Minutes of the twenty-fifth meeting of the Ministerial Board on Deaths in Custody
28 February 2018
1 Parliament Street, London

Attendees:
Rt Hon Nick Hurd MP - Minister for Policing and the Fire Service, Home Office (Chair)
Rory Stewart OBE MP - Minister of State for Prisons and Probation, MoJ
Jackie Doyle-Price MP - Minister for Care and Mental Health

Nick Poyntz	- Deputy Director, Prison Safety and Security, Ministry of Justice
Clare Checksfield	- Director, Immigration Enforcement, Home Office
Heidi Pearson	- Deputy Head of Police Powers Unit, Home Office
Chris Barnett-Page	- Head of Safer Custody, HMPPS
Richard Pickering	- Head of Fatal Incidents, Prisons and Probation Ombudsman
Deborah Coles	- Director, INQUEST
Peter Dawson	- Director, Prison Reform Trust
Juliet Lyon	- Chair, Independent Advisory Panel on Deaths in Custody
Michael Lockwood	- Director General, Independent Office for Police Conduct
HHJ Mark Lucraft QC	- Chief Coroner
Colin Allars	- Chief Executive, Youth Justice Board
Nick Ephgrave	- Chief Constable – Surrey, National Policing Lead - Criminal Justice
Nev Kemp	- ACC, NPCC Custody Portfolio
Dame Anne Owers	- National Chair of Independent Monitoring Boards
Kate Davies	- Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England
Jonathan Tickner	- Safety Lead, HM Inspectorate of Prisons
Britte Van Tiem	- Programme Manager, Samaritans
Sherry Ralph	- Chief Operating Officer, Independent Custody Visiting Association
Frances Crook	- Chief Executive, Howard League for Penal Reform
Richard Mason	- Deputy Director, Civil Law and Justice, Ministry of Justice
Linda Robinson	- Health and Policing Team, Home Office
Tom Bainbridge	- Head of Civil Legal Aid, Ministry of Justice
Andrew Fraser	- Head of Secretariat to Ministerial Council,
Kishwar Hyde	- Deputy Head of Secretariat to Ministerial Council (minutes),

Apologies
Charlie Taylor, Chair, Youth Justice Board
Fiona Malcolm, Deputy Chief Executive, Samaritans
Kim Forrester, Care Quality Commission
Peter Clarke, HM Chief Inspector of Prisons
Michael Spurr, Chief Executive, HMPPS
Andy Herd, Mental Health Policy, Department of Health

Item 1: Welcome, apologies and minutes

1.1 The Chair welcomed all members to the meeting and noted the apologies. He explained that the minutes of the last meeting had been agreed but members should advise the Secretariat of any matters of accuracy.

1.2 The Chair stated that there were still too many people dying in custody. Dame Elish's review and the work that flow from it must ensure that lessons are learnt and change happens. He quoted from the report:

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

1.3 The Chair emphasized that the Board has a collective responsibility to take action on lessons and to challenge itself to improve matters. He noted the amount of work on the Board's work programme and said that he was grateful for the manner in which organisations had engaged with the process. He said that the NPCC had written to him explaining the work they are doing in response to Dame Angiolini's review, and these workstreams have been incorporated into the wider work programme. The Chair explained that work was progressing across a wide range of workstreams and not all of them could be discussed within this meeting. The agenda was therefore focussed on those work streams where input from the Board was most needed at this point, and others, such as the IAP research report on alternatives to restraint, would be discussed in later workshops and meetings.

Item 2: Ministerial Board work programme on Dame Angiolini's report

Healthcare in police custody

2.1 The circulated paper covered the proposed methodology to be used to compare and collate good practice in police healthcare across the country. The Chair introduced Linda Robinson.

2.2 Linda stated that Department of Health were proposing to conduct a baseline review of healthcare in police custody. This is to be delivered in four tranches:

1. Analyse the range of guidance and legislation covering healthcare in police custody
2. Consult with police and healthcare colleagues to see if the standards are being met.

3. Analyse variety of commissioning models used by police forces across England and Wales
4. Gap analysis of the whole system

2.3 Linda explained that a small advisory group, which includes NPCC, has been set up to provide help but its membership could expand as the review progressed.

2.4 Minister Doyle-Price asked if those commissioning the healthcare services have sufficient skills and guidance in this area. Deborah Coles observed that the NHS provision of healthcare in custody suites had been discussed at the Board before, and members asked if this would be considered in the work. Minister Doyle-Price noted that the work suggests analysing the current situation and potential problems, without presuming which commissioning model will best address them. The Board supported the approach outlined, and requested an update at the next meeting.

Action 1: The Board gave the team endorsement for its approach, and asked it to report back on progress at the next meeting.

Support for families

2.5 Heidi Pearson explained that the Board's work programme contains a workstream for improving immediate post-incident support to bereaved families. Heidi explained that they had mapped the existing guidance for families and were grateful to INQUEST in helping to identify options for developing improvements. The information provided to families in the first instance is key to empowering them. Common themes important to families were consistency of information and understanding their rights.

2.6 Heidi drew attention to actions the IOPC were taking in this area such as reviewing the literature and information they provide to families. The Chief Coroner's Office will also be working with the MoJ to update its *Guide to Coroner Services.*

2.7 Heidi explained that the proposal from this workstream is to work with bereaved families and colleagues to develop a single, simple leaflet that would be distributed to bereaved families by all agencies in the immediate circumstances after a death in custody. The Board recognised that the most important element is for families to be shown care by people rather than simply being managed through a process. However, members also noted that a simple, clear leaflet could be an important source of consistent messages. Minister Doyle-Price noted that the recent NHS report on learning from deaths may have some helpful lessons for the leaflet. Deborah Coles confirmed that INQUEST would be keen to help facilitate the family input into the development of the leaflet.

2.8 Minister Stewart asked if there should be fewer lawyers at inquests. The Chief Coroner said that his priority is a more level playing field, which could mean fewer lawyers but does not necessarily lead to that. Board members noted that lawyers working for the bereaved families do help to ensure that someone is entirely 'on the families' side', and provides them with someone familiar with the relevant laws.

Action 2: The Board agreed the family support workstream should progress to producing a draft leaflet, and asked for it to be brought to the next meeting.

2.9 Minister Stewart also noted that Dame Elish's report recommended specialist bereavement counselling be provided for families following a death in custody and asked for information on this for the next Board.

Action 3: The Board asked for an update on specialist bereavement counselling for families be provided at the next Board.

Legal Aid update

2.10 The Chair noted that Legal Aid funding for families following deaths in custody was identified by Dame Elish as a priority area, and it remains an issue of importance for many Board members.

2.11 Richard Mason explained that the paper circulated to the Board covered two pieces of work:

- Review of the Exceptional Case Funding guidance; and
- A wider review of Legal Aid

2.12 Richard Mason explained that the MOJ is recommending a change in emphasis in the Guidance to effectively ask why shouldn't the family get funding rather than why should they? He also explained that the scope of the review of Legal Aid is still being confirmed although it will be wider than just deaths in custody and is likely to cover all inquests. He noted that everyone involved in its preparation recognised the urgency of the issue.

2.13 Deborah Coles confirmed that the current means test is a particular concern of families and said that they have many examples of the problems it causes. She noted that INQUEST would have welcomed the chance to input into the paper before the Board.

2.14 Board members spoke of the importance of making progress in this area, and Minister Hurd noted that he would like to discuss it with Minister Frazer (the MoJ Minister in charge of Legal Aid). Board members encouraged the team to progress this work quickly, and the Legal Aid team were asked to provide a further update to the Board shortly after the meeting.

Action 4: Minister Hurd to have a bilateral meeting with Minister Frazer to discuss Legal Aid further

Action 5: Legal Aid team to circulate an update to the Board on this issue.

Making inquests more sympathetic to the needs of bereaved families

2.15 Richard Mason reported that closely linked to the work on Legal Aid was Dame Elish's concern that the inquest process should take account of the needs of the bereaved families. Richard Mason explained that there are three main strands to this work:

- Considering the best way of controlling the number and actions of lawyers: a cross- Whitehall round table in April will look at the option of reducing the number of lawyers representing public bodies attending inquests. The MOJ are developing an evidence base on the experiences of bereaved families and a survey to coroners will ask their views on how to make inquests better for families.

- Working with the Chief Coroner to provide training for coroners in controlling the courtroom and improving lawyers' conduct in the court to make it less adversarial. Meetings and events are planned for March and April with the Solicitors' Regulation Authority.

- Extending support services to every coroner's court. Currently Coroners' Courts Support Services cover 33 of the 89 Coroner courts in England and Wales. The MOJ will go out to tender in Autumn 2018 with the aim of awarding a new contract for such support by the end of the financial year. Richard Mason explained that the MOJ are also scoping what specific guidance is provided for families attending a death in custody inquest with the aim of refreshing their guidance material.

2.15 The Chief Coroner explained that he supports the general approaches laid out in the paper, but is unclear about the timings involved in each strand. He confirmed that he will be taking forward 'judgecraft' training for coroners, and said that he supports the work of the support services in coroners' courts.

2.16 Deborah Coles asked who will be attending the cross-Whitehall group to discuss lawyers' actions. Richard Mason said that the team would consider the attendees, and clarify it with the Board. Deborah Coles also noted that the revised guidance about coroners will need to be coordinated with the leaflet for families. The Board agreed the work set out in the paper but requested clearer delivery times for each workstrand for the next Board.

Action 6 – MOJ Inquests Team to progress the workstreams but to provide clearer timelines on the policy options.

IAP paper on repeat recommendations

2.17 Juliet Lyon stated that Board had discussed repeat recommendations on several occasions. The IAP have been looking at the recommendations made most frequently and leading work on considering how best to help the custodial services focus on, and embed, them. Consultation with stakeholders indicated that there are enough cross-cutting themes to make a class of cross-sectoral recommendations possible. This would include recommendations concerning the quality of care, information sharing, the importance of integration, shareable IT systems, healthcare, effective emergency response and the involvement of families.

2.18 The Board noted that, in some areas, there may also be benefits to splitting out the recommendations by custodial sector as the priorities and information available vary in different custodial environments.

Action 7: The Board supported the IAP's work to develop a top 10 model for the next Board.

2.19 Minister Stewart asked Board members to share their thoughts on the areas that the Minister should look at in the forthcoming year. Members suggested that the Minister should consider issues such as the quality of emergency response, looking after staff to increase retention rates, getting prisoners out of their cells and keeping them meaningfully occupied.

Item 3: Custodial services updates

3.1 The Chair asked the custodial service sponsors to provide brief updates to the Board.

Home Office - Immigration Enforcement

3.2 Clare Checksfield explained that Stephen Shaw will report in the Spring on progress against the recommendations made in his 2016 review of the welfare of detainees in immigration removal centres. The existing DSO on managing self-inflicted deaths in detention is also being updated in parallel to HMPPS work.

Home Office – police custody

3.3 Heidi Pearson explained that the Home Office paper sets out the statistics for 2016/17 when there were 14 deaths in or following police custody, which is broadly consistent with recent years.

3.4 Deborah Coles noted that the number of apparent suicides following police custody is higher than 14, and commented that attention also needs to be given to this. The Chair asked for these to be included in the update paper for the next Board.

Action 8: HO to provide figures on the numbers of apparent suicides following police custody in future update papers.

HM Prison and Probation Service

3.5 Chris Barnett-Page explained that the circulated presentation showed a fall in numbers of deaths, although HMPPS would continue to try to reduce this further. The later slides including information on:

- prioritising safer custody training in prevention,
- establishing a central support group for establishments where improvements were most needed and
- training for new and existing staff. 14,300 have received the latest suicide and self-harm training so far
- Recruiting 2,500 new staff

Item 4: Any other business

4.1 Richard Pickering informed the Board of the death of two children in Secure Children's Homes in the last year.

4.2 Juliet Lyon advised that Kathy Biggar, who had set up the Samaritan Listeners Scheme in prisons and who had been very active in helping the IAP in their recent Keeping Safe report, was very ill. The Board expressed their sadness at hearing this, and praised Kathy Biggar's dedication to keeping those in custody safe over her career.

4.3 The Chair noted the concerns of families regarding the length of time taken by investigations. Michael Lockwood said that the IOPC would look at the length of their investigations and also the end-to-end process, in collaboration with partners and will provide a paper on this work for the next Board.

Action 9: IOPC to provide a paper on the timeliness of investigations for the next Board.

Item 5: Date of next Ministerial Board on Deaths in Custody

5.1 The Chair thanked all the attendees and asked everyone to note the actions to be taken before the next Board. He said that the next Ministerial Board will be held in mid-2018 at the Department of Health.