Supplementary written evidence submitted by Juliet Lyon CBE, Former Chair, Independent Advisory Panel on Deaths in Custody (IAP0001)

I am writing to thank you for inviting me to provide oral evidence to the Justice Committee on 18 April. I appreciated the opportunity to reflect on progress made – and steps still to be taken – in reducing deaths in prison custody during my time as chair of the Independent Advisory Panel on Deaths in Custody (IAPDC). There were some topics we were not able to cover during the session, and I am grateful for the invitation to answer those questions in writing.

What progress has been made on preventing self-inflicted deaths in prisons, including progress on the introduction of more safe cells and the removal of ligature points across the estate?

Self-inflicted deaths in prisons remain high and subject to fluctuation. There is no such thing as an acceptable level of such deaths. Following a steep rise in the number of self-inflicted deaths in 2016, with 124 people taking their own lives in prison, the numbers decreased in 2017 and 2018, then began to rise again. The most recent figures show 82 self-inflicted deaths in the 12 months to March 2023.[1]

There appears to be an increase in "clusters" of self-inflicted deaths or multiple deaths in particular establishments. This phenomenon is of particular concern. While I welcome the work of the prison service to develop postvention support for prisoners and staff after a death and a defined process for responding to cluster incidents, more must be done to put in place protections to account for the impact of heightened exposure to suicidal behaviour sadly so common in our prisons.

As I indicated to the committee during oral evidence, my first priority as IAPDC chair was to examine the causes of self-inflicted deaths in prison. Through work with Inside Time and the Samaritans, the Panel consulted people in prison on the problems and solutions required. Compassionate and experienced staff, meaningful regimes, increased contact with families, and improvements to the assessment, care in custody and teamwork (ACCT) system were all identified as priorities.[2] Support provided by a full complement of Samaritan Listeners was seen as vital.

Progress in these priority areas has been mixed. Steps have been made to improve family contact, notably through the prisoners' families helpline facilitated in partnership with the charity Pact. Supportive, understanding staff are of course in post, though the committee is well aware of workforce challenges currently endemic across the prison estate with dangerously low staffing levels in some establishments. Restoration of keyworkers across the male estate, and their introduction into women's prisons, and purposeful regimes (including support for the Listener programme) are painstakingly slow in the aftermath of the COVID-19 pandemic. Mental and physical health checks have not been conducted systematically. Despite a very high incidence of confirmed cases of COVID-19 among staff and almost 50,000 infections among prisoners and children in custody[3], little or no account

[1] HMPPS & MoJ, 'Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to March 2023 Assaults and Self-harm to December 2022', 26 January 2023, available here.
[2] IAPDC, 'Keeping safe – preventing suicide and self-harm in custody', December 2017, available here.
[3] MoJ, 'HM Prison and Probation Service COVID-19 Statistics, February 2023', 10 March 2023, available here.

has been taken of those suffering from Long Covid. These factors are directly relevant to deaths. The increase in self-inflicted deaths in recent months needs proper scrutiny. When it comes to the safety of those in their care, it is essential that departments and agencies are wise before the event.

On ligature points, the use of ligature has historically been the main method used for suicide in prison, and the percentage of deaths caused by ligature remains consistently high since 2000. Hanging accounted for 82% of all incidents in 2022.[4] Increasing the number of ligature resistant cells will help address this.

HMPPS' commitment to establish 290 ligature resistant cells in accordance with the IAPDC's advice is welcome. However, the removal of ligature points must apply retrospectively to the whole estate and not just be factored into the design of new cells. A full review of ligature points is also necessary. Piping, wall fittings, and light fittings would appear reasonably straightforward to remove and this would go some way to addressing this issue.

Prison governors should be required to review and remove avoidable ligature points and be provided with appropriate funding to do so. Learning from the secure hospital estate demonstrates that such an approach can have a marked impact on the number of self-inflicted deaths. For example, evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health shows there were approximately 20-30 deaths per year by hanging/strangulation between 2008 and 2014. However, following ligature reviews, this number has fallen to between 15-20 since 2015.[5]

The Draft Mental Health Bill – what you'd like to see in the Government's response to the Joint Committee's report on the draft Bill, particularly in relation to the ambition to remove the use of prison and police cells as a place of safety, and the introduction of a 28-day time limit on transferring prisoners from prison to hospital?

The IAPDC welcomed the proposal within the Draft Mental Health Bill to end the use of prison and police cells as 'places of safety'. Their use in such circumstances poses serious risk to individuals experiencing mental health crises and therefore places lives in danger. However, this needs to be properly funded and resourced. At present, it is a lack of available healthcare resource which leaves vulnerable people being placed in prison and police cells. Additional healthcare resource to free up beds, as well as commissioning of health-based places of safety, is urgently needed. This issue was also highlighted by the Joint Committee in its report, calling for "adequate community crisis care and health-based places of safety to support these changes".[6]

The proposal within the Bill to introduce a time limit on mental health transfers from prisons to hospitals was also welcomed by the IAPDC. However, the language within the draft Bill does not appear to require any authority involved to ensure that transfers actually take place within 28 days. Rather, they must "seek to ensure" that the individual is transferred within that time. Placing no stricter duty on anyone to effect transfer may leave the time limit significantly less likely to be met. The IAPDC was pleased to see the Joint Committee adopt

[4] HMPPS & MoJ, 'Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2022 Assaults and Self-harm to September 2022', 26 January 2023, available here.
[5] National Confidential Inquiry into Suicide and Safety in Mental Health, 'Annual report 2021: England, Northern Ireland, Scotland and Wales', May 2021, available here.
[6] Joint Committee on the Draft Mental Health Bill, 'Draft Mental Health Bill 2022' 19 January 2022, available here.

its recommendation to place relevant bodies under stronger obligation, which I hope to see accepted by the Government.

Lengthy waiting times ahead of transfer can lead to the serious deterioration of unwell prisoners' mental health, potentially leading to their being segregated, placed on constant watch, and at risk of suicide.

Safety Impact Assessments – how their use improves safety in custody, and what benefits you believe placing them on a statutory footing would bring.

The Safety Impact Assessment is a device, designed by the IAPDC during my tenure and endorsed by the Prison Governors' Association and the Prison Officers' Association, to inform decision making from the perspective of safety at a systemic level. It is intended to help maintain a consistently high level of priority for keeping prison staff and prisoners safe. Modelled in part on the equality impact assessment, it aims to ensure all proposals affecting custodial institutions include assessment of their likely impact on the health and safety of prisoners and staff charged with their care, particularly where such proposals might increase the risk to life. If risks to the lives or safety of staff or prisoners are identified, steps in mitigation should be set out before final approval is given.

Responsibility for such considerations cannot reasonably be left to any one group within the prison or probation service but needs to be addressed from the earliest stages in policy development. Putting the Safety Impact Assessment on a statutory footing would ensure the safety and welfare of staff and prisoners are placed at the forefront of all new policies or major operational changes. While this has yet to be taken up by the Government, I welcome work led by senior officials to integrate the Safety Impact Assessment tool into key governance processes within the department and HMPPS. MoJ evaluation shows that this has had a positive impact on policy and operational decisions from the perspective of safety.

I understand that the Home Office is making use of safety impact assessments in the development of the immigration estate at Haslar and Campsfield House immigration removal centres. It is clear that more must still be done to ensure that safety is systematically prioritised on a permanent basis across decision making regarding detention settings – particularly by ministers, who carry ultimate responsibility for taking active steps to protect the lives of those in their care.

IAPDC appointments – concerns regarding delays in appointments, how this affects the work of the Panel and the MoJ, and any action you'd like to see to ensure timely appointments to the Panel in future?

I was frustrated by the consistent and considerable delays to appointments to the Panel throughout my tenure. Most notably, this included a delay to the appointment of a panel member with human rights expertise, a role vital to the work of the IAPDC from the perspective of its grounding in Article 2 of the European Convention on Human Rights. The appointment of Raj Desai, a highly respected barrister specialising in human rights and public law, in March 2023 took place well over a year after the campaign for the position was launched in December 2021 and interviews conducted in May 2022. This significant delay undermined the Panel's ability to provide full advice to ministers and the speed with which it could progress its work. There was also a considerable delay to appointment of my successor, Lynn Emslie, which resulted in two extensions to my tenure.

I was pleased to learn of the recent appointments of Pauline McCabe MBE and Dr Jake Hard, both of whom will bring invaluable knowledge and expertise to the IAPDC. The timely completion of appointments is crucial to ensuring the IAPDC can fulfil its core function of providing independent, expert advice to ministers and senior officials on how they can meet their human rights obligations to protect the lives of people detained in state custody. Disruption to the appointment process has a negative impact on continuity, momentum, and the balance of expertise held by the IAPDC.

Combined with delays to the appointment of the new Prisons and Probation Ombudsman, these delays undermined the quality and timeliness of independent evidence and challenge provided to ministers and officials on the vital issue of custody deaths during this period. Thought must be put in to how these processes can be improved to avoid unnecessary bureaucracy. High-quality appointments must be made in a timely, professional manner to ensure ministers receive the best possible advice.

What you'd like to see in terms of future priorities and areas of focus for your successor?

The Panel's remit is wide. There is a significant range of interventions that it could continue to make meaningfully in the coming months and years. The new chair and her panel colleagues are formulating a strategic programme of work. I understand, and welcome, that response to mental health need is likely to remain an area of focus.

Work nearing completion includes informing the Department of Health and Social Care's new suicide prevention strategy to ensure the prioritisation of vulnerable people in detention; engagement with police forces across England and Wales to prevent deaths at point of arrest and on release from custody; and concluding work to improve the impact of prevention of future deaths reports issued by coroners. The question must be addressed of how independent recommendations can be better enacted and embedded by custodial services. The Panel's monitoring of compassionate release decisions should help to identify and eradicate remaining blocks to fairness, transparency and timeliness.

I hope that the Panel continues to adhere to the strategic principle developed during my tenure of striving to engage those in custody and bereaved families throughout its work.

What you think the Panel needs from the MoJ in order to fulfil its functions effectively?

Effective working, shared visits to establishments and good communication between the IAPDC and ministers and officials at the Ministry of Justice and prison service are vital to ensuring improvements to the safety of prisoners and conditions within custody.

Crucially, ministers must prioritise this issue and take active steps to protect the lives of all individuals detained by the state. Their leadership of the Ministerial Board on Deaths in Custody and the facilitation of meaningful collaboration between co-sponsoring departments are needed to ensure joined-up working across policy boundaries and agencies. Continued improvement to data collection and the evidence base are vital to better understand and direct interventions towards the prevention of deaths.

I would like to take this opportunity to thank IAPDC colleagues for drawing so generously on their knowledge and skills, as well as colleagues from co-sponsoring departments, the Ministerial Board on Deaths in Custody, and the practitioner and stakeholder group. I would

also like to pay particular tribute to people with lived experience and bereaved families who were pivotal in the design and delivery of the Panel's work. It was a privilege to work with them and to serve as chair of the Panel.

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