

Independent Review into Deaths in Custody of Young Adults (aged 18-24)

Terms of Reference

The Independent Advisory Panel on Deaths in Custody (IAP) is invited to conduct an independent review into the self-inflicted deaths of young adults aged 18 to 24 in NOMS (prison) custody. You should report to me, Jeremy Wright, with your recommendations for reducing the risk of future deaths of young adults.

The methodology of the review will be at your discretion but should adopt the following broad outline;

- The review should take into account deaths of young adults aged 18-24 in prisons and Young Offender Institutions in England and Wales.
- The review should examine cases since the roll out of ACCT was completed on 1st April 2007.
- The review should identify whether appropriate lessons have been learned from those deaths and if not, what lessons should be learned/what actions should be taken to prevent further deaths.

The review should focus on the following themes:

- Vulnerability – including the management of the risk of self-harm or suicide, mental health and other healthcare needs; learning disability and other complex needs.
- Information sharing – the provision of information to NOMS (including from agencies outside of the criminal justice system such as health, education and social care agencies; and including any relevant factors arising from their experiences prior to entering the custodial system) the transfer of information within the criminal justice system and whether information can be better utilised to assess risk factors.
- Safety – including violence reduction (bullying), the built environment and emergency response.
- Staff prisoner relationships.
- Family contact.
- Staff training.

Whilst the review will focus on the 18-24 age group, you should take account of learning which has been undertaken in respect of the youth estate and identify wider learning that will be of benefit to any age group.

As part of your review, you will take into account the views of stakeholders including:

- Prison Reform Trust, INQUEST, Howard League, Coroner's Society, Prisons and Probation Ombudsman, HMIP and YJB.
- Young adults in custody.
- Practitioners.
- Families of those who have died in custody during this period.

Stakeholder views may be obtained by written or oral evidence (or both) and by site visits. Evidence should seek to elicit the experience of stakeholders of deaths in prison custody and what improvements could be made but should not reinvestigate nor consider issues of liability in respect of individual deaths.

You are entitled to consider any information which is publicly available, which has been made available to you as part of your evidence gathering exercise or which can be disclosed by the Ministry of Justice in accordance with data sharing laws.

The Ministry of Justice will make available two full time members of staff of relevant experience and expertise for the period of the review and will cover reasonably incurred expenses which arise as a result of the review.

You should report to me with your conclusions and with your recommendations as to what further action should be taken. Your report is due to be presented by Spring 2015 and will subsequently be published in full.