and risk aversion. The schemes are hard to understand, difficult to explain and close to impossible to deliver"*
> **Tweet by David Lammy MP, 1 June 2020**

A whole-institution approach to prisoner vaccinations

Based on the success of universal vaccination in care homes for vulnerable and elderly people as well as advice from the World Health Organisation (WHO), the panel strongly recommended the adoption of a whole-institution approach to vaccinations in prisons, rather than just the priority cohorts, as a clear method of saving lives and bringing a swifter end to extended lockdown and severe restrictions. This approach was endorsed and advanced by, amongst others, Public Health England, the World Health Organisation (WHO) members of the Ministerial Board on Deaths in Custody, and the Government's own Scientific Advisory Group on Emergencies (SAGE).[1]

The SAGE report published on 23 April noted that *"increasing early vaccination of all prisoners and staff would allow faster lifting of severe restrictions, reduce outbreaks and decrease mortality, and benefit the wider control of COVID-19".* Following its publication, the panel wrote again asking that the Joint Committee on Vaccinations and Incentivisation (JCVI) take full and proper account of SAGE's conclusions and revise its advice. In the media, Juliet Lyon set out the case for universal prison vaccinations to prevent the risk of prisons acting as "amplifiers or reservoirs of infection".

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[1] Scientific Advisory Group on Emergencies (SAGE), *COVID-19 Transmission in Prison Settings*, March 2021, S1166_EMG_transmission_in_prisons.pdf (publishing.service.gov.uk).

In December 2021 the IAPDC wrote to the co-chairs of the Ministerial Board on Deaths in Custody and to the Lord Chancellor setting out concerns and advice regarding the new COVID-19 variant. We received a disappointing response reinforcing their stance that they were following JCVI guidance that vaccinations would be prioritised based on age and clinical vulnerability.

Consulting prisoners on their safety during COVID-19

> *"A period of increased isolation and dependence has been mitigated for some people … by good communication, sound professional relations with staff, routines and small acts of kindness. It has been exacerbated for others by uncertainty and fear, bleak conditions and poor treatment."*
>
> **IAPDC, *Keep Talking, Stay Safe***

In June 2020, in partnership with National Prison Radio (NPR), the IAPDC published a report, *Keep Talking, Stay Safe: A rapid review of prisoner experiences under COVID-19*, drawing on messages from around 200 prisoners across 55 prisons which shed light on a period of heightened isolation and uncertainty. The IAPDC made ten recommendations grouped under five prevailing themes:

1. The importance of clear, accurate information and good honest communication;
2. Staff attitudes and approaches and continuing need for independent scrutiny;
3. Cleanliness, decency and variation in regimes;
4. Mental health, wellbeing and vulnerability; and
5. Family contact, loss and bereavement.

In September 2020 the IAPDC published *Just One Thing: Prison Safety and COVID-19*, an outline analysis of over 40 detailed prisoners' responses on suggestions for how to improve safety in prisons during COVID-19 and in the long-term. The briefing argued for a holistic approach to safety that prioritised purpose, humanity and identity. Findings from both reports were incorporated into wider 'lessons learned' research by HMPPS and discussed with the Lord Chancellor, prisons minister, and senior officials across both HMPPS and MoJ.

As the Government made plans for easing lockdown restrictions in 2021, the panel and NPR conducted the third and final part of their series to understand thoughts from people in prison about emerging after a prolonged period of severe restriction. Production of the '*Safe'* series began in May with programming broadcast throughout June 2021. It featured interviews with IAPDC chair, Juliet Lyon, a former Samaritan Listener, a family member of a prisoner during the pandemic, and panel member Professor Jenny Shaw.

Preventing deaths during the COVID-19 recovery period

While severe restrictions and extreme isolation imposed at the outset of the pandemic saved lives, the toll on mental and physical health is high and currently not fully understood. In April 2022 the IAPDC wrote in conjunction with Medical Royal Colleges, staff associations and unions, scrutiny bodies and leading health and justice charities to the Secretary of State for Health and Social Care, and the Deputy Prime Minister, Lord Chancellor and Secretary of State for Justice. The letter asked that their departments work together to provide additional mental health support for prisoners and offer individual mental and physical health checks to everyone in custody. It stated that it is essential to review the impact both of the pandemic itself and incidence of Long Covid, and of prolonged restrictive regimes on the mental and physical health of people in custody and the staff charged with their care. The response received was partial and did not take proper account of the advice given or help offered by signatories.

Today, Covid outbreaks continue to occur. Severe restrictions, including 23-hour lockdown, are still in place in some establishments. The IAPDC has contributed to the painstaking process of recovery, now lengthened by severe staff shortages and mounting population pressure. **The panel is preparing evidence for the independent public inquiry into Covid-19 and has written to its chair, Baroness Heather Hallett.**

Background

Panel appointments

The panel was pleased that ministers agreed to the reappointment of its members at the end of their original tenures in 2021 for an additional two years. This has allowed them to continue work on important panel projects and to take a more enhanced role in the reforms to the Ministerial Board on Deaths in Custody. The loss of one panel member with human rights knowledge of deaths as they relate to the law at the beginning of 2022 and the protracted campaign to recruit a successor has had a negative impact on the panel's ability provide specific advice to ministers and to progress some work areas as quickly as we would have hoped.

The Ministerial Board on Deaths in Custody

The Ministerial Board on Deaths in Custody (MBDC) brings together Ministers, senior leaders from relevant agencies and departments, the IAPDC, charities, the Chief Coroner and independent scrutiny bodies to progress and monitor work to bring about a continuing and sustained reduction in the number and rate of deaths in state custody in England and Wales. Its scope covers both self-inflicted and other deaths, spanning the police, prisons, immigration and secure mental health settings. The Board is supported by the panel which provides advice and challenge on policy and practice.

Following a review of the Board in early 2021 the panel has been involved in setting priority focus areas for the Board and developing its workplan. The panel has contributed substantively to agenda items on coroner PFDs and deaths involving the police, among others. The panel continue to provide advice and challenge on policy and practice and to monitor progress of the workplan.

Practitioner and Stakeholder Group

The panel has taken effective steps to engage and extend the size and impact of the Practitioner and Stakeholder Group, the third tier of the Ministerial Council on Deaths in Custody. The Group is drawn from inspectorate and investigative bodies, lawyers, third sector organisations, families, academics and practitioners from across the custodial sectors. The panel encourages practitioners from a range of organisations, particularly mental health settings, as well as bereaved families and former detainees, to join the group. Members of the group receive regular communication with links to relevant news and publications from across the sectors, updates from the IAPDC website and invitations to stakeholder events. It is a panel priority to make the most of this group's expertise and shared ambition to prevent avoidable deaths. You can join the group here.

Strategic partnerships

"May I thank-you for actually writing to liaise with those of us best positioned to give advice, those of us who are forced to endure the blunt end of the CJS"

Prisoner, HMP Northumberland

The panel has made it a priority to work collaboratively with a range of organisations during this period. This has included regular meetings with co-sponsoring Ministers and with officials and service leaders, as well as with several third sector organisations, Royal medical colleges, the Chief Coroner, scrutiny bodies and academics. This has included partnering with relevant expert organisations on specific projects. Where possible, the panel has made it a priority to consult with people in detention through organisations such as Inside Time and National Prison Radio.

Media and social media

The panel has continued to secure strategic visibility of its work in national and specialist media. This has included coverage of the panel's COVID-19 advice as well as individual reports. Juliet Lyon has also written monthly for Inside Time. The panel has established and amplified a presence on social media in this period. You can follow the panel at @IAPDC_UK.

IAPDC website

The IAPDC website, which includes links to our work and the minutes of our meetings, was relaunched following a full redesign in 2020. Some of the new features of the website include:

- The COVID-19 information hub, which was developed upon the outbreak of COVID-19 and presents the latest work from the IAPDC and others to protect the lives of people in state custody during the pandemic.
- The Resources for Families page, which provides resources, information and guidance for families and friends bereaved or affected by a state related detention or death.
- The Learning Library, which brings together evidence from different places of detention relating to deaths in custody. The hub is a collection of reports, research articles and statistics from government agencies, academics, the third sector and international bodies spanning prisons, police custody, immigration detention and Mental Health Act detention.

List of major IAPDC publications in this period

Subject	Publication	Date
Cross-cutting across places of detention	*Statistical analysis of recorded deaths in custody between 2016 and 2019*	Nov 2021
Immigration Detention	*Priorities for a prevention of deaths strategy in Immigration Removal Centres*	Oct 2020
Policing	*Preventing deaths at the point of arrest, during, and after police custodyPreventing deaths at the point of arrest, during, and after police custody*	Dec 2022
Prisons	*Avoidable natural deaths in custody: Putting things right*	Sept 2020
	Protecting lives: a cross-system approach to addressing alcohol and drug-related deaths within the criminal justice system'	Jan 2022
COVID-19	*Keep Talking, Stay Safe: A rapid review of prisoner experiences under COVID-19*	June 2020
	Just One Thing: Prison Safety and COVID-19	Sep 2020

The Panel and Secretariat

Juliet Lyon CBE, Chair
Juliet 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 Fellowships Advisory Council. She was previously director of the Prison Reform Trust, secretary general of Penal Reform International and a Women's National Commissioner. In September 2019, Juliet was re-appointed for a further three years. Her tenure has since twice been extended to end January 2023.

Jenny Talbot OBE
Jenny works for the Prison Reform Trust and chairs the HMPPS and NHSE/I National Women's Prison Health and Social Care Review Group. Jenny's main IAPDC project areas have been on work with the police, on Community Sentence Treatment Requirements and natural cause deaths in prisons. Jenny was appointed to the IAPDC in July 2018 and re-appointed in June 2021 for a further two years.

Professor Jennifer Shaw
Jennifer is a Professor of Forensic Psychiatry, University of Manchester and Honorary Consultant Psychiatrist Greater Manchester Mental Health NHS Foundation Trust. She has over thirty years' experience working clinically in the NHS. Jennifer has undertaken IAPDC projects in prisons involving substance misuse-related deaths and natural cause deaths in prisons, as well as cross cutting work on coroners Prevention of Future Deaths reports. Jenny was appointed to the IAPDC in July 2018 and re-appointed in June 2021 for a further two years.

Professor Seena Fazel
Seena 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. Seena's main project areas for the IAPDC have focused on cross-custody data analysis and deaths under the Mental Health Act. Seena was appointed to the IAPDC in July 2018 and re-appointed in June 2021 for a further two years.

Deborah Coles
Deborah is the Executive Director of the influential human rights charity INQUEST, that works on state related deaths. She has been involved mainly in cross-cutting work for the IAPDC including coroners' Prevention of Future Deaths reports and engagement with bereaved families. Deborah was appointed to the IAPDC in July 2018 and re-appointed in June 2021 for a further two years.

John Wadham (former member)
John is a human rights lawyer and was chair of the National Preventive Mechanism 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. John led the IAPDC's work on policing and undertook work with the Home Office on immigration detention. John was appointed to the IAPDC in July 2018. In June 2021, he accepted an extension to his appointment for a further six months, until December 2021.

Secretariat
The panel is supported by a knowledgeable secretariat (Lana Ghafoor, Sam Johnston-Hawke, Piers Barber and Kishwar Hyde) based in the Ministry of Justice. They can be contacted at iap@justice.gov.uk.