Written evidence from the Independent Advisory Panel on Deaths in Custody

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 the Home Office. The Council consists of three tiers:

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

The remit of the IAP (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 IAP, 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 IAP.

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

Key points:

- **Active steps must be taken to ensure inquests are inquisitorial, not adversarial. Bereaved families deserve to be treated with respect and have an important role to play in the process. Their involvement should be facilitated and prioritised, and supported through the provision of non-means tested public funding.**
- **Cross-cutting, collaborative work must be carried forward to ensure learning from deaths, and specifically coroners' prevention of future deaths reports, are appropriately disseminated and embedded into policy and practice.**
- **The resources and scope of the Coroners' Office should be expanded to enhance their ability to identify the cause of deaths occurring in custody and, where relevant, examine significant preceding events.**

1. The Independent Advisory Panel on Deaths in Custody (IAP) welcomes this inquiry into the effectiveness of the Coroners Service. The IAP's focus falls on the deaths of those in custody, cases which frequently lead to the most complex inquests.[1]

[1] Independent Advisory Panel, 'About the Independent Advisory Panel on Deaths in Custody',

2. The coroner's inquest, together with the investigation by the Prison and Probation Ombudsman (PPO), are the principal means in England and Wales by which the State seeks to meet its obligations to carry out an effective and timely investigation of deaths in state custody (as required by Article 2 of the European Convention on Human Rights).[2] Inquests can be a vital tool for examining the causes of the death of someone in the care and detention of the state and play a key role in alerting public authorities to failures in policy implementation.

3. The system therefore requires fair and adequate funding. This is particularly relevant given the pressures that the COVID-19 pandemic has placed on the holding of inquests which have highlighted and reinforced the need for the system to be adequately resourced.

4. This evidence draws on the IAP's work, both through its own output and contributions to the Ministerial Board on Deaths in Custody, to highlight and strengthen the role of coroners in preventing avoidable future deaths. This includes the Harris Review into self-inflicted deaths in custody of 18-24 year olds, published in July 2015, which called for enhanced arrangements to follow-up actions highlighted by coroners and inquest findings.[3]

Improving inquests and supporting families

5. The Harris Review highlighted the importance of addressing delays in the completion of coroner investigations. Such delays often have a serious impact on bereaved families, especially following a death in custody, who too often face a substantial period when important questions are yet to be answered. The Review concluded that the Chief Coroner should work closely with the PPO to reduce the time taken between a death and the subsequent inquest hearing. Where there are delays, families should be kept regularly updated on progress and informed when an inquest will be held.[4]

6. Inquests must be inquisitorial not adversarial. They should be held in dedicated courts whenever possible and otherwise in an appropriate and authoritative setting. As Deputy Chief Coroner HHJ Alexia Durran told the IAPs Keeping Safe Conference in February 2020, *"an inquest is an inquest, not a public inquiry"*.[5] Research by the charity INQUEST shows that it is not uncommon for the deceased to have no family representatives present at inquests, in contrast to the government institution which often has significant legal representation.[6] There is a risk that this undermines the purpose of inquests: to identify systemic trends with a wide scope and provide appropriate scrutiny.

7. In addition, non-relatives and relevant organisations should be permitted to attend inquests where it is not possible for family members to attend, and improvements made

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https://www.iapondeathsincustody.org/about-us-1.

[2] European Convention on Human Rights, https://www.echr.coe.int/Documents/Convention_ENG.pdf

[3] The Harris Review, 'Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds', July 2015, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ee0f0fc53012b3f15e7a217/1591800075717/Harris-Review-Report2.pdf.

[4] *Ibid.*, p.183.

[5] Presentations from the Keeping Safe conference, February 2020, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ece24a095844040ae2773c9/1590568118694/Keeping+Safe+Conference+2020+PRESENTATIONS.pdf

[6] Submission to the Harris Review received from INQUEST on 13 October 2014. Submissions can be found at https://www.iapondeathsincustody.org/hr-submissions.

to the information provided to families, including sources of specialist advice and support.[7]

8. 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.[8] This would ensure meaningful participation and 'parity of arms'.

9. A considerable amount of scrutiny is undertaken in the aftermath of a death in custody, including internal reviews, external investigation reports and inquest findings. Families should be promptly and appropriately notified of action taken in response to the outcomes of the investigation and inquest process, and supported to provide feedback on the actions and behaviour of the services following a death in custody as well as their experience.

10. Inquest outcomes and narrative verdicts should also be collated and published in order to best fulfil their potential of highlighting wider issues and failings.

Embedding learning

11. Deputy Chief Coroner Durran's presentation to the IAP's Keeping Safe conference highlighted the importance of making full use of coroners' reports to learn lessons about how future deaths can be prevented.[9] The IAP supports calls to strengthen coroners' role in this area, and is particularly keen to explore how to ensure that coroners' recommendations made in prevention of future deaths reports (PFDs) are implemented across custodial services.[10] These reports present essential insight for departments and services responsible for the safety of people in their care.

12. Steps must be taken to ensure PFDs are appropriately distributed to services with the power and capacity to implement them. For deaths in police custody, for example, mechanisms should be in place to ensure PFDs are routinely shared with police forces, as well as other organisations such as the College of Policing, which would be best placed to consider whether the report's conclusions should inform national training. For deaths which occur in prison they should be distributed and embedded into learning within the Ministry of Justice, HM Prisons and Probation Service, scrutiny bodies including the HM Inspectorate of Prisons, the IAP, and the area manager and governor of the establishment where the person died. In addition to the Chief Coroner's annual report to the Lord Chancellor, summary reports should be presented to the Ministerial Board on Deaths in Custody.

13. This work should form part of wider improvements required to increase the capacity for, and commitment to, developing a learning culture within custodial settings, as well as information sharing between services.[11]

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[7] IAP paper to the Ministerial Board on Deaths in Custody, 'Achieving accountability and embedding recommendations - Learning from bereaved families', June 2018, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5f4f82de6d5d88276e3859cf/1599046370597/MBDC+20190227-+5+Learning+from+bereaved+families+report_.pdf.

[8] 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.

[9] Presentations from the Keeping Safe conference, February 2020.

[10] The Coroners and Justice Act 2009 made it a duty, rather than a 'discretion', for Coroners to produce Prevention of Future Deaths reports following inquests where clear lessons can be learned.

[11] IAP paper to the Ministerial Board on Deaths in Custody, 'Embedding recommendations to prevent

14. In a forthcoming report, the IAP draws on evidence from coroners to understand how deaths defined as naturally occurring could be prevented. As part of this work, the IAP recommends regular standing meetings between the Prison and Probation Ombudsman, the office of the Chief Coroner, prison governors and healthcare managers to consider often repeated recommendations with solutions found and actioned.[12]

Compliance

15. The IAP supports and will continue to champion calls to make more effective use of reports and recommendations made by coroners, regulators and independent monitors.

16. Summarising this issue, the Angiolini Review concluded:

> *"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".[13]*

17. Going forward, this can be achieved through the creation of a national oversight mechanism to monitor deaths in custody, specifically the implementation of official recommendations arising from post death investigations.[14] Such an independent, public sector body would monitor the take-up of recommendations and inquest PFDs and enhance government obligation to respond and adhere to relevant inquiries.

Structure and ambit of coronial services

18. The IAP recommends that that the office of the Chief Coroner is provided with the capacity and resources to publish information and produce searchable data so that prevailing themes and risks leading to deaths can be identified.

19. The IAP also believes that consideration should be given to extending the remit of coroners' to relevant preceding events before a death occurred in custody – for example a self-inflicted death in prison where someone has clearly identified and unmet mental health needs and where they could have been sentenced to be detained under the Mental Health Act and receive treatment rather than be consigned to prison custody.[15]

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deaths in custody', October 2018, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf.

[12] Independent Advisory Panel and the Royal College of Nursing, 'Avoidable natural deaths in prison custody: putting things right', Forthcoming September 2020.

[13] Angiolini Review, p. 226.

[14] See Angiolini Review, p. 13; IAP paper to the Ministerial Board on Deaths in Custody, 'Embedding recommendations to prevent deaths in custody', October 2018. A national oversight mechanism is a proposal originally developed by the charity INQUEST.

[15] For example, see The Women's Institute, 'Care not Custody' campaign, https://www.thewi.org.uk/campaigns/past-campaigns/care-not-custody.