House of Lords
House of Commons

Joint Committee on Human Rights

Deaths in Custody: Interim Report

First Report of Session 2003–04

HL Paper 12
HC 134

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Report and Written Evidence

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JOINT COMMITTEE ON HUMAN RIGHTS

The Joint Committee on Human Rights is appointed by the House of Lords and the House of Commons to consider matters relating to human rights in the United Kingdom (but excluding consideration of individual cases); proposals for remedial orders, draft remedial orders and remedial orders.

The Joint Committee has a maximum of six Members appointed by each House, of whom the quorum for any formal proceedings is two from each House.

Current Membership

HOUSE OF LORDS	HOUSE OF COMMONS
Lord Bowness	Mr David Chidgey MP (Liberal Democrat, *Eastleigh*)
Lord Campbell of Alloway	Jean Corston MP (Labour, *Bristol East)* (*Chairman*)
Lord Judd	Mr Kevin McNamara MP (Labour, *Kingston upon Hull*)
Lord Lester of Herne Hill	Mr Richard Shepherd MP
Lord Plant of Highfield	(Conservative, *Aldridge-Brownhills*)
Baroness Prashar	Mr Paul Stinchcombe (Labour, *Wellingborough)*
	Mr Shaun Woodward MP (Labour, *St Helens South*)

Powers

The Committee has the power to require the submission of written evidence and documents, to examine witnesses, to meet at any time (except when Parliament is prorogued or dissolved), to adjourn from place to place, to appoint specialist advisers, and to make Reports to both Houses. The Lords Committee has power to agree with the Commons in the appointment of a Chairman.

Publications

The Reports and evidence of the Joint Committee are published by The Stationery Office by Order of the two Houses. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/commons/selcom/hrhome.htm. A list of Reports of the Committee in the present Parliament is at the back of this volume.

Current Staff

The current staff of the Committee are: Paul Evans (Commons Clerk), Ian Mackley (Lords Clerk), Professor David Feldman (Legal Adviser), Róisín Pillay (Committee Specialist), Duma Langton (Committee Assistant) and Pam Morris (Committee Secretary).

Contacts

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Report

The Inquiry

1. We announced our inquiry into human rights and deaths in custody in July 2003. The inquiry considers deaths in prisons, police detention, immigration detention and detention under the Mental Health Act, as well as other deaths in the custody of the State. The inquiry sets out to consider the problem of deaths in custody from a human rights perspective, in particular in terms of the obligation to protect the right to life under Article 2 of the European Convention on Human Rights, incorporated into UK law by the Human Rights Act 1998.

Background

2. We issued a call for evidence in July 2003. In it we noted that Government figures indicate that the numbers of deaths in custody are high and are increasing. Our inquiry responds to this, and has two aspects.

3. First, we wish to assess how a human rights approach to the management of prisons and other places of detention can assist in preventing deaths in custody. Under the European Convention on Human Rights there is a positive obligation on the UK, and on the responsible public authorities, to take steps to protect the right to life,[1] the right to freedom from inhuman and degrading treatment[2] and the right to physical integrity[3] of those in the custody of the State who are known to be at risk of harm. The inquiry is concerned with how these obligations are complied with through ensuring adequate and appropriate conditions of detention; by appropriate healthcare provision; in the management of places of detention; and by the monitoring of prisoners at risk.

4. Secondly, the inquiry examines how deaths in custody are investigated, in light of the requirement of Article 2 of the ECHR that there should be an effective, independent official investigation following a death in custody. The European Court of Human Rights has set out the requirements of such an investigation.[4] It specified that an investigation should be: on the initiative of the State; independent, both institutionally and in practice; capable of leading to a determination of responsibility and the punishment of those responsible; prompt; allowing for sufficient public scrutiny to ensure accountability; and allowing the next of kin sufficient opportunity to participate. This inquiry is being conducted at a time when a number of measures are being taken or considered to provide more effective and independent mechanisms of investigation into deaths in custody. These include: proposed changes to the inquest system, following the Fundamental Review,[5] the imminent establishment of the new Independent Police Complaints Commission (IPCC); and proposals for a more independent system of investigations of deaths in prisons.

1 Article 2

2 Article 3

3 Article 8

4 In *Jordan v UK*

5 Death Certification and Investigation in England, Wales and Northern Ireland, the Report of a Fundamental Review, 2003

Call for Evidence

5. In our call for evidence we invited respondents to address the following specific points—

— What are the main causes of deaths in custody? Are there any common factors? Are there particular aspects of conditions of detention, or the treatment of detainees, or the cultural background of prisoners or prison officers, that contribute to:

- suicide and self-harm in custody?
- other deaths or injuries in custody?

— What practical steps have already been taken, and what further steps need to be taken to prevent:

- suicide and self-harm in custody?
- other deaths or injuries in custody?

— What can a human rights approach to conditions of detention and management of detention facilities contribute to the prevention of deaths in custody?

— What can be done to foster a greater "human rights culture" in prisons and other detention facilities?

— Are the Article 2 ECHR requirements of an effective, prompt and independent investigation of deaths in custody, with effective participation by the next-of-kin, met by:

- the coroner's jurisdiction, including the inquest;
- investigations by the Prison Service;
- investigations by the new IPCC;
- criminal prosecutions;
- civil proceedings; or
- any other avenues of investigation?

— If not, what should be done to satisfy the Article 2 ECHR requirement of an independent, transparent and effective investigation?

Responses

6. We received responses from a wide range of organisations and individuals, including evidence from the Home Office and the Department of Health, from the relevant investigatory authorities and inspectorates, and from NGOs, academics, lawyers, and relatives of those who have died in custody. These submissions are printed as appendices to this report. While the Committee's inquiry into the complex issues raised by deaths in custody is still continuing, this report is designed to make available the written evidence we have so far received in connection with this inquiry.

Progress of the Inquiry

7. We will shortly begin to hear oral evidence in relation to this inquiry. We would welcome further written evidence until 30 March 2004. We hope to publish our final report and conclusions on this inquiry in the later part of 2004.

Formal Minutes

Monday 15 December 2003

Members Present:

Jean Corston MP, in the Chair

Lord Bowness	Mr David Chidgey MP
Lord Campbell of Alloway	Mr Kevin McNamara MP
Lord Judd	Mr Paul Stinchcombe MP
Lord Lester of Herne Hill	
Baroness Prashar	

The Committee deliberated.

Draft Report [Deaths in Custody: Interim Report], proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 7 read and agreed to.

Resolved, That the Report be the First Report of the Committee to each House.

Ordered, That certain papers be appended to the Report.

Ordered, That the Chairman do make the Report to the House of Commons and that Baroness Prashar do make the Report to the House of Lords.

[Adjourned till Monday 12 January at a quarter past Four o'clock.

List of Written Evidence

Government

Inspectorates and Commissions

Organisations

Individuals

Written evidence

1. Memorandum from the Home Office

DEATHS IN POLICE CUSTODY

Introduction

1. The Home Office welcomes the Joint Committee's inquiry into this complex area and offers its full co-operation and participation. Any death in police custody is a tragedy and police forces across the country are taking a whole range of actions to ensure that such deaths are kept to a minimum. The Human Rights Act has incorporated the provisions of the European Convention of Human Rights into UK law and the Home Office is committed to its principles and requirements and is determined to ensure that all those held in police custody are as safe as possible. Reducing all types of death in police custody, but especially suicide and self-harm, is a key objective and a great deal of work has been and continues to be done in this area.

2. The Home Office publishes annual statistical bulletins to record deaths in police custody or those that follow any kind of contact with the police. Copies of bulletins for the years 1999–2000, 2000–01, 2001–02 and 2002–03 are attached as background briefing.[1] Prior to April 2002, deaths in police custody were broken down as:

Category A—where the deceased was in any type of police detention or hospital having been arrested for an offence;

Category B—this category was defined as where the deceased was otherwise in the hands of the police or death resulted from the actions of a police officer in the purported execution of his duty.

3. With effect from 1 April 2002 the Home Office introduced new and broadened categories covering all deaths of members of the public during or following police contact. This was done because it is considered important to record all deaths that follow contact with the police, however minimal. The categories are as follows:

Category 1

Fatal road traffic accidents involving the police

This definition covers all deaths of members of the public resulting from road traffic incidents involving the police, both where the person who dies is in a vehicle and where they are on foot.

Category 2

Fatal shooting incidents involving the police

This definition covers circumstances where police fire the fatal shots.

Category 3

Deaths in or following custody

This definition covers the deaths of persons who have been arrested or otherwise detained by the police. It also includes deaths occurring whilst a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

Category 4

Deaths during or following other types of contact with the police

This definition covers circumstances where the person dies during or after some form of contact with the police which did not amount to detention and there is a link between that contact and the death.

Deaths in Police Custody—2002–03

4. The Home Office has not yet published the statistics bulletin on deaths for 2002–03—this will be done in the autumn. The bulletin will be made available to the Select Committee as soon as it is published.

[1] Not printed here.

Q1. *What are the main causes of deaths in police custody? Are there any common factors? Are there particular aspects of conditions of detention, or the treatment of detainees, or the cultural background of detainees that contribute to?*

— Suicide and self-harm in custody?

— Other deaths or injuries in custody?

The table below sets out the main causes and numbers of deaths in police custody since 1999:

Year	*Alcohol/ Drugs*	*Road Traffic Accidents*	*Shootings*	*Suicides*	*Natural Causes*	*Restraint*	*Misc*	*Total*
1999–2000	15 (3)	22	3	11 (3)	5 (3)	2	12	70
2000–01	12 (4)	16	2	5 (2)	5 (1)	—	12	52
2001–02	11 (2)	34	4	4 (1)	9 (1)	2	6	70
2002–03	13 (2)	40	3	11 (2)	11 (1)	2	19	104

The figures in brackets refer to deaths which occurred in police stations.

Deaths during or following contact with the police—statistics for 2002–03

Although the statistics for 2002–03 appear to have risen (from 70 in 2001–02 to 104 this year) they are not really comparable. Prior to April 2002, there were only two categories to record deaths—those that occurred where the person was detained in police custody, and where the deceased was otherwise in the hands of the police. If the previous definitions had been used, the total for 2002–03 would be 77.

With effect from 1 April 2002, the Home Office introduced revised categories covering deaths in police custody—deaths of members of the public during or following police contact. This was done to ensure that all relevant deaths involving any form of contact with the police were included in the statistics; and to draw a clear distinction between those where there was direct contact with the police and those where it was less obvious.

Suicide/self harm deaths

In 1999, of the 14 suicides all were male and 13 were white. Three people hanged themselves in police cells and the rest committed suicide following some other form of contact with the police.

In 2000, all suicides were white males and two people hanged themselves in police cells.

In 2001, all suicides were white males and all deaths occurred outside police detention, but following some form of contact with the police.

In 2002, two white males hanged themselves in police stations. Nine white males, one black male and one white female committed suicide following some other form of contact with the police.

Age seems to have no bearing on those who commit suicide—ages range between 17 and 60.

Road traffic accidents

People killed in road traffic accidents were almost exclusively white males and approximately 90% were under the age of 30, with many of those under the age of 25. Almost all these deaths were due to police cars pursuing vehicles that were either suspected of being stolen or being driven in an erratic manner. In 2002–03, we started recording any death that followed some sort of contact with the police. We have therefore included eight deaths that occurred to either pedestrians or other drivers while the police were pursuing people committing road traffic offences.

Alcohol/drug-related deaths

People who suffer alcohol related deaths tend to be white males over the age of 35, and although they have died after some form of contact with the police, there is usually a history of alcohol abuse, which has largely contributed to their deaths.

The main cause of drug-related deaths in police custody is ingestion of controlled substances following arrest. Again, these tend to be white males, although usually under the age of 35.

Since 1999, eight people from an ethnic minority background have died as a result of either alcohol or drugs; and five women have died as a result of ingesting drugs.

Fatal shootings by police

Since 1 April 1999, 12 people have been fatally shot by the police. All were males, and 10 were white. Ages ranged between 19 and 62. In all cases, before the police fired the fatal shot, they challenged the individual to disarm.

Five of the shootings arose after domestic incidents, where people had threatened a member of their family with either a gun (real or fake) or a knife. Two of these incidents developed into siege situations.

Five incidents concerned people armed with firearms in town centres and threatening others. One person was diagnosed with schizophrenia. In another incident, plain clothes police attempted to arrest two drug dealers, one of whom shot at the police. Police returned fire, killing the marksman. In another case, police were informed that the deceased was armed. When challenged, he threatened police with a handgun and was shot.

Deaths from natural causes

Every death from natural causes (except three) that has occurred since 1 April 1999 has been of older white males. One black male in his fifties died of heart failure. One black male of 23 and one white male of 26 died in custody, but all the others were over the age of 45 and almost all died of heart attacks following arrest. Six deaths occurred in police stations.

Use of restraints

Since 1999, six deaths have occurred where the use of restraints was a primary factor. Three of these were white males over the age of 40. One had a history of mental disorder and was restrained to prevent his aggressive behaviour towards members of the public; four were restrained because of their aggressive behaviour towards the police or members of their families and the public. The sixth person who died whilst being restrained was an Asian male of 26 who was restrained for causing a disturbance.

Other people have died whilst in restraints, but this was not the primary cause of death. In the majority of cases, they were restrained due to their violent behaviour caused by drugs, and it was drug overdoses that caused their deaths.

Miscellaneous deaths

This category covers accidental deaths (other than road accidents) and misadventure.

Q2. *What practical steps have already been taken, and what further steps need to be taken to prevent:*

— Suicide and self-harm in custody?

— Other deaths or injuries in custody?

In May 2003, the Police Leadership and Powers Unit of the Home Office wrote to all Chief Officers, setting out the key initiatives that could be taken to reduce the numbers of deaths in police custody. The letter was intended to raise forces' awareness of the additional measures they could take or procedures they could adopt. These are set out below.

Organisation of Custody Facilities

A number of forces already concentrate custody facilities at a smaller number of police stations where superior provision for detention and care is available. This is certainly a positive development in terms of reducing deaths in custody and merits wider consideration.

Some forces are also creating a custody specialism with its own management and command structures. This also deserves further attention as a means of increasing the professionalism, knowledge and skills of those responsible for the custody of detainees. A number of forces now operate custody user groups where officers involved in this area of work can share experience, learning and skills amongst themselves and with other professionals involved in the custody environment. This is an excellent way of spreading good practice, particularly in relation to critical issues linked to deaths in custody.

Custody Officer Training

CENTREX provide a national custody officer training programme which is reviewed and updated every six months. Many forces now use this programme or have amended their existing courses in light of the national programme. Many forces provide two or three weeks training before officers are appointed to custody duties and refresher training is becoming much more common. Input into the central framework comes from bodies such as the ACPO Medical Working Group. The key areas regarding deaths in custody are: risk assessment, adequate checking on vulnerable prisoners, first aid, liaison with medical personnel,

searching, hazard awareness, record keeping, and conflict resolution. It is imperative that all new custody staff are trained appropriately (and given refresher training as necessary). Forces need to be proactive in seeking custody staff's views on where they would benefit from additional training on deaths related issues.

A number of forces have introduced additional training for operational officers in the searching of detainees in order to identify and remove all possible ligatures or items which could be used to cause self harm.

The Metropolitan Police have produced a training video which gives various scenarios which could lead to a death in custody, whether in cells or otherwise. This is used by a number of forces as part of their custody officer-training package. Another video, "Their lives in your hands", has been produced by South Wales Police. This analyses a death by suicide in custody and includes open input by the custody officer on duty at the time. He describes how the incident affected him, his colleagues and family.

Risk Assessment and Information

Prisoner risk assessment has historically been a difficult issue within the police service, but many forces are making rapid strides to improve their procedures and ensure that structured processes are in place to assess and document specific risks presented by detainees coming into custody. It is encouraging to see that all forces have responded to Home Office Circular 32/2000 that relates to prisoner risk assessment, including the Prisoner Escort Record form. The responses vary from introducing a formal written risk assessment process to amending previously used systems.

Home Office Circular 28/2002, "Learning the lessons from adverse incidents", highlighted a case where a detainee was returned to his cell without having his trainers removed and subsequently hanged himself with his shoe laces. It was suggested that laces were not always removed due to the requirement for proportionality under the Human Rights Act. However, under Article 2 of the European Convention on Human Rights "Everyone's right to life shall be protected by the law", and the police must have the highest regard for this. It is worth re-inforcing that items such as shoelaces and belts that can most easily be used for self-harm should always be removed, especially where there are grounds for believing that someone may be a suicide risk. There is no legal obstacle under the Human Rights Act to doing this.

Many forces have a local index of detainees who have "self harmed" whilst in custody. These are normally computerised and many form part of the custody handling system. Those that form part of the custody handling systems are configured so that the warning notice appears on the screen whenever that person is being booked in.

Some forces have introduced written guidelines for custody officers, which advise on identification of risks to ensure that additional supervision is given where appropriate. Other forces have introduced written briefing instructions to custody staff who are given the duty of constantly monitoring any detainee who presents a high risk.

Some forces have piloted a system whereby details of incidents relating to individuals which take place in prisons, which would assist and inform future risk assessments of that individual are communicated to the local force. The force then evaluates the information and, where appropriate, it is placed on the PNC. The ACPO Prison Intelligence Group is currently evaluating this system.

One force is considering introducing a policy whereby all detainees who are suspected of having swallowed drugs or are suspected of being "mules" would be taken directly to hospital. ***This form of action is subject to the police surgeon's decision on what course of action to take if there is a perceived immediate risk***.

Use of CCTV to Monitor (Vulnerable) Detainees in Custody Suites

Many forces have CCTV (including sound) at their custody reception points and CCTV (vision only) in all corridors, entrances, exits etc. Some have installed CCTV cameras in a limited number of cells suitable for vulnerable persons. The effective use of CCTV equipped cells for vulnerable prisoners presupposes early and accurate identification of such persons by custody staff but the use of CCTV does not remove the need for effective monitoring and checking. There is considerable scope for these systems to reduce the overall level of risk and all forces are encouraged to consider how they can most usefully be applied.

Designing out Suicide/Self Harm Risks from Cells

The Home Office Building and Estate Management Unit (BEMU) is a source of expertise in the area of designing out flaws in custody suites (including cells) and police station specifications. General guidance on making police cells safer was included in Home Office Circular 28/2002, "Learning the Lessons from Adverse Incidents".

All new cells in all forces are constructed in accordance with the Home Office design guide. Some forces have instigated periodic custody unit inspection by officers from other custody units. In this way, familiarity with cells is alleviated in the identification of possible ligature points. Most forces have replaced the old "T"

shaped cell door handles with anti-ligature handles. All forces have local instructions which state that cells hatches should be kept closed at all times. Some have attached a notice to the outside of each cell door reminding staff of this instruction.

Where forces have a totally computerised system, many have been designed or amended to give reminders that the maximum time since a detainee was last checked is almost complete. This can be set according to the instructions of the custody officer following the risk assessment.

The cells in some forces are regularly searched by experts to ensure that any dangerous objects, which have been missed at a time the detainee was searched and are later secreted in a cell, are safely removed.

Many forces provide ligature cutters on cell key rings, or at various places throughout the custody units, or as a personal issue to all custody staff. Some forces use a restraint belt to prevent self-harm and suicide attempts by detainees who have been identified as presenting a high risk.

Encouraging the Use of Innovative New Technology

Some forces have been trialing a life signs monitoring system which uses low power microwave transceivers to detect movement within custody cells. Progressive warnings are sounded if an occupant's breathing becomes very low or ceases altogether. The system is currently being assessed. Early indications are favourable and a further letter will be sent to police forces shortly.

There are also broader design and technology issues to take account of in establishing good practice. For example, to reduce self harm some forces supply safer unbreakable plastic cutlery for use by detainees while the majority of forces only supply unbreakable spoons to detainees irrespective of the meal being provided.

Policing the Mentally Ill

There are currently several strands of work focused on improving police practice in relation to mentally ill individuals. Together with the Department of Health and ACPO, the Home Office is considering the development of national protocols covering the interaction between the police and health services in dealing with the mentally ill, ***and significant progress will be made in 2003–04. The Department of Health envisages a two-year project regarding this development***. The revision of the PACE Codes of Practice has further strengthened protections for mentally ill detainees, particularly in terms of assessing their vulnerabilities and fitness for interview. In addition, the review of the Mental Health Act that is underway recognises that police cells are not generally appropriate places for assessing whether a person needs medical treatment.

Provision of Medical Services at Police Stations

The quality of medical services at police stations is inextricably bound up with the delivery of the police surgeon service. The Home Office Working Group on Police Surgeons made a number of recommendations about the organisation of the service and connected issues such as training, accreditation and the delivery of care. Linked to that, there is scope to improve the availability and timeliness of medical services by enabling a wider range of healthcare professionals such as nurses to take a broader role in the custody suite.

The intention is to move towards a position where there is a significantly greater role for registered healthcare professionals within custody suites, but where they work in partnership with police surgeons, and police surgeons retain clearly defined responsibilities to intervene where their broader skills are likely to be required. As well as improving the standard and delivery of clinical treatment for detainees, the introduction of nurses and other healthcare professionals to police custody suites is seen as a key initiative in helping to reduce the number of deaths in police custody.

Increasing the range of custody healthcare professionals is expected to result in increased flexibility, improvements in response times and the opportunity for best value efficiencies in the way healthcare is delivered in custody suites.

Some forces have reviewed their provision of police surgeon services and have brought in new requirements regarding their training in forensic medicine and medical jurisprudence. There are some police surgeons who refuse to prescribe drugs to detainees within their first 6–12 hours of detention so that there is no possibility of overdose caused by the detainee's consumption of drugs prior to arrest. ***The national guidance on "Substance Misuse Detainees in Police Custody: Guidelines for Clinical Management" provides well documented information in regard to this, and stresses the importance of when a police surgeon should/ should not administer drugs to a detainee.***

The ability to read the handwriting of medical staff is crucial to the risk assessment process and some forces ask the custody officer to check the custody record entries of police surgeons to check legibility before the surgeon leaves the unit.

THE POLICE AND CRIMINAL EVIDENCE ACT 1984—CODES OF PRACTICE

- The Codes of Practice deal with contact between the police and the public. They regulate police powers and procedures in the investigation of crime and set down safeguards and protections for members of the public.
- The Codes are subject to regular review and measures currently proposed in the Criminal Justice Bill look to speed up and make more effective the process by which the Codes can be updated.
- It is essential that the Codes are relevant, effective and accurate to the needs of the public and the investigation of crime, and that they ensure there is a high level of protection and safeguards for people in police custody.
- The latest revisions of the PACE Codes of Practice were issued on 1 April 2003. This revision includes a new section on identifying needs for urgent health care intervention. If a person fails to meet the following criteria, an appropriate health care professional or an ambulance must be called.
  - Rousabilty—can the detainee be woken?
  - Response to questions—can they give appropriate answers to basic simple questions?
  - Response to commands—can they respond appropriately to simple commands?
- Custody Officers are reminded to take into account the possibility or presence of other illnesses, injury or mental condition, as a person who is drowsy and smells of alcohol may also have the following:
  - Diabetes;
  - Epilepsy;
  - Head injury;
  - Drug intoxication or overdose;
  - Stroke.

METROPOLITAN POLICE SERVICE DEATHS IN CUSTODY GROUP

The Metropolitan Police Service (MPS) has instigated a Deaths in Custody Group to consider how best to ensure the safety of detainees and the attached summary at Appendix A shows how the MPS is developing best practice in this area, including improved cell design, widening the range of healthcare professionals involved in the treatment of detainees, and involving other agencies to ensure detainees receive appropriate care in police custody.

INITIATIVES TO REDUCE ALCOHOL/DRUG-RELATED DEATHS

There has been recognition for many years that people who are incapable through drink or drugs would usually be better and more safely cared for in dedicated facilities than at a police station. Intoxication, whether through alcohol or drugs, remains a significant factor in some deaths in custody. It also places a severe burden on the police who have to deal with severely intoxicated people who might be better cared for elsewhere. Recent Home Office research studies have indicated that alcohol/drugs are a factor in almost a third of arrests and have recommended a number of approaches related to the care and management of intoxicated detainees in custody suites, including the provision of alternative settings for the care and treatment of those who are incapable through drink or drugs.

Arrest referral and diversion pilots have an extremely important contribution to make in improving the framework within which intoxicated detainees are handled and we are giving serious consideration to the use of alcohol treatment centres as an alternative to police custody for intoxicated detainees. At present only a minority of forces have dedicated alcohol referral schemes for those in police custody and even fewer forces are seeking to divert intoxicated people to alternative treatment facilities. Historically there have been examples of good practice, for example the St Anne's Centre in Leeds, and arrest referral and diversion schemes at Holborn and Watford will offer an opportunity in the short term to evaluate innovative best practice.

There is scope for broader action in this area across the police service, particularly in terms of pilot projects. Some forces have established policies of taking the grossly intoxicated and communication incapable arrestee to hospital for assessment or at least to have them assessed immediately by the police surgeon before detention for any length of time is contemplated.

In May 2003, the Police Complaints Authority (PCA) published a report into drug-related deaths in police custody.

The report highlights the need for improvements in police training to raise awareness of the risks associated with substance misuse and also highlights the need for improvements in the medical support services available to assist police officers. The report cites more systematic screening of substance misuse problems by custody staff or the availability of trained custody nurses equipped to deal with substance

misusing populations as possible mechanisms for managing the risks associated with substance misuse detainees. The report also highlights the need to improve the training of Forensic Medical Examiners (FMEs) in the areas of alcohol, drugs, mental health and dual diagnosis and to address the complex funding issues affecting the delivery of the FME service in some areas of England and Wales.

We are already addressing the issues highlighted in the PCA Report:

The revised PACE Codes of Practice permit healthcare professionals in custody suites and a current survey of forces has indicated that at least 11 forces are already using nurses in their custody suites, whilst a further nine forces are actively considering this option. The policy intention behind the revisions to Code C is to increase the scope for widening the range of healthcare professionals involved in the treatment of detainees in custody suites. The revisions are intended to result in increased flexibility, improvements in response times and the opportunity for best value efficiencies in the way healthcare is delivered in custody suites.

- Annex H of the revised PACE Code of Practice C provides an observation list for custody officers to follow for detainees with known risks, including drug intoxication.
- We issued guidance to police forces about detainee risk assessment in Home Office Circular 32/2000. This circular sets out minimum standards for risk assessment procedures to be applied to all detainees coming into police custody and covers the key risk factors including drug/alcohol and mental health issues.
- Drug testing of detainees is currently being piloted in certain police areas in England and Wales under provisions introduced by the Criminal Justice and Court Services Act 2000. These allow, in certain circumstances, for the taking of saliva samples from persons in police detention, and at other points in the criminal justice system, to test for the presence of specified Class A drugs (heroin and cocaine/crack). From 1 April 2003 drug testing in police custody is being extended to 30 Basic Command Units and will assist in targeting those arrestees who were not picked up or engaged at the initial booking-in stage.
- We set up an Advisory Forum on Police Surgeons in April 2002, which not only provides a national oversight and monitoring of the police surgeon service but is also tasked with facilitating the professional development of the service. Its programme of work includes developing and monitoring centres of excellence for training police surgeons and overseeing assessment, training and accreditation procedures.
- First aid training is included in mandatory training for probationer police officers and national occupational standards have been developed for Custody Officers.

"Excited Delirium" Syndrome

A delirium is characterised by a severe disturbance in the level of consciousness and a change in mental status over a relatively short period of time. There is a reduced clarity of awareness of their environment. The ability to focus, sustain or shift attention is impaired. The individual's attention wanders and is easily distracted by other stimuli. The individual is almost certainly disoriented and may not know what year it is, where they are, what they are doing and the impact of their behaviour. Perceptual disturbances are common and the person may hallucinate. A delirium is the result of a serious and potentially life threatening medical condition. Potential causes include infection, head trauma, fever, and adverse reactions to medications or overdose of illegal drugs such as cocaine and methamphetamines. Any person who is delirious requires prompt medical evaluation and treatment.

The delirious person is likely to manifest an acute behavioural disturbance. These individuals can appear normal until they are questioned, challenged or confronted. When confronted or frightened these individuals can become oppositional, defiant, angry, paranoid and aggressive. Further confrontation, threats and use of force will almost certainly result in further aggression and even violence. Attempting to restrain and control these individuals can be difficult because they frequently possess unusual strength, pain insensitivity and instinctive resistance to any use of force. As many as five to eight people may be required to restrain one delirious adult.

The Police Complaints Authority (PCA) recommend the following training for police officers to help them differentiate between intoxication and excited delirium syndrome:

- Learn how to recognise the signs of delirium or the initial symptoms;
- Obtain immediate medical consultation and attention for any person who may suffer from a delirium;
- Do not excite, confront or agitate individuals who are delirious;
- Contain rather than restrain when the individual is not dangerous to self or others;
- Avoid the use of force unless individual is dangerous to self or others;
- Use the lowest level of force necessary as well as a method of restraint that will not cause asphyxiation; and
- Be cautious and aware of potential side effects of medication.

SAFER USE OF RESTRAINTS

A conference entitled "Safer Restraint Conference—Health, Prison and Police", organised by the Police Complaints Authority, took place on 17 April 2002. The conference focused on the management of acute violent incidents and provided an opportunity for best practice in the three services to be disseminated and new methods of restraint to be discussed, in order to reduce the risk of deaths within the custodial services.

We have held discussions via a cross-government group with colleagues from the Department of Health (mental health branch, prison health care, NHS Executive and the National Institute for Mental Health) on police, health service interface issues relating to the management of potentially violent behaviour and the use of restraint. The group is working to produce joint guidance on local inter-agency protocols and to develop accredited training in order to reduce the incidence of deaths involving the use of inappropriate restraint techniques.

The ACPO/Centrex Personal Safety Manual of Guidance should form the basis of all restraint training for police officers. Civilian support staff that come into contact, or have dealings with persons who are detained in police custody, such as Detention Officers should also receive training based on this manual. The content of this manual was extensively researched in terms of the legality of all the technique and tactics contained within the manual, and the medical implications. Recent cases were considered during this research process. The manual contains specific sections on restraints, and control techniques. The section on medical implications includes information on positional asphyxia, excited delirium, and dealing with persons who may be effected by alcohol, drugs, or mental illness.

There is a section on Custody Skills that provides guidance on cell extraction and insertion, and tactics to assist in the safe taking of fingerprints and DNA samples by force when appropriate. Other sections contain information and guidance on communication skills to assist in the diffusion of potentially violent situations without the use of force.

The manual is the subject of an annual review and maintenance cycle that should ensure that it remains a live and valid document. This process will take account of emerging cases that may impact upon use of force issues, including persons in police custody.

ACPO gives recommendations in respect of the amount of training that police officers should receive in Personal Safety. However, Chief Constables make the final decision as to how much time will be allocated to Personal Safety training for their officers. Unfortunately this varies a great deal from force to force, from as little as four hours annually up to four days annually. Obviously the amount of training received has a direct impact upon the effectiveness of personal safety training, which will affect all use of force issues, including those in custody areas. This of course can compromise both police officers and subjects alike.

The police service shares a certain amount of common ground with the prison and mental health services with regard to restraint.

It too views the use of force as a last resort. Indeed, ACPO guidance makes clear that: "Before resorting to the use of force, police officers should use all other methods to achieve the desired outcome of a situation."

It is also clear from the legal standpoint that officers' use of force should be reasonable, necessary and proportionate and that each individual is accountable to the law for his or her actions. The police service shares the same focus on the human rights aspects of the issue and the view that no death in these circumstances is acceptable.

It uses many of the same control and restraint techniques used in the prison and mental health services. And it is working both on its own and with them to continually review these techniques, learn lessons from experience and find alternatives wherever possible.

On the other hand, the context in which the police operate is very different to that of the other two services.

The nature of their role as an emergency service means that they are often dealing with crises and unpredictable circumstances. They are usually the first port of call, often the first to arrive and accept the responsibility to act as gatekeepers, dealing perhaps with medical or mental health emergencies until other agencies arrive.

The environment in which potentially violent incidents unfold is not controlled in the same way as it is in either prison or mental health settings. The events are spontaneous, the dynamics unknown and officers usually have very little time to assess a situation and plan a response. The challenges they face are particularly difficult when the behaviour of those they confront is affected either by mental illness, psychiatric disorder or by the consumption of drugs or alcohol.

Moreover, officers may have conflicting priorities. At the same time as they have a duty of care towards the individual, they are also required to protect the public—and themselves—from harm.

In some instances then, restraint will be necessary but the police service is striving to make it a safer option by following five main steps:

1. Informed by a working group on self-defence and restraint, ACPO establish clear national policy; individual forces set their policies within this framework.

2. Best practice and procedures are set out in a personal safety manual, the national guidance for all forces and officers.

3. Training is based on the manual and supplemented by first aid training.

4. Equipment is tested, approved and recommended to support best practice, tactics and procedures.

5. Use of force is continually monitored and best practice and procedures reviewed and reformed as necessary in order to continue to minimise risk.

Training is the key to turning policy into action on the ground. Beyond the fundamental principle that they must always act within the law, officers are taught conflict resolution. The model moves through a structured approach to threat assessment that enables officers to choose an appropriate response including a level of force. They are also taught to continually reassess the threat so that they can de-escalate or escalate the use of force as necessary.

At one end of the continuum of force, an officer's presence is often enough to defuse a situation. ACPO guidance emphasises the importance of good communication. Officers' training in verbal de-escalation techniques is underpinned by many of the same elements found in prison and mental health services training—body language interpretation, cultural awareness and an understanding of certain medical conditions, particularly associated with acute behavioural disturbance or the consumption of drugs or alcohol. It is important that officers do not make any assumptions and thereby overestimate the threat.

Where communication, negotiation and the threat of using equipment such as CS spray fail, containment of the individual is the next option. Ultimately, at the other end of the continuum of course, is the use of force. The challenge is to ensure that 130,000 officers dealing with 1.25 million acts of restraint a year apply that restraint properly and safely.

The police service is responding to criticism and striving to minimise risk, continually evaluating techniques and keep officers' training up to date in terms of best practice and the human rights context. The personal safety manual, for example, devotes a chapter to acute behavioural disturbance, its possible causes and implications and the signs and symptoms to identify risk factors. Positional asphyxia and the dangers that neck holds carry inherent risks and are not acceptable.

Officers' equipment is also kept up to date and comes into use only after it has been subjected to rigorous medical scrutiny and evaluation. The police service continues to look for safer alternatives including less lethal alternatives to firearms.

Ultimately, there is an understanding that public scrutiny and public confidence are vital to policing by consent and that the police must exercise force ethically, lawfully, restraining someone in the prone position for too long are covered in similar detail. The manual also clearly states proportionally and with sensitivity if they are to retain that consent.

Police Pursuits

— Everything should be done to minimise the risk of accidents involving police vehicles. The police fully recognise that and are aware of the need to maintain a balance between, on the one hand, responding promptly to emergencies, which may entail the apprehension of offenders, and, on the other, ensuring the safety of the public.

— In the late 90s following several high profile fatalities and police officers being convicted of serious driving offences, ACPO began a general review of police driver training. The resulting report "Police Pursuit Driver Training" by Rodney Lind, ACC of Wiltshire at the time, was issued in September 1998. It provided 33 recommendations for chief officers to consider.

— Measures are in place, or are in the process of being implemented, which are intended to reduce the need for high speed chases involving the police.

— There is a nationally agreed ACPO Pursuit Code of Practice.

— Work is going forward on a national basis to implement recommendations from the Lind report on police pursuit driver training.

— ACPO recognises that the police service has a fundamental duty to equip officers with the necessary training. In December 2000 they launched their new police driver-training course, introducing a universal standard for driving in England and Wales. An essential element of the course is that officers recognise the need to give priority to public safety above all other considerations such as attending an incident or apprehending a suspect.

— It is already policy to consider continuously the consequences of a pursuit and whether to break it off.

— Operational measures to avoid pursuits or curtail them include the use of helicopters, the early deployment of tyre deflation devises across the carriageway and tactical pursuit and containment in which a number of police vehicles are deployed in a planned manner to box in the target vehicle and bring it safely to a halt.

— It is right that the police should be able to pursue suspects and respond to emergency situations without being restricted to speed limits. Accordingly, when it is operationally necessary, the police have statutory exemption from speed limits and general compliance with red traffic signals. However, these statutory exemptions do not remove the need for police drivers to exercise the greatest care.

— The police have statutory exemption from speed limits and general compliance with red traffic signals. For the first, Section 87 of the Road Traffic Regulation Act 1984 states that no statutory provision imposing a speed limit on motor vehicles applies to any vehicle when it is being used for fire brigade, ambulance or police purposes, if observance of the limit would hinder the vehicle in its purpose. The corresponding provision for red traffic light signals is set out in section 33(1)(b) of the Traffic Signs Regulations and General Directions 1994.

Q3. *What has been done to foster a greater "human rights culture" in prisons and detention facilities? What more could be done? Would a human rights approach to conditions of detention and management of detention facilities contribute to the prevention of deaths in custody?*

(i) *What has been done to foster a "greater human rights culture" in detention facilities?*

— The Police Skills and Standards Organisation has developed national occupational standards and accredited training for custody officers in police stations. A key area of training is human rights which includes the right to privacy and the right to life.

— It is Home Office policy to ensure that persons detained in police custody receive quality clinical treatment in a timely manner when required, as our main concern is to ensure the safety and well-being of both detainees and police custody staff.

— Our aim is to reduce deaths in police custody by improving the quality of healthcare provided in police custody suites. This includes reducing the time taken to administer medication when required as part of an individual's clinical treatment.

— Our objective is the development of multidisciplinary clinical teams within police custody suites that parallel similar developments in NHS primary care. This would ensure that the standard of healthcare provision in police custody suites mirrors that in the wider healthcare community.

— We have also introduced legislation to ensure that detainees have access to independent custody visitors. They are members of the local community who visit police stations unannounced to check on the welfare of people in police custody. Custody visitors are independent and impartial and interview detainees out of the hearing of police officers, and their reports provide a vital source of information on the environmental and welfare conditions in which detainees are held.

— The Codes of Practice to the Police and Criminal Evidence Act 1984 require that an appropriate adult should be called following the detention by the police of a vulnerable person (a juvenile or someone who is mentally vulnerable). This action provides support for the individual, and safeguards their human rights by providing an independent validation of the procedures followed during the period in custody.

(ii) *What more could be done? Would a human rights approach to conditions of detention and management of detention facilities contribute to the prevention of deaths in custody?*

In their dealings with detainees, all police officers must bear in mind that everyone has a fundamental right to life, and there is a strong emphasis on that right in all aspects of custody officer training and in the day-to-day care of detainees. However there can be conflict between an individual's right to privacy and their right to be protected from self-harm. Home Office Circular 28/2002, "Learning the lessons from adverse incidents", highlighted a case where a detainee was returned to his cell without having his trainers removed and subsequently hanged himself with his shoe laces. It was suggested that laces were not always removed due to the requirement for proportionality under the Human Rights Act. However, under Article 2 of the European Convention on Human Rights "Everyone's right to life shall be protected by the law", and the police must have the highest regard for this. It is worth re-inforcing that items such as shoelaces and belts that can most easily be used for self-harm should always be removed, especially where there are grounds for believing that someone may be a suicide risk. There is no legal obstacle under the Human Rights Act to doing this.

The Home Office already does a great deal to foster a human rights culture in custody suites. Police follow an interventionist approach, with regular checks and risk assessments made on mentally vulnerable detainees, removing shoe laces and other items of clothing that might provide ligatures etc. This attitude does raise issues under the requirement for privacy under the Human Rights Act, but there is a need to strike a balance to ensure that the fundamental right to life is protected.

Q4. *Are you satisfied that Article 2 ECHR requirements of an effective, prompt and independent investigation of deaths in custody, with effective participation by the next-of-kin, are met by the current system?*

In England and Wales, all deaths in custody (along with violent, unnatural deaths and those with unknown causes) must be referred to the Coroner. The Coroner may then conduct a post mortem, and if not satisfied that the cause of death is natural, hold an inquest.

To meet ECHR we rely on a mixture of the availability of the following processes: the police investigation, Police Complaints Authority supervision of police investigations, the Coroner's Inquest, the Courts, Judicial Review and the Crown Prosecution Service.

Deaths that occur in the custody of the police are referred to the Police Complaints Authority (PCA). The PCA may then supervise a police investigation. Whether the PCA choose to involve themselves or not, there will always be a police investigation and the involvement of the Coroner.

Where there is a suggestion of criminal activity revealed by the Coroner or an investigation report, this is forwarded to the Crown Prosecution Service who will independently determine if criminal charges should be brought against any individuals or organisation.

While it is likely that requirements under Article 2 are satisfied through the current arrangements, we have recognised the need for improvements to be made. To achieve this, new provisions within the Police Reform Act 2002 create a new system for the handling of complaints and incidents of alleged misconduct by members of the police service.

We are currently awaiting the decision of the House of Lords in the case *R* v *Secretary of State for the Home Department ex parte Amin*. It is hoped that this will provide a clear indication as to the Government's investigatory obligations under ECHR in the event of a death of a person in the care and responsibility of State agents. Their Lordships are considering whether to uphold the Court of Appeal decision that in this case the requirements of Article 2 have already been met and an additional independent inquiry need not be instituted.

How could the effective investigation of deaths in custody be better ensured?

Under the new police complaints system all deaths in custody will be referred to the IPCC and they will be able to investigate these independently of the police.

Provisions in the Police Reform Act, 2002, are intended to ensure that all investigations under the new system comply with the procedural requirements of ECHR wherever these rights are engaged. The IPCC will be able to determine what type of investigation is appropriate for a particular incident, and they will be able to choose to investigate a death themselves.

In comparison to the current system for PCA investigations under the 1996 Act, there will be:

— greater involvement of the complainant in the investigation of the complaint;

— greater openness in disclosing materials to the complainant; the legislation will prevent class claims of public interest immunity in respect of investigation reports;

— more effective powers to direct that disciplinary charges be laid against police officers;

— and (in relation to IPCC investigations) greater independence of the person carrying out the investigation.

This change will strengthen the range of remedies available following a death in custody that engages ECHR Article 2.

The Coroner's system is currently being reviewed to determine if improvements can be made.

Hazel Blears MP
Minister of State Home Office

18 September 2003

APPENDIX A

MPS DEATHS IN CUSTODY GROUP

INTRODUCTION

In November 2002 the Metropolitan Police created the Department of Criminal Justice headed by Commander Alan Given. The Department's remit was to bring together the various strands of criminal justice work that were taking place across several departments and ensure a unified and corporate approach to delivering on key Government targets around narrowing the justice gap and bringing more offences to justice.

At the time the Dept of Criminal Justice was formed, the MPS' Property Services Department (PSD) reported the findings of a survey they had commissioned of MPS custody suites to ascertain if they were fit for purpose and what action the MPS needed to take to ensure that detainees were held in the safest possible environment. The results of the survey highlighted areas where improvements were required. As a result of this Commander Given formed the Death in Custody Group.

The Death in Custody Group

At the first meeting, initial discussions focused on implementing a high-level programme of work to eradicate potential ligature points from cells and refurbish cell wickets. Prioritisation of work was undertaken using analysis supplied by the Dept of Professional Standards (DPS), into the number of instances of self-harm or attempted self-harm by detainees. The demographic make up and political sensibilities of local communities were also considered as part of an intelligence led approach as the MPS was concerned to ensure that its policy of improvements within cell areas impacted on members of all community groups who may come into police custody. This programme of work continues and costs approximately £6,000 per cell.

Responsibility for preventing deaths in police custody had previously been led by DPS. It was however decided to use the Death in Custody forum as an opportunity to adopt a holistic approach to the whole issue of prisoner safety and prisoner care. It was therefore, formally agreed that the Dept of Criminal Justice would take responsibility for ensuring the safety of detainees whilst being held in custody suites. Should a death in custody occur at any other stage of a detainee's interaction with police eg in the back of a prison van, it would be investigated by DPS/Police Complaints Authority (PCA) and follow up action would be directed to the most appropriate department.

Membership

In order to take forward this new area of work, it was agreed that the group should meet on a monthly basis and membership was drawn from the following groups and departments:

- Department of Criminal Justice;
- PSD;
- DPS;
- Directorate of Training;
- Occupational Heath Branch;
- the Police Federation;
- Dept of Information and Technology;
- Dept of Legal Services;
- Linguistic and Forensic Medical Services branch; and
- a Forensic Medical Examiner (FME)/HM Coroner.

In addition to permanent members, the group also seeks expert advice from other organisations with an interest in preventing deaths in custody. An example of this is the recently (accepted) invitation to the Police Complaints Authority to sit as members of a small working sub-group, considering the best methods of deployment and monitoring of CCTV in custody suites.

Areas of Responsibility

In addition to overseeing the cell improvement plan, the group takes responsibility for the following areas:

General building improvement works

- In addition to the work to replace cell wickets and remove potential ligature points, the Death in Custody Group is also overseeing the general upgrade of cells. This includes replacing doors and benches and improving toilet areas.

Scope training requirements for custody staff and gaolers at both an initial and refresher level. This includes:

- conducting training needs analysis;
- liaison with Directorate of Training as to course design and methods of delivery; and
- reviewing the content of courses to ensure they reflect current policy and new thinking.

Act as a conduit for new legislation and policy that effects operations within custody suites.

— The Dept of Criminal Justice has a dedicated policy unit, a representative of which sits on the Death in Custody Group. The policy office scopes new legislation and proposes new policies and methods of operation within custody suites. A current example of their work is the formation of a sub-group to look at the development of a "Detainee Welfare Folder", which would contain all the relevant documentation, including risk assessments, relating to a detainee's welfare and a record of any medical care he/she receives whilst in custody.

Oversee the installation and upgrading of CCTV in custody suites and developing corporate operating procedures and policy.

— As mentioned above a sub-group has been formed to develop proposals in this area and will produce a policy covering the usage of monitors; how they will be viewed; ergonomic factors; integrity and security.

Consider the lessons to be learned from DPS inspections and investigations, near misses (incidents where a detainee has tried to commit suicide or self-harm but fail), recommendations from HM Coroners.

— Occupational Health branch have responsibility for collating details of "near misses" and the findings from these and the other sources mentioned above are debated at the Death in Custody meeting and taken into account when training is planned. The Dept of Criminal Justice holds monthly meetings with Criminal Justice Unit (CJU) managers who are based on boroughs and in most cases have responsibility for managing their custody suites. Lessons learned, best practice and details of new policy are promulgated to them and they have the responsibility for cascading this information to custody staff.

Work is also ongoing into developing an intranet site containing useful information and best practices which all MPS staff can access.

Custody-nursing pilot

In addition to the work of the Dept of Criminal Justice, the Metropolitan Police custody-nursing pilot started in July 2001 at Charing Cross Police Station. The evolution of the MPS custody nurse scheme has been incremental to ensure a safe environment for all concerned, and has received the backing of the Association of Police Surgeons. The changes to the PACE Codes of Practice enable custody nurses to undertake certain medical tasks that were previously the sole responsibility of the FMEs. A Psychiatric Nurse is available to support and advise custody staff and detainees on an on-call basis between 9am–9pm. Outside these hours the nurses and the custody officers rely on the duty Mental Health Social Worker.

Research conducted thus far indicates that detainees will often provide custody nurses with information about themselves that they are reluctant to impart to custody staff, and this information is of considerable value, both in identifying if a prisoner is ill and also if they may be pre-disposed to self-harm.

The MPA approved the scheme to be a permanent feature in October 2002. A decision to roll out the custody nurse programme further will be taken once the nurses' extended working practices have been evaluated and balanced against other factors, including cost effectiveness.

Drugs Mules

Earlier in the year, Commander Given chaired a small working group looking into the issues surrounding "drug mules" and what action police could, and should, take when such individuals are arrested to ensure everything possible is done to preserve of life. Expert opinion was sought from consultants and nurses who were able to provide relevant information as to the type of medical intervention required, the circumstances under which they could act, ie a person who has swallowed a cachet of drugs or inserted it into their body is not regarded by the medical profession as ill, but rather as being in a particular condition. Therefore unless the drugs get into the system no medical treatment is required.

HM Customs and Excise invariably detain drugs mules however, under PACE they have no legal authority to charge, bail or detain prisoners after charge (this includes transporting detainees to court from police stations). This is why their prisoners pass into police care and control. As a direct result of the meetings a protocol was drawn up between the police and HMCE, which set out the roles and responsibilities of both organisations. The ultimate aim of the protocol is to reduce as far as possible the amount of time drugs mules spend in police custody, and ensure they have access to FMEs who will be able to risk assess their condition.

CONCLUSION

The formal structure and multi discipline approach of the Death in Custody Group has raised the profile of improving the safety of detainees in custody suites. There are regular clear lines of communication to CJU Managers and on to operational officers working in custody suites which enables the promulgation of relevant information in a direct and timely manner. The Group supports and influences funding necessary to improve custody suites and install and upgrade CCTV. Issues are debated and decisions are made in a

constructive way. The range and experience of members of the group, particularly HM Coroner and Legal Services, ensures that issues take into account human rights, diversity legislation, health and safety and the expectations of external colleagues and agencies.

DEATHS IN IMMIGRATION DETENTION

Since 1989 there have been five deaths of persons held in Immigration Service detention centres (now known as removal centres). In all but one of the cases, death was self-inflicted[1]. Coroners' inquest verdicts in the cases concerned have been either suicide, death by misadventure or "open". Central records of incidents of self-harm are not maintained.

With such a relatively small number of deaths in immigration detention compared to the total number of individuals likely to have been detained over the same period it is difficult to establish statistical trends. However, to the extent that common themes emerge in the individual cases concerned, it appears that incidents of self-inflicted death have preceded the proposed or potential removal of the person concerned from the UK. This is also a common theme in incidents of actual or attempted self-harm involving immigration detainees, which for the most part appear to be designed to delay or prevent removal.

To the extent that it is possible to do so where very little may be known about the individuals concerned, the Immigration Service will, amongst other risks or special needs, identify whether a person who is being detained is likely to present a risk of suicide or self-harm and this information will be passed to the detaining agency.

Under the Detention Centre Rules 2001, Detainee Custody Officers are required to be alert to the particular anxieties to which detainees may be subject and the sensitivity that this will require, especially when handling issues of cultural diversity. Within removal centres there are a range of measures in place to prevent suicide and self-harm, and all centres are required to comply with an Operating Standard on suicide and self-harm prevention. Specific measures include:

- all staff receive suicide awareness training, refreshed annually;
- display of notices to detainees and visitors in relevant languages about informing staff where they have concerns about a detainee;
- Suicide Prevention Committees which meet monthly and involve detainees;
- all staff receive training in emergency first aid; and
- systems for paying particular attention to detainees on their first night in detention and in cases where removal directions are known to the detainee or immediately prior to removal.

The death of an immigration detainee would be subject to a number of separate investigations. The centre operator would carry out an internal investigation and the Immigration Service would conduct its own investigation.

In all cases, the police would be called in to investigate the incident and there would, of course, be a Coroner's inquest.

18 September 2003

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2. Memorandum from the Department of Health

A Detention Under the Mental Health Act 1983

It may be helpful to consider this aspect of the inquiry under three headings, each relating to a different set of circumstances.

(a) Death by suicide and untoward incidents including homicide (Section A);

(b) Accidental death following the use of control and restraint (Section B); and

(c) Death by natural causes where neglect or an action by an agent of the institution may have contributed.

Although there may be general and crosscutting issues to consider (such as the availability of means to commit suicide and the general availability of treatments for severe mental illness), every death merits an analysis of the individual circumstances. In many cases it is the combination of factors rather than a single cause that needs to be understood.

[1] The single exception is the apparent murder in May 2003 of a female detainee by her partner. The cause remains under investigation by the police.

A "human rights approach" to the management of settings can, and has been, helpful in preventing and investigating deaths in custody or deaths amongst those who are detained in a variety of settings. Section C contains examples from high secure hospital settings. Sections D and E contain information about the work of the Mental Health Act Commission (MHAC) and the causes or detention under the Mental Health Act respectively. Section F explains what is being done to reform the inquiry process.

While the focus of the inquiry is on the settings in which people may be detained, it is also important to remember that it is possible for patients detained under the Mental Health Act to have home leave. This can be a time of high risk for them (see Sections A and D). This means that a focus on the whole system of care, including care planning and follow up, is as important as the care setting. Furthermore, this will become more important if the proposed reforms to the current law contained in the Mental Health Bill are implemented.

Section A: Suicide by People with a Mental Illness

Suicide accounts for 2% of all male and 1% of all female deaths and is associated with nearly half a million years of life lost for those under 75. It is now the leading cause of death for young men under the age of 25. Having a severe mental illness is a risk factor; for example, around a quarter of people who commit suicide have a severe mental illness and their lifetime risk is 10–15%.

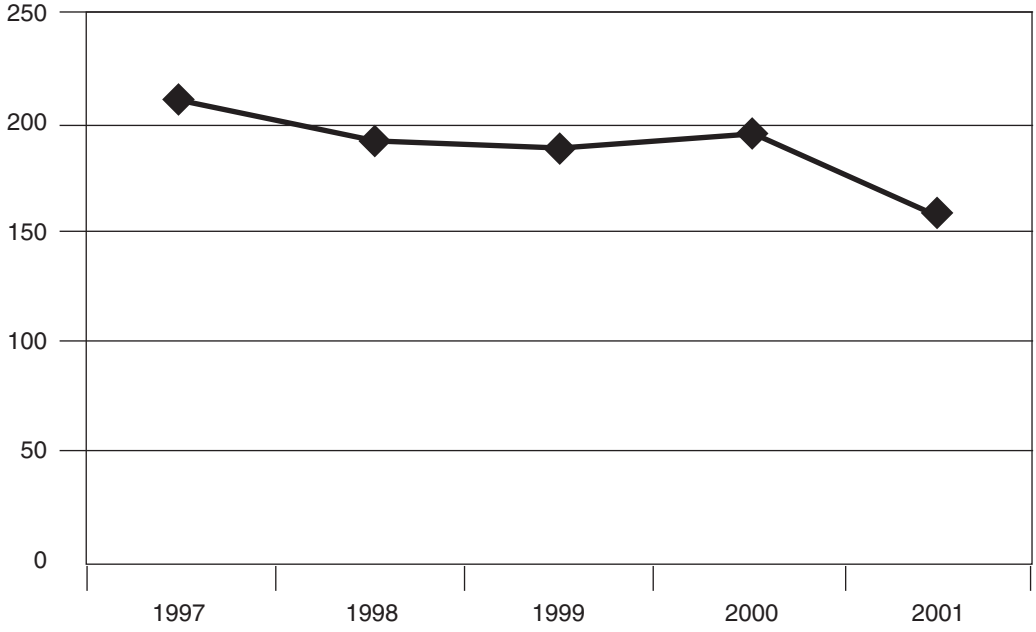
Three-year (rolling) averages are the usual way to record suicide and the latest figures for the three-year period 1997–2000 show a small rise (4.1%). Data for 1998–99–2000 (three-year average) show a rate of 9.4. deaths per 100,000 population—a rise of 4.1% over baseline (1995–97). However, although suicide rates fluctuate year on year, they show an overall downward trend since the early 80s. The suicide rate for the year 2001, the most recent available, was the lowest recorded (8.9 per 100,000). This is encouraging and if the rate remains low next year, the three-year average rate will fall.

The likelihood of a person committing suicide depends on several factors. These include physically disabling or painful illnesses and mental illness; alcohol and drug misuse; and level of social support. Stressful life events such as the loss of a job, a death or divorce can also play a part. For many people, it is the combination of factors which is important, rather than any single factor. Because a significant number of suicides occur during a period of inpatient care, of shortly after discharge, managing risk effectively and ensuring good continuity of mental health care is essential.

In-patient suicides

Following the Chief Medical Officer's report "An Organisation with a Memory", the Department of Health issued a directive that required all local mental health services to reduce to zero the number of suicides on acute psychiatric wards by ensuring that immediate action was taken to remove all non-collapsible structures such as bed, shower and curtain rails in all psychiatric in-patient settings. All Trusts have since complied. The chart below illustrates the fall in in-patient suicide in 2001.

In-patient suicides



Policy Background

National Service Framework for Mental Health (NSF) September 1999

The Government's White Paper *Saving Lives: Our Healthier Nation* sets out a challenging target to reduce the rate of death by suicide and undetermined injury by one fifth by the year 2010.

Standard Seven of the Department of Health's National Service Framework for Mental Health (NSF) (1999) sets out the action needed to achieve this. In addition, it sets out the action to be taken to support prisons in preventing suicides among prisoners by ensuring that staff are competent to assess the risk of suicide among individuals at greatest risk; and develop local systems for suicide audit to learn lessons and take any necessary action.

Services were asked to:

— review the physical environment in in-patient settings and make changes necessary to reduce access to means of suicide;

— help prevent suicides amongst high risk groups, ie all patients with a current or recent history of severe mental illness and/or deliberate self harm, and, in particular, those who at some time during their admission were detained under the Mental Health Act because of high risk of suicide. They must be followed up (by a face to face contact with a mental health professional) within seven days of discharge from in-patient hospital care; and

— develop local systems for suicide audit to learn lessons and take any necessary action.

National Suicide Prevention Strategy for England

On 16 September 2002, the Department of Health published the National Suicide Prevention Strategy for England, the first of its kind in this country. It was developed under the direction of the National Director for Mental Health, Professor Louis Appleby, to ensure that we are doing all we can to prevent suicide in pursuit of the *Saving Lives: Our Healthier Nation* target. The strategy is a co-ordinated set of activities that will take place over several years and which will evolve as new priorities and new evidence on prevention emerge. It provides comprehensive, evidence-based guidance on the action needed to reduce risk; reduce the availability and lethality of means; and promote mental health.

Implementation of the strategy is one of the core programmes of work of the National Institute for Mental Health in England (NIMHE). It will involve close working with a range of health and social care agencies, other Government Departments and voluntary sector organisations. NIMHE is also developing a toolkit to support the implementation of Standard Seven of the National Service Framework for adult Mental Health (suicide prevention). This is planned for publication in autumn 2003 and will include an audit tool and examples of good practice.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

The Department of Health funds the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness to ensure that everyone involved in mental health services learns and implements lessons from the factors associated with serious incidents. The inquiry is crucial to gaining a better understanding of the circumstances surrounding homicides and suicides committed by people with mental illness. The inquiry's fifth report "Safety First", which was published March 2001, says that of 1,579 homicides notified to the inquiry:

— Around a third had a diagnosis of mental disorder, the most common being alcohol dependence, drug dependence and personality disorder (9%).

— Only 15% (of the whole sample) had symptoms at the time of the offence.

— Only 5% had a diagnosis of schizophrenia.

— Most were male (ratio of nine men to one woman) and most were young (median age 27).

The report recommended "Twelve points to a safer service" covering the most important policy and practice issues. These are intended as a checklist for local services where service development is supported through the NIMHE programme.

Section B: Management of Violence and Use of Restraint in Mental Health Settings

Work in Progress

Owing to concerns about safety in mental health settings expressed by users, carers and staff, a Cross-Government Group on the Management of Violence was set up and had its first meeting in October 2002. A number of progressive services already have policies and protocols in place but there is a need to share and disseminate positive practice. The Cross-Government Group will therefore develop guidance to help local agencies collaborate; promote and develop strategies on the management of violence, and support the development of policy between agencies on information sharing, referrals, custody procedures and training.

NIMHE will appoint a project manager for two years from 2003–04 to work in partnership with the National Patient Safety Agency. The post holder will develop a proposal for accreditation of training and trainers; design and commission appropriate training; update the Mental Health Code of Practice, and convert current guidance into standards and audit. Mr Gary O'Hare has been appointed on an interim basis from 1 September 2003.

The National Institute for Clinical Excellence (NICE) has been commissioned to develop guidance on the short-term management of disturbed (violent) service users in adult inpatient psychiatric settings. This should be available in August 2004.

The Department of Health has funded the British Institute of Learning Disabilities (BILD) to establish a system of accreditation for trainers and programmes in the learning disability speciality.

The Department of Health (DH) and the Department of Education and Skills have issued guidance for Restrictive Physical Interventions for people with learning disabilities and Autistic spectrum disorder.

The National Assembly for Wales has drafted "Overarching principles and expectations to inform restrictive physical intervention policy and practice when managing challenging behaviour for health, social services and education settings", which will be issued in early 2004.

Work to be Developed

The Department of Health has developed a Zero Tolerance campaign, which does not always fit with the philosophies of Mental Health Services and needs of service users. There is a requirement to interpret and adapt for mental health settings.

The Home Office is working on principles for liaison between police and local mental health services into which DH officials will provide a health perspective.

The National Patient Safety Agency has expressed an interest in taking forward an investigation of the use of restraint.

Background

In February 2002 the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (UKCC) issued a report into the therapeutic management of violence in mental health care. It made a number of recommendations which included the need for appropriate training; the need to consider the issues of race, culture and ethnicity; and standards relating to skills in physical interventions and physical care. It also recommended that:

— Policies and principles should be developed on controversial issues, such as the use of CS Spray, the institution of criminal proceedings against patients, mechanical restraints, pain compliance and other legal, ethical and human rights issues.

— Research should be commissioned into the safety, effectiveness and professional acceptability of de-escalation techniques, seclusion and physical interventions.

Following the death of David Bennett, the then Minister of State at the Department of Health (Jacqui Smith) gave a commitment to Dr Joanna Bennett to write to her ministerial colleagues for their support in delivering a more consistent cross-Government approach on restraint. This was also stated in the adjournment debate of 9 November 2001. The most recent meeting of the Cross-Government Group was held in July 2003.

Concerns about safety expressed by users, carers and service staff. There is evidence of concern from services in respect of Health and Safety imperatives, injuries to patients and staff, European Human Rights legislation, ethical issues, the increasing use of substance misuse, presence of weapons and the need for searching. A number of progressive services have policies and protocols but there is a need to share and disseminate positive practice.

MHAC—The reform of the Mental Health Act and the revision of the Mental Health Act Code of Practice, taking account of modern approaches to mental health care, more enlightened approaches to prevention and management of disturbed behaviour and the need for close collaboration and co-operation between the Police and other agencies to reduce risk.

Section C: High Security Hospitals

Human rights awareness

The high security hospitals provide the most secure settings available within the NHS and accommodate the most potentially dangerous mentally disordered patients. This means that robust security arrangements need to be put in place. However, there is a need to strike the right balance between considerations of security and therapy. The general principle is that good security should provide a safe environment for patients and staff in which therapeutic activities can flourish.

Human rights issues are very much to the forefront of thinking about policy and procedures in the high secure hospitals. For example, the Fallon Inquiry into Ashworth Hospital identified shortcomings and inconsistencies in the security arrangements at Ashworth Hospital. As a result the high security hospital Safety and Security Directions were drawn up to bring robust and consistent security arrangements across the three high security hospitals sites.

These Directions were scrutinised carefully for compliance with human rights legislation and, in view of the Department of Health, struck the right balance between human rights considerations and legitimate security concerns. Nevertheless, some patients and staff feel that the pendulum has swung too far towards security. Consequently, there have been a number of human rights related challenges/threatened challenges to the Directions, none of which have so far been taken successfully through the courts.

Amongst the security and human rights considerations it is important to bear in mind in relation to the high secure hospitals:

— The Mental Health Act 1983 Code of Practice has been complied with human rights issues in mind. For example, the first guiding principle on page three of the Code states that people to whom the 1983 Act applies should receive recognition of their basic human rights under the European Convention on Human Rights.

— In paragraph one on page one of the Code it is stated that the Act does not impose a legal duty to comply with the Code but it is a statutory document and failure to follow it could be referred to in evidence in legal proceedings. The Code has a high profile and a high status; and routine monitoring is undertaken by the Mental Health Act Commission.

Examples of issues challenged include:

— The arrangements for listening into/recording some patient telephone calls.

— The restrictions on visitors bringing food and tobacco into the hospitals for patients.

— The arrangements for searching patients and visitors.

— The control on the volume of possessions that patients may keep in their rooms.

Other human rights related challenges include:

— Against the seclusion policy at Ashworth Hospital (on the grounds that it did not fully comply with the Code of Practice).

— Patients being treated for a disorder that they were not classified for under the Act (eg a patient legally classified as mentally ill being treated for a personality disorder). Both these challenges were successful but may be appealed.

Deaths in untoward circumstances

Action taken by high security hospitals to prevent deaths in untoward circumstances:

— All deaths in untoward circumstances are investigated with a view to learning lessons for the future.

— Observation levels are increased for patients who are thought to be at risk of self-harm/suicide.

— There are robust commissioning and performance management arrangements in place, one of the objectives of which is to improve the treatments and activities available to patients and thus improve their quality of life and hopefully reduce the danger of self-harm/suicide.

— Central funding has been provided to aid the removal of ligature points. Efforts have also been made to make seclusion rooms safer.

— Life saving equipment is available (eg defibrillators are available to all wards and staff are trained to use them).

Other action that may serve to reduce self-harming and suicidal intent:

— There have been delays in moving patients out of the high security hospitals. This may, for some patients, have increased any suicidal tendencies. The Department of Health has initiated an accelerated discharge programme (NHS Plan Commitment) to reduce the problem of delays in moving patients out of the high security hospitals. This is linked to the wider development of secure psychiatric services to facilitate the movement of patients to whatever is the most appropriate level of security at any given moment in time.

— The number of women patients in high security is being significantly reduced through the accelerated discharge programme such that only one site, rather than all three, will need to provide such a service. Alternative, more appropriate, services are being developed for women who do not require high security.

— The high security hospitals have become less isolated by virtue of their integration into NHS Trusts. This has improved links with the wider NHS easing staff exchange, etc. As a result the high security hospitals are developing more of an NHS ethos.

— There have been some reductions in ward sizes (patient numbers). There are plans for further reductions but they depend on funding being made available.

— General health care advice to patients is improving, although there is still room for improvement.

Section D: Mental Health Act Commission (MHAC)

The MHAC is a special health authority with responsibility for monitoring and reviewing MHA implementation as it relates to patients who are detained or liable to be detained under the Act in England and Wales. The MHAC publishes a report every second year on its rolling programme of visits to all hospitals and nursing homes, and its findings based on reviews of patient records, examination of policies and systems, and meetings with detained patients. The report for 1999–2001 was laid before Parliament in 2002. Although it is not possible to address all the recommendations, a sample of important issues arising from the report are highlighted below.

Information

Chapter 2 concerns patients' rights. The report comments that, where patients do not understand their legal position, it is often as a result of poor practice in providing communication at an appropriate level and checking that it has been understood. Although there is no evidence that poor or inadequate information has led to or contributed to deaths, it is likely to be important in adding to a sense of isolation amongst those with severe mental illness and/or depression who are at risk.

The MHAC recommended action to reduce the stigma of mental illness (being taken forward by the NIMHE) and to ensure patient information is adequate in an appropriate range of languages and formats. NIMHE's programmes on the mental health of black and minority ethnic communities and strategy for people with mental illness who are deaf are both relevant here.

Deaths of Detained Patients

The MHAC maintains a record of every patient who has died whilst subject to detention under the MHA and inquires as to the circumstances. Its most recent report considers the deaths of 1,471 patients over a three year period, of whom hospital staff reported that 1,218 died of natural causes (an estimated rate of 822/100,000 sections per annum for 1997–2000). The most significant finding is that 47% of such patients died within one month of admission and 18% between one month and 10 weeks.

Two hundred and fifty three (17%) of the 1,471 cases resulted in an inquest. Of these, 168 verdicts were recorded as suicide or "open" verdicts, 31 as accident or misadventure, four due to drug abuse and five as natural causes. Only 2% of the unnatural deaths were among people over the age of 75. The majority (78%) were under the age of 45 years and most (72%) were men. Almost half of those who died an unnatural death were diagnosed as having schizophrenia and 20% were diagnosed as having depression. Hanging was reported to be the cause of death in 40% of suicides and 16% of deaths by accident or misadventure—pointing to the importance of removing ligature points.

Analysis of the cases reported as suicide (or open verdicts thus classified) indicates that younger people detained because of a mental disorder are more at risk than older people. 25% (41) of suicides occurred whilst the patient was being observed every 15 minutes—which emphasises the importance of reviewing observation procedures. This is a point also made in the 1999 Report of the National Confidential Inquiry.

Only 32% of unnatural deaths occurred within a psychiatric unit, and the remainder occurred whilst the patient was on leave. This finding is consistent with the findings of previous reports and reinforces the importance of risk assessment and management, security and policy on granting leave under Section 17 of the Act, particularly if a patient fails to return at the expected time. Thirty one (12.5%) of deaths were categorised as accidental (18 men and 13 women, most under the age of 45) and almost a third of these were in psychiatric wards.

Among the deaths reported to a coroner, the MHAC information showed 22 instances in which restraint had been used in the week before death and two of these concerned patients from African or Caribbean ethnic cultural groups. Although the small numbers make it difficult to assess statistical significance, the MHAC recommended attention to this, especially as there is a relatively high number of people from black and minority ethnic groups who are detained under the MHA.

The MHAC makes a series of recommendations concerning their findings on risk assessment, data capture (including about ethnicity), the use of restraint, analysis of deaths by hanging, removal of means to assist suicide, and audit and inquiry after a death by suicide.

Section E: Mental Health Act (1983) Detention

This Annex contains an extremely brief overview of the provisions of the Mental Health Act 1983.

The MHA governs all aspects of compulsory admission to hospital, as well as the treatment, welfare, and aftercare of patients. It provides for mentally disordered persons who need to be detained in the interests of their own health, their own safety or the safety of others. The Act sets out when and how a person can be "sectioned" and ensures that the rights of detained patients are protected.

The Act sets out the rights of people who are detained to have information about the reasons for the detention; an explanation of the relevant section; information about the right to appeal to the Mental Health Review Tribunal; information about care and treatment; information about social security benefits; information about how to complain; and about plans for discharge.

Section 1 of the Act defines mental disorder in terms of mental illness, mental impairment, severe mental impairment, or psychopathic disorder. Mental impairment means a state of arrested or incomplete development of mind, including significant impairment of intelligence and social functioning which is associated with abnormally aggressive or seriously irresponsible conduct. Psychopathic disorder means a persistent disorder or disability of mind resulting in abnormally aggressive or seriously irresponsible conduct.

An individual with a mental disorder may be compulsorily admitted to hospital where this is necessary:

— in the interests of his or her own health, or

— in the interest of his/her own safety, or

— for the protection of other people.

Only one of these grounds needs to be satisfied in addition to those relating to the patient's mental disorder.

Section 2 concerns admission for assessment or admission for assessment followed by treatment for up to 28 days. Section 3 concerns compulsory detention for treatment up to six months. Section 4 concerns admission in an emergency and section 5 is for emergencies amongst those already in hospital. The Act also covers circumstances for people subject to criminal proceedings (sections 37, 37/41, 47 and 48). Section 2 and 3 treatment orders may not be applied unless treatment could not be delivered without them. Treatment can be delivered without consent in those circumstances for up to three months.

The Responsible Medical Officer (RMO) can agree to specified periods of leave, possibly with conditions attached, although some sections are restricted and the Home Office must be informed.

Reform of the 1983 Act

A draft Mental Health Bill and Consultation document was published for consultation between 25 June and 16 September 2002.

Mental health legislation sets out the circumstances in which people can be treated for mental disorder without their consent and the safeguards to which they are entitled.

The Bill will replace the current Mental Health Act 1983 and is the first major overhaul of the system since the 1950s. The objectives are:

— to make significant improvements to patients' safeguards;

— to provide a modern framework of legislation in line with modern patterns of care and treatment and human rights law; and

— to protect public safety by enabling patients to get the right treatment at the right time.

The Bill forms a vital part of the Government's wider strategy to improve and modernise mental health services for all. This includes increased investment and current reform of services.

The vast majority of people with mental health problems are not a risk to anyone and will never need compulsory treatment. However, there is a small number of patients who need compulsory treatment, mainly for their own safety, and on very rare occasions for the safety of others. The Bill aims to ensure that these seriously ill people receive the treatment they need.

It will break the automatic link between compulsory treatment and detention, allowing patients to be treated in the setting most appropriate to them. Treatment in the community will provide a positive alternative for the many patients who do not want or need to be detained in hospital and an opportunity to minimise the disruption to their lives.

It will introduce new rights and safeguards for patients, including:

— A requirement for every patient to have an individual written care plan.

— All compulsion beyond 28 days to be authorised independently by the new mental health tribunal.

— Access to new specialist mental health advocates to support patients and their nominated person.

The combination of the new definition of mental disorder and the tight set of conditions for compulsion can ensure that all patients, whatever their diagnosis, will be considered on the basis of their individual needs.

The Bill aims to strike the right balance between safeguarding the rights of individual patients and protecting patients from harming themselves or others.

The Department of Health received nearly 2,000 responses to the consultation exercise. It is now completing and refining the Bill in the light of those responses to ensure it achieves the intended effect. A new Mental Health Bill will be introduced as soon as Parliamentary time allows.

Section F: Reform of the Inquiries Process

The then Minister of State for Health (Jacqui Smith) announced in 2002 that the Government intended to reform and strengthen the process of inquiries following homicide by a person with a mental illness. The National Patient Safety Agency (NPSA) is road testing "Root Cause Analysis", the approach outlined in the Chief Medical Officer's report "Building a Safer NHS for Patients" published in 2001.

Background

"Safety First", the fifth report of the National Confidential Inquiry into suicide and homicide by people with mental illness, was published March 2001. The report says that, of 1,579 homicides notified to the inquiry:

- Around a third had a diagnosis of mental disorder, the most common diagnoses being alcohol dependence, drug dependence and personality disorder (9%).
- Only 15% (of the whole sample) had symptoms at the time of the offence.
- Only 5% had a diagnosis of schizophrenia.
- Most were male (ratio of nine men to one woman) and most were young (median age 27).

The key issues in the guidance issued by the Department of Health, HSG (94) 27, are that:

- In the event of a homicide committed by a person in contact with specialist mental health services an inquiry into the treatment and care provided should be commissioned and this inquiry should be independent of the providers of care.
- Responsibility for commissioning such inquiries was recently transferred from the former health authorities to the strategic health authorities. This makes the most sense in view of Primary Care Trusts' increasing involvement in service provision.
- The National Patient Safety Agency, part of the Modernisation Agency, is currently road-testing the "root cause analysis" approach for homicides committed by a person in contact with specialist mental health services.
- A number of external stakeholders, such as the Royal College of Psychiatrists are actively involved in the process of advising on reform. For example, Jayne Zito has a particular interest following her work to strengthen systems of care and investigations of incidents after the death of her fiancé at the hand of Christopher Clunis.

B Deaths in Prison Custody

How does the prison healthcare system seek to prevent deaths in prisons, in particular through mental healthcare and drug detoxification programmes?

The Prison Service's published objective is to provide prisoners with access to the same range and quality of health services as the general public receives from the National Health Service (NHS). In pursuing achievement of this objective, it seeks to go considerably further than just meeting the obligations in Articles 2, 3, and 8 of the European Convention on Human Rights (ECHR).

Amongst key epidemiological factors which influence views on suicide and self-harm in prison and their prevalence, prevention, assessment and management are the following:

- Prisoners are known to be most vulnerable to suicide during their first day, first week and first month in custody, and during similar periods of time following their transfer to a different prison.
- It is well known that 90% of prisoners have at least one significant mental health problem (Psychiatric Morbidity amongst prisoners in England and Wales Office for National Statistics 1998). One fifth have four out of five of the major categories of mental health disorders considered in the ONS survey (psychosis, neurotic disorder, personality disorder, drug dependence and alcohol misuse).
- The National Confidential Inquiry report in to the Suicides in Prison (1999–2000) found that 72% of those who died had at least one psychiatric diagnosis recognised on their reception into prison. This was at a time when the Prison Service was poor at identifying mental ill health during the

reception screening process so it is possible that an even higher number of those who died had a mental disorder. The commonest mental disorder identified was drug dependence. Sixty two per cent of those who died had a history of drug misuse and 30% of alcohol misuse; only half of whom had been referred to the prison healthcare service.

— Ninety two per cent of self-inflicted deaths in prison are the result of hanging; very importantly the commonest ligature being bedclothes. Twenty five per cent of those who died had open 2052SHs, indicating the recognition of risk but 75% did not. This is no worse than for suicides in the community, where only 2% of people who died had been recognised as being at high risk.

These facts about the epidemiology of suicide and self-harm in prison have informed management policies in a number of ways.

Reception Arrangements

Research indicated that the Prison Service's reception screening processes were failing to identify up to three-quarters of the prisoners who had a severe mental illness. To rectify this, new triage-based reception screening arrangements were developed and piloted during 2001–02 at 10 local prisons. They focus on identifying and managing a prisoner's immediate and significant health needs on first reception into prison custody, so that more effective use can be made of existing staff resources and skill mix. This work has been closely linked to development of the Prison Service's suicide prevention strategy and four of the reception screening pilots also form part of the Prison Service's Safer Locals Programme. Evaluation of experience at the pilot sites showed a substantial improvement in the identification of prisoners with a severe mental illness. The new reception health screening system is being phased in at all local prisons over a 12-month period that began last April.

Significantly, evaluation of the new reception screening tool at the pilot prisons revealed that only 3% of receptions, when asked, stated that they were suicidal. Only two individuals in this group had no mental disorders. All the others were identified through the reception screening tool as having either a significant mental illness or an addiction to alcohol and/or drugs, or both.

The Clinical Management of Substance Misusers Including Detoxification

The Prison Service expects good quality clinical substance misuse services, including detoxification, to be available in all local prisons and remand centres. Its Standard for Health Services to Prisoners requires all establishments to have in place a written and observed statement of their substance misuse service which must be in line with the latest Department of Health guidance on drug misuse and dependence (1999).

The general health examination/assessment a prisoner receives on first reception into custody aims to identify past and present drug usage and engagement with community drugs teams. A clinical decision is then reached about the next steps in the management of each individual prisoner. This can be either detoxification of substitute prescribing, as a prelude to a broader based drug treatment programme.

Prison Service Order (3550), (December 2000) introduced a new Standard for Clinical Services for Substance Misusers, which concerns the effective clinical management of the substance misuse treatment service provided by staff working in prisons. It is in line with current Department of Health guidelines for such a service, forms part of the overall Prison Service Drug Strategy, and underpins delivery of the Prison Service Standards of Health Services for Prisoners and Drugs. It was designed to ensure, once fully implemented, that good quality clinical substance misuse services are available in all local prisons and remand centres to a level that is at least comparable with those in the community.

The Standard requires all establishments to have in place a written and observed policy statement on their substance misuse service. All prisoners must have immediate access to detoxification programmes for opiates, alcohol and benzodiazepines in line with Department of Health guidelines (1999). They must be provided with information about substance misuse treatment services, health promotion and harm minimisation.

The Standard also requires establishments to have evidence-based guidelines for maintenance prescription which are also in line with the current Department of Health guidance. Is specifically indicates that maintenance prescribing is likely to be suitable for prisoners on remand or serving short sentences who have been maintained on methadone in the community and for whom there is evidence that engagement in such a programme has had a beneficial effect. Such programmes are also indicated for pregnant women and people with serious physical illnesses.

Guidelines should include information about maintenance on naltrexone and its use in relapse prevention management.

The Standard goes on to say that, as new evidence becomes available on the chemical management of detoxification or abstinence, establishments should develop further treatment guidelines which are in line with those available in the National Health Service.

The National Treatment Agency (NTA) has undertaken a considerable amount of work in conjunction with the Department of Health on the prevention of drug-related deaths. Prison Health and the Prison Service's Drug Strategy Unit are both members of the NTA's drug-related deaths working party, thereby ensuring that its work is relevant to prisoners and the prison setting. A significant amount of harm minimisation material has been developed for treatment providers, service commissioners, general health providers, drug users, and marginalised groups, which, when published, will also be available and applicable to prisoners and prison staff.

Mental Health Services

Despite the best efforts of the Prison Service, the majority of deaths occur in people who have not been recognised as being vulnerable to suicide at that time. It is known that death is most likely to occur during the first month in custody, for the person to have a mental health problem, most likely a drug problem. This confirms the importance of continuing with the current approach, which is to assess and manage those prisoners whom staff identify as vulnerable through self-report or emotional distress. It also highlights the importance of treating all prisoners decently and humanely at all stages of their time in prison custody and of continuing to improve the assessment and management of prisoners with mental disorders and/or dependence on drugs and alcohol.

The work that is currently underway to improve mental health services in prisons should be seen in the context of the government's overall strategy for improving prison health care generally, and is being taken forward within that framework. Concern about the quality of health services available to prisoners increased during the early and mid-1990s. The Home Secretary and the Secretary of State for Health jointly set up a Working Group of officials from the Prison Service and the NHS Executive to consider the future organisation of, and ways of improving, prisoners' health care. The strategy that is now being implemented stems from the findings and recommendations of that Working Group, as set out in its Report "The Future Organisation of Prison Health Care" (1999). The basic principles were succinctly summarised as follows:

> "Healthcare in prisons should promote the health of prisoners; identify prisoners with health problems; assess their needs and deliver treatment or refer to other specialist services as appropriate. It should also continue any care started in the community contributing to a seamless service and facilitating through care on release".

One of the source documents used by the Working Group was an earlier Report of the Independent Standing Health Advisory Committee for the Prison Service, "The Provision of Mental Health Care in Prisons" (1997). That report stressed the importance of "equivalence", that is, that the mental health services available to prisoners should be of the same type and range, and of the same quality, as those available to NHS patients in the community. The Joint Working Group accepted this principle, both in terms of mental health services and of prison health care generally, and it formed the starting point of all their recommendations, and of the prison health care strategy developed subsequently.

The prison population is now around 74,000, and over 140,000 are received into custody each year, most only staying for a short time before being released back into the wider community. It has been estimated that around 90% of prisoners can be diagnosed as suffering from at least one of the five main categories of mental disorder (psychosis; neurosis; personality disorder; alcohol misuse; drug dependency). Around 20% of those on remand and 12–15% of those serving sentences suffer from four out of the five. On any one day in prisons in England and Wales there will be around 5,000 prisoners with a severe and enduring mental disorder.

The Department of Health's NHS Plan (July 2000) included the following specific commitments on the provision of mental health services for prisoners:

> "Within the new partnerships between the NHS and local prisons, some 300 additional staff will be employed.
>
> By 2004, 5,000 prisoners at any time should be receiving more comprehensive mental health services in prison. All people with severe mental illness will be in receipt of treatment, and no prisoner with serious mental illness will leave prison without a care plan and a care co-ordinator."

The government's strategy for developing and modernising mental health services in prisons, *Changing the Outlook, a Strategy for Developing and Modernising Mental Health Services in Prisons* was published in December 2001. It set out a vision of where prison mental health care was expected to be in three to five years time and identified the steps that would have to be taken if it were to be realised.

Referring specifically to suicide prevention, paragraph 3.24 of *Changing the Outlook* stated:

> "Nine per cent of all suicides in prison occurred during the first 24 hours in custody, 27% during the first week, and 43% during the first month. The Director General of the Prison Service has made it clear that he considers suicide prevention to be one of the key objectives of the Prison Service. The mental health NSF gives it the same emphasis by including it as one of the seven standards and by identifying prisoners as one of the key vulnerable groups within the standard which the NHS should be specifically targeting. Thus both the Prison Service and the NHS have been given a clear responsibility to work together in this field. The Prison Service has recently launched a new strategy for suicide prevention, and piloting has begun in five prisons. On the NHS side, the first

wave sites for mental health in-reach deliberately include those five establishments, in acknowledgement of the vital links between mental ill health and suicide. However, providing effective care and treatment for suicidal prisoners will be a key task for all prisons, not just those involved in these initiatives."

The basic principle underpinning the prison mental health strategy is that services should be provided, as far as possible, in the same way as they are in the wider community. Prisoners who, were they not in prison, would be treated in their own homes under the care of Community Mental Health Teams (CMHTs), should be treated on the wings, their prison "home". Those needing more specialist care should be able to receive it in the prison Health Care Centre, and there should be quick and effective mechanisms to transfer those requiring specialist in-patient treatment to hospital. Any prisoners already receiving treatment for mental health problems in the community through, for example, the Care Programme Approach, should continue to have access to that level of service while they are in prison and, if appropriate, on release.

The prison mental health in-reach project, which began in 2001, is the mechanism through which the specific commitments in the NHS Plan are being implemented. Dedicated funding has been made available from the NHS budget to support the introduction into prisons of multi-disciplinary teams which are designed to provide mental health services for prisoners along the lines of the community mental health teams which already provide mental health services in the community at large. The project began at 18 establishments in England and the four in Wales in 2001–02, and was extended to another 26 sites during 2002–03. During this financial year in-reach teams are being developed in another 46 establishments. So far more than 150 additional NHS staff have become involved in providing mental health services in prisons. That number will double by the end of 2003–04, as the target in the NHS Plan is met. Between March 2004 and March 2006 it is expected that NHS mental health in-reach investment will double. This should mean that within the next three years there will be in-reach type services available to every prison in England and Wales. The extra investment will also support many of the existing teams in expanding the services they can offer.

Changing the Outlook signalled the intention to establish a prison mental health collaborative to support and empower staff to modernise clinical services for prisoners with mental health problems. This collaborative is now well underway, in partnership with the National Institute of Mental Health and the NHS Modernisation Agency. It involves training and empowering groups of clinical staff to make improvements in clinical practice. Amongst its objectives are the establishment of an infrastructure to identify and share good practice and the identification of the training requirements needed for modernising clinical services. It is also concerned with empowering staff to make decisions about their own services and to realise small areas of change and it aims to be a means of bringing about better peer group support and improved satisfaction for service users.

Prison Health has funded an evaluation of in-reach that is being commissioned through the NHS Forensic Research and Development Programme. It has also established a transition group to oversee the transfer of responsibility for prison mental health policy development and implementation to the National Institute of Mental Health in England (NIMHE). It will assist the Prison Service's Safer Custody Group to establish links with NIMHE.

There is, however, more to the mental health strategy than the in-reach project. Prisons already spend anything up to half their total health care expenditure on mental health care. Every prison is expected to look critically with its NHS partner at its existing provision to establish whether it meets the needs identified in the Health Needs Assessment and is in line with the principles and standards set out in both the Mental Health NSF and *Changing the Outlook*. In many cases a very medicalised model was in place which took little account of recent developments in mental health care and did not allow for modern multi-disciplinary approaches. The strategy will mean a period of major change for virtually every establishment. It must be recognised also, that change will not happen overnight but will be an evolutionary process over several years. Some establishments will be able to progress faster than others.

Transfer to Hospital

Prisoners who need in-patient treatment for their mental disorders should be transferred to hospital as soon as possible. Generally speaking, the arrangements for assessments and transfer in such circumstances work smoothly and very many prisoners get transferred to hospital quickly. But problems of apparently excessive delay can still occur in some individual cases. This can give rise to distress in the prisoners themselves, their families and friends and also the prison staff responsible for looking after them while they wait for a hospital place. Prison Health and NHS Regional Commissioners of Forensic Mental Health Services have looked at ways to reduce the time prisoners may have to wait for a hospital place. In parallel tighter regular monitoring has been introduced to identify prisoners who have been waiting unacceptably long periods for transfer to hospital. All establishments must provide regular returns to the headquarters Prison Health team showing how many prisoners are awaiting either assessment or transfer, and of the latter, how many have been waiting for more than three months following acceptance. A protocol has been issued which sets out the actions required of both the Prison Service and the NHS when a prisoner reaches that three-month deadline.

Information Sharing

The importance of information sharing in assisting to prevent self-inflicted deaths is well recognised. Prison Service Instruction 25/2002. "The Protection and Use of Confidential Health Information in Prisons and Inter-Agency Information Sharing" and its associated Information and Practice note were issued in May 2002. They require prisons, generally with the prisoner's consent, to request any information required from a prisoner's GP or other relevant service with which he/she has recently been in contact. They also provide guidance on information sharing with other agencies, particularly the NHS, and provide a framework for developing effective inter-agency information sharing, including information sharing protocols. The issue of detailed guidance on best practice for information sharing within current legal requirements and professional codes of conduct should increase staff confidence in sharing information in appropriate circumstances, in particular when a patient is at risk.

Following publication of *Changing the Outlook* all prisons, in collaboration with their local NHS partners, will have completed a detailed review of their mental health needs and developed action plans to fill any gaps in service provision they identified. The challenge to all concerned if the desired degree of improvement in prison mental health services is to be achieved is considerable. Nevertheless we expect over the next three years or so to see all, or at least most, of the following outcomes:

- Fewer mentally disordered prisoners accommodated in prison health care centres, with resources re-deployed to provide day care and wing-based support.
- A reduction in the average length of time mentally disordered prisoners spend in those prison health care beds that remain.
- A more appropriate skill mix among those who are providing mental health services in the prison setting.
- Quicker and more effective arrangements for transferring the most seriously ill prisoners to appropriate NHS facilities and receiving them back.
- Closer collaboration with NHS staff in the management of prisoners who are seriously mentally ill, including those who may be vulnerable to suicide or self-harm while they are in prison.

Are any further measures being considered to address the problem of deaths in custody?

While there has been substantial progress in the provision of non-clinical drug services across the prison estate, clinical services have been slower to develop. Detoxification, of a pre-set duration, remains the solitary prescribing response to drug dependence in the majority of local prisons. However, while detoxification may remain the preferred method of clinical management for some drug-dependent prisoners, it is recognised that other treatment options are required to manage problems, including the growing issue of suicide and self-harm during the period of withdrawal. The Prison Service's review of prevention of suicide and self-harm in prisons recommended that special attention should be paid to the safe management of prisoners in the early stages of custody in a prison. This should include a focus on excellence of care for all prisoners in reception, first night, induction and detoxification units. A broader range of clinical responses to drug dependence, such as extended detoxification and maintenance programmes, can help to reduce incidents of suicide and self-harm among those at risk, particularly prisoners with co-existent drug and mental health problems.

To address this and other problems Prison Health has been developing a clinical management model to cover up to the first 28 days of a prisoner's period in custody. It has recently begun to seek observations from a range of key agencies and professional bodies on the form and content of this proposed model.

Further Research into Suicide and Self-Harm

Prison Health is continuing to fund "The Confidential Inquiry into Prison Suicide", a three-year study being undertaken by University of Manchester. An Interim report is due to be delivered this Autumn. In addition "cases" will be analysed against controls, ie prisoners who did not die. Such a study helps to get closer to the precipitating factors for death. For example, rather than saying drugs are implicated in suicide in prison we may have a clearer view that it may be heroin or cocaine only, both in combination. Prison Health is also funding a study to ascertain the influence of supporting staff at Holloway prison who are dealing with women prisoners who self-harm.

Are you satisfied that guidance and practice in the prison healthcare service is sufficient to comply with obligations under Articles 8, 3, and 2 of the European Convention on Human Rights?

What has been done to foster awareness of human rights in the prison healthcare service? Could a human rights approach to prison healthcare contribute to the prevention of deaths in custody?

The continuing programme to achieve significant reform and improvement of the organisation and delivery of health services to prisoners, begun in April 2000 on the basis of a new partnership between the Prison Service and the NHS, is designed to go much further than complying with the requirements of these Articles of the ECHR. In the written evidence he sent to Ms Roisin Pillay on 18 August, the Director General of the Prison Service responded to these questions on behalf of the Service as a whole and his response applies in respect of health care staff.

3. Memorandum from HM Prison Service

INTRODUCTION

1. The Prison Service welcomes the Joint Committee's inquiry into this complex area and offers its full co-operation and participation. Any death in custody is a terrible tragedy that brings the Prison Service's duty of care to people in its custody into sharp focus. The Human Rights Act has incorporated the provisions of the European Convention on Human Rights into UK law and the Prison Service is committed to its terms and is determined to ensure that all those held in our custody are as safe as possible. Reducing suicides and self-harm in prison is a key objective and a great deal of work has been and continues to be done in this area.

2. Deaths in prison remain a rare event. Sadly, the largest proportion of those who die in custody take their own lives (see Table 1 below). Good care and support from staff saves many lives, but such instances go largely unreported. 141 prisoners were resuscitated following self-harm incidents in 2002, which reflects a lot of staff effort and skill. The rate of self-inflicted deaths in prison is substantially higher than the rate of self-inflicted death in the community (although it is not greater than that of people under supervision in the community).

3. An increasing number of vulnerable people are passing through the Criminal Justice System and the general prison population contains very large numbers of prisoners who enter custody already struggling to cope with a wide range of difficult issues. These include drug and alcohol abuse, family background and relationship problems, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems. Studies suggest, for example, that 90% of all prisoners have shown evidence of at least one of the following: personality disorder, psychosis, neurosis, and alcohol misuse and drug dependence. These factors increase the likelihood of self-harm and suicide; indeed, self-harming and suicidal behaviour often pre-date custody, and may have started early in life. Statistics show that 20% of sentenced men and 44% of women on remand report having attempted suicide in their lifetime.

4. The Prison Service is taking forward initiatives to help people deal with these issues and make them more able to cope in the prison environment, and in the future upon their release. But there are, regrettably, no simple solutions, and the reasons for self-inflicted deaths are complex.

Q1. *What are the main causes of deaths in prisons? Are there any common factors? Are there particular aspects of conditions of detention, or the treatment of detainees, or the cultural background of prisoners or prison officers, that contribute to:*

— Suicide and self-harm in prisons?

— Other deaths or injuries in prisons?

1.1 Suicides in prison seem to be caused by the combined effects of imported vulnerability, the exposure of this vulnerability by aspects of prison regimes, the effects of prison quality and continuing life events occurring once in prison. Table 1 shows the number of deaths in custody during the period 1998–2002:

Table 1

Year	*Self-inflicted deaths**	*Deaths by natural/other causes*	*Total*
1998	82	56	138
1999	91	58	149
2000	81	63	144
2001	72	68	140
2002	94	71	165
Total	420	316	736

*The term self-inflicted death includes deaths where it appears that the death occurred as a result of a person's own actions.

1.2 In the calendar year 2003 to date (13 August), there have been 61 self-inflicted deaths; and 49 deaths by natural/other causes. In the financial year to date (13 August) there have been 31 self-inflicted deaths and 31 deaths by natural/other causes. This compares to 55 self-inflicted and 47 natural/other cause deaths at this time last calendar year and 36 self-inflicted deaths and 25 natural/other cause deaths at this time last financial year.

1.3 The most common method of self-inflicted death in prison is hanging, which is likely to be related to the restriction of access to other methods in a prison environment. The methods of self-inflicted deaths (1998–2002) are shown in Table 2.

Table 2

Year	*Sex*	*Hanging*	*Overdose*	*Cutting*	*Suffocation*	*Food refusal*	*Refused medication*	*Self-strangulation*	*Arson*	*Total*
1998	Male	78	0	1	0	0	0	0	0	79
1998	Female	3	0	0	0	0	0	0	0	3
1999	Male	81	2	2	0	0	0	1	0	86
1999	Female	5	0	0	0	0	0	0	0	5
2000	Male	66	4	2	0	0	0	0	1	73
2000	Female	7	0	0	1	0	0	0	0	8
2001	Male	58	2	2	2	1	0	1	0	66
2001	Female	6	0	0	0	0	0	0	0	6
2002	Male	80	1	1	0	1	2	0	0	85
2002	Female	9	0	0	0	0	0	0	0	9
Total		393	9	8	3	2	2	2	1	420

1.4 The causes of deaths by natural and other causes in the years 1998–2002 are provided in Table 3. The general upward trend of natural cause deaths is probably accountable to the increasing numbers and age of the prison population.

Table 3

Cause of death	*1998*	*1999*	*2000*	*2001*	*2002*	*Total*
Stroke related	0	1	1	0	5	7
Heart related	5	13	16	9	18	61
Cancer related	1	7	12	2	5	27
Asthma related	0	3	1	2	1	7
Long term illness	0	1	2	1	0	4
Brain related	1	3	1	0	1	6
Not recorded	39	20	17	44	19	139
Liver or renal failure	0	2	0	0	1	3
Drug abuse	1	2	3	0	4	10
Other	2	4	1	2	17	26
Outside prison*	3	1	3	8	0	15
Homicide	4	0	3	0	0	7
Choked on vomit	0	1	0	0	0	1
Pneumonia related	0	0	1	0	0	1
Mutilation	0	0	1	0	0	1
Old age	0	0	1	0	0	1
Total	56	58	63	68	71	316

*This category includes deaths of prisoners on leave, or who absconded.

1.5 The characteristics of prisoners who have died in custody by self-inflicted means during 2002 are overviewed below. Where relevant, comparisons are drawn with deaths that have occurred in previous years, and where possible, statistics are given for 2003 to date.

Age

1.6 The age-profile of those who died in 2002 is shown in Table 4. Most deaths occurred in the 25–39 age groups. The age-range of the 94 deaths was from 16 to 58. The mean age was 32 years. Two juveniles (15–17 year olds) and 12 young offenders (18–20 year olds) died. The remaining 80 were adults, 38% of whom were in the 30–39 year age group. This is similar to the age-profile of those who have died in previous years and broadly reflects the age-profile of the general prison population.

Table 4

Age Group	*Number*	*%*
15–17 years	2	2
18–20 years	12	13
21–24 years	11	12
25–29 years	17	18
30–39 years	30	32
40–49 years	16	17
50–59 years	6	6
Total	94	100

Gender

1.7 Ten per cent of cases of self-inflicted death involved females. This figure is higher than would be expected, given that women only account for 6% of the prison population. So far in 2003, the relative proportion of female SIDs is even higher—of the 58 deaths up to 4 August, 10 have been female. An important point is that, in the community, women make up a quarter of all deaths. Taking into account the proportions of men and women in custody, a disproportionate number of those who kill themselves in prison are women.

Ethnicity

1.8 Eighty nine per cent who died in 2002 were white; white prisoners comprise around 78% of the prison population. 4% of those who died were Asian; around 3% of the prison population is Asian. Five per cent of those died were black; around 15% of the prison population is black. In 2003 (to 4 August), of the 58 deaths, four have been non-white. These figures show that a disproportionate number of self-inflicted deaths occurred amongst white prisoners. This is a consistent research finding.

Offence type

1.9 As illustrated in table 5, the most common offence-type of those who died during 2002 is violence against the person, followed by robbery, other criminal offences and burglary. Published research is consistent in reporting that those who die are more likely (than the general prison population) to be imprisoned for violence-related offences.

Table 5

Offence-type	*Number*	*%*
Violence against the person	25	27
Sexual offences	7	7
Burglary	12	13
Robbery	15	16
Theft & handling	11	12
Fraud & forgery	1	1
Drug offences	9	10
Other offences	14	15
Total	94	100

Legal Status

1.10 Forty one (44%) of those who died in 2002 were sentenced; the remainder were either on remand (38%), convicted unsentenced (13%) or in prison awaiting further reports (Judgement Respited—J/R) (5%). Unsentenced prisoners account for less than 20% of the prison population. That the vast majority of those who die are unsentenced is consistent with previous years.

Sentence Length

1.11 Consistent with previous years' data and published research, sentenced prisoners who die are likely to be serving lengthy prison terms or life. In 2002, 71% of the 41 sentenced prisoners who killed themselves were serving terms of over 18 months. Twenty two per cent were serving life-sentences.

Latency

1.12 A consistent finding is that the majority of prisoners who die have been in the establishment for relatively short periods at the time of death. Table 6 shows the latency between prisoners' receptions at the establishment and their death. Just over half (54%) of prisoners who died in 2002 spent less than a month in custody (52% in 2001).

Table 6

	Number	*%*
< 1 day	7	7
1 to 2 days	7	7
3 days < 1 week	12	13
1 week < 1 month	25	27
1 month < 3 months	21	22
3 months < 6 months	13	14
6 months < 12 months	7	7
1 year or more	2	2
Total	94	100

Establishment-Specific Factors

1.13 As in previous years, the majority of self-inflicted deaths (64%) in 2002 occurred in Category B Local prisons. It has been found that male local prisons that experience a self-inflicted death are statistically more likely to experience further death/s. In 2002, 52 establishments experienced a self-inflicted death:

— 2%—One prison (Durham) experienced six deaths (four males and two females).

— 4%—Two prisons (Lewes and Holme House) experienced five deaths.

— 4%—Two prisons (Dovegate and Hull) experienced four deaths.

— 10%—Five prisons (Exeter, Leeds, Woodhill, Bullingdon and Bedford) experienced three deaths.

— 25%—13 prisons experienced two deaths (Blakenhurst, Bristol, Brixton, Doncaster, Liverpool, New Hall, Northallerton, Nottingham, Parc, Preston, Styal, Wandsworth and Wealstun).

— Finally, 56%—29 establishments experienced one death.

1.14 There is no firm evidence of a correlation between the prison population and the number of prisoners who kill themselves, although it is likely that an increase in prison population has an impact on the amount of time staff can spend with each individual prisoner. Overcrowding may also result in an increase in the length of time prisoners are locked in their cells, rather than engaged in purposeful activity. More people being received into custody may mean that some prisoners are located further from home, which, in turn, may mean that they receive fewer visits from family and friends.

1.15 Only three (Dover in Kent, Haslar in Hampshire and Lindholme in Doncaster) of the UK's nine removal centres are managed by the Prison Service. They hold only male detainees (individuals detained prior to removal from the UK, overstayers, failed asylum seekers and illegal immigrants). These centres are managed under the Detention Centre Rules published in April 2001. The regime is considerably more relaxed than the regime in prison (as detainees are not criminals).

1.16 Since September 2000, there have been two self-inflicted deaths involving detainees in the Prison Service managed centres. (On 31 January 2003, Michail Bodnarchuk, a Ukrainian national, hanged himself at HM Immigration Removal Centre Haslar. He was due for removal on the day of his death, and had been resident at Haslar since 8 November 2002. On 31 March 2003, Rajwinder Singh Mutti hanged himself at HMP Blakenhurst. Mr Mutti, an Indian national, had been on remand at Blakenhurst since 3 February 2003 for an offence of grievous bodily harm; he was also detained under the 1991 Immigration Act.)

1.17 The identification of at-risk detainees is made more difficult by the difficulties in communication and the lack of personal history information. The F2052SH (see paragraph 2.5 below) procedure operates in detention centres as it does in prison establishments, with an active Suicide Prevention Team.

1.18 As mentioned above, evidence suggests that minority ethnic prisoners are less likely to take their own lives than white prisoners. Cases of self-inflicted death among black and Asian prisoners are proportionately less in comparison with the rest of the prison population; the statistics for the years 1996–2002 show that, while 20% of the prison population is composed of individuals from minority ethnic groups, minority ethnic prisoners represent only 9% of the number self-inflicted deaths.

1.19 The Prison Service annual report, published on 15 July 2003, said that over the past financial year, 5.1% of staff were from a minority ethnic group (exceeding the key performance target of 4.5%). Good prisoner/staff relationships are central to the quality of life in prison, which is thought to be a factor in suicide prevention. Results of research measuring the quality of prison life are expected in the summer of 2004.

Q2. *What practical steps have already been taken, and what further steps are being considered to prevent:*

— Suicide and self-harm in prisons?

— Other deaths and injuries in prison?

2.1 Reducing prisoner self-inflicted deaths and managing self-harm is a key priority for Ministers and the Prison Service. A proactive three-year strategy to develop policies and practices to reduce prisoner suicide and manage self-harm in prisons was announced in February 2001 by the then Home Secretary, Jack Straw, and was implemented from April 2001. The launch of the current strategy followed a thematic inspection review by Sir David Ramsbotham and an internal review by Ingrid Posen (former Head of Safer Custody Group). It replaced the 1994 Caring for the Suicidal in Custody Strategy, which was generic across the estate, focussed on awareness, and stressed the responsibility of all staff. Pre-1994 approaches had been primarily medical.

2.2 The current strategy is holistic in approach, more overtly preventative, risk-based, and strongly dependent on other approaches (within prisons on a supportive culture based on good staff/prisoner relationships and constructive regimes; beyond prisons on the cooperation of other agencies). It is ambitious in scope and in demanding year-on-year reductions in suicide and self-harm.

2.3 Projects are underway to improve pre-reception, reception an induction arrangements, to better facilitate inter-agency information exchange, and to develop safer prison design, including "safer cells". New evidence based healthcare reception screening arrangements are being implemented and include measures to better detect vulnerable prisoners. Thirty full-time suicide prevention co-ordinators (SPCs) have been appointed in high-risk establishments, and a further 102 mostly part-time SPCs are now operating across the estate. Wing staff are supported in their work by prisoner peer support schemes and, in the most needy prisons, by mental health in-reach teams, similar to community mental health teams. Samaritans are working with the Prison Service to select prisoner "Listeners", who are then trained to listen (though not to give practical advice) to all prisoners who need somebody to talk to, often seven days a week, 24 hours a day.

2.4 An investment of over £21 million is allowing physical improvements to be made at six pilot sites: Feltham, Leeds, Wandsworth, Winchester, Eastwood Park and Birmingham. The money is being spent on improvements to detoxification centres, reception and induction areas, the installation of First Night Centres and the creation of crisis suites and gated cells that enable staff to watch at-risk prisoners closely.

2.5 Improved processes for the identification and management of prisoners at risk of suicide and self-harm are being developed to replace the current "F2052SH" procedures. Any member of staff can raise an F2052SH in respect of a prisoner considered to be at risk of suicide or self-harm. An individual care plan is then put in place for so long as the crisis lasts, with regular multi-disciplinary reviews. Changes in detoxification facilities and procedures are also being introduced. Staff awareness and training are recognised as key to the successful outcome of many of these initiatives and training programmes are being developed alongside new procedures.

2.6 The Prison Service is also determined to learn lessons from death in custody. The programme of work embarked upon includes a fresh look at strengthening investigations procedures to include an independent element and better learning and dissemination of lessons arising in particular cases. Investigation reports are already routinely disclosed to the families concerned. (See also question 5 below.)

2.7 Problems of inter-prisoner violence and bullying, particularly among young people in custody, are being readdressed through development of a violence reduction strategy. This will provide a national framework of protective mechanisms and positive behaviour management. Work is on going with other services to ensure that the Prison Service's work in this field is consistent with a national, multi-agency approach.

2.8 There is strong support for the strategy from groups represented on the Ministerial Roundtable on Suicide, which is chaired by the Prisons and Probation Minister, Paul Goggins. Membership includes the Howard League, Prison Reform Trust, Inquest, the Youth Justice Board, Prisons and Probations Ombudsman, HM Chief Inspector of Prisons and Samaritans. Prison Health, the partnership between the Prison Service and the Department of Health, is also represented.

2.9 A number of intervention strategies have been introduced into prisons for people who self-harm. These include crisis counselling, support groups and specialised psychological interventions. The Prison Service recognises that self-harm is a particular problem among women prisoners. Safer Custody Group findings reveal that attempted suicide/self-injury is more prevalent amongst women that men in prison by a ratio of 18:1 (2003). At three women's prisons—Holloway, Durham and Bulwood Hall—Dialectic Behaviour Therapy has been introduced. This is an innovative programme developed in the USA by Marsha Linehan, originally for women with "borderline personality disorder" (BPD) who also self-harm or engage in suicidal behaviours. It has been well researched and found to be significantly better than other treatments in producing positive changes for this client group. Treatment targets of DBT include reducing self-harm, increasing coping skills, decreasing impulsive behaviours and improving emotional regulation. DBT has also been found to have positive treatment effects on other behaviours such as abuse and aggression.

2.10 Over the next few months the outcome of the Safer custody strategy will be reviewed, taking into account pilot project evaluations and emerging research findings. The next steps and approaches will be resolved in consultation with partner agencies and organisations. It is likely that approaches in the future will concentrate more on better care for people than on processes and the Prison Service will seek to reduce the desire of individuals to attempt suicide by improving the custodial experience and the feelings of safety in establishments. It will seek to build on the close relationship and working partnership with Prison health. For many in prison the growing links with local healthcare will aid continuity of treatment. The strategy is also likely to include greater links with the resettlement agenda and a broader understanding of the issues to share with the public.

Q3. *What has been done to foster a greater "human rights culture" in prisons and other detention facilities? What more could be done? Would a human rights approach to conditions of detention and to prison management contribute to the prevention of deaths in custody?*

Q4. *Are you satisfied that guidance and practice in the prison service is sufficient to comply with obligations under Articles 8, 3 and 2 of the European Convention on Human Rights?*

3.1 The Prison Service has undertaken an extensive programme of training for staff on the introduction of the Human Rights Act and its implications for the Prison Service. This has been supported by the provision of written information to every member of staff, together with information packs made available to prisoners through the prison library. In conjunction with the Prison Reform Trust, a booklet specifically designed for prisoners was produced and issued in July 2001. Legal Services Officers from all prisons have attended conferences, and governors together with senior policy staff have attended seminars. Presentations have been made to dispersal prisons, staff responsible for life sentenced prisoners and Race Relations officers.

3.2 All policy leads are aware that both new and existing policy must be HRA compliant. In those areas where there has been doubt, legal opinion has been sought and changes made. During the consultation process for new policy the Human Rights implications of any changes must be considered by policyholders.

3.3 The belief is that current policy and guidance in the Prison Service is in line with ECHR; however, if successfully challenged as non-compliant, we will address those issues at the time. The general nature of some ECHR terminology and its reliance on general principles mean that it is often through a policy being tested in the courts that precedent or non-compliance is established.

3.4 While it would be naïve to insist that all practice is always compliant with policy, we have a thorough process of Internal Audit, auditing of Prison Service Standards and both announced and unannounced visits by Her Majesty's Inspectorate of Prisons that is designed to ensure that policies are being correctly applied. To support this we also have complaints procedures that allow prisoners to complain about their treatment to the Prison Service, and finally, if not satisfied, to the Prisons and Probation Ombudsman.

3.5 The provisions of the Human Rights Act and its underlying principles contribute to suicide and self-harm reduction in prison. (See also Question 5 below.)

Q5. *Are the Article 2 ECHR requirements of an effective, prompt and independent investigation of deaths in custody, with effective participation by next-of-kin. Met by the current system? How could the effective investigation of deaths in custody be better ensured?*

5.1 Since April 1998 all deaths in custody have been investigated by the Prison Service. Investigations are carried out by senior governors. Although "independent" of the prison concerned, investigating officers are usually from the same area and our investigations could not be regarded as other than internal. Investigating officers act on behalf of the Commissioning Authority (CA), the area manager or equivalent, responsible for the establishment in which the death occurred, to whom they are accountable. The CAs are in turn accountable to the Director General and his Deputy. Currently therefore both the commissioning of investigations and "ownership" of reports rest with the operational line of the Prison Service.

5.2 The short answer to the first part of this question, therefore, is that the Prison Service is playing its part but currently remains vulnerable to judgements in individual cases that our internal investigations do not contribute enough—thus supporting the case for strengthening our investigations, which we are doing as part of the three-year Safer Custody Programme. (See paragraph 2.1 above.)

5.3 The Joint Committee will be aware that this is a fast moving and still developing area of jurisprudence, which we expect to be further clarified when the Lords give their judgement in the case of *Amin* (heard in July) and *Middleton*, which is to be heard early next year. Currently the position is that the requirements of an Article 2 investigation (the so-called "Jordan" criteria of independence, effectiveness, reasonable promptness, public scrutiny and family involvement) can be met by an amalgam of inquiries and investigations—the Prison Service investigation, the Inquest, civil proceedings, a criminal trial—and no single element is expected to meet Article 2 on its own (although that is possible). The Lord chief Justice went out of his way to praise Governor Ted Butt's report in the *Mubarek* case, notwithstanding that it was internal.

5.4 The attached Annex A[2] prepared as background to our work in this area, provides further information about the current legal position. But the reasons for strengthening investigations into death in custody go beyond Article 2 compliance. The main reason we want to strengthen our investigations into deaths in custody is to contribute to the suicide prevention strategy—to ensure a better focus on what went wrong and why and to extract learning so as to minimise recurrences. The three-year safer custody programme therefore incorporated a project designed to establish a system of investigation into deaths in custody, which is:

— fair, open and timely;

— has appropriate elements of specialist input and independence;

— secures public confidence;

— explains what happened and why;

— provides for the Prison Service to learn from any identified failures;

— provides the fullest possible factual information to the Coroner as a basis for the inquest; and

— involves the family of the deceased fully and appropriately.

5.5 During 2001 Safer Custody Group undertook a wide scale consultation exercise, consulting interests within and outside the Prison Service on how such a system could be developed. Following this exercise an options paper was put to Ministers in which four options were identified. These were:

— extend an existing external prisons-related role, most likely that of the Prisons Ombudsman, with both commissioning and investigations independent of the Prison Service;

— create a new independent body based on the police model, with a mixture of external and internal investigators, with commissioning and investigations independent of the Prison Service;

— dedicated team(s) of investigators with pools of expert assistants. All investigations independent-led or supported depending on circumstances of case, with Prison Service retaining commissioning and some "ownership" of investigation reports; and

— strengthened inquest process. (At the time the options paper was prepared the fundamental review of the Coroner's system had been commissioned but had not reported.)

5.6 Ministers asked for the Prisons and Probation Ombudsman option to be worked up and costed and this work is currently in hand. It is being taken forward by the Home Office in the context of putting the Prisons and Probation on a statutory footing and, simultaneously extending his role to include investigating deaths in prison custody (and deaths of probation hostel residents). Both the report of the fundamental review of Coroners and Dame Janet Smith's report into the Harold Shipman affair make recommendations for radical changes to the Coroner's role, on which a view needs to be taken before a final decision on the Prisons and Probation Ombudsman option is made.

5.7 The Prisons and Probations Ombudsman is unlikely to take over responsibility for investigating deaths in custody before April 2005. In the interim Safer Custody Group is working with area managers (who commission death in custody investigations) to do what we can to strengthen our current procedures in a variety of ways, for example, by improving clinical input, incorporating independent elements into some investigations and their management, widening terms of reference and involving families to a far greater extent. Five areas are trialling revised guidance on investigating deaths in custody. This is attached at Annex B.[3]

Phil Wheatley
Director General

18 August 2003

4. Memorandum from the Commission for Racial Equality

Introduction

Established under the Race Relations Act 1976, the Commission for Racial Equality has a statutory duty to work towards the elimination of unlawful racial discrimination and the promotion of equality of opportunity and good relations between people of different racial groups.

[2] Not printed here.
[3] Not printed here.

Following the recommendations of the Stephen Lawrence Inquiry and representations the Commission itself had long made[4], the Act was amended in 2000 both to extend its provisions on unlawful racial discrimination to cover the operations of the criminal justice agencies and to establish a duty on such bodies to work towards the elimination of unlawful racial discrimination and the promotion of equality of opportunity and good relations between people from different racial groups.

This later duty to promote race equality lies upon not only the criminal justice, health service and other agencies responsible for holding people in custody but also upon the bodies responsible for inspecting and investigating them, or supervising those who do.

In the case of all such bodies, the amended Act requires them to prepare and implement race equality schemes indicating how these duties will be implemented, how progress toward these aims will be monitored and how those affected will be consulted. The pursuit of such work will assist agencies involved in custodial care and the investigation of deaths in custody in focusing effectively on their functions, learning lessons from catastrophic events such as deaths in custody and in recognising the negative impact such events can have on race relations generally.

Background

The experience of the Commission, including that arising from its conduct of an ongoing formal investigation under the 1976 Race Relations Act into possible unlawful racial discrimination by HM Prison Service of England and Wales[5], is that:

- The impact upon race relations of controversial deaths in custody involving members of different ethnic minority communities has been, and continues to be, strongly negative.
- The perception of wrong doing has persisted even where public authorities may, upon investigation, have been shown to have acted correctly, partly because the independence of the investigation has not been accepted or not been evident.
- When more general failures of practice linked, directly or indirectly, to race have been inadequately investigated, left unresolved or have just not been acknowledged by those responsible, the damage to good race relations has been significant.

We share the view expressed on these matters by the Attorney General in his recent *Review of the Role and Practices of the CPS* that:

> A death in custody takes on added significance when the person who has died belongs to a group which considers itself as having had historically strained relationships with the police and other institutions of the criminal justice system.[6]

As, in the recent past, members of various ethnic minorities have been significantly over represented at various times in different aspects of death in custody (for instance, deaths in police custody excluding deaths arising from police car chases, deaths from the use of control and restraint procedures in HM Prison Service establishments or suicide in those establishments), the Commission has been directly interested in ensuring the full investigation of such deaths and in seeing established effective mechanisms to ensure that the lessons learned from such investigations are properly followed up by improvements in practice.

The Commission has given evidence and published its views over a number of years in respect of the concerns it has shared about the issue of deaths in police custody, the significant over representation of black members of the public in such deaths and the obvious weaknesses in the investigation machinery involved. More recently, there has been progress in establishing more independent means of investigation. The establishment of the Independent Police Complaints Commission is a further step in a direction that the Commission welcomes. Progress also appears to have been made in reducing the previously marked disproportionality in ethnic minority involvement in such deaths[7].

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[4] *The Stephen Lawerence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny*, February 1999 and *Review of the Race Relations Act*, April 1998.

[5] The Commission does not have a power to investigate deaths in custody but sections 48 to 52 of the Act give the Commission the power to conduct formal investigations into the actions of organisations if it has grounds to believe that unlawful racial discrimination may have taken place. In the summer of 2000, the Commission was considering launching such an investigation into HM Prison Service of England and Wales. Following the conviction in November 2000 of Robert Stewart for the murder of Zahid Mubarek in YOI Feltham, the Commission decided to add "the circumstances leading to the murder of Zahid Mubarek and any contributing act or omission on the part of the Prison Service" to the matters to be investigated.

[6] *A Review of the Role and Practices of the Crown Prosecution Service in Cases Arising from a Death in Custody* by the Rt Hon The Lord Goldsmith QC Her Majesty's Attorney General, July 2003, page 3.

[7] Though different totals are provided (arising possibly from different definitions as to the term "in custody"), figures issued for the police related deaths for the period from 1999 to 2002 show that though ethnic minorities are still over-represented, there has been a downward trend in the percentage of those involving black or Asian members of the public as shown in annual statistics issued by the Home Office, the Police Complaints Authority, and Inquest as well as in the above mentioned Review of the CPS.

However, there remain significant areas concern. The over representation of individuals from particular ethnic groups in some areas of deaths in custody continues and, while progress has been made in respect of the responses to deaths in police custody, those in other areas of custody have not been the focus for the same institutional arrangements. There is, for instance, no parallel body to the Police Complaints Authority or the future IPCC in respect of deaths in the custody of HM Prison Service.

There are several race equality issues which arise from all these matters. These include:

— Do the arrangements mean that issues of possible racial motivation in respect of the actions which led to or caused the death have been effectively brought out and considered?[8]

— Do the arrangements enable the race equality consequences of poor practice and different needs/ circumstances of different ethnic groups among those in custody to be understood and responded to?

— Do the arrangements properly respond to the needs and concerns of relatives from ethnic minority communities?[9]

Some of these concerns should be the focus for the work the various agencies involved should be undertaking as a result of the Race Relations (Amendment) Act 2000 as suggested in the Introduction.

In this evidence to the Joint Committee we wish to drawn the Committee's attention to three matters:

— The need for a primary attention to be focused upon the use of lessons gained from the investigation of those deaths which have occurred to prevent any further such tragedies.

— The urgency of following the better practice which has been developed in respect of deaths in police custody with parallel arrangements for other areas of custody.

— The problem faced by relatives when seeking expert or legal representation.

The Importance of Ensuring that Good Practice in Custodial Care is Developed and Followed

Much of the discussion around Article 2 of the European Convention of Human Rights has focused on the issues of how best should investigations be conducted in order to fulfil the procedural obligation which falls upon the state as a result of the article[10]. There has been less discussion about the need to ensure that the lessons learned from individual investigations are then followed through either by the development of better custodial practice or by ensuring that measures already agreed upon as part of such a practice are actually implemented.

While clearly the procedural obligation is necessary to determine whether or not the state has fulfilled its positive duty to take reasonable steps to safeguard the lives of those in its custodial care, the existence of arrangements to ensure that the lessons learned from investigations are effectively implemented is fundamental to the actual fulfilment of that duty. The Commission is concerned that any procedures put in place to conduct investigation of individual deaths are also capable of examining how the lessons which should have been learned from one death may not have been implemented effectively enough to prevent subsequent deaths.

In 2000, the Commission launched a formal investigation under the Race Relations Act 1976 into, among other matters, the circumstances leading to the death of Zahid Mubarek who was murdered while in the custody of HM Prison Service of England and Wales. The overall investigation has not yet concluded and the Commission is not in a position at the time of preparing this submission to discuss all the issues arising from the investigation that might be relevant to the Joint Committee's deliberations. However, the report of the investigation in so far as it directly concerned the murder of Zahid Mubarek has been published[11].

The Commissioners nominated to conduct the investigation found that the prison authorities failed to follow their own stated procedures and that these failures created the circumstances in which a prisoner with a record of violence and known racist views was able to share a cell with a prisoner from an ethnic minority who was, therefore, more likely to be a target for assault by him. In particular, the Commissioners noted that several of the practice areas concerned procedures which had been laid out in HM Prison Service Orders or Instructions over a period of many years. In several instances, the fact that these Orders or Instructions were not being followed was a matter known to HM Prison Service, either as a result of published reports by HM Chief Inspector of Prisons or as a result of the Service's own internal audits.

[8] Section 9 of the Attorney General's *Review of the CPS* discusses this issue appropriately.

[9] For instance, the *Fundamental Review* of the coroners service found that among its "critical weaknesses" was the fact that "There has been no reliable or systematic response to minority community wishes, traditions and religious beliefs" (p 17, point g, Cm 5831).

[10] These issues include not only matters such as the independent nature of any investigation and whether or not relatives have a right to participate in any investigation but also whether or not there should be an investigation of a public character. The House of Lords will indicate further its opinion on some of these matters when it delivers its judgment in the case of *Amin* concerning the death of Zahid Mubarek.

[11] *A Formal Investigation by the Commission for Racial Equality into HM Prison Service of England and Wales: Part 1: The Murder of Zahid Mubarek*, CRE, July 2003. It is the intention of the Commission to conclude the investigation and publish a final report in the autumn of 2003.

In addition to the issue as to whether or not the family of Zahid Mubarek have a right to a public inquiry into what happened, there is, therefore, also the issue of how such persistent failures of good practice can be identified and prevented.

It is apparent that, even in areas of custody—such as the police—where some institutional arrangements have existed with a responsibility to give attention to such matters, persistency of bad practice is hard to shift.

The review by the Police Complaints Authority of police shootings under section 79(1) of the Police Act 1996 published by the Authority in January 2003 found that

> Although each incident in which a member of the public is shot by an armed police officer is the subject of a detailed and thorough investigation, systematic analysis across time and over incidents is limited.[12]

It noted that "there has been one important UK shootings review prior to this one", the "Burrows Report", covering shootings between 1991 and 1993. The authors added:

> It is beyond the scope of the current review to comment on the scope of the recommendations arising from the Burrows Report. However, it is regrettable that there is no formal mechanism for assessing their implementation and many of the findings presented below would suggest that implementation has not been universal.[13]

The concern such a failure to act provokes is reinforced by the finding of the review in regards to the shootings it examined.

> Investigations often produced recommendations which were accepted at Chief Officer level but did not appear to be reflected in the future operation behaviour of the force, compounded by the fact that there is no outside monitoring of the forces response to the recommendations made.[14]

The review recommended that the recommendations for action made by investigators should be passed to the Inspectorate and to the bodies in the police service responsible for disseminating best practice including the "Standing Committee to Learn Lessons from Adverse Incidents".

The Prison Service does not have a parallel to the PCA and the future IPCC. Proposals have been consulted upon by the Home Office to establish the present office of the Prisons and Probation Ombudsman upon a statutory footing and to extend his remit to cover all deaths in HM Prison Service custody. The Commission has not itself been consulted upon these proposals. While it supports the long standing request by the Ombudsman that his office be put on a statutory footing, the Commission's own experience in conducting an investigation into the circumstances leading to one death in which negligent actions by HM Prison Service staff created the context in which a murder could take place, suggest that a more substantial change is required.

At present, under the Coroners Act, all deaths in prison custody must result in a Coroner's inquest before a jury. This requirement, which has been part of coronial law for centuries, is an important expression of the need for independence in the investigation of any death in a prison. It does not, however, meet two considerations relevant to our concerns on how to ensure the implementation of good practice.

First, if a coroner is expected to fully explore the factors of possible negligence lying behind a prison death, the scale of the investigation may be beyond their capacity to deliver. This point was made by the West London Coroner in evidence to the House of Lords in respect of the death of Zahid Mubarek when she explained why she did not consider that she was in a position to hold an inquest into his death. For a coroner in such circumstances to rely upon an internal investigation by HM Prison Service would be both inappropriate and inadequate. The findings of our Nominated Commissioners in respect of the murder of Zahid Mubarek reinforce this point: the internal investigations were inadequate and the causes were complex.

Secondly, the coronial system is not designed to ensure the pursuit of good practice on the part of agencies such as HM Prison Service. A Coroner's power to notify any authorities of actions it may be advisable to take related to issues revealed by the death they have investigated (letters sent under rule 43 of the Coroners Rules) is not consistently used nor is it publicly reported. Research conducted for the Fundamental Review of the service[15] found that

> One third of Coroners did not use rule 43 at all last year. At the other extreme 6% of Coroners raised more than 10 letters and one raised 60.
>
> No outcome was reported for about a quarter of the rule 43 interventions. In 45% of the cases some change had been implemented or the matter was in the action plan for the Agency concerned. In a further 21% of cases the issue was under review. In 10% of cases, the letter had either been rejected or inadequate action (in the Coroners' view) taken.[16]

[12] Review of shootings by police in England and Wales from 1998 to 2001, Police Complaints Authority, January 2003, p 12.
[13] Review of shootings by police in England and Wales from 1998 to 2001, Police Complaints Authority, January 2003, p 14.
[14] Review of shootings by police in England and Wales from 1998 to 2001, Police Complaints Authority, January 2003, p 112.
[15] *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review,* 2003, Cm 5831.
[16] Review of Coroners: Analysis of Survey: UK of rule 43, 2003, p 4.

> In 6.6% of the cases, the rule 43 letter was sent to HM Prison Service [17]. Neither the Prison Service nor any agency assisting Coroners, had, at the time covered by the Commission's investigation into the circumstances leading to Zahid Mubarek's death, any way of gathering together what these letters may have said, whether they were being properly responded to by the Service and whether that response led to the replacement of poor or negligent practice by consistent good practice.

In contrast to this situation, a recommendation that came out of the review of police shootings cited above was that recommendations made by one investigation into a shooting involving a particular police force should be included in the terms of reference of any future investigation into a shooting involving the same force [18]. This would help to make the issue of any persistent failure to follow proper practice clear and open.

The Fundamental Review went some way down this road in recommending that:

- a coroner's findings and recommendations be sent to any statutory regulatory service which regulates the activities of the recipient body and any inspectorate which inspects its work;
- these bodies should report on such recommendations and say whether or not they are satisfied with the actions of the agency concerned which have followed; and
- the recipient agency should inform the coroner as to what they have done[19].

These are clearly steps which are sensible, but they need an effective institutional apparatus to handle them if they are to result in the permanent implementation of better practice.

Such arrangements would need to supplement them with their own wider reviews to examine aspects of deaths of custody which may not become apparent from the investigation of individual deaths. This is particularly the case with differentials arising between ethnic groups.

One example of an area in which this kind of approach could have significant impact on Prison Service practice is that of drug related deaths in prisons or the period immediately after release. Research evidence indicates that crack cocaine (a stimulant) is the Class A drug most frequently used by ethnic minority males rather than heroin (a depressant) which is the Class A drug most apparent in the white prisoner population. Drug treatments in prison have been focused on heroin and not crack cocaine[20]. Monitoring and race impact assessments of policies of the kind promoted by the amended Race Relations Act could help significantly to direct improved practice to overcoming such differentials.

Another example is that of suicide in prison. Ethnic monitoring is not yet adequately developed to pinpoint the extent and nature of the involvement of prisoners of Irish and Irish Traveller origin in suicide. Significant concerns have been expressed by voluntary sector agencies working with such prisoners that the treatment of such prisoners has not adequately met their needs and so has contributed to what some evidence suggests may be higher rates of self harm and suicide in these groups[21]. On the other hand, no research appears to have been conducted so far into the significantly lower rates of suicide for the Black group in prison. The contrast is marked. Were the white group to experience the same rate of suicide as the black group several dozen lives would be saved each year.

We consider the practical implications of these issues under the next heading.

Ending the Inconsistency Across Areas of Custody

The present arrangements for investigating deaths in custody provide no consistency between the different regimes. This both denies relatives of those who die in prison custody, for instance, the same level of response to that provided after those who die in police custody. The contrast will become the greater after the IPCC starts work.

It also means that good practice developed in response to deaths in one area of custody are unlikely to be followed more widely. There is no practical reason for this inconsistency.

While the proposals of the Fundamental Review of the Coroners' service would, if implemented, improve matters so far as investigation of individual deaths is concerned, they would not of themselves resolve the more fundamental problems: the level of investigation would continue to be limited (both by resourcing and by the difficulty that the investigation of individual deaths would not succeed in uncovering important background patterns) and the mechanisms for ensuring best practice was consistently implemented would be weak.

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[17] Review of Coroners: Analysis of Survey: UK of rule 43, 2003, p 17.

[18] Review of shootings by police in England and Wales from 1998 to 2001, Police Complaints Authority, p 113.

[19] *Fundamental Review*, pages 95 to 96.

[20] *See* for instance *Differential Substance Misuse Treatment Needs of Women, Ethnic Minorities and Young Offenders in Prison: Prevalence of substance misuse and treatment needs*, a Home Office Research, Development and Statistics Directorate paper available on-line at www.homeoffice.gov.uk/rds/pubsintrol.html published in 2003. in the week following release, prisoners are 40 times more likely to die than the general population and over 90% of these deaths are related to misuse of drugs (see Drug-related mortality among newly released offenders, Home Office research Findings Number 187, 2003). See also the report *Drug-related Deaths in Police Custody: A Police Complaints Authority study* May 2003.

[21] In 2003, HM Prison Service published a report, *Review of Deaths in Custody at HM Prison Brixton*, following concern over the suicide of seven men of Irish origin in the prison between December 1999 and May 2002 which concluded that "no corroboration was found for the general complaints made to us" but added that "the Service should not be complacent about these matters . . . There is a need to provide better guidance for prison staff if such issues are to be properly addressed" (paragraphs 8.29 and 8.30).

At the very least, there is a clear argument for extending the kind of arrangements proposed for the police to all other areas of custodial practice (prisons, mental health, immigration detention centres and detention centres run by the Services).

The design of the institutional arrangements should be guided by the principle that all areas of custody are covered by arrangements which provide for:

— Accountable, independent and effective investigation of individual deaths.

— A central focus where patterns of causes and contributory factors can be understood and analysed.

— Development of adequate remedial measures and lessons learned and their translation into good practice guidance for the relevant staff.

— Establishment of monitoring and regulatory procedures and powers to ensure that the lessons learned are implemented, lead to changed practices and that deaths do not continue to be caused by the same contributory factors over a significant period of time.

The present situation is unsatisfactory and neither assists the staff of the agencies involved to improve the way they work nor secures public confidence. The proposal to give the Prisons and Probation Ombudsman responsibility to investigate deaths in prison custody should be considered in the light of such principles. If an extended Ombudsman's office was to be provided with the powers and the resources to meet those principles, then the establishment of an additional agency might be considered disproportionate.

Providing Proper Assistance to Relatives

A responsibility laid upon the Commission by section 66 of the Race Relations Act is to consider applications for assistance from members of the public who consider that they may have been unlawfully discriminated against. The Commission has assisted many thousands of individuals in this way either with legal representation or with expert advice. It is the experience of the Commission that the generality of these individuals would not have succeeded with their claims if the Commission had not assisted them.

Relatives seeking to establish what happened after a death in custody face particular difficulties. Unless they are completely confident in the independence of the investigation which then follows and wish to play no part themselves, they need the assistance of expert advice and possibly also legal representation. The present arrangements rely upon the work of voluntary agencies such as Inquest which have limited resources.

Such arrangements as are put in place in the future need not only to be open and accountable to relatives, but also to provide them with the means to play their part in the investigative process.

15 October 2003

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5. Memorandum from Mental Health Act Commission

I. Causes of Deaths of Detained Patients

Commission research into deaths of detained patients

1. Research undertaken by the Mental Health Act Commission on deaths of detained patients between 1997 and 2000 show that, as might be expected, the highest proportion of such deaths (more than 80%) result from natural causes[22]. The 253 deaths from unnatural causes were mostly suicide. The causes of these deaths, as determined at inquest, break down as follows:

Hanging[23]	86	Method unclear	7
Jumped from height	36	Accidental	5
Hit by train	29	Fire	5
Drowning	21	Hose-pipe to car exhaust	3
Self-poisoning by overdose	13	Self-suffocation	2
Unsure accident/suicide	15	Death caused by another person	1
Jumped from vehicle	9	Self-strangulation	1

Category split of 233 unnatural deaths of detained patients 1997–2000[24]

[22] Mental Health Act Commission (2001) *Deaths of Detained patients in England and Wales; a report by the Mental Health Act Commission on information collected from 1 February 1997 to 31 January 2000.* Nottingham: MHAC. March 2001. p 8.

[23] In our *Deaths of Detained patients* report (MHAC 2001, paragraphs 81–85), we note that various load-bearing supports, not all of which would allow for suspension, were involved in deaths classified as "hangings" at inquest. This is further discussed at paragraph 5.18 below.

[24] Source: Mental Heath Act Commission (2001) *Deaths of Detained Patients in England and Wales (ibid)* Chart 14. This table excludes 20 deaths whose cause was unknown at the time of the study.

2. Twenty-two of the above patients had been subject to restraint in the week before their death, and four of these were being restrained at the time of the incident that proved fatal to them. Researchers did not draw any conclusions about the use of medication in this study, but the Commission's 1995 study of deaths between 1992 and 1994 counted 15 deaths (approximately 7% of all deaths in that study) as "iatrogenic", defining this in a non-pejorative sense as any death consequent to a health-care intervention[25]. Of these, 10 deaths appeared to be directly related to psychiatric medication. We discuss this further below (see 5.14 *et seq* below), although not all of the 10 deaths will have been as a result of emergency interventions.

3. Only a third of the deaths tabulated above took place within hospital premises. About half of the deaths took place in the wider community (through patients being absent from their place of detention, whether authorised or not): the remainder took place in general hospital environments (where a patient may have been moved following the incident leading to death).

4. In our reports on deaths of detained patients, the Commission has drawn general conclusions for services regarding risk-assessment, observation of vulnerable patients, granting of leave etc. We do not restate these in any detail in this submission, but will rather concentrate on those aspects of services that give us much concern, and the ways in which we perceive human rights-based approaches being central to challenging and developing current practices.

II. Matters of Concern to the Mental Health Act Commission in the Prevention of Patient Deaths

5. Particular aspects of conditions of detention and the treatment of detainees that cause the Commission concern and are, in its view, avoidable contributory factors in patient deaths are set out in the following paragraphs.

Anti-therapeutic environments within hospitals

5.1 Poor therapeutic environments within hospitals may be caused by bed pressures, inappropriate mix of patients, or simply the general environmental state of wards. Such conditions may retard patients' recovery and can also be contributive to patient behaviour that causes management problems, leading to control and restraint, seclusion, etc, or to episodes of self-harm or suicidal attempts. In one recent visit report on a London hospital, for example, Commissioners have alerted the hospital managers to the continuing effects of 200% bed-occupancy, low staff morale and the use of excessive force during control and restraint. We have advised the hospital to attend these concerns urgently before there are serious injuries on the ward.

5.2 The Commission has noted Government recognition of "the significant pressure on acute psychiatric beds, with services forced to maintain waiting lists, send people home on leave and place users in services outside their area" and the need for a whole-systems approach in tackling the problem[26]. We also recognise that the Department of Health's Policy Implementation Guidance seeks to address the problems of providing a therapeutic experience to patients under circumstances of overcrowding and pressures on services[27]. Nevertheless, in our view there is much work to be done (see also paragraph 5.19 below) and the Commission will continue to give high priority to monitoring the general conditions into which detained patients are compelled to receive treatment for as long as we continue to exist.

Bullying, sexual and racial harassment on wards

5.3 Many hospitals fail to deal adequately with patient to patient bullying or harassment. Some of the Commission's concerns in relation to this problem are specific to women patients and patients from black and minority ethnic communities.

Women patients

5.3.1 Twenty eight per cent of detained patients dying unnaturally between 1997 and 2000 were women[28]. In its Ninth Biennial Report, the Commission noted some slow progress towards implementing NHS directives on safety, dignity and privacy in mixed environments[29]. Whilst, in some hospitals, excellent women's services are being developed and implemented, the experience of Commissioners in visiting services suggest that implementation of these objectives, which included establishing separate washing and toilet facilities and safe sleeping arrangements alongside more general organisational arrangements for the safety and security of women patients, has not been met in any meaningful sense in a number of services,

[25] Banerjee S, Bingley W and Murphy E (1995) *Deaths of Detained Patients: a review of reports to the Mental Health Act Commission.* A joint report of the Mental Health Act Commission and the Division of Psychiatry, United Medical and Dental Schools of Guy's & St Thomas' Hospitals, London: Mental Health Foundation, December 1995. p 19.

[26] Department of Health (2002) *Cases for Change, Introduction.* National Institute for Mental Health, England. p 6.

[27] Department of Health (2002) *Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Units;* Department of Health (2002) Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision.

[28] Mental Health Act Commission (2001) *Deaths of Detained patients in England and Wales (ibid)* paragraph 49.

[29] Mental Health Act Commission (2001) *Ninth Biennial Report 1999–2001,* London: Stationery Office. Chapter 6.33 *et seq.*

notwithstanding the view of the Department of Health that there is at least 96% compliance[30]. We have previously warned that some services may comply with the basic elements of the Government's objectives without in reality offering a quality service to women. The Commission has listed the following issues to be addressed by service commissioning bodies and providers in providing care to detained women patients:

Service commissioning bodies and service providers should agree and monitor services for women patients to ensure that such patients can:

- lock bedroom doors, using a system capable of being overridden by staff in an emergency;
- have a choice of a female key-worker;
- be in contact with other women;
- have the opportunity to take part in women-only therapy groups and social activities but have the choice of taking part in mixed groups where appropriate;
- engage safely in a full range of such activities, even where their number is small compared to the hospital population;
- have physical health checks on admission;
- have access to a female doctor for medical care;
- have access to a female member of staff at all times; and
- be assured of adequate supervision at night.

MHAC Practice Guidelines: service for women patients—(Recommendation 63, MHAC (2001) Ninth Biennial Report, Chapter 6.38)

5.3.2 In our Eighth Biennial Report (1999) we suggested to Government that services could also be required:

- to have policies relating to women's safety available on every ward and reviewed every two years;
- to identify through risk-assessment women who are particularly vulnerable to sexual exploitation or harassment and also men who have a history of harassment or violence towards women;
- to monitor all incidents of sexual harassment to identify problems in service provision;
- to ensure staff are appropriately trained in gender awareness and that safety and special needs of women patients; and
- to appoint a designated officer with oversight for women's issues[31].

We continue to suggest such measures as elements of good practice in women's services.

Black and minority ethnic patients

5.3.3 The Commission has long stressed the overrepresentation of patients from Black and minority ethnic communities amongst the detained patient population, and the lack of equality in the provision of services to such patients. We have been pleased to work alongside the University of Central Lancashire in the recently published report for the Department of Health *Engaging and Changing: Developing effective policy for the care and treatment of Black and minority ethnic detained patients*[32].

5.3.4 A lack of racial harassment policies outlining how to deal with harassment between patients, as well as between staff and patients, continues to be a problem. The death of David Bennett starkly illustrates the need for effective policies in this area. Mr Bennett died in a medium secure unit having been restrained for 25 minutes, following an incident sparked by racial abuse directed at him. The coroner recognised that the lack of a racial harassment policy and procedure in the unit was a contributory factor in the events that led to his death[33]. Government has recognised generally that insufficient attention has been paid to ethnicity and gender and protection from abuse/harassment in acute mental health care[34] and has made it a minimum standard for Psychiatric Intensive Care Units and low secure units to operate "a clear policy on equal opportunities and racial harassment which all staff and patients are aware of covering staff/patient and patient/patient harassment signed up to by Trust Board and with monitoring of adherence"[35].

[30] Department of Health, personal communication to Mental Health Act Commission.

[31] Mental Health Act Commission (1999) *Eighth Biennial Report 1997–99,* London: Stationery Office. Chapter 10.72.

[32] Department of Health (2003) *Engaging and Changing: Developing effective policy for the care and treatment of Black and minority ethnic detained patients,* London: National Institute for Mental Health in England, UCLAN & Mental health Act Commission.

[33] Mental Health Act Commission (2001) *Ninth Biennial Report 1999–2001,* London: Stationery Office. Chapter 6.26. At the time of writing the independent inquiry into Mr Bennett's death is preparing its report. The MHAC gave evidence to that enquiry, thus retaining its involvement and close interest in the case.

[34] Department of Health (2002) *Mental Health Policy Implementation Guide: Adulty acute Inpatient Care Provision.*

[35] Department of Health (2002) *Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Units.* Paragraph 9.2.1.

5.3.5 The Commission recommends that services enhance minimum standards set by Department of Health guidance by adopting the recommendation from *Engaging and Changing* that, alongside an establishment's anti-bullying or general harassment policies, which should include racial harassment in their scope,

> ". . . in a mental health setting, a separate section or stand alone policy aimed at protecting patients from racial harassment by other patients, by visitors or by staff should be established to acknowledge the special need for protection of these patients. A clear definition of racial harassment should appear on the policy, encompassing the continuum of behaviours including forms of subtle racism."[36]

Other patient-to-patient bullying or intimidation

5.3.6 We hope that effective policies that provide appropriate service responses to sexual or racial harassment of patients in inpatient surroundings will foster a wider culture of zero tolerance towards any such patient-to-patient bullying where staff intervention does not stigmatise or isolate the victim. The Commission is aware, for example, of some inner-city wards where patients are likely to be pressurised into buying illegal drugs from other patients, and has recently been informed of such an occurrence where the patient concerned was a minor.

Illicit Drug cultures within psychiatric hospitals

5.4 The culture of illicit drugs in some psychiatric inpatient units clearly poses a threat to the care and treatment of all patients resident within those units, particularly where, as we believe is often the case, vulnerable patients are exploited by drug-dealers, whether the latter are fellow-patients or persons from outside the unit (see 5.3.6. above). It is difficult to over-emphasise the distress to patients and relatives, and the demoralisation of mental health staff, caused by involuntary admissions to wards that pose such dangers.

Unregulated use of control and restraint techniques, including seclusion practice

5.5 Restraint is widely practiced across mental health services that detain patients under the 1983 Act. The Code of Practice (Chapter 19) provides a substantial list of general preventive measures that hospital managers and staff can take to reduce problem behaviour on wards and thus reduce incidences of control and restraint. Although managers must attend to issues of safety in using restraint, it is also imperative that they consider these issues so as to avoid aggressively coercive practice where possible[37].

5.6 There are clear dangers inherent in the use of restraint, as exemplified by the death of David Bennett (see 5.3.4 above). The particular dangers of positional asphyxiation in psychiatric patients may be enhanced by side effects of medication; excited delirium, prolonged struggle or exhaustion; and obesity or underlying ill health[38]. It is therefore important that patients' previous histories are well established when they are deemed at risk of requiring restraint. The dangers of seclusion are less self-evident, although the Commission is currently investigating the death of a patient whilst in seclusion in a high security hospital, and the Commission's 1995 report noted a death of a young woman patient whilst in seclusion. Both of these deaths appear to be related to the emergency administration of psychiatric drugs to the patient in seclusion.

5.7 Patients frequently react to seclusion and restraint episodes with anger and a sense of injustice, often refusing to accept the justification of the intervention after the event. Restraint episodes can be particularly distressing for patients who have suffered sexual or physical abuse and staff should be aware of such issues through patients' care-plans regarding restraint practice. It is important that patients are told as much as possible of the reasons for their restraint and/or seclusion during the intervention itself, provided with care and support immediately after an incident[39], and that the requirements of the Code of Practice regarding post-incident visits to the patient to talk about the incident and ascertain any complaints are met.

5.8 The Code of Practice requires the use of restraint to be recorded in various ways: individual patients' care-plans should state under what circumstances physical restraint should be used, what form it will take and how it will be reviewed. All episodes of such restraint should be carefully documented and reviewed. Reasons for decisions to allow physical restraint in any care-plan, and for each episode of physical restraint that takes place, should be carefully recorded in the patient's notes. The Commission recommends that policies dealing with practice issues where restraint may be used, such as policies on holding powers under sections 4, 5 or 136, should explicitly state the need for records to be made of any physical restraint.

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[36] Department of Health (2003) *Engaging and Changing: Developing effective policy for the care and treatment of Black and minority ethnic detained patients. (ibid).* p 5.

[37] The Commission acknowledges that Government guidance already is available, although this has limited application to the care of the majority of detained patients: see Department of Health and Department of Education & Skills (2002) *Guidance for restrictive physical interventions: how to provide safe services for people with learning disability & Autistic Spectrum Disorder.* Available from www.dohgov.uk/qualityprotects/index.htm.

[38] *See* also Police Complaints Authority (2003) *Safer Restraint: Report of the conference held in April 2002 at Church House, Westminster*, London: PCA. www.pca.gov.uk. pp 10–12.

[39] Mental Health Act Commission (2001) *Ninth Biennial report 1999–2001.* London: Stationery Office, Recommendation 44.

5.9 In our Ninth Biennial Report we recommended that all services should ensure that each use of C&R is immediately reviewed, with regular audits to ensure that management and training lessons are learnt. The apparent slow take-up of the Commission suggestions appear to us to indicate further the need for statutory regulation. We have argued for the passing of new legislation to be taken as an opportunity to reconsider and strengthen advice and practice requirements relating to seclusion and restraint. Notwithstanding the fact that the Court of Appeal recently has given the Code of Practice greater legal weight (see paragraph 6 below), we believe that it is now appropriate to provide a framework of statutory regulation around these important issues. Regulations could also introduce statutory documentation for episodes of seclusion and serious restraint, both as a means of ensuring that actions and their justifications are considered and recorded, and to direct that certain actions be undertaken through requirements to record their having taken place. We have therefore suggested, in our responses to the consultations over the next Mental Health Act that new mental health legislation should provide statutory requirements and, where appropriate, limitations, in relation to the following:

- the institution, recording and monitoring of seclusion (including its duration) and time-out;
- the environment used for the purposes of seclusion;
- the provision of food and drinks and other basic amenities to patients subject to seclusion;
- the removal of clothing and/or bedding from patients subject to seclusion, and in relation to "protective" clothing/bedding;
- the use, recording and monitoring of physical restraints and in the training of staff in such procedures;
- the locking of wards;
- the qualifications of staff who institute the above; and
- the observation and care of patients who are at risk of self-harm or of harm to others.

5.10 The Commission is aware of ongoing work by the National Institute for Clinical Excellence (NICE) in reviewing research relating to the use of seclusion and restraint so as to develop practice guidelines. We look forward to the publication of NICE's draft guidelines and good practice points and to participating in the ensuing discussion over their final form. NICE's consideration of good practice guidelines will be able to draw on a raft of existing and previously issued guidelines, including:

- the current Mental Health Act Code of Practice, Chapter 19;
- the Mental Health Act Commission Ninth Biennial Report recommendations 42–45;
- the Institute of Mental Health Act Practitioners' Policy Compendium guidance on seclusion and restraint policies;
- the Police Complaint Authority's Policing Acute Behavioural Disturbance, (revised March 2002)[40];
- guidance on restrictive physical interventions in relation to people with learning disabilities and autistic spectrum disorder, issued by the Department of Health and Department for Education and Skills in July 2002[41];
- the resource sheets made available by the Department of Health as a part of its Zero Tolerance campaign on managing violence in health services[42];
- the Royal College of Psychiatrists' 1998 report, The management of imminent violence: Clinical practice guidelines to support mental health services guidance; and
- the UKCC (now the Nursing and Midwifery Council) report, The recognition, prevention and therapeutic management of violence in mental health care, published in February 2002[43].

In the Commission's view, this raft of guidance requires consolidation and official sanction, so that detailed guidance with formal status and legal weight underlies statutory regulation.

Inappropriate transportation methods used for detained patients

5.11 The Commission has been made aware of some detained patients having been transported between hospitals, sometimes for considerable distances, inside private security company vans fitted with security cages and barely adequate seating. In one case a patient was driven from Bristol to London (120 miles), in another from Aintree to Darlington (140 miles). In the latter case, the van had no windows and the driver was unable to see the patient, who had no access to toilet facilities or drinking water during the non-stop journey. Prior to the journey the patient had been given a high dose of Acuphase for sedation. There were clear risks to the patient's life in such circumstances, and we consider that such procedures, where they are

[40] available from www.pca.gov.uk

[41] Department of Health & Department for Education and Skills (2002) *Guidance for Restrictive Physical Interventions—How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder*. London Department of Health July 2002.

[42] www.nhs.uk/zerotolerance

[43] available on www.nmc-uk.org

allowed to occur by any detaining authority responsible for a patient, will eventually lead to a death in custody. In the case described, the detaining authority accepted the Commission's representation that such arrangements were unacceptable and has changed them.

5.12 The Mental Health Act Code of Practice (Chapter 11) provides guidance on the conveyance of patients which could be strengthened under the next Mental Health Act. It may be that, following the 2003 Court of Appeal judgment discussed at paragraph 8 below, practices that fall short of the requirements of Code without good reason would already be found to be unlawful on human rights grounds.

Police intervention on psychiatric wards

5.13 Situations may arise where nursing staff require the help of the police to control or resolve incidents in hospital environments. In our Fifth Biennial Report (1993) we expressed our concern at police involvement in clinical situations, following reports of police being called to assist in giving forcible medication[44]. We continue to hear of such practices, which are surely an indictment of staffing and staff-training levels on the hospital wards concerned.

The use in emergencies of psychiatric medication with insufficient supervision or protocols

5.14 In the Commission's report *Deaths of Detained Patients* (December 1995), we noted, over the period 1/4/92 to 31/3/94, 10 deaths of detained patients that were secondary to prescribed medication[45]. Of these, one occurred whilst a patient was in seclusion and one whilst the patient was being physically restrained by staff. The report noted that:

The overall impression from the inquest reports was of inexperienced nurses and trainee doctors attempting to control a difficult and potentially dangerous patient outside of normal working hours without sufficient help and supervision[46].

We recommended that:

— all sudden deaths where prescribed medication or a health care intervention could have played a causal role in the death should be the subject of an internal review and multi-disciplinary audit[47]; and

— every unit should have an agreed clinical protocol which would include a medication schedule for rapid tranquilisation and guidance on how and when to ensure that senior nurse specialists and consultant psychiatrists are involved in the care of difficult patients out of hours[48].

5.15 In our evidence to the on-going David Bennett Inquiry, the Commission pointed to the fact that emergency medication had been administered to Mr Bennett on the apparent authority of a nurse during the control and restraint episode in which he died. The on-call doctor had not yet arrived at the scene. Medication had therefore been administered outside of the authority of the 1983 Act, which does not allow nursing staff to authorise medication without consent, even in an emergency.

5.16 Whilst section 62 of the Mental Health Act 1983 allows for treatment that would normally require the special authorisation of a Second Opinion Appointed Doctor to be given under the direction of the RMO in an emergency, the Commission is concerned that this should not undermine safeguards to patients. In particular, individual patients' risk-assessments should take account of likely emergency situations and the appropriate response, including questions of PRN medication[49], so that such matters can be considered for inclusion in SOAD authorisations. In this way, safe upper-limits to medication might be ensured.

5.17 At paragraph 11 below we note that emerging structures of service delivery may create more frequent legal and ethical dilemmas of the kind faced by the staff involved in the incident during which David Bennett died. The 1983 Act's and Code of Practice's procedural requirements for some emergency interventions, such as that emergency treatment should be given under the direction of the RMO, or that a doctor must attend seclusion episodes, may be impossible to meet given the staffing of some units. Yet, by definition, in a genuine emergency, some sort of intervention is required and staff may be held accountable for failing to take appropriate action. We recognise this as an issue that requires Government consideration (not least in the formulation of the next Act, which shall, we trust, seek to enhance rather than lessen safeguards for patients). In our Tenth Biennial report, we will be suggesting to the Secretary of State that limitations on the use of restraint practices and seclusion in non-medical staffed units might be justified on

[44] Mental Health Act Commission (1993) *Fifth Biennial Report 1991–93*. London: Stationery Office, Chapter 3.5(f).

[45] Banerjee S, Bingley W and Murphy E (1995) *Deaths of Detained Patients: A Review of reports to the Mental Health Act Commission. (ibid)* p 19.

[46] *ibid*, p 28.

[47] *ibid*, p 30.

[48] *ibid*, p 28.

[49] ie Pro Re Nata (PRN)—as required.

safety grounds[50]. We consider there to be an even stronger case for non-medical staffed units to have strict policies against the giving of medication outside of limits authorised, even in an emergency, given the very great risks to patients that such practices can entail.

Dangers in ward environments: ligature points and other opportunities for suicide

5.18 Many hospitals' physical estates provide a number of hazards to patients who are at risk of self-harm or suicide. Government has recognised this and has, for instance, issued guidance on and a target for the removal of ligature points such as non-collapsible shower rails and hanging rails within wardrobes[51]. In its 2001 report on patient deaths, and in its Ninth Biennial Report of the same year, the Commission highlighted the dangers of self-strangulation rather than hanging as a method of suicide and suggested that attention must be given to a wider range of potential ligature points and hazards than had been identified in Government guidance. Commissioners continue to draw attention to weight-bearing ligature points in many services, including some that should now have been eliminated following Government guidance. The Commission has also called for staff training to take account of its findings relating to patient deaths, so that staff observing patients are aware of the dangers of self-strangulation and staff are trained in appropriate resuscitation techniques. In some older establishments, including, for example, Broadmoor Hospital, observation itself can be impeded by the physical layout of wards. This raises real concerns over patient safety.

Leave and absence without leave as opportunities for suicide

5.19 In our Ninth Biennial Report we stated that one in five detained patient deaths occurs whilst a patient is on authorised leave from hospital. One third of deaths of detained patients by suicide occurred whilst the patient was absent from hospital without leave[52]. Patients' care plans should therefore pay particular attention to the risks of leave and absence without leave with regard to every individual patient. It is likely that, in areas where bed-occupancy is over 100%, doctors are faced with difficult decisions as to which patients should be sent away on leave to free spaces, and may be forced to take more risks in granting leave than they would otherwise consider reasonable (see paragraphs 5.1–2 above). The Commission has also heard of patients being sent on leave from wards as a response to staffing shortages.

Prisons

5.20 The Commission's remit does not extend to prisons, although prisoners who are transferred to hospital under the 1983 Act fall within our purview. The Commission is extremely concerned that such transfers may often be delayed under present conditions, and that services available to seriously mentally disordered prisoners within prison are inadequate. Many prisoners awaiting transfer will be kept in physical isolation that is quite deleterious to their mental condition, with inadequate medical intervention. As a result, some prisoners are difficult to manage upon transfer and may experience further episodes of seclusion even when transferred to high secure services. The Commission is also concerned that no specialist monitoring protection is extended to prisoners undergoing treatment and/or care for mental disorder. It is beyond the Commission's scope to investigate how such prison-based care for the mentally disordered relates to deaths within prison, but we feel that such a study could be usefully undertaken.

III. The Role of Human Rights-based Approaches in Preventing Detained Patients' Deaths

The place of human rights in patient safety

6. The Commission views as incontrovertible that human rights based approaches to the detention and care of psychiatric patients can play an essential role in preventing patient deaths. Clearly, emphasis on patient's right to life (Article 2) is of primary importance in healthcare interventions which involve the compulsion of vulnerable patients. Although Article 3 protections against inhuman or degrading treatment are very broadly drawn under existing case law, in conjunction with Article 8 rights to respect for physical integrity these have provided a lever for legal challenge to practices where patients have felt their rights to have been abused.

7. The Human Rights Act 1998 did not, however, only bring the lever of legal challenge closer to patients and their representatives. It also created a duty on all public authorities to operate their powers according to ECHR principles. The Commission notes the Joint Committee on Human Rights' own concerns that this aspect of the 1998 Act has only partially been implemented, and that "the high-water mark has been

[50] Mental Health Act Commission (in press) *Placed Amongst Strangers: Twenty years of Mental Health Act 193 and future prospects for Psychiatric Compulsion*. Tenth Biennial Report 2001–03. London, Stationery Office. Publication due in December 2003.

[51] Department of Health (2001) *Building a Safer NHS for Patients: implementing An Organisation with a Memory*. London: Stationery Office p 54.

[52] *See* Mental Health Act Commission. (2001) *Ninth Biennial Report*, paragraphs 4.23, 4.26 and Appendix B.

passed"[53]. The Commission will be highlighting this concern alongside its own observations in its Tenth Biennial Report to the Secretary of State, published in December 2003. The Commission notes that the thrust of Government policy appears to be that health and social authorities should become more locally accountable, and that this implies a lessening of prescriptive guidance from central government. We agree with the aim of encouraging nursing and other professional leadership, and the fostering of grassroots pioneers in local services to revitalise the notion of human rights as positive entitlements that are considered on a day-to-day level in service development. But, particularly in relation to the restriction of fundamental human rights as a health or safety measure on the authority of the State, the Commission views any divestiture of responsibility by Government as inappropriate, both in legal terms and in a wider ethical sense. For practitioners to attain the confidence to move beyond a defensive approach to human rights they must have the support of adequate and authoritative guidance on legal and practice issues. The Commission believes it to be the task of Government to provide authoritative guidance on the law and requirements of good practice relating to the compulsion of psychiatric patients. We are therefore pleased that the Court of Appeal took a similar view in the *Munjaz* case, which underlined the States' general responsibility for the treatment of those whom it has deprived of their liberty, and which we discuss below.

The Mental Health Act Code of Practice and human rights legislation

8. In the *Munjaz* judgment of 2003, the Court of Appeal has stated that the Mental Health Act Code of Practice is one of the positive steps that the State takes to protect the health and rights of persons deprived of liberty[54]. In part, this means that the State is responsible for ensuring that authorities exercising its powers do so in accordance with human rights principles[55], and the Code is a tool that it uses to meet this obligation. The Code can provide transparency and predictability where ECHR compliance requires this but the law is insufficiently defined[56]. The Code therefore should be afforded a status consistent with its purpose: "the State should therefore give it some teeth"[57]. The Commission's analysis of the *Munjaz* judgment is given below.

Seclusion, the ECHR and the Code of Practice following R (on the application of Colonel Munjaz) v Mersey Care NHS Trust and others; and S v Airedale NHS Trust and others [2003]

(a) Seclusion itself is not a violation of patient's rights to protection from inhuman or degrading treatment under ECHR Article 3, although used improperly or with little regard to the patient's welfare, it could become so [paragraphs 53–55].

(b) Seclusion, by denying association and placing a patient under close surveillance, is necessarily an interference with the right to respect for private life, but one that may be justifiable under ECHR Article 8(2). To be so justified it must be operated predictably and transparently within limits set by domestic law [65].

(c) The State is under an obligation:

(i) "to know enough about its patient to provide effective protection" [58]; and

(ii) to ensure that other public authorities act compatibly with the ECHR [59].

(d) The Code of Practice is one essential means by which the State undertakes its duty at 3(ii) above in respect of detention and treatment of patients under the MHA 1983. The Code of Practice:

(i) can provide transparency and predictability where ECHR compliance requires this but the law is insufficiently defined [65, 74]; and

(ii) should be afforded a status consistent with its purpose [60, 71–6].

(e) The Code should therefore be observed by all hospitals unless there is a good reason for particular departures in relation to individual patients. It is not acceptable to depart from the Code as a matter of policy, although policies may identify circumstances when such departures might be considered on a case-by-case basis [76].

(f) Seclusion that is not practiced in accordance with the Code's definition and requirements, unless it can be justified as necessary in an individual patient's case, will not meet the requirement of legality set by the ECHR. Policies that depart from the Code's guidance on an arbitrary basis may be similarly unlawful [74, 76–7].

(g) Whilst seclusion of a patient who is already detained does not engage ECHR rights to liberty under Article 5, the process of detention itself clearly does so. Where the Code deals with the processes of detention, adherence to its guidance is similarly an ECHR requirement for the hospital's policy or actions to be lawful, unless a departure from the Code's guidance can be shown to have been necessary in a particular case [70,74].

[53] Joint Committee on Human Rights (2003) *The Case for a Human Rights Commission: Sixth Report of Session 2002–03*, Volume 1. HL Paper 67-I, HC 489-I. London, The Stationery Office, March 2003. Pp 6–7.

[54] R (on the application of Colonel Munjaz) v Mersey Care NHS Trust and (i) Secretary of State for Health and (ii) MIND; S v Airedale NHS Trust (i) the and Secretary of State for Health and (ii) MIND [2003].

[55] *ibid*, paragraphs 59–60.

[56] *ibid*, paragraphs 65, 74.

[57] *ibid*, paragraph 56.

(h) It is therefore possible for a hospital's actions or policies to be in unlawful breach of the Mental Health Act Code of Practice on issues that engage ECHR issues [77].

9. We hope that Government will now reconsider its approach towards Codes of Practice in mental health legislation, and ensure that they are given a clear status under statute that reflects the position reached through judicial challenge. Both the draft Mental Health Bill of 2002 (clause 1) and the Mental Incapacity Bill (clause 30) provide only that professionals must "have regard to" the respective Codes of Practice. We believe that this reflects a legal position pre-Munjaz, and that more emphatic language would now be appropriate. This is not to say that we want the Code necessarily to be statutorily binding on authorities where there are good reasons for departure from its guidance based upon an individual's situation. If authorities are to be forced to follow the Code to the letter irrespective of circumstance then the distinction between the Code and primary legislation would be lost. In our response to the Mental Health Legislation Review Team (1999) we expressed our concern that providing statutory weight to a Code of Practice would be likely to water-down its provisions until they were a set of minimum standards, rather than a guide to good practice[58]. It may be that the precedent of section 7 of the Local Authority Social Services Act 1970, which obliges social services authorities to act under the general guidance given by the Secretary of State, could provide a model for legislation that gives a Code "teeth" in the sense required by the Court of Appeal.

Creating and maintaining a human rights focus in developing psychiatric services

10. There remains much to do to bring about a psychiatric service that fully respects human rights values. Patients are still compelled to reside on wards that are acknowledged by those responsible for them to be substandard, frightening and even dangerous. The majority of patients who are compelled to reside on such wards are subject to such compulsion for reasons of their own health or safety. The Commission considers it possible that the courts will, at some point, accept a human rights-based challenge to the lawfulness of such a detention on the grounds that the services provided under compulsion have neither addressed nor provided for the health or safety of the patient concerned.

11. The Commission understands and welcomes the apparent intention of Government to make mental health care "a little less institutional and a little more diverse" through the provision of smaller inpatient units with closer links to the community[59]. It is easy to see how such a service could solve some of the most obvious problems inherent in acute inpatient care as presently organised and as discussed at paragraphs 5.1–5.4 above. There are, however, particular and perhaps obvious risks inherent in having physically decentralised structures of smaller inpatient units operating powers of compulsion on behalf of the State. One such risk is the spreading of available medical and other expertise too thinly, so that no inpatient units could realistically have immediate access to a doctor when emergencies arise. Where patients are detained for their own safety, this may raise a similar ethical and potential legal dilemma to that faced by mental health professionals whose admission wards fall below acceptable standards under the current system. Similar issues relating to economies of scale pose other challenges. Staff who are given powers of coercion (and the responsibilities that go with such powers, from using them appropriately to being held accountable when things go wrong) must of course be allowed appropriate resources, human and otherwise, to carry them out effectively. For example, Mental Health NHS Trusts and large Independent Hospitals usually now employ a Mental Health Act administrator to ensure that legal powers and duties of compulsion are operated and documented correctly. Where such employees establish an effective foothold within their organisation, their work can have marked benefits for the treatment and safety of patients. Although it is perhaps likely that some shared managerial structures, such as the increasingly large NHS Trusts of today, will allow for such posts to continue, isolated units may not have sufficient resources.

12. A less obvious risk of decentralised structures, and indeed the potential converse of positive attempts to make the provision of mental health services "patient-centred", is what a "less institutional" framework could mean for the practice of compulsion. The danger of emphasising the need for less formal structures of care is that these may disguise or detract from underlying realities of coercion. The Commission has, in previous submissions to the JCHR, expressed our concern over patients who, under current mental health legislation, are *de facto* detained in hospitals with none of the protections of the law, including our oversight and monitoring. We have similar concerns that, under envisaged structures of mental health care, and in the absence of sufficient central guidance and monitoring, laudable aims of less formality with greater immediacy of response and availability of appropriate care could lead, in practice, to the casual and unregulated application of powers of coercion. We believe that this would increase the dangers to patients, not only of arbitrary and unfair interference with their rights, but of dangerous or potentially abusive practice.

[58] Mental Health Act Commission (1999) *The Mental Health Act Commission. Submission to the Mental Health Legislation Review Team*, Jan 99, p 10.

[59] Professor Louis Appleby (National Director for Mental Health) giving evidence to the David Bennett inquiry [2003]. Inquiry transcript II.6-650.

Regulation of specific areas of compulsion

13. The Department of Health has acknowledged that authorities treating patients under compulsion acquire reciprocal duties to ensure that their care is provided safely and in accordance with good practice. Whilst we would agree that "higher levels of risk [and] loss of liberty suggest a greater need for clinical audit and monitoring than usual, with particular attention paid to areas such as: observation; seclusion; restraint and rapid tranquillisation"[60] we suggest that Government should itself seek to ensure that issues such as seclusion and restraint are operated on its behalf in ways that are safe and appropriate. Following the *Munjaz* judgment of 2003, discussed above, the Code of Practice can be used to provide practical guidance that will be generally binding on authorities. We suggest, in addition to such guidance in a Code of Practice, that Government should take the opportunity of new legislation to consider statutory regulation of aspects of particularly invasive or contentious practices. Such regulation could, at the very least, institute record keeping and reporting requirements utilising statutory documentation. It could also ensure training standards in relation to, for example, the physical restraint of patients, and introduce safeguards in relation to certain treatments, such as naso-gastric feeding of anorectic patients, or following rapid tranquilisation of any patient, etc. We also suggest that core requirements regarding seclusion practice (such as particular triggers for multidisciplinary review and particular reporting procedures) could be given unequivocal legal force by use of secondary legislation under a new Act.

The framework of compulsion under the Draft Mental Health Bill proposals of 2002

14. Although the draft Mental Health Bill of 2002 proposed powers that would compel patients to accept psychiatric treatment without consent in the community, it does so at the expense of existing supervisory powers applicable to community-based patients under the 1983 Act's Guardianship and Supervised Discharge provisions. It seems likely that patients who are subject to these relatively weak powers of coercion (which allow for the specification of a place of residence, access for medical and social care professionals and for the patient to attend at certain places) could drop out of the view of authorities. Although the numbers of patients currently subject to these powers is small (slightly less than 1,000 patients would seem to be subject to Guardianship at any one time), it may be that the next Mental Health Act, by replacing Guardianship and supervised discharge with powers of community treatment, will reduce the protection for vulnerable persons in the community who do not meet the threshold for the imposition of these more far-reaching powers. It may be that a reconsideration of a form of Guardianship under the next Act could address the reasons for its low usage and so provide supportive supervision of patients in the community who do not meet the criteria for non-consensual treatment.

A human rights culture in the coercion of psychiatric patients

15. In our Tenth Biennial Report[61], the Commission acknowledges that a culture of human rights cannot be imposed upon services from above, but that Government nevertheless has an important role in establishing the boundaries within which services work. By establishing such ground-rules, and by doing so with a particular regard to human rights issues, Government can at least partially fulfill its obligation to ensure that powers used in its name are implemented in accordance with principles of the European Convention.

16. In our view, the safety of patients similarly cannot be imposed through increased physical safety measures without an equal emphasis on "relational security". Relational security "begins with the patient and is essentially concerned with detailed knowledge of the patients and their situation it will extend to relationships and professional agencies outside the hospital, so that although the institutional boundaries are very definite, effective security can often have its roots in the community. The provision of education, rehabilitation and pastoral facilities as well as leisure and social activities all have an important part to play"[62]. Relational security is therefore grounded on the fair and decent treatment of patients, which is best assured by a human rights-based approach that is vigilant towards potentially dehumanising or infantilising aspects of care under compulsion. Whilst, therefore, the Commission has particular concerns over those aspects of mental health care outlined above as causative factors in patient deaths, to really improve patients' experiences of safe and supportive care these concerns must be addressed within a holistic, human-rights based approach to all aspects of mental healthcare.

15 September 2003

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[60] Department of Health (2002) *Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Units*. Paragraph 13.3.1.

[61] *See* note 50 above. The Commission's Tenth Biennial Report was in press at the time of this submission.

[62] Kinsley, J (1992) *Security in the Special Hospitals—a Special Task*. Published as Annex F of Department of Health (1994) *Report of the Working Group on High Security and Related Psychiatric Provision* [the Reed report]. London, Department of Health.

6. Memorandum from The Police Complaints Authority

1. Introduction

(i) The Police Complaints Authority submits this memorandum of evidence to the Committee to which is attached an Appendix comprising a research paper supplied to it by Dr David Best, Head of Research, Police Complaints Authority. This memorandum will outline the role and responsibilities of the Police Complaints Authority, will summarise research and reporting published by the Police Complaints Authority during the past five years on matters material to the inquiry and will offer further observations in response to the questions posed by the inquiry. The Research Appendix provides detailed data on fatal incidents.

(ii) The Police Complaints Authority, having 18 members (full-time and part-time) and approximately 70 staff (largely seconded civil servants but some permanent staff) has two principal roles under the legislation governing its activity, the Police Act 1996. Firstly, it supervises police investigations into complaints alleging serious misconduct or incidents causing public concern. Approximately 350–400 investigations are subject to supervision at any one time. The police service is required under legislation to refer certain matters to the Authority. It has the power to refer incidents not subject to complaint to the Authority and most fatal incidents are referred in this way with investigations in the majority of cases being accepted for supervision by the Authority. The supervising member has the power to approve, or withhold approval of the appointment of the investigating officer where a matter is supervised; may issue directions as to the conduct of the investigation; and must issue a statement at its conclusion stating whether the investigation was, or was not, conducted to the Authority's satisfaction.

(iii) The Authority's second principal role is, at the conclusion of all investigations, to undertake an independent review of the evidence to determine whether any police officer should have his/her conduct referred to a misconduct hearing. All matters supervised by the Authority, whether or not a public complaint was made about the conduct of any police officer, has to be reviewed and the Authority has the same legal powers to direct formal disciplinary action as it would in a case of a public "complaint".

(iv) The Authority's supervisory function is governed by an internal manual of practice agreed with and circulated to individual police services. This manual provides detailed guidance to Authority members, staff and the police service on referrals and initial action; discharging the responsibilities of ongoing supervision; standards expected of those investigations subject to the Authority's supervision; family liaison and community relations and the disclosure of information or evidence to complainants, next of kin or in the public domain during or after the supervision of an investigation.

(v) Prior to September 2001, the Authority had no dedicated research capacity but since 1998 had undertaken some specific research work relevant to the remit of the inquiry which will be summarised below.

(vi) The Authority has operated from a single central London office with Authority members and caseworkers having responsibility for a range of different police services. The statutory powers of the Authority do not include the power to inspect police facilities or management arrangements governing the detention of those in custody. However Authority members will, in their contacts with police staff and investigators, gain some local knowledge and understanding of custody arrangements material to the investigations they supervise or review and finalise. Based on the information and impressions gained by this casework experience, observations are offered both in Reports and in the following observations and impressions.

2. Observations and Lessons Emerging from PCA Annual Reports 1997–98 to Date

(i) *1997–98 Annual Report*

The report noted that police service practice in relation to referral of cases for voluntary supervision had improved and that virtually all deaths in custody were now subject to Authority supervised investigation. The report stated that the Authority's experience suggested some deaths could have been avoided if more effective procedures and safeguards had been in place and it focused on two key individuals in the process, namely the custody officer and the forensic medical examiner. The Authority summarised the findings of a survey into custody officer training which indicated that most police services provided dedicated custody officer training. However only seven required the successful completion of such a course before a custody officer took up his/her duties. In approximately one third of all police forces in England and Wales, custody officers generally did not receive specialist training until after they had taken up their duties and in some cases such training might be delayed for months or even years. A telephone survey of 620 custody officers in 401 custody suites covering all forces suggested that at any one time, some 23% were carrying out their complex and demanding duties without having had the benefit of specialist training. The Authority stressed the need for training to be provided before custody officers took up their duties at all and such training should enable them to recognise danger signals amongst those appearing to be drunk, those who might be at risk of attempting suicide or those who might be suffering from a potentially dangerous medical condition. The Authority also highlighted the need for:

— ensuring that custody officers received appropriate support and supervision;

— encouraging better communication between custody officers and forensic medical examiners;

— introducing a standard practice during the presentation and booking in process to identify those detained persons who might be at risk of suicide or self-harm;

— introducing a simple method of monitoring the consciousness of detained persons;

— extending CCTV systems to cover observation cells for particularly vulnerable detainees and developing appropriate guidelines to protect the dignity of those concerned;

— establishing detoxification centres to deal with people arrested for alcohol or drug abuse; and

— improving cell design to reduce suicide risks; providing appropriate specialist training for all forensic medical examiners and considering centralised custody suites and a specialised custody service.

In October 1998 the Police Complaints Authority organised a special one-day conference entitled "Deaths in Police Custody: Reducing the Risks" to ensure that these essential recommendations were understood by relevant police managers and Police Authorities and their implementation taken forward.

As a result of the conference, a research and policy paper "Deaths in Police Custody: Reducing the Risks" was published by the Authority in 1999. This report analysed deaths in custody cases from 1994–98 and highlighted where the Authority's supervision experience indicated deaths occurring in circumstances previously seen. The Authority highlighted, a relation to the risk of harm or death from suicide, the importance of reducing risks by the removal of ligature points; and the removal of clothing which may pose a risk. The report made 16 detailed recommendations calling for the revision of Code C, Police and Criminal Evidence Act Codes of Practice, to clarify the requirement to rouse drunken detainees; practice by custody staff in regard to rousing and recording their actions. The Authority felt consideration should be given to including in the Codes of Practice a specific requirement for custody staff to make regular checks on detainees suffering from drug abuse. The report repeated recommendations made earlier concerning specialist training for custody officers and police surgeons together with the introduction of new procedures to improve risk assessment practice. The Authority in its report called for a nationwide programme of cell modernisation designed to reduce the risk of self harm and accidents and asked the Home Office to consider amending the statutory requirements to enable some procedures in custody suites to be carried out by suitably qualified health care professionals other than doctors. The Authority felt that police forces should consider concentrating custody operations in a small number of specialist centres and should examine the benefits of establishing a custody service as a specialist unit. The Authority repeated the calls previously made that the case for abolishing the criminal offence of being drunk and incapable should be re-examined and called for further examination as to the feasibility of appropriate alternatives to police custody including reception centres and detoxification centres for those suffering from substance abuse. The Authority called, also, for police officers to be given refresher training in the safe use of force in self defence and to affect arrests given the risks associated with the use of restraint.

(ii) *1998–99 Annual Report*

In its report for this year, the Authority reported that in the previous four years an upward trend in the number of deaths in police custody cases supervised by the Authority had been seen, culminating in 65 cases that year, 41% more than in 1995–96. The year had seen the largest number of deaths in police care or custody on record. Deaths from self harm, the effects of alcohol or drugs and from identified medical conditions were the causes of the great majority of such deaths. In that year, 18 people appeared to have caused their own death while in custody representing a rise from a total of seven in 1996–97.

The report repeated previous recommendations for change and in addition recommended that at risk detainees, (identified at booking-in, from the police national computer or elsewhere) be kept under constant supervision using CCTV or civilian staff until their mental state had been fully assessed; in urban centres appropriately trained nurses to be on call to the police to undertake assessments, liaise with psychiatrists and advise police surgeons and custody sergeants as appropriate; forensic medical examiners be required to train to the standards set by the Association of Police Surgeons.

Revision to Code C to require the police to visit and rouse on a regular basis any detainee who may have taken a class A drug; training for forensic medical examiners to ensure that clear oral and written guidance is provided for custody officers; including the results of assessments and symptoms to be monitored with indicators of risk and actions to take when needed; a simple consciousness scale to be adopted by forensic medical examiners and custody officers to enable clear communication to take place about the welfare of vulnerable detained persons over the period of their detention; and specific training for custody officers on the care of detainees who appear to have used alcohol or drugs in order to provide them with information concerning the potentially life-threatening conditions which may generate an appearance of drunkenness.

The report reminded the police service of the need for high standards of management in custody areas and the need for regular spot checks in such facilities to ensure that force orders, police guidance and codes of practice were being followed.

The Authority in this Annual Report repeated its call for the decriminalisation of being drunk and incapable. The Authority considered such an action would immediately crystallise the need for care in reception centres for those grossly intoxicated, staffed by nurses and paramedics. Such establishments would meet the immediate overnight needs of people found incapable in a public place. The longer terms needs of those suffering the effects of alcohol dependency could only be met through the establishment of detoxification centres, again staffed by professionals.

(iii) *Annual Report 1999–2000*

This report noted a fall in the number of those who had died in police care or custody and there was a decline by a third in the number of deaths due to self-harm from the previous year. The report highlighted the impact of a pilot in Devon and Cornwall Constabulary of "in-cell" CCTV. During 1999 the Authority published a follow-up report to its earlier one "Deaths in Police Custody—Reducing the Risks". The report provided the detailed results of a questionnaire survey to police forces in England and Wales assessing the response made by the police service to each of the recommendations appearing in the Authority's earlier report. Action taken by each police service responding to the Authority's survey was described in this report highlighting good practice developments. The Authority drew particular attention to the importance of the use of CCTV to monitor the risk of harm to detained persons in custody; the improvement of ventilation in cells since cell hatches had to remain closed. The Authority called for a cost-benefit analysis of using trained nurses and community psychiatric nurses in custody areas. The report recommended that police services consider establishing custody users groups and it repeated a call previously made on a number of occasions for the introduction of the Association of Police Surgeons' medical form as standard throughout the police service.

(iv) *Annual Report 2000–01*

It was reported that deaths in police care or custody in this year fell sharply to 32, the lowest number of such deaths since 1993. Deaths in cells or police stations numbered 16 compared with 19 in the previous year. In 2000–01 the Authority reported that only two cell deaths appeared to be due to self-harm, one sixth of the total of two years previously. The Authority drew particular attention in this Annual Report to deaths due to restraint and the importance of improving inter-agency co-operation and practice in regard to the treatment of persons detained or under arrest who have mental health problems. Issues in relation to restraint were discussed at a seminar which included international and UK experts on forensic pathology and accident and emergency medicine. As a result of the conference the Authority published a guidance note for police officers, forensic medical examiners and other treating physicians concerning the management of acute behavioural disturbance and the special risks of positional asphyxia. Detailed guidance was also included to forensic pathologists undertaking the pathological examination post mortem of a person suspected to have died following such a disturbance.

The report noted that recent deaths in custody had exposed weaknesses concerning the collaboration between NHS Mental Health Trusts and the police service. The report noted that responses to the arrest by police of persons under Section 136 Mental Health Act needed to improve so that such persons could be taken immediately to a designated hospital and not to a police cell and NHS Trusts would need to staff a Section 136 reception room which could be attached to accident and emergency departments; NHS Trusts and police services also needed to agree a written protocol for the handover from police to medical staff of Section 136 patients on arrival at the hospital and Trusts with responsibility for detailed psychiatric patients and the police needed to agree clear written protocols to clarify the respective responsibilities of hospital staff and the police for returning to hospital detained patients who were absent without leave.

(v) *Annual Report 2001–02*

In this year a small rise from 32 to 36 investigations into persons who had died in police care or custody was noted. This was still less than that recorded in each of the preceding five years. The report highlighted developments by the Home Office on the provision to custody of health care professionals. The Authority expressed a hope that the revision of PACE Codes of Practice would adopt recommendations made by the Authority to enhance the effectiveness of the duty to rouse intoxicated detainees. The Authority's report drew attention to the need for appropriate police practice for dealing with a suspect who is thought to have swallowed drugs. The report emphasised the need for the police service to raise its performance in dealing with such circumstances to reduce the risk to life to a minimum. The report commended an MPS standing order requiring that in every case someone who is thought to have swallowed drugs must be taken to hospital for an emergency examination.

(vi) *Annual Report 2002–03*

This report showed that the Authority supervised 14 investigations into deaths occurring in a police cell or police station. Medical causes and the effect of alcohol and/or drugs remained the most prevalent apparent cause of death. In detailed analysis providing observations on causes and prevention strategies, the report noted that despite improved training for custody staff and efforts to make cells safer, some investigations revealed concerns which underlined the need for constant vigilance and greater efforts to publicise the dangers posed by alcohol, drugs or the risk of self-harm. The Authority recorded its disappointment that some police services still lacked CCTV cameras in their custody areas and that insufficiently urgent consideration was given to the removal of ligature points in cells to reduce the risk of cell hangings. The Authority reported that many deaths of drunken detainees were preventable if rapid medical assessment was provided and individuals were transferred to hospital. The report repeated that drunken detainees were in danger from alcohol poisoning and serious head injury masked by their intoxication. The management of drunken detainees, it was accepted, is a stressful and resource sapping activity for the police service but the Authority is concerned that, while custody staff generally recognise the symptoms of excess alcohol, there is much less awareness of the symptoms and dangers of alcohol withdrawal or the combined effects of alcohol and illicit drugs.

The report referred to a PCA study into the risks of detaining alcohol impaired people in custody suites carried out in the MPS which suggested that, while custody officers know they are accountable for the health and welfare of all detainees in their care, they do not feel that they are properly resourced or supported in this task. The research noted a general dissatisfaction with current training arrangements, including the role specific training for staff working as gaolers and with the initial custody officer course in relation to alcohol issues.

The study also raised questions about forensic medical examiners who it was felt may lack specific training in managing alcohol-related problems and may also be reluctant to get too close to potentially dangerous individuals.

Drug misuse remained a significant factor in deaths in police custody or following police contact and typically the report showed that these arose from attempts by detainees to swallow the evidence when confronted by police. Arresting officers might not be aware of these attempts and a detained person might not be showing symptoms of drug abuse. For some drugs, if the symptoms of overdose were recognised early then medical interventions can prevent a death; for others such as cocaine this may not be possible.

The report highlighted its findings in a very recent PCA study "Drug Related Deaths in Police Custody" which noted that even when a detainee who later died reported symptoms of medical distress, police officers initially believed that the illness was being feigned. The study highlighted important learning points with regard to the training of police officers in both drug awareness issues and in providing emergency first aid; in the need for the development of policies for the management of drug intoxicated individuals and for the use of medical expertise in police custody. The study highlighted that the increased prevalence of drug use nationally and within arrested populations would suggest an increase in the prevalence of drug related custodial fatalities.

In April 2002 the Police Complaints Authority held a national conference to raise and consider issues concerning the safe use of restraint in custodial settings. Detailed recommendations emerged from the conference as to measures which would prevent or reduce the incidence of restraint-related deaths. Detailed recommendations also emerged as to the standards to be employed in investigating restraint-related deaths and, in particular, the relationship between investigators, the public body where death has occurred and bereaved families.

(vii) *Other reports*

The Authority has published three other reports on policing practice and performance relevant to the Inquiry. In 1998 a short report on the police use of new batons was published comparing the impact of different equipment provided in police services in England and Wales. It was noted that the rigid side-handled baton had led to most complaints though the Authority's limited study could not determine why this should be the case. It appeared that the skills required to make full use of the PR24 baton were considerable and it may be that training needed to be carefully geared to the skills of the officer and probably needed to be undertaken more frequently than was necessary with other equipment.

The Authority in 2000 published a more in depth research report on the use of CS spray and its impact on the public. The report concluded that CS incapacitant spray did not appear to present a serious risk to the public. From the sample of complaints analysed it was not possible to conclude that permanent injury was caused by use of the spray and there was no reported fatality known to have been caused by it. The Authority noted that the introduction of CS spray had made a significant impact on safety for police officers. However, the study raised concerns amongst significant population groups, particularly those vulnerable through mental illness, alcohol or drugs. It called for further research to be undertaken and continued

caution in the use of the spray to be reflected in guidance and training for police officers. The report urged police services to act on the guidance introduced in 1999 particularly in relation to the safe and appropriate use of spray for those with a mental illness, its use in crowded areas, on car drivers and in relation to incidents involving firearms. In 10 recommendations the report highlighted the need for better training of staff so as to render practice more appropriate particularly when dealing with persons with a mental illness. Other less safe or inappropriate uses of spray were highlighted in the recommendations. The report called for research into alternatives to the solvent MIBK which can cause burns and blistering; the long term effect of CS sprays used and the effect of the CS spray on those with mental illness and drugs associated with this.

In 2003 a major review of shootings by police in England and Wales from 1998–2001 conducted by the Police Complaints Authority was published. Such incidents now comprise category two deaths in custody. The review was requested by the Home Office Minister of State and in the terms of reference the Authority was asked to have particular regard to—

— the planning, control and conduct of operations;

— the way in which the concerns of the bereaved families were addressed and how they were kept informed of the progress of the investigation; and

— the training and skill needs of the police officers involved in such operations particularly at command level.

Twenty-four incidents were examined. The review addressed the following key questions:

— Who was shot and why? Detailed analysis and narratives show the circumstances in which shots were fired and what had provoked this police action. The review classified the incidents as to whether they were "spontaneous" or "pre-planned" and whether the behaviour of the person who was shot appeared rational or irrational. In the incidents reviewed many of those shot were vulnerable due to a combination of alcohol or illicit drug misuse and/or mental health problems.

— What were the command and practice issues, and how could these be addressed? The review identified a number of weaknesses in command and proposed changes to strengthen, particularly, the role of the intermediate ("silver") command in the management of incidents. It examined the potential impact of tactical choice on outcome and the role for approaches that take account of the needs of vulnerable suspects.

— What were families' concerns and how could these be met? Contact with bereaved families uncovered poor experiences of the investigation, inquest and disciplinary processes. These were judged to be too protracted, secret and unresponsive.

The review made 48 wide-ranging recommendations to the Home Office and to the police service. Central to these was the concern that lessons may not be adequately learned from firearms incidents. The discharge of weapons by the police remains a rare event in England and Wales but the arrangements for disseminating lessons for police forces and others remain unsatisfactory. The Authority recommended that more research data was needed on:

— the effective use of police dogs in firearms incidents;

— the testing and application of less lethal weapons;

— the impact of verbal challenges on suspects, particularly for vulnerable people and when suspects are challenged from behind;

— regional variations in rates of police shootings and the relationship between the use of specific tactics and the likelihood of discharge of police weapons; and

— the relationship between deployments and discharges, and the factors that predict when police discharges are likely to occur.

The Home Office has now convened a Working Group combining the PCA, ACPO, Metropolitan Police Service, Association of Police Authorities, Metropolitan Police Authority, HMIC, Home Office and Department of Health to consider and, if appropriate, take forward the recommendations of the review.

(viii) *Home Office Learning the Lessons Committee*

In 2002 a Standing Committee on Learning the Lessons from Adverse Incidents was convened by the Home Office. It is chaired by ACPO, the Authority provides the secretariat, and it has representation from the Home Office, HMIC, Centrex, APA, the Police Standards Unit and the Crown Prosecution Service. Its terms of reference are to:

— review adverse incidents which occur in the police service;

— identify lessons to be learned from such incidents, with the aim of preventing similar incidents from occurring elsewhere and developing good practice; and

— disseminate the findings and recommendations of the Committee.

The Committee also hopes to encourage a culture in which the police service, and those working with it, are willing to share information to help each other learn from adverse incidents, rather than a culture pre-occupied with allocating blame. Its work has already resulted in a Home Office circular (HOC 18/2002)

following an investigation supervised by the Police Complaints Authority into a cell death by hanging. The guidance drew attention to the need for special vigilance by those managing custody facilities in relation to the risks posed by the physical characteristics of the accommodation. The circular guidance also reminded the police service of the need to balance considerations of privacy and dignity (Article 8 ECHR) against the sometimes more important principle of preserving the right to life (Article 2 ECHR).

3. Questions Posed by the Inquiry

(i) *Preventing deaths in custody*

What are the main causes of the deaths in custody? Are there any common factors?

Please see detailed research evidence compiled by Dr David Best, PCA Research Department and above comments and published reports.

Are there particular aspects of conditions of detention, or the treatment of detainees, or the cultural background of prisoners or prison officers, that contribute to:

Suicide and self-harm in custody?

Suicide and self-harm is now much rarer. The Authority would draw particular attention to the continued use by the police of custody area accommodation ill-designed for the detention of vulnerable prisoners. Home Office guidance issued in July 2002 drew attention to the contribution which such outmoded accommodation made in the death due to self-harm of a detained person earlier that year. Detailed guidance was given to the police service stressing the importance of identifying and removing physical features which present an opportunity for use as a ligature point. Later incidents confirmed the Authority's belief that in the police service estate there still exist detention areas unsuited to holding vulnerable prisoners. The same circular guidance highlighted, from the cases supervised by the PCA, the need to remove from those assessed as at risk clothing which might be used to self-harm. The Authority has drawn attention, in its previous reports, to the difficulties of balancing respect for personal privacy and dignity with the need to protect risks to life and safety. Some police services adopt strict practices with regard to the removal of laces, belts and cords. Other police services (including the Metropolitan Police Service) do not, in some cases arguing that to insist in every case on such a measure would infringe the human rights of the person detained. This Inquiry may need to clarify where the balance should lie in relation to human rights principles so as to encourage greater consistency across the police service in the humane and safe detention of persons in custody.

Other deaths or injuries in custody?

Dr Best's research study highlights the prevalence of drugs, alcohol and mental health problems amongst those who die in police custody. The combination of these factors raises special challenges for police officers without medical knowledge or training and forensic medical examiners who may have limited experience and/or expertise in relation to these problems. Those deaths which appear to have been avoidable demonstrate inter alia poor assessment of the true causes of the arrested or detained person's condition; poor practice in relation to their monitoring or rousing when detained in cell accommodation; poor liaison (if any) with the forensic medical examiner; poor diagnosis and/or treatment decision making by the medical practitioner asked by the police to examine the person; and, lastly, lack of urgency in ensuring that appropriate medical treatment is provided.

What further steps need to be taken to prevent suicide and self-harm in custody?

The incidence of death in a cell or police station due to self-harm has decreased over the past five years and this may be due, in part, to improved risk assessment and monitoring together with better quality custody accommodation. However, practices remain varied across the police service with regard to measures designed to reduce risk. Custody accommodation, itself, remains of variable quality; custody staff in different police services receive different levels of training at different times; custody offices are staffed differently, some having entirely dedicated staff and others staff drawn from general duty on a rota basis. Some custody areas and services have a high component of civilian staff undertaking work of significant responsibility. Other police services continue with largely police officer staffing of the custody function.

The Authority has highlighted above many of the practical steps which could be taken to prevent suicide and self harm in custody. Clearly, early and rigorous compliance with the new provisions found in Code C will prove a positive influence in reducing the risk of harm.

Better liaison with, and inter-agency co-operation between, police services, forensic medical examiner services, mental health trusts and accident and emergency departments are essential to reaching and sustaining the lowest level of risk attainable. Practical measures to reduce the risk of harm must include the

acceptance by the police service that CCTV vision and audio recording of custody areas is an essential pre-requisite. CCTV systems must also monitor some cell accommodation for vulnerable persons to facilitate more effective monitoring.

Other deaths or injuries in custody?

The second part of this memorandum showed the specific steps the Authority has taken to highlight practical measures to reduce the risk of deaths in custody. The more rigorous requirements of new Code C will be of direct relevance to these cases and better liaison with and inter-agency co-operation between the police and community mental health services will be important to the humane and safe treatment and detention of those with mental health problems. In the Metropolitan Police Service area pilot procedures are being introduced to test the feasibility of the NHS radically changing its response to the mentally distressed or disordered person in the community where the police may be conventionally expected to deal with the problem. Northumbria Police are, with its local university, developing specific training which will provide local police services with police officers trained in crisis intervention for persons with severe mental illness. Such a resource to a police service could well improve its capacity to deal differently with those presenting disorders and possibly threatening behaviour without resorting to the use of significant physical force.

In relation to both risks the Authority will, in the time remaining to it, report to the Learning the Lessons Committee concerns arising from its supervised investigation casework to ensure that lessons are generalised throughout the police service.

What kind of Human Rights approach to conditions of detention and management of detention facilities contribute to the prevention of deaths in custody?

The Authority is not specifically aware of the police service taking a "human rights approach" to the management of conditions of detention. The codes of practice which govern much of the treatment of those in detention pre-date the Human Rights Act and was introduced when the vast bulk of police powers were codified and prescribed. Nevertheless, PACE and the codes of practice, particularly Code C, made under it are mainly if not entirely compliant with ECHR obligations resulting from Articles 2, 3, 5, 8 and 14. Such standards as are reflected in Code C clearly encourage the belief amongst police staff that persons detailed in their custody have fundamental rights and there are specific obligations many directed to ensuring their humane and safe detention. Custody visitors provide an important independent scrutiny and discipline having direct access to persons detained at the time of their detention and gaining from this direct reports as to the standards of treatment and conduct. Custody visiting must also provide police managers with independent observation on the standard and adequacy of cell accommodation. No doubt, from time to time, custody visitors raise concerns with custody staff and managers within a "human rights framework" and they should be encouraged in so doing.

(ii) *Investigation of deaths in custody*

The Authority notes that the Committee intends to consider this issue from the point of view of the new arrangements to be introduced from 1 April 2004 under the Police Reform Act and with the creation of the new Independent Police Complaints Commission.

The Authority's view is that current law and the manner in which it supervises police investigations meets ECHR requirements for an effective, prompt and independent investigation with effective participation. However, it is recognised that a human rights culture is present where judgement merely as to legal compliance form only the foundation upon which better practice is built. Where a next of kin or bereaved family lack confidence in the integrity of an investigation or it takes too long to undertake or it has been unduly secretive to those with a personal stake in the inquiry, then the spirit of the ECHR may be compromised.

Current arrangements have not permitted this Authority, and investigating officers supervised by it, to provide in every case an inquiry which has enjoyed such confidence and many investigations have been far too protracted where the time taken by the Crown Prosecution Service to determine the issue of criminal culpability and the time for a Coroners' inquest to be held are taken into account. The legal framework within which the Authority has had to work has been unduly restrictive in relation to the following elements:

— Neither PACE 1984 nor the Police Act 1996 require the police to refer to the Authority for it to supervise an investigation into a death in custody where no complaint has been made. This is remedied by the provisions in the Police Reform Act.

— Section 80 of the Police Act 1996 has been seen as a barrier to disclosure in the past. Sections 20 and 21 Police Reform Act and regulations made under that Act will impose positive obligations to inform and disclosure whereas formerly the Police Act 1996 appeared to assume a largely secret process of inquiry and feedback on outcomes.

— Since the legal arrangements have prevented the PCA investigating allegations or incidents itself, this has limited the impact of independent supervision where hostility and/or mistrust is felt towards police investigators. The investigation powers under the Police Reform Act and the resources to be committed to independent investigation will help to reduce or remove this severe limitation on the PCA's effectiveness where confidence is a serious issue.

It is, of course, essential for the IPCC to be properly resourced for its new independent investigation task and essential that it recruits and prepares staff sufficient in number and expertise to deal with the enormous challenge of independent investigation with effective and sensitive family liaison.

19 September 2003

APPENDIX

DEATHS IN CUSTODY—AN ANALYSIS OF POLICE-RELATED DEATHS IN HOME OFFICE CATEGORIES 1, 2 AND 3 BETWEEN APRIL 1998 AND MARCH 2003

Dr David Best

Police Complaints Authority

19 September 2003

Background and Rationale

From 2 October 2000, the Human Rights Act 1998 was incorporated into UK law, including Article 2 on the "right to life" stating that "Everyone's right to life shall be protected by law". The report below attempts to address issues around the right to life and its manifestation in police custody and broader contact between the police service and the general public, to examine the main causes of deaths in custody and underlying common factors in the context and characteristics of these deaths. One of the main emphases of the work will be on vulnerable populations, in the context of suicide, and in relation to ethnicity as an indicator of increased likelihood of custody death.

According to Home Office data, just under 1.3 million people suspected of committing an offence are arrested every year. In 2001–02, of this 1.3 million arrests, 97,800 (8%) were recorded as being black, 55,600 (4%) as Asian and 11,800 (1%) as being of other "non-white" groups. This represented a rise of 7% for Asian and 12% for black arrestees when compared with the previous year.

However, among all ethnic groups, death in custody is an exceptionally rare event, with the PCA Annual Report (2003) indicating that there were a total of 27 Category 3 custody deaths (see below for definition) in 2001–02 and 30 such custody deaths in 2002–03. Although the periods of assessment are not directly comparable, this means that there are slightly more than two deaths per 100,000 arrests in England and Wales.

However, every such incident is a tragedy and is investigated accordingly. This investigation will be undertaken by the professional standards department of the police force in which the incident occurred or, on occasion, of an independent force. All of the deaths included in this analysis have also been supervised by an independent oversight body, the Police Complaints Authority (PCA).

The PCA has previously attempted to address this issue in two linked reports (1999). The first of these highlighted risks around custody and made recommendations to address a number of risk factors with the follow-up report identifying successes—a success that is evidenced in the reduction in custody deaths over the course of the 1990s.

The PCA is in a unique position to assess police-related deaths through its supervision role, by which all deaths involving the police are referred voluntarily by the relevant force for supervision of the investigation. The PCA file therefore is based on the police investigation and will supplement this with the relevant correspondence involved in the investigation of the death and with any matters arising.

To make most use of the PCA evidence base, the paper will examine as many of the supervised cases involving the death of a member of the public as can be accessed in a five-year window, relating to the Home Office categories 1 to 3. The definition classes police-related deaths as:

Category 1: Fatal road traffic incidents involving the police

Category 2: Fatal shooting incidents involving the police

Category 3: Deaths in or following custody

Category 4: Deaths during or following other types of contact with the police

For the purposes of the current analysis two groups have been excluded. Category Four deaths in custody and road traffic incidents involving emergency responses and standard patrol collisions. The reason for this is that each of these groups will include deaths among those not involved directly with the police. As the unit of analysis in the current study is the individual who has died, it was decided that the primary focus of

the study would be on those who died in police custody, but to use an overview analysis of pursuits and fatal shootings as both a context and as contrast groups for the main analysis. In sum, what this means is that the results are presented as:

1. Summary characteristics of the 302 deaths considered in the report
2. Comparison of Category 3 custody deaths with pursuit and shootings deaths from the same period
3. Analysis of Category 3 custody deaths
4. Analysis of ethnicity factors in Category 3 custody deaths

This, in effect, means that the study will consider fatal road traffic incidents, deaths in police care and custody and fatal police shootings that have been supervised by the PCA.

The five-year window selected, from April 1998 to March 2003, is an attempt both to maximise the sample and to ensure that as much of the information that can be accessed within the PCA is used. There are limitations in data at both ends of the selection. For the earliest year, 1998–99, a number of the files have been destroyed and so some of these are likely to be excluded (in cases where no information can be accessed from other sources). For the most recent year, 2002–03, the problem is that many investigations have not been completed by the time of writing, and so there will be limited information available, and what information there is, will be of limited reliability as it will not have been confirmed through all the relevant investigative channels.

The search strategy for identifying files was by using the PCA Annual Reports and then reconciling these with information accessed from the PCA computerised database or from the PCA Press Office files. Once the files had been identified, the physical tracking down of the case used one of four sequential mechanisms:

1. Was the file held by the PCA research department?
2. Was the file available in the storeroom of completed files within the PCA?
3. Was the file held at the PCA archives depot?
4. Is the file currently with the member or caseworker as it is an ongoing case?

A total of 305 files were identified, but three of these files could not be tracked down, meaning that the total number of cases entered on the database is 302. For this reason, the data presented below, on the 302 files accessed, analysed and entered, is less likely to involve ongoing "live" cases (most likely from 2002–03) or those held in the archives (1998–99). Similarly, even among older cases, those that are particularly complex are more likely to be ongoing and so are less likely to be complete, for the purposes of the current analysis.

Analysis and Basic Results

The analysis outlined below is based on the 302 cases identified as falling into one of the first three categories, divided as below:

Fatal police shootings 12 (4%)
Road traffic incidents 137 (45.4%)
Deaths in custody 153 (50.7%)

This is reflected in the year breakdown, shown in Table 1 below

Table 1

YEARLY BREAKDOWN OF CASES INCLUDED IN THE STUDY

1998–99	*1999–2000*	*2000–01*	*2001–02*	*2002–03*
46 (15.2%)	57 (18.9%)	57 (18.9%)	70 (23.2%)	72 (23.8%)

There are two reasons why this cannot be regarded as definitive trend data in spite of the apparent increase in numbers over the period of study. First, the availability of information relied on access to the file (although this was possible in almost all cases). However, it is also reliant on referral policy (particularly in road traffic incidents about whether the police involvement was sufficient to refer) and subsequent PCA decision-making about the acceptance of referrals. More importantly, the overall data disguise shifting patterns within the two main classes of death examined—fatal road traffic incidents and deaths in custody (as shown in Figure 1 below). Thus, while the total number of deaths in custody have remained broadly consistent over the course of the study, the number of fatal road traffic incidents have increased dramatically in the same period.

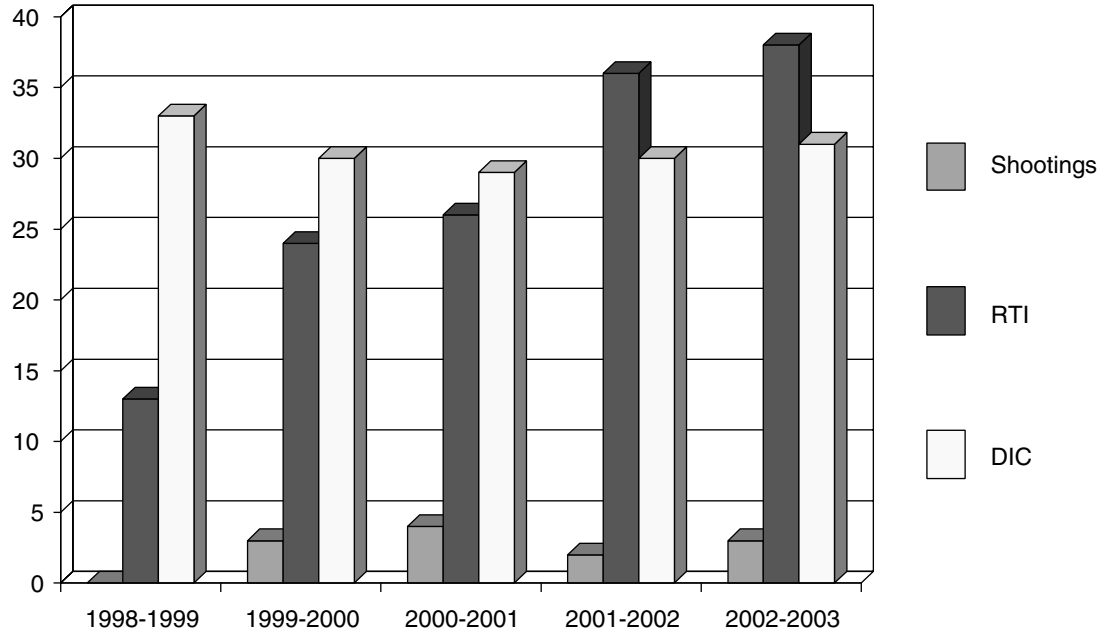

Figure 1: Shifts in patterns of police-related death by category

Characteristics of those who have died

The mean age of those who died was 34.4 years, although it should be pointed out that there is a wide range with the youngest victim two years old (a victim in a road traffic incident) and the oldest 87 years old. The sample was also predominantly male (n = 271, 89.7%), with only 31 deaths (10.3%) involving female victims. While all of the victims of police shootings were male, 20 of the female deaths were in road traffic incidents and 11 were deaths in police care or custody.

Ethnicity data was available for 271 individuals (90%). Of these, 218 (80.1%) were classed as white, white British or white European, with 27 victims classed as black, black British or Afro-Caribbean (9.9%), 20 (7.4%) as Asian or Indian, and seven as from other ethnic backgrounds (2.6%).

In terms of vulnerability, 90 of the 293 cases where this was known (30.6%), involved a victim with a previously identified mental health problem—in 26 cases this had been diagnosed by a psychiatrist, in 22 cases by the individual's GP and in 42 cases, mental health problems had been identified elsewhere (eg by prison doctors or social workers). While up to three separate diagnoses were recorded for six individuals, a history of self-harm was indicated in 29 individuals (32.2%), depression in 32 cases (35.6%), alcohol dependence in 21 cases (23.3%), drug dependence in 13 cases (14.4%) and schizophrenia or psychotic symptoms in 20 cases (22.2%). A further indication of substance use was derived from the post mortem toxicology reports, with an average of 1.2 active drugs reported from the toxicology reports. Of the 297 cases for which information was available, 178 individuals (59.9%) were positive for at least one drug or alcohol.

Alcohol was the substance most frequently identified, present in 107 cases (35.4% of the total sample). With regard to illicit drugs, cannabis was identified post mortem in 50 deaths (16.8%), cocaine in 34 cases (11.4%) and heroin or heroin/morphine in 22 cases (7.4%). The other drugs frequently recorded were benzodiazepines in 38 cases (12.8%), although it is not clear if this was prescribed or illicitly diverted drugs and novel stimulants (such as ecstasy and its analogues) in 24 cases (8.1%).

In terms of the location of the incident, large urban forces were, as would be expected, highly represented. A total of 48 cases (15.9%) occurred in the Metropolitan Police area, with the next highest prevalence in Greater Manchester (n = 21, 7%), followed by West Yorkshire (n = 17, 5.6%) then both Devon and Cornwall and Thames Valley (n = 14, 4.6%). However, each of the 43 Home Office forces has experienced at least one death in the five-year time window (a full breakdown is presented in Appendix 1).

Although difficult to classify, the reason the individual was initially in contact with the police was as a result of police intelligence in 166 cases (55.7%) or as a result of driving matters (89 cases, 29.9%). Other reasons for initial police involvement were being observed committing a crime (in 14 or 4.7% of cases), routine stops (in 11 or 3.7% of cases) or because the individual was reported to have been "behaving suspiciously" (in 13 or 4.4% of cases).

Data were also gathered on the location of death although this can be misleading as it will often reflect where death was pronounced to be extinct rather than where the individual died. For this reason, the most common location was in hospital (in 130 cases, 43.5%), followed by in a public place (106 cases, 35.5%). Only 51 of the 298 cases on which this data was available (17.1%) actually died in police cells or other parts of the police station. A further 12 (4%) died at home.

At the time of the incident, 124 of the 298 of the individuals for which the information was available (41.4%) were either detained or under arrest. In the remainder of cases, the police were attempting to arrest the individual (91 cases, 30.4%), there was no arrest intention (69 cases, 23.1%) or the death occurred after the individual had been released from police custody or contact (15 cases, 5%).

Causes of death and issues of concern for the police

In 24 cases (8.1% of the 298 cases for which information was available) there was a restraint concern that was subject to investigation (although this concern was not necessarily upheld by the investigators), ten of these involving the use (and alleged misuse) of handcuffs. These include two cases where the individual was still in handcuffs when taken to hospital, one case where an individual was handcuffed while unconscious, and one occasion where the individual had flexi-cuffs used to restrain his or her legs. In four cases, the restraint issue relates to the use of CS spray, in one case to the type of restraining hold used by the police officer and in two cases to the length of time the individual was left sitting restrained in a police van. However, in a number of other incidents the matter investigated related to the technique used by officers to control the individual—including the use of a "bear hug" in one incident, forcing a man's arm up behind his back in another and the violent struggle preceding arrest in a third case.

Similar problems exist in making sense of the cause of death identified at the post mortem, not least because in 13 cases, three causes of death are given while in a further 40 cases, two causes of death are provided by the pathologist. However, among the 301 cases for which at least one cause of death was available from the post mortem investigation, the most common main cause of death was "multiple injuries" in 76 cases (25.2%), followed by alcohol or drug toxicity in 47 cases (15.6%) and "head injury" in 33 cases (10.9%). Cause of death in all 12 fatal shooting cases was given as the effects of the shot or shots.

In 10 cases (3.3%), "hanging" was given as the cause of death, with ligature strangulation given as the cause of death in one additional case. In four cases, excited delirium is given as the cause of death and, in five cases, asphyxiation is given as the cause of death. However, there are a total of 73 primary causes of death cited in cases included in the study.

Complaints, criminal and disciplinary outcomes

In only 16 of 300 cases (5.3%) was there a formal complaint made by family members as a result of the incident that led to the death—10 of these arising in custody deaths, five relating to road traffic incidents and one following a police shooting. However, in several of these cases, more than one issue was raised in the course of the complaint (see Table 2 below). Furthermore, there are concerns expressed by family members that are recorded in the investigation file in a number of cases, while there may yet be complaints from family members in some of the cases that have not yet been completed.

Table 2

COMPLAINTS ARISING FROM DEATHS INVOLVING THE POLICE

Category	*Nature of complaint*
Pursuit	Officers knew the occupants and therefore should not have pursued; There was a delay in notifying the family about the incident; Witnesses stated that an officer kicked the deceased.
Pursuit	Passenger in pursued car complained that he was assaulted by an officer.
Pursuit	Pursuing officer committed traffic offences in the pursuit; The pursuit was dangerous and should not have taken place; The FLO lied to the family; The officer was unsympathetic.
Pursuit	Relating to the actions of the police prior to the collision, at the scene, at the hospital and with regard to family liaison.
Pursuit	Should not have been pursued; conduct of the pursuit.
Death in custody	Obvious ligature point in the cell.
Death in custody	Unlawful arrest; unnecessary force used.

Category	*Nature of complaint*
Death in custody	Officer failed to look after the individual's health and welfare; officer should have acted quicker; officer's actions contributed to the death; officer was aggressive and assaulted victim's mother.
Death in custody	Failed to provide proper medical attention; Custody officer listed victim as unknown when he was known to the police.
Death in custody	Breach of Code C: failure in duty.
Death in custody	Unlawful detention: officers acting outside the powers of the Mental Health Act; excessive use of force.
Death in custody	Deceased not allowed to use toilet nor to change clothes; FME pronounced the deceased fit to detain; Delay in informing family; FLO attitude not acceptable.
Death in custody	Failure of officers to make inquiries about drugs and alcohol consumption; Failure to update custody records; Failure to observe detainee properly.
Death in custody	Inadequate investigation; Dishonesty of police officers; Failure of officers to intervene.
Death in custody	The actions of officers caused the deceased to lapse into unconsciousness due to the failure to monitor prisoners.
Shooting	Initial complaint of unlawful use of force and falsified accounts. Subsequent complaint alleged that: Family not informed soon enough about the death; FLO had no respect for family privacy; Offer to pay for funeral was made and withdrawn; Scene of shooting was managed insensitively.

The final report records concerns expressed by family members or community groups in a further 12 cases where no formal complaint was made. These included:

— Concerns that the deceased should have been taken to hospital earlier.

— Concern that the time for arrest given by the police was inaccurate.

— Concern that the FME was not called, while the officers were watching football and that the officers did not do all they could to preserve safety.

— Concerns about the level of care and why the individual was not taken to hospital.

— Concerns about delays in informing the family and that clothing was seized.

— Dissatisfaction with the IO who was seen as rude by the family.

— Family concern that police actions contributed to the death.

— Concerns that the deceased was beaten and that potential witnesses were not requested.

In only three of the finalised cases did officers face criminal charges for involvement in a death, and, on each occasion, was subsequently acquitted (although a further 31 cases have not yet reached this stage). These were:

(a) Five officers were acquitted of misfeasance and manslaughter following a death in a custody suite in Humberside.

(b) One officer was acquitted of misfeasance following a cell death in Lancashire.

(c) A police driver was found not guilty of dangerous driving following a police pursuit.

In one further case, an officer was required to resign at a disciplinary hearing. In no finalised case were any officers demoted in rank following disciplinary proceedings.

In terms of formal disciplinary proceedings, 16 of 260 cases (6.2%) resulted in officers receiving formal disciplinary outcomes. In eight cases an officer was admonished, in six cases this happened to two officers, and in one case each, three and four officers respectively were admonished or received a warning following investigations into police-related deaths. A total of 168 officers received advice from a senior officer in a total of 65 cases (of 260 that had reached disciplinary conclusions by the time of writing). In one case, a total of 15 officers were given advice following the investigation.

At the time of analysis, information regarding recommendations was only available in 259 cases. Of these 259, policy, training or organisational recommendations were made in only 96 cases. The number of recommendations made in each case ranged between one and 30. In the remaining 163 cases (62.9%) no recommendations of any sort were made. Where recommendations had been made, information about implementation would not always be provided to the PCA, as the Authority has no role in monitoring the implementation of such recommendations.

Finally, at the time of writing, an inquest had been held in 194 cases. In a further 56 cases the inquest date was yet to be set. In 45 cases no inquest was scheduled to take place, generally involving road traffic incidents where those driving the cars that killed the victims were later convicted of causing the death. Of the inquests held, 73 returned a verdict of "accidental death" (37.8%), with the jury in one further case returning a verdict of "accidental death contributed to by neglect". A further 26 cases (13.5%) resulted in verdicts of

"misadventure" and 28 cases (14.5%) in verdicts of "natural causes". In 15 cases, an "open" verdict was returned, and in five cases the verdict was "lawful killing" (these were all police shootings). In a further six cases, the verdict was "drug-related death".

Twelve cases (6%) resulted in "unlawful killing" verdicts (although all but one of these involved police pursuits and related to instances where the pursued driver had killed another road user or pedestrian). In only one custody case, relating to the death of a black man in Humberside, did a custody death result in a verdict of unlawful killing.

Ten deaths resulted in verdicts of suicide and two in verdicts of "suicide contributed to by neglect". One of the 10 suicide deaths was a police shooting described by the coroner as a "suicide by cop" incident.

Comparison of death categories

There was a significant disparity in age profiles with the mean age of deaths in custody (mean = 40.5 years) markedly higher than fatal shootings (mean = 33.7 years), which in turn was significantly higher than road traffic incidents (mean = 27.2 years; $F = 28.1$, $p > 0.001$). The largest proportion of female deaths was in road traffic incidents (14.6%) compared with none of the 12 shootings and 7.2% of deaths in custody, which constitutes 11 cases ($x^2 = 5.73$, $p = 0.06$, ns).

In terms of shifting patterns of deaths over the period of investigation, the basic trends are shown in Table 3 below:

Table 3

BREAKDOWN OF CASES BY YEAR FOR EACH OF THE DEATH CATEGORIES

Year	*Shootings (n = 11)*	*RTI (n = 117)*	*DIC (n = 122)*
1998–99	0	13 (9.5%)	33 (21.6%)
1999–2000	3 (25.0%)	24 (17.5%)	30 (19.6%)
2000–01	2 (16.7%)	26 (19.0%)	29 (19.0%)
2001–02	4 (33.3%)	36 (26.3%)	30 (19.6%)
2002–03	3 (25.0%)	38 (27.7%)	31 (20.3%)

When ethnicity is compared by category of death, there is no significant difference. To enable this analysis, ethnicity categories were collapsed into four groups—white, Asian, black and other. For all three categories of death, over 75% of those who died were white. Of the 27 deaths classed as among black people, two (17.4%) were police shootings, 13 were in fatal road traffic incidents (48.1%) and 12 were deaths in custody (42.3%). Of the 20 individuals classed as Asian who died, 11 (55%) died in road traffic incidents and nine (45%) in deaths in custody.

Those involved in road traffic incidents were less likely to come from identified vulnerable populations. With regard to a confirmed mental health indicator, this was the case for 9/12 (75%) of those fatally shot by the police, and 50% ($n = 75$) who died in police custody, compared with only 4.5% of those whose status was known in road traffic incidents ($x^2 = 81.7$, $p < 0.001$). Similarly, while victims of fatal road traffic incidents averaged 0.7 different active drugs in their bloodstream at post mortem, the average for fatal shooting victims was 1.2 (in each case this included alcohol) and in deaths in custody the average was 1.6 ($F = 16.6$, $p < 0.001$).

There were significant differences in the disciplinary outcomes as a consequence of the category of incident (see Table 4)

Table 4

DISCIPLINARY OUTCOMES BY CLASS OF INCIDENTS

	Shooting (n = 11)	*RTI (n = 117)*	*DIC (n = 122)*	*F, sig*
No of officers disciplined	0.14	0.01	0.20	5.61, $p < 0.01$
No of officers given advice	1.57	0.18	1.06	11.61, $p < 0.001$
No of policy recommendations	4.6	0.4	1.3	13.46, $p < 0.001$

As is evident from the above table, road traffic incidents were markedly less likely than either of the other classes of police-related deaths to result in disciplinary outcomes or in recommendations of policy change by the SIO (which were most common in cases of police shootings). However, it is notable that the highest levels of both main disciplinary outcomes occurred in death in custody cases.

Focusing only on deaths in custody

This section of the analysis will focus on the 153 cases of Category Three death according to the Home Office classification scheme. To re-iterate the main characteristics of the group, their mean age was 40.5 years (with a range of 15 to 76 years), and they were predominantly male (142/153 or 92.8%). A total of 27 individuals (17.6%) were categorised as non-white in the sample—nine as Asian, 12 as black and six as from other ethnic backgrounds. However, ethnicity data were missing on 11 cases (generally among files from the earlier years where the file was no longer available).

On average, post mortem analysis revealed that they had consumed a mean of 1.6 active substances[63] in the period prior to their death—most commonly alcohol, which was detected in 67 cases (43.8% of cases). Other drugs consumed are shown in Table 5 below:

Table 5

MAIN SUBSTANCES DETECTED POST MORTEM AMONG DEATH IN CUSTODY CASES

Substance	*Number of cases*	*%*
Cocaine	27	17.6
Heroin	19	12.4
Benzodiazepines	31	20.3
Ecstasy	13	8.5
Cannabis	21	13.7

It is important to note that benzodiazepines will include those prescribed therapeutically—in some cases in custody—and so are not, unlike the other substances included, necessarily indicative of drug abuse.

The group was rendered further vulnerable by the prevalence of mental health problems identified. Just over half of the cases for which information was available (75/149, 50.3%) had a prior indication of mental health problems—with 17 individuals having a previous diagnosis by a psychiatrist, 20 having GP indications of mental health problems and with the remaining 38 having other indications in the investigation files of earlier mental health problems. This is a level of mental health problems considerably in excess of that generally reported in custody populations (Bennett, 1998; Ingram and Johnson, 1998).

For 30 individuals (19.6% of all custody deaths included) there were prior indications of anxiety or depression, 26 had recorded histories of self-harm (17%), 17 had markers for psychosis or schizophrenia (11.1%), 12 had histories of drug dependence (7.8%) and 18 (11.8%) had histories of alcohol dependence. "Behaviour problems" or other psychiatric problems were recorded in six further individuals. In other words, for a substantial proportion of the custody death group considered in this report, there were not only indications of mental health problems and/or substance abuse, but there were previous contacts with health agencies attempting to address these problems.

Locations of the death

Again, the police service most commonly associated with custody deaths was the Metropolitan Police Service (MPS) accounting for 32 (20.9%) cases. The force with the next highest level of custody deaths was Northumbria (n = 10), followed by West Midlands and Devon and Cornwall (eight deaths each). However, the 153 deaths were spread between 36 different police forces in England and Wales.

In more specific terms, the place of death was recorded as the police station or cell in 45 cases and "police vehicle" in a further six cases—in other words 33.8% of the 151 cases for which this information was available involved death in a police location. The other main locations for death recording were in hospital (79 cases or 52.3% of the valid sample), with 12 individuals dying in a public place and nine at home.

The initial contact resulted from "police intelligence" in the vast majority of cases (111 or 74.5% of the death in custody cases). Less frequent reasons for the initial police involvement were traffic or driving matters (in 13 cases), the individual being observed committing a crime (12 cases), the police perception that the individual was engaging in suspicious behaviour (seven cases) or routine stops (four cases). Other reasons were given in a further two cases and this information was not available in four cases. As has been detailed above for all deaths, there were restraint-related aspects of the investigation in 23 cases (15.4%)—generally relating to the timing and location of handcuffing, the use of force in the initial arrest attempt, the use of CS spray or delays in the removal of restraints when it was apparent that the individual was experiencing significant health problems.

[63] Active substances refers to illicit drugs, alcohol or prescribed medications (including those diverted through illicit routes).

Although custody detention issues are likely to be significant, the attempt to quantify this is problematic. The calculated mean time is 384 minutes (just over six hours), but this is heavily skewed by two cases where the individual is in custody for more than two days. However, it is worth noting that in nine cases, the individual is in detention for 24 hours or more.

The prevalence of substance use is clearly indicated by the fact that "toxicity" is cited as a cause of death in 47 cases (31.8% of the 148 cases for which this information is available). Head injuries are cited in 12 cases, hanging in 10 cases, multiple injuries in seven, hypoxia in five cases and excited delirium in four cases. In at least seven further cases, alcohol-related factors are cited among the causes of death. Changes over time in the frequency of both toxicity deaths and hanging deaths are given in Figure 2 below:

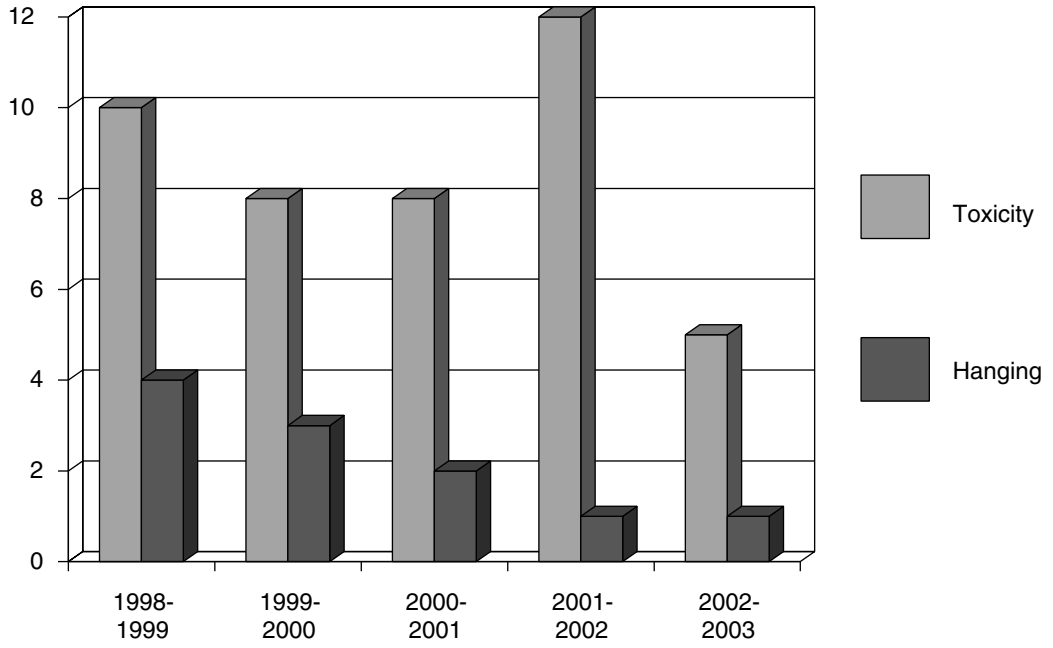

Figure 2: Change in frequency of toxicity and hanging as causes of death over time

As can be seen from the above table, there is no consistent pattern in deaths where toxicity is given as a cause, but there appears to be a positive change in the number of strangulation or cell deaths with only one death in each category in each of the last two years.

Investigations and outcomes

In only two of the 131 cases that have reached that stage was there a criminal trial of an officer, with six officers tried in total, with all six being acquitted. An officer was required to resign following one of the custody deaths, and in 14 cases a total of 25 officers were warned or admonished following the investigation. In 45 of the 127 cases (35.4%) completed to date, officers were given advice by a senior officer, resulting in a total of 134 officers dealt with in this way.

In 49 of these 127 cases (38.6%), the Senior Investigating Officer (SIO) recommended further action at a policy level. The most common areas identified by senior investigators as needing to be addressed were:

— Training needs for officers (n = 39, 30.7%).

— Issues around the management of vulnerable populations (n = 31, 24.4%).

— Equipment issues (n = 30, 23.6%).

— Incident management issues (n = 21, 16.5%).

The other most common themes identified by SIOs were custody management issues (in nine cases), failures of inter-agency working (in seven cases) and failures of post-incident investigation (in five cases).

A further investigation was carried out in the form of a coroner's inquest in 112 cases. Details of the inquest outcomes are given in Table 6 below. It should be noted that multiple verdicts are given in a number of cases:

Table 6

INQUEST VERDICTS GIVEN IN DEATH IN CUSTODY CASES IN CASES COMPLETED TO DATE

Inquest verdict	*Frequency*	*%*
Accidental death	29	19.1
Misadventure	15	9.9
Open	13	8.6
Drug related	6	3.9
Suicide	10	6.6
Accidental death contributed to by neglect	1	0.7
Natural causes	28	18.4
Suicide by neglect	2	1.3
Accidental death contributed to by restraint and failure to provide medical care	1	0.7
Misadventure contributed to by police neglect	1	0.7
Pending	38	25.0
Unknown	2	1.3
Total	147	96.7

For the 10 complaints received to date (details of which are provided above), four are still under active investigation. In the remaining cases, one has been informally resolved, two have been upheld in part and three have not been upheld.

Examining ethnicity issues among custody deaths

This part of the analysis will focus on the 27 non-white individuals who died in custody in the period of the review. The mean age of the non-white group was 37.3 years (range of 19–66 years) and consisted of 26 males and one female.

Seven of these individuals (26.9%) had a previous indication of mental health problem(s)—three on the basis of psychiatrist diagnosis and four based on information from other sources in the SIO's report (information was missing in one case). Four of these individuals had drug dependence indicators and one had an alcohol dependence marker. Two individuals had indications of schizophrenia, two had markers for either anxiety or depression, and one had another psychiatric problem. In other words, there were a total of 10 symptoms indicated in this group.

In 22 of the 26 cases where this information was available (84%), there was at least one active substance present at the toxicology. As with the larger sample, the most common substance present was alcohol (48%), followed by cocaine (28%), heroin or morphine (20%), cannabis (20%) and benzodiazepines (16%). There was no relationship between mental health status and the likelihood of substance use prior to death.

More than half of the cases (n = 14, 53.8%) of custody deaths involving ethnic minority individuals occurred within the MPS, with a further four deaths occurring in West Midlands, two in Sussex, and one each in Northumbria, Essex, West Yorkshire, Hampshire, Surrey and Hertfordshire.

For the ethnic minority group, just over half the deaths occurred in hospital (13/25, 52%) with four occurring in police stations or cells and one in a police vehicle. Three individuals died at home and four in a public place. In the majority of cases (17/25), the reason for the initial police contact was based on police intelligence, and also for the majority (18/26) the individual was under arrest at the time of the death. However, for a further five, death occurred post release, and for the final three individuals death occurred either while the police were in the process of attempting to arrest or detain the person.

In five of the 23 cases for which this information was available, there was a restraint issue, four relating to the method of restraint (generally about the use of handcuffs) and one involving a violent struggle prior to the arrest.

However, in 11 cases (42.3%) toxicity was cited as a cause of death, with multiple injuries cited in three cases, and excited delirium and head injury in two cases each. The full range of primary causes of death are given in Table 7.

Table 7

PRIMARY REPORTED CAUSE OF DEATH IN CUSTODY DEATHS AMONG NON-WHITE DEATHS

	Post mortem cause of death			
Year	*First*	*Second*	*Third*	*Inquest verdict*
1998–99	Toxicity			Unknown
	Advanced alcoholic liver disease			Natural causes
	Multiple injuries			Accidental death
	Hypothermia			Misadventure
	Toxicity			Accidental death
	Dilated cardiomyopathy			Natural causes
	Toxicity			Misadventure
	Bronchopneumonia	Inhalation of vomit	Toxicity	Accidental death
	Excited delirium			Pending
	Not known			Unlawful killing
1999–2000	Toxicity			Accidental death
	Irreversible cerebral anoxia	Toxicity		Misadventure
	Ischaemic heart disease	Coronary heart disease	Toxicity	Natural causes
	Head injury			Accidental death
	Hepatitis	Multi organ failure		Open
	Head injury			Accidental death
	Excited delirium	Toxicity		Drug related
	Asphyxiation			Misadventure
2000–01	Toxicity			Accidental death
	Unknown			Open
2001–02	Toxicity			Misadventure
2002–03	Multiple injuries			Pending
	Chronic bronchitis	Emphysema		Pending
	Cardiac arrest			Pending
	Respiratory distress syndrome	Toxicity		Pending
	Tracheobronchitis	Skull fracture		Pending
	Multiple injuries			Accidental death

In outcome terms, there has been one trial in the 22 completed cases, with 21 inquests having taken place. The details of inquest verdicts are given in Table 8 below:

Table 8

INQUEST VERDICTS IN DEATHS IN CUSTODY INVOLVING INDIVIDUALS FROM BME GROUPS

Inquest verdict	*Frequency*	*%*
Accidental death	8	29.6
Misadventure	5	18.5
Open	2	7.4
Drug related	1	3.7
Pending	6	22.2
Unknown	1	3.7
Natural causes	3	11.1
Unlawful killing	1	3.7

In four of the 22 cases completed to date, a total of eight officers were warned or admonished and a further 21 officers were given advice by senior officers.

When inferential statistical comparisons were carried out comparing white and non-white custody deaths, almost no statistical differences emerged. Although white custody deaths were typically older (40.7 years versus 37.3 years) this was not significant.

A significantly lower proportion of non-white deaths in custody involved mental health problems (28% versus 55.4%; c2 = 6.12, $p < 0.05$).

There has also been a significant reduction in the proportion of non-white deaths over time within the window of investigation in the study, which does achieve statistical significance.

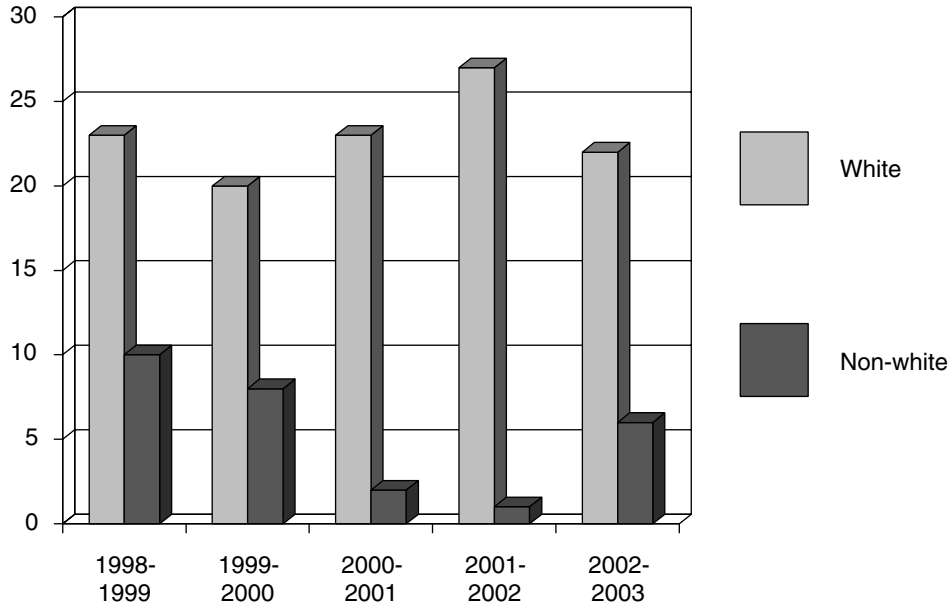

Figure 3: Proportion of deaths by ethnicity over time

As can be seen from the figure above, the number of deaths among non-white individuals decreased over the first four years of investigation but has increased in the most recent year, while the total number of white deaths has remained relatively constant over the period of investigation.

Finally although it did not attain statistical significance and the numbers are relatively low, it is notable that there are restraint issues in a higher proportion of the deaths involving non-white individuals (21.7%) than among white individuals (12.3%) (see Appendix 2).

In terms of investigation outcomes, a slightly higher mean number of officers received warnings or admonishments in non-white deaths (mean = 0.36) than in white deaths (mean = 0.18) but this was not significant. Conversely, more officers received advice on average for white custody deaths (mean = 1.2) than in non-white custody deaths (mean = 0.9) but this also failed to attain significance.

Overview

The study shows a relatively consistent pattern of custody deaths in the five-year window examined, with the 153 PCA-supervised custody deaths roughly equally spread across the period of investigation. This contrasts with the comparison group of pursuit deaths where the trend is upwards over the period of assessment, with the exception of the most recent year. Although exceptionally low as a proportion of arrests (153 deaths from around 6–7 million arrests in the period of investigation), it would not indicate that recent developments in monitoring or training are having a resulting effect on the overall number of fatalities. However, it is important to note that, over the last 10 years, the trend has been towards reduced numbers of deaths, particularly from hangings, the cause of death that is most obviously preventable. However, similar improvements have not been detected in the prevention of alcohol and drug-related deaths.

Within this custody group, there are marked variations in the demographic characteristics of those who have died. The group are primarily male, more than 80% are of white ethnic origin, and with a mean age of around 40 years (although there are a broad range of ages). There is an over-representation of ethnic minority individuals in custody deaths in the five-year window studied—while 17.6% of deaths are of individuals classed as non-white, the 2001 census for England and Wales reported that 9% of the population are from BME groups. It is also slightly higher than the arrested population reported by the Home Office for 2001–02, which showed that 13% of the total arrested population were from minority groups. While this may partly relate to the way ethnicity has been classified in some cases (and inconsistencies across measures), the over-representation of ethnic minority groups among the deceased group should not be ignored.

One of the main findings of the study is the exceptionally high prevalence of mental health problems recorded in the police investigation reports, at around 50% although higher among white deaths than among ethnic minority groups. In contrast, deaths among minority detainees were slightly more likely to result in the investigation considering aspects of the restraint of the detainee. However, there are very few clear,

statistically identifiable group differences in the characteristics of the incident or the individual as a function of ethnicity, although the small numbers of individuals from BME groups means that statistically robust differences are difficult to detect.

The general issue of vulnerability cannot be overstated. The preponderance of alcohol consumption and illicit drug use (particularly relating to the use of both cocaine and benzodiazepines) is a risk in its own right and compounds the risk associated with mental health problems. The latter, referred to as dual diagnosis (Strathdee et al, 2003), is associated with markedly increased risk of mortality from both custody deaths and from police use of firearms.

One of the most contentious issues will be the apparently low levels of culpability for police officers resulting from the total of 300 cases. Although seven officers were charged with criminal offences, none were convicted. One officer was required to resign and none were demoted. Similarly, in only one case, did an inquest verdict of "unlawful killing" relate to police activity (in the same case that five officers were charged and subsequently acquitted of criminal offences). However, in many of these cases, none of the adjudicating bodies—the inquest, the Crown Prosecution Service, the police investigators or the PCA supervising members—have found fault with police conduct and many of the disciplinary outcomes relate to ancillary matters rather than the actual cause of death.

Before drawing tentative conclusions, it is important to acknowledge the limitations of the study. All of the analyses are based on summaries of the PCA file, which in turn is heavily reliant on the final police report into each incident. These reports not only vary in depth and quality, they are also designed for a purpose other than research and so may not be consistent with the aims of the project.

However, there are a number of key inferences that can be derived. Although there have been significant gains, it is essential that the police remain vigilant and seek to eliminate the preventable deaths that do, on occasion, still occur. However, deaths are not randomly distributed across the population or indeed the arrest population, and this is mediated by incident and response type. Vulnerable populations (those with a mental illness and/or users of alcohol or illicit drugs are hugely over-represented), while those from ethnic minorities are less likely to have a recorded mental health problem but are likely to be slightly younger and slightly more likely to have been involved in an incident that provoked concerns about the method of restraints.

There are a number of implications of this for training and supervision. Earlier access to medical interventions are essential as is first aid training and refresher courses for all officers involved in custody. Similarly, officers must be made aware of the risk factors for self-harm and mental health problems, and for ensuring that a "safety first" approach is adopted in custody suites. It may appear that, following the significant gains in the late 1990s, some forces may have allowed complacency to creep in thus generating risks for those held in custody.

All deaths in custody are, at one level, preventable, although in practice, this is obviously not achievable as many "natural causes" deaths may be completely unrelated to any actions on the part of the police. The repetition of areas of recommendations from final reports suggests that prevention is not yet a sufficient objective and that some opportunities for organisational learning are not being taken. To ensure that HRA requirements are adhered to, the police service must ensure that lessons are learned and that deaths, particularly those involving vulnerable groups, are minimised.

All analyses are also made more problematic by the huge variations in the causes of death identified at post mortem, and this is reflected in the inquest verdicts passed down. In only one cases was the inquest verdict "unlawful killing" in relation to actions of the police and, given this finding, it is perhaps not surprising that only one officer was charged with a criminal offence. The most common disciplinary outcome (in cases where this arose was either formal admonishment or advice for officers), and the recommendation of organisational issues varied markedly from case to case, although much more common in shootings cases than in deaths in custody or even more markedly when compared to road traffic incidents.

APPENDIX 1

POLICE FORCE LOCATION (ALL DEATHS)

	Frequency	*%*	*Valid Percent*	*Cumulative %*
Cleveland	3	1.0	1.0	1.0
Devon & Cornwall	14	4.7	4.7	5.6
Northumbria	12	4.0	4.0	9.6
Metropolitan Police	48	15.9	15.9	25.6
Essex	7	2.3	2.3	27.9
Leicestershire	3	1.0	1.0	28.9
South Yorkshire	5	1.7	1.7	30.6
Merseyside	13	4.3	4.3	34.9
Greater Manchester	21	7.0	7.0	41.9

	Frequency	*%*	*Valid Percent*	*Cumulative %*
Durham	3	1.0	1.0	42.9
South Wales	11	3.7	3.7	46.5
Lincolnshire	5	1.7	1.7	48.2
Sussex	8	2.7	2.7	50.8
West Midlands	12	4.0	4.0	54.8
West Yorkshire	17	5.6	5.6	60.5
Avon & Somerset	7	2.3	2.3	62.8
Dorset	4	1.3	1.3	64.1
Gloucestershire	3	1.0	1.0	65.1
Hampshire	7	2.3	2.3	67.4
City of London	1	.3	.3	67.8
Derbyshire	3	1.0	1.0	68.8
Gwent	2	.7	.7	69.4
Surrey	7	2.3	2.3	71.8
Kent	1	.3	.3	72.1
Bedfordshire	3	1.0	1.0	73.1
Nottinghamshire	3	1.0	1.0	74.1
Thames Valley	14	4.7	4.7	78.7
North Wales	5	1.7	1.7	80.4
West Mercia	4	1.3	1.3	81.7
Staffordshire	7	2.3	2.3	84.1
Wiltshire	1	.3	.3	84.4
Norfolk	4	1.3	1.3	85.7
North Yorkshire	4	1.3	1.3	87.0
Cheshire	3	1.0	1.0	88.0
Humberside	4	1.3	1.3	89.4
Hertfordshire	1	.3	.3	89.7
Cambridge	2	.7	.7	90.4
Lancashire	9	3.0	3.0	93.4
South Yorkshire	3	1.0	1.0	94.4
Dyfed Powys	5	1.7	1.7	96.0
Cumbria	3	1.0	1.0	97.0
Warwickshire	3	1.0	1.0	98.0
Northamptonshire	3	1.0	1.0	99.0
Suffolk	2	.7	.7	99.7
British Transport	1	.3	.3	100.0
Total	301	100.0	100.0	

APPENDIX 2

ETHNICITY, RESTRAINT ISSUES, CAUSE OF DEATH AND INQUEST VERDICT IN CUSTODY DEATH CASES WHERE RESTRAINT WAS PERCEIVED TO BE AN ISSUE

	Ethnicity	*What was the restraint issue*	*Cause of death*	*Coroners verdict*
1998–99				
	white	Use of CS on person with MH problem	Organ failure	Suicide
	white	Held around the chest in reverse bear hug.	Brain injuries	Accidental contributed by restraint and failure to provide
	black	Complaint about handcuffing	Excited delirium	pending
	black	dragged from van—then left on ground with handcuffs on	Multiple Injuries	unlawful killing
1999–2000				
	black	handcuff marks, but pathologist could not comment on role restraint played in death	Toxicity	accidental death

	Ethnicity	*What was the restraint issue*	*Cause of death*	*Coroners verdict*
	white		Excited delirium	accidental death
	white	deceased had spent over half an hour sitting handcuffed in the van outside the custody suite	Aspiration of stomach contents	misadventure
	white	use of CS	Toxicity	misadventure
	white	was handcuffed during hospital transfer	Hypoxia	Accidental death
2000–01				
	asian	officers use of flexi-cuffs to restrain legs in contravention of force police	Toxicity	accidental death
		deceased was conveyed to hospital still cuffed	Myocardical infarction	pending
		restrained for hospital transfer	Multiple Injuries	
	other	violent struggle prior to arrest	Unknown	open
	white	handcuffed white unconscious	Toxicity	unknown
2001–02				
	white	restrained at hospital due to fear of assault on staff—handcuffs not suitable for long term use	Acute alcohol withdrawal with ketosis	
	white	police took hold of man's arm, put it up his back and forced him to the ground	Ischaemic heart disease	pending
2002–03				
	black		Cardiac arrest	pending
	white	police assaulted him during arrest but no evidence to link to stroke	Bronchopneumonia	pending
	white		Excited delirium	pending
	white		Cardio-respiratory failure	pending
	white		Unknown	pending
.		blood in cell. no explanation as yet	Inconclusive	pending
	white	struggled to put on handcuffs and CS used twice	Inconclusive	pending

7. Memorandum from the Prisons and Probation Ombudsman for England and Wales

It may be helpful for members of the Joint Committee to know that, in its 2002 White Paper, *Justice for All*, the Government said that it was considering whether to extend the remit of the Prisons and Probation Ombudsman's Office to include the investigation of self-inflicted deaths in custody. Further to that statement, the Home Office has conducted a consultation exercise and proposals are expected to be put before Ministers shortly.

My own view is that independent investigation will bring with it significant benefits. Public confidence and the safeguards under Article 2 ECHR should both be enhanced. Investigations (and reports) should be more consistent and of a higher quality. The focus can be less on whether the rules have been followed and more on the merits of decisions. And it will be possible to look at the actions and inactions of decision-makers outside prison as well as inside. Should the responsibility pass to me, I should also be looking at ways to involve the bereaved families of those who have died.

That said, I commend the efforts the Prison Service has made in recent years to improve the openness and usefulness of its own investigations. Indeed, members of my office have been involved in several independent advisory panels that the Prison Service has set up to review particular deaths.

The Home Office consultation exercise about extending my remit to deaths in custody has been both fruitful and encouraging. A resource issue will have to be faced (at present, the costs of internal Prison Service investigations are very largely opportunity costs alone). But if that is resolved, then I believe my office would be well-equipped to take on the daunting responsibility of investigating deaths both in prisons and of the residents of probation hostels.

I should prefer if that extension of responsibility came with a full array of statutory powers. However, as a stage towards a full statutory system (if there is no room at present in the legislative timetable), consideration could properly be given to an administrative scheme.

Members of the Committee should also be aware that, at the request of the Home Secretary, I am currently leading an investigation of a death that occurred in August of a prisoner at HMP Styal. My terms of reference also require me to consider that death in the context of five other deaths to have occurred at Styal over the past year.

This is the first time that the investigation of a death in a British prison has been independently conducted. I believe my terms of reference are also unique so far as consideration of the other deaths is concerned. Although features of this investigation are unlikely to be repeated if my remit were extended to all deaths, my colleagues and I have learned a huge amount from the exercise.

More generally, I have views on the development of what I have termed "the Caring Prison"; in other words, institutions in which prisoners and staff treat each other with respect and where suicide and self-harm become less likely. Although overcrowding and the consequent "churn" of prisoners through the system have undoubtedly exercised a malign effect throughout the prison system in recent years, I decry those who fail to acknowledge the significant changes for the better that have also occurred. I see this both in my direct work as Ombudsman and in the many and regular visits I make to prison establishments.

I hope these thoughts are helpful. Either I or colleagues would be delighted to present evidence in person should that be the wish of the Committee.

Stephen Shaw

Prisons and Probation Ombudsman for England and Wales

8 September 2003

8. Memorandum from Bail for Immigration Detainees

1. BID are a small charity that was established in 1998 to prepare and present bail applications on behalf of asylum seekers and migrants in immigration detention. In the past five years, BID have obtained release for over 500 detainees and have wide experience of the policies and procedures of immigration detention and mechanisms for accessing an independent review of detention. Through BID's three offices (London, Oxford and Portsmouth), we advise, represent and support people detained at any of the UK detention centres. The organisation has four paid staff and around 20 casework volunteers. Between August 2001 and July 2002, 790 detainees sought advice or assistance from BID. BID went on to prepare bail applications for 492 people. 246 bail applications or other applications for release were made, for people from countries including Zimbabwe, Uganda, India, China, Afghanistan, Cameroon, Colombia and Algeria. BID aim to increase the number of legal representatives who conduct bail applications for their clients, through training, information and raising awareness. In 2003, BID published a "Notebook on Bail" for detainees and were asked to write a *Best Practice Guide to Challenging Immigration Detention* for practitioners, which is to be published shortly by the Immigration Law Practitioners Association, the Legal Services Commission and the Law Society. Based on our casework experience, BID conduct campaigning, policy and research work targeting policy shapers and decision makers. BID aim to encourage the government to consider more proportionate, humane alternatives to detention and campaign for international and domestic human rights standards to apply to immigration detention in the UK.[64]

2. BID welcome the inclusion of immigration detention facilities in the remit of the JCHR's inquiry into deaths in custody. The information provided below focuses on the "preventing deaths in custody" part of the inquiry. We do not have the relevant expertise to make submissions regarding investigating deaths. Sections of this paper are based on information that has also been submitted to the Department for Constitutional Affairs in response to the consultation on proposed caps on legal aid for asylum seekers and migrants.[65]

[64] In particular, the UN Convention on the Rights of the Child, the UNHCR Guidelines on applicable Criteria and Standards relating to the Detention of Asylum Seekers (1999) and the European Convention on Human Rights.

[65] *See* "Bail for Immigration Detainees, response to legal aid consultation, August 2003".

3. BID have represented a significant number of detainees who have attempted suicide and self-harm. We are also aware that there have been several suicides in immigration detention in the past few years.[66] Significant numbers of those we represent have serious medical and psychological needs which, in our experience, are not adequately met in detention centres. Further, a significant number of detainees have reported to BID that they have suffered injuries in detention at the hands of escort companies and detaining officers.

4. BID is opposed to arbitrary and unnecessary use of immigration detention and believe that there are alternatives to detention, such as reporting requirements. It is BID's experience that immigration detention is used unnecessarily, arbitrarily, for unacceptable lengths of time and for vulnerable people. BID's concerns about detention policy are set out in detail in our 2002 *Submission to the UN Working Group on Arbitrary Detention* (not printed here). In summary, BID's key concerns about immigration detention are as follows:

— Primary legislation which is silent on the presumption in favour of liberty.

— No statutory time limit on the duration of detention.

— No automatic review of detention by an independent body capable of considering the lawfulness and appropriateness of the initial detention decision or the need to maintain detention.

— A failure to consider alternatives to detention, such as reporting restrictions.

— The requirement for sureties as a precondition of bail (and bail applications) for asylum seekers who frequently have no family or contacts in the UK who are able to stand surety for them.

— The application of a "merits test" for the use of public funds for legal representation in bail applications.

— A failure on the part of the UK Immigration Service (UKIS) to properly inform detainees of the detailed reasons for detention and to routinely disclose UKIS reviews of the detention decision.[67]

— A failure on the part of the UKIS is to abide by the principle of "equality of arms" by refusing to disclose documentation relating to the reasons for detention or the reasons for maintaining detention.

— The reluctance of Adjudicators of the Immigration Appellate Authority (IAA) to consider the European Convention of Human Rights in bail applications.

— The lack of any appeal right against a negative bail decision by an Adjudicator of the IAA.

— The paucity of research into detention and bail leading to decision-making by the Immigration Service and courts which is not evidence-based. This results in flawed initial decision-making by the UKIS and flawed bail decisions by the IAA.

— The use of immigration detention for children and children in families, pregnant women, those with serious mental and physical health problems and those who have experienced torture, including rape.

5. BID believe that the prevalence of suicide and self-harm attempts in detention is a direct and inevitable result of the current policy and practice of immigration detention. We are also concerned that the heavy handed approach of escort services and detaining authorities may result in deaths during the process of detention and of attempted removal.

6. Detention policy is mostly contained in the Operational Enforcement Manual (OEM), chapters 38 and 39. The OEM applies to enforcement departments of the Home Office[68]. The Operational Enforcement manual ("OEM") sets out, at paragraph 38.8, categories of people "normally considered suitable for detention in only very exceptional circumstances". These categories are:

— Those suffering from serious medical conditions or the mentally ill.

— Those where there is independent evidence that they have been tortured.

— Pregnant women, unless there is the clear prospect of early removal and medical advice suggests no question of confinement prior to this.

— Unaccompanied minors.

— The elderly, especially where supervision is required.

— Those with serious disabilities.

[66] For example, on 31 January 2003, Mikhail Bodnarchuk, a Ukrainian who had been detained at Haslar for four months, committed suicide. It is BID's understanding that Mr Bodnarchuk did not have a legal representative to submit an appeal on his behalf and that he was wrongly accused by the Immigration Service of claiming asylum in two identities. He was due to be returned to Ukraine on 31 January 2003. Early on the morning of January 31 he killed himself.

[67] The requirement to give reasons for continued detention is contained in the Detention Centre Rules which came into force in April 2001. In BID's experience, this Rule is often ignored by the Immigration Service.

[68] BID understand that similar policy is set out in Immigration Directorate Instructions ("IDIs") on ports. However the IDIs have never been disclosed.

It is BID's view that these guidelines fail to protect vulnerable groups most likely to be at risk of suicide and self-harm—vulnerable groups such as torture survivors, those with serious mental and physical health problems and disputed minors. In BID's experience[69], groups such as these are detained.

7. Once a person with a serious medical condition or particular health needs is detained, the detention centre has certain statutory obligations. These are set out in the Detention Centre Rules (DCR 2001). Rule 35 DCR 2001 contains the duties of medical staff at the detention centre[70]. However, it is BID's experience that this rule is not operating correctly. BID have been involved in cases in which medical reports, for example expressing serious concerns that continued detention would be detrimental to a detainee's well being or that there was a risk of suicide, have not been forwarded by the Medical Practitioner to the manager of the centre or to the Immigration Service. Indeed, information given by medical staff at Harmondsworth in a "Stakeholder meeting" on 9 April 2003 indicated that there was not a clear procedure for passing medical reports from the GP to the Centre Manager to Immigration, particularly if the report has not been commissioned by healthcare. It was indicated that a report stating that further detention was injurious to health, a statement to this effect would be passed to the centre manager who should then pass this on to the IS. The report itself would not be sent. This comment is consistent with our experience in a number of cases where vital medical information has not been passed to the manager of the centre and therefore it has not reached the Immigration Service file. In one case, a mother was detained with her young child for over five months, continuing even when the detention medical centre expressed concerns about the stress caused to the mother by caring for her child in detention and the effect of the stress on the child's well-being and safety.

8. In BID's experience, in some cases detention has lead to a deterioration of the detainee's mental health. Eventually, detainees are released for psychiatric treatment when the detention centre medical teams are unable or unwilling to care for them.

CASE STUDY[71]

A young woman, "I", overstayed her student visa and was detained. She then sought asylum as she had been severely traumatised by experiences in her country of origin. She remained detained awaiting an appeal during which time her mental health deteriorated. "I's" legal representatives took the view that two sureties would be required for a bail application and as she had only one, they felt unable to present a bail application. Her mental health deteriorated further and the medical team at the detention centre referred "I" to the local Area Health Authority psychiatric team where she was diagnosed as suffering from post traumatic stress disorder (PTSD). Despite this, the Immigration Service maintained detention in breach of their instructions regarding detention of the mentally ill. BID sought bail on several occasions but was forced to withdraw due to problems with sureties. Finally, a successful application was made with one surety who had met "I" briefly. Bail was granted with one surety offering £500. This was the first bail application that had been heard in four months of detention.

9. The detention of people at risk of suicide or self harm in immigration detention contrasts with the Home Office guidelines to Courts, the Police and the Probation Service on the detention of mentally disordered offenders which state:

> "Courts are asked to ensure that alternatives to custody are considered for all mentally disordered persons, including bail before sentence, and persons who are in need of medical treatment are not sent to prison."[72]

[69] *See "A Crying Shame: Pregnant asylum seekers and their babies in detention"*, McCleish, J, Cutler, S & Stancer, C, Maternity Alliance, Bail for Immigration Detainees & London Detainee Support Group, September 2002 and *"Protection Not Prison: Torture Survivors detained in the UK"*, Dell, S & Salinsky, M, Medical Foundation for the Care of Victims of Torture, 1999.

[70] Rule 35 Detention Centre Rules 2001
"(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
(2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions . . .
(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.
(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.
(5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care."
These statutory obligations are relevant where a detainee's
— mental or physical health is being harmed by detention
— needs treatment for mental health problems
— is considering or attempting self harm or suicide
— is a victim of torture or rape
— And has requested assistance from the medical centre.

[71] This case study was referred to in BID's submission to the UN Working Group on Arbitrary Detention, September 2002.

[72] MNP/90 1/55/8.

10. In detention there may be some access to mental health services but this varies between centres. In *A Second Exile: the Mental Health Implications of Detention of Asylum seekers*, the author, a psychiatrist, considers both the effect of detention on mental health and the care available for those who have mental health needs. The report, based on in-depth interviews, concluded that:

> "Detention creates trauma regardless of previous traumatic experiences producing anxiety, depression, isolation and so on, all components of traumatic experience. It was felt that such trauma may be worse than what may have been previously endured."[73]

The report also identified that the indefinite nature of detention was a particular cause of mental stress.

11. In addition to the above points, we wish to draw the attention of the committee to the following policy aspects of detention, which we believe illustrate the absence of meaningful human rights for immigration detainees.

(a) *Use of detention for people who have just arrived and for those who have rights of appeal outstanding*: The power to detain applies to all asylum seekers and migrants, is without time limit and is not automatically subject to independent review.[74] The government does not make available statistics as to the status of detainees' cases, however it is BID's experience that significant numbers are detained on arrival, with appeals outstanding and for lengthy periods (many months) awaiting travel documents. The use of detention under these circumstances prolongs detention and therefore gives rise to mental health concerns.

(b) *Absence of automatic, independent review of detention and maintaining detention*: There are serious inadequacies in the process for applying for bail under existing legislation, which result in significant numbers of detainees being unable to access judicial oversight of detention. A brief survey of BID cases between February and July 2002 showed that in 79% of bail applications, the application by BID was the first time that an independent review of detention had taken place. The average length of time without review by a court, before the first bail application by either BID or a solicitor was approximately 16 weeks, or four months. The average total duration of detention was 20 weeks, or five months. Previous legislation that made automatic provision for bail applications was never implemented and was repealed by the 2002 Nationality, Immigration and Asylum Act. Considering the repeal of automatic bail hearings, the report of the Joint Committee on Human Rights into the NIA Bill accepted that "safeguards are meaningful and effective only if appropriate legal advice and information are available to detainees"[75] and concluded that "these matters should be carefully monitored . . . [as to the] effectiveness of safeguards for the human rights of detainees." The Minister, Beverley Hughes MP, has stated that an automatic mechanism for bail was unnecessary ". . . in the light of the fact that people can through their representatives apply for bail at any time at all seemed an unnecessary bureaucracy"[76]. The comment by the Minister that independent review by a court is "an unnecessarily stringent safeguard and one that is actually unnecessary" demonstrates an alarming complacency on behalf of the government whose current policy and practice in relation to detention disregards protection of the fundamental principle of liberty and fails to acknowledge that large numbers of detainees are not represented.

(c) *Inadequate access to legal representation and a sense of isolation, disempowerment and hopelessness*: It is BID's experience that significant numbers of detainees do not have access to good representation or may have no representation at all. This issue was raised as a matter of concern by HM Inspectorate of Prisons in April 2003, particularly in relation to Lindholme[77] and Haslar. The report about Dungavel states "Access to quality legal representation and information about the progress of their cases was poor and these factors afforded little protection against the damaging effect of unanticipated and indeterminate detention." BID's existence is evidence that effective, good-quality immigration representation is not adequately accessible from detention centres. Where an individual is unable to access representation and has lost hope in the justice of the determination system, suicide and self-harm issues are more likely.

BID are particularly worried about the potential impact of the proposed cuts to legal aid for asylum seekers and migrants, announced by the Government in June 2003. If these proposals are implemented, there will be an even greater number of detainees who are not represented.

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[73] A Second Exile: The Mental Health Implications of Detention of Asylum-seekers in the United Kingdom, Pourgourides, C K, Sashidharan, S P, Bracken, P J, Northern Birmingham Mental Health Trust, 1996, p 66.

[74] The provision for automatic bail hearings contained in the 1999 Immigration and Asylum Act was repealed in 2002.

[75] Nationality, Immigration and Asylum Bill, Seventeenth Report of Session 2001–02, *House of Lords, House of Commons, Joint Committee on Human Rights HL Paper No 132, HC 961*, p 32.

[76] Oral submissions to the Home Affairs Committee on 4 March 2003 Ev. 682.

[77] "The questionnaire revealed that after a few days at Lindholme the vast majority of detainees (75%) did not know how to obtain legal advice or get a solicitor. Over a quarter (27%) were without representation, and only a third (37%) of these knew how to obtain legal advice . . . A significant proportion of detainees had no legal representation and the majority of the unrepresented did not know how to obtain legal advice. Of those who were represented, a number appeared to be receiving an inadequate service, and access time for legal representatives was restrictive. There was evidence of detainees being exploited by unscrupulous representatives." HM Inspectorate of Prisons, *Inspection of Lindholme Removal Centre, March 2002*, published April 2003.

(d) *Continued use of prisons*: The UK detains between 1,300 and 2,000 people under immigration act powers at any one time. Home Office statistics show that at 29 March 2003, 19% (255 people) of the 1,355 people detained solely under immigration act powers were held in criminal prisons. This is despite a government commitment in October 2001, that the use of criminal prisons would cease.[78] BID is concerned that the use of criminal prisons for asylum seekers and migrants leads to an increased risk of suicide and self-harm.

(e) *An aggressive, target-let removals policy*: In BID's experience, removal is being attempted of people who have a valid claim, or whose claim has not yet been heard. Wrongful attempts at removal increase the risk of violent treatment and inappropriate restraint methods being employed. The HM CIP report on Dungavel notes that detainees may have ". . . difficulty accessing competent legal advice which may prevent their removal to an unsafe country or situation". Our concern is that the use of immigration detention in its current form obscures the reality of the process of removal, making it extremely difficult to assess whether removals are being conducted as humanely as possible and with due, independent regard to any compassionate factors in the particular case. The pursuance of a removal "target", whether explicitly stated as a figure per month, or implicit in the whole emphasis of the asylum process, is impacting upon the way in which removals are attempted and indeed upon who is detained in the first place. This is resulting in the removal of individuals and families without proper legal advice or adequate representation, without consideration of compassionate factors; in short without due process. If removal becomes the overriding goal in immigration control, rather than a fair consideration of the case, there is a risk that detention will be employed for vulnerable people ie detention criteria which state that vulnerable people are normally unsuitable for detention other than in exceptional circumstances are being overridden. This is illustrated by the frequent use of detention for those acknowledged to be suffering mental illness and survivors of rape and torture. Detention in these cases is not being employed as a "last resort" immediately prior to removal, but often from arrival. BID is concerned that a significant number of detainees report violent and abusive treatment at the hands of security guards and escorts, including racist abuse.

12. BID believe that urgent action is required to implement a human rights approach to the use and management of immigration detention. Significant changes in policy and practice must be introduced in order to reduce the incidence of self-harm and suicide and deaths in immigration detention. The use of immigration detention is now widespread and the Government have indicated that they wish to expand the detention estate to comprise 4,000 places, an increase from around 250 spaces a decade ago.[79] However, BID wishes to emphasise that immigration detainees are not charged with a criminal offence. They are detained for the administrative convenience of the state. Whilst BID urge the Government to fully uphold its duty of care towards those whose liberty it denies, we also wish to record our concern that there is an over use of detention. There must not be a "sticking plaster" approach to dealing with the inevitable consequences of detention policy, which include self-harm and suicide. A focus on procedures and safeguards that reduce incidence of harm should of course be in place, but should not obscure the need to review whether detention practice itself is proportionate, necessary and acceptable in a human rights framework. In particular, we wish to draw the attention of the committee to the following actions that BID believe the Government should take.

(a) Implement and resource the recommendations of the recent reports of HM Inspectorate of Prisons.

(b) Use detention in line with international, European and domestic human rights standards, in particular with a maximum duration specified by law and automatic provision of independent review.

(c) Improve access to legal advice and representation.

(d) Protect vulnerable people from detention by introducing statutory criteria for detention and statutory instructions about who may not be detained.

13. Evidence given to the Home Affairs Committee investigation into asylum removals by the private contractors operating detention facilities claimed that suicides were not taking place.[80] However, in order for parliament and the public to be able to effectively scrutinise the incidence of harm, BID consider that it would be an important development for regular statistics to be published as to the incidence of self-harm and suicide.

[78] In October 2001 the Government gave an undertaking that the detention of asylum seekers in prisons would cease as from 25 December 2001. However, the use of prisons was re-introduced after the fire at Yarl's Wood Detention Centre on 14 February 2002. The Secretary of State, David Blunkett, on 24 February, stated that:
". . . detainees with a history of violent or criminal behaviour and those considered a danger to safety have been transferred to prison."
BID is concerned that detainees are being transferred to prisons as a punitive measure. There is a lack of transparency and accountability surrounding the process of movement of detainees to prisons. Neither detainees nor their legal representatives are provided with the reasons for deciding that they represent a security risk. In several cases, detainees have been moved to a prison for a number of weeks, then returned to a detention facility without explanation as to why they are no longer deemed a risk.

[79] *See* February 2002 White Paper, *Secure Borders, Safe Haven*.

[80] Para 357, Tuesday 28 January 2003, Evidence to the Home Affairs Committee.

14. Finally, BID would like to draw attention to the recent report on immigration detention by the United Nations Special Rapporteur on the human rights of migrants, published in December 2002.

> The Special Rapporteur is concerned that in a considerable number of countries, measures aimed at stopping irregular migration undermine migrants' basic rights, including the right to seek asylum and minimum guarantees against arbitrary deprivation of liberty.
>
> In particular, there is a tendency to provide immigration officials with broad powers to detain groups of migrants in conditions and facilities that seriously curtail their right to judicial or administrative review of the lawfulness of detention and to have their asylum claims reviewed.
>
> . . . the Special Rapporteur would recommend that . . . Governments should consider the possibility of progressively abolishing all forms of administrative detention and, when this is not possible, take measures to ensure respect for the human rights of migrants deprived of liberty[81].

15 September 2003

9. Memorandum from the Committee on the Administration of Justice (CAJ)

Introduction

CAJ have been active on the issue of inquests for many years. Our focus has predominantly related to deaths caused by the security forces or where there have been allegations of collusion but we have also provided advice and assistance to others.

The starting point for our critique of the system has been the extent to which it does not conform to international human rights standards, both the European Convention on Human Rights, the International Covenant on Civil and Political Rights and other "soft law" international standards. In the mid and late 1990s we were approached by a number of families who had just completed their inquests and were at a loss as to how to proceed. We advised them to take their cases to the European Court of Human Rights arguing that the UK had violated the procedural aspect of Article 2 of the Convention guaranteeing an adequate *ex post facto* investigation of a killing involving the state. We lodged the cases in Strasbourg and acted as lawyers for the families before the Court, culminating in the successful judgments of Kelly *et al* v UK, Shanaghan v UK and more latterly McShane v UK.

The cumulative effect of these judgments in our view obliges the UK government to completely overhaul the way in which these cases are investigated should they occur in the future. The judgments are of course not restricted to the issue of inquests. They involve the police, the DPP, and the police complaints system. However, it is equally clear that major change must occur within the coronial system in Northern Ireland in order to ensure that it complies with Article 2, which of course is now domestic legislation by way of the Human Rights Act.

In this context we were disappointed to see no mention of Northern Ireland in the Call for Evidence from the Joint Committee. While the Inquiry relates to deaths in custody we believe that any such inquiry should also look to deaths caused by the state, particularly in the context of the adequacy of investigations. Our comments relate primarily to the procedural aspect of Article 2 and while they are grounded in the experience of Northern Ireland, we believe they have relevance for England and Wales.

It is also of course the case that there have been and continue to be prison deaths in Northern Ireland. Inquests, which we have observed into a number of these deaths, suggest that prison authorities in Northern Ireland are no better equipped at dealing with vulnerable prisoners than their counterparts in Britain.

[81] "Specific Groups and Individuals: Migrant Workers—Report of the Special Rapporteur", Ms Gabriela Rodriguez Pizarro, submitted pursuant to Commission on Human Rights resolution 2002/62 E/CN.4/2003/85, 30 December 2002.

Interpretation Of The Right To Life Provisions

In the cases of Kelly v United Kingdom[82], Shanaghan v United Kingdom[83], Jordan v United Kingdom[84] and McKerr v United Kingdom,[85] the European Court of Human Rights took the opportunity to clarify the exact parameters and criterion required for an investigation to comply with Article 2 of the Convention.

In the "landmark judgment(s)"[86] the Court made specific reference to various provisions of UN "soft law"[87] and in summary concluded that the UK had breached Article 2 on the procedural ground on the basis of the:

- Lack of independence of the police investigation, which applies to police killings (Jordan, McKerr), army killings (Kelly), and cases of alleged collusion (Shanaghan).
- The refusal of the DPP to give reasons for failing to prosecute.
- Lack of compellability of witnesses suspected of causing death.
- Lack of verdicts at the inquest.
- Absence of legal aid and non-disclosure of witness statements at the inquest.
- Lack of promptness in the inquest proceedings.
- The limited scope of the inquest.
- Lack of prompt or effective investigation of the allegations of collusion.

In addition to this:

What form of investigation will achieve those purposes may vary in different circumstances. However, whatever mode is employed, the authorities must act of their own motion, once the matter has come to their attention. They cannot leave it to the initiative of the next of kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures[88].

The next-of-kin must be adequately involved in the investigative proceedings also to the extent that it safeguards his or her legitimate interests[89]. Ineffective securing of evidence will hamper the establishment of the cause of death or the person responsible and, thus, would constitute a breach of article 2[90].

Scope of the Inquest

The purpose of an Inquest is to inquire into unexpected, unexplained or suspicious death so that the facts may be ascertained and the public assured that any necessary action by the authorities is promptly taken to ensure that similar avoidable deaths do not occur in the future.[91]

Rule 15 of the 1963 Rules sets out the precise ambit of the Inquest[92]:

The proceedings and evidence at the inquest shall be directed solely to ascertaining the following matters, namely:

(a) who the deceased was;

(b) how, when and where the deceased came by his death;

(c) the particulars for the time being required by the Births and Deaths Registration (Northern Ireland) Order 1976 to be registered concerning the death.

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[82] Kelly v UK, Application No 30054/96, Judgment of 4 May 2001.

[83] Shanaghan v UK, Application No 37715/97, Judgment of 4 May 2001.

[84] Jordan v UK, Paragraph 95, Application No 24746/94, Judgment of 4 May 2001.

[85] McKerr v UK, Application No 28883/95, Judgment of 4 May 2001.

[86] Amnesty International News Report, AI Index EUR 45/010/2001. *See* also comments of Nuala O'Loan (*Irish Times* October 11 2001 page 8) this judgment "will be the greatest challenge to most existing police complaints system(s) in Europe". "Recent events in London, with the Lawrence case, and in Ireland, with the Abbeylara case, have shown that there is a demand for openness, transparency and independence in the investigation of allegations of misconduct by the police. I believe this can lead to an enhanced police service."

[87] *See* Kelly v UK, Application No 30054/96, Judgment of 4 May 2001. Reference was made to The United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials (UN Force and Firearms Principles) (adopted on 7 September 1990 by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders) Paragraph 21, 22. United Nations Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions (adopted on 24 May 1989 by the Economic and Social Council Resolution 1989/65), Paragraph 9, 10-17. The "Minnesota Protocol" (Model Protocol for a legal investigation of extra-legal, arbitrary and summary executions, contained in the UN Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions), Section B "Purposes of an inquiry".

[88] Kelly v UK, Paragraph 94, Application No 30054/96, Judgment of 4 May 2001. *See* also Ilhan v Turkey, Paragraph 63, ECHR 2000-VII, Judgment of 27 June 2000.

[89] Güleç v Turkey, Paragraphs 82, Reports 1998-IV, Judgment of 27 July 1998 (where the father of the victim was not informed of the decisions not to prosecute); Ogur v Turkey, Paragraphs 92, Application No. 21954/93, ECHR 1999-III.

[90] Salman v Turkey, Paragraph 106, ECHR 2000-VII, Judgment of 27 June 2000, Tanrikulu v Turkey, Paragraph 109, ECHR 199-I, Judgment of 8 July 1999.

[91] *See* British Irish Rights Watch, *Current Developments in Inquests in Britain and Ireland: Record of Proceedings,* (June 1992).

[92] The equivalent English provisions are S.11(5) of the *Coroners Act 1988* and Rule 84, *Coroners (Practice and Procedure) Rules 1988.*

It would appear on a cursory reading of the foregoing, that the scope for determination of the circumstances surrounding a death is quite broad. However, Rule 15 has been greatly constrained by two factors.

Firstly, Rule 15 is subject to the provisions of Rule 16 which provides that:

> Neither the coroner nor the jury shall express any opinion on questions of criminal or civil liability or on any matters other than those referred to in the last foregoing rule.

Secondly, the construction of the word "how" has been construed in a very narrow form by the judiciary, to exclude the possibility of a true appraisal of the question.

In the Northern Ireland Courts in *In Re: Bradley and Larkens Application*[93] Justice Carswell stated:

> The word "how" means "by what means" rather than "in what broad circumstances". The enquiry must focus on matters directly causative of death. . .It should not embark on a wider inquiry relating to the background circumstances of the death; it is not its function to provide the answers to all the questions, which the next of kin may wish to raise.

Thus, it is apparent from the foregoing cases that a full consideration of the broad circumstances in which the deceased came by his/her death is firmly held to be not within the competence of the Coroners Court[94].

In the decision of Shanaghan v United Kingdom[95], the Court specifically criticised the fact that the scope of the examination of the Inquest excluded the family's concern of alleged collusion by security force personnel in the targeting and killing of Patrick Shanaghan:

> The domestic courts appeared to take the view that the only matter of concern to the inquest was the question of who pulled the trigger, and that, as it was not disputed that Patrick Shanaghan was the target of loyalist gunmen, there was no basis for extending the enquiry any further into issues of collusion. Serious and legitimate concerns of the family and the public were therefore not addressed by the inquest proceedings.

In case of McKerr v United Kingdom[96]:

> Serious concerns arose from these three incidents as to whether police counter-terrorism procedures involved an excessive use of force, whether deliberately or as an inevitable by-product of the tactics that were used. The deliberate concealment of evidence also cast doubts on the effectiveness of investigations in uncovering what had occurred.

Therefore, the Court concluded that, notwithstanding the existence of a criminal trial running parallel with the Inquest, Article 2 may require a wider consideration of the possibility of excessive use of force by the security forces. The Court went beyond the dicta of the domestic Courts by looking to the underlying objective of the inquest, that of re-assuring the public and the members of the family as to the lawfulness of the killings. It concluded that due to the fact such a purpose had not been accomplished by the criminal trial, the positive obligations inherent in Article 2 required an adequate procedure whereby such doubts could be addressed[97].

In cases like that of McCann v United Kingdom[98] it is clear that issues relating to the planning and control of the operation which leads to the death must be included within the scope of the inquest. Indeed, the Coroner for Belfast in the Jordan case has now accepted, as a matter of principle that such matters lie within the proper scope of the inquest[99].

The investigation must focus upon (a) not only those who were allegedly directly responsible for the death, but (b) the planning and organisation of the state agency or operation that provided the context in which the deaths took place and any systemic deficiencies therein[100] Where appropriate it must also indicate those who were responsible[101].

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[93] [1994] NI 279. See also Hutton LCJ in *Re Ministry of Defence's Application,* [1994] NI 279, 307, Simon Brown LJ in *R v HM Coroner for Western District of East Sussex, ex p Homber* (1994) 158 JP 357,369.

[94] Thus in the *McKerr* case the judge held that the Coroner was not entitled to attempt to ally allegations of a "shoot to kill" policy by examining the "broad circumstances" in which the deceased had met their deaths (unreported QBD (Crown Side), 11 July 1994).

[95] Paragraph 111, Application No 37715/97, Judgment of 4 May 2001.

[96] Paragraph 137, Application No 28883/95, Judgment of 4 May 2001.

[97] Id.

[98] Series A No 324, Judgment of 27 September 1995.

[99] See Treacy, Seamus, *Article 2 and the Future of Inquests in Northern Ireland: A Practitioner's Perspective,* (Transcript from CAJ and British Irish Rights Watch, Inquest Seminar dated 23 February 2002).

[100] *Andronicou and Constantinou v Cyprus,* Reports 1997–VI, *McCann and Others v the United Kingdom, Series A No 324,* Judgment of 27 September 1995.

[101] *Jordan v United Kingdom,* Application No 24746/94, Judgement of 4 May 2001, *Ögur v Turkey,* Paragraph 88, Judgment of 20 May 1999, Application No 21594/93.

ADJOURNMENT/DELAY

Great concern has been expressed over the inordinate delays in the commencement of Inquest proceedings in Northern Ireland[102]. This is particularly disturbing in cases involving allegations of systemic deficiencies which remain unaddressed for such a long period of time.

The Coroner must decide whether or not to hold an inquiry without delay and the inquiry must be held "as soon as practicable" after the coroner has been notified of the death[103].

As a matter of practice, inquests in Northern Ireland do not commence, until the Coroner is informed by the police or the DPP, that they may open proceedings. This practice effectively nullifies the applicability of the provisions of the Coroners Rule in that the Coroner is powerless to control the timing of the Inquest. This has a significant effect on the efficiency and promptness of the process.

By way of contrast, in England the inquest is opened and then readjourned[104] where criminal prosecution is imminent. In this way, the Inquest will be in advance of ultimate decision on prosecution. The British practice reflects the underlying purpose of the rules by making it clear that the Coroner is in control and the police can be summonsed to give account for themselves if there is an unreasonable delay.

Whereupon a criminal charge is brought on account of the death, the Inquest in Northern Ireland is postponed until the conclusion of all criminal proceedings, including appeal[105]. In contrast, In England and Wales, adjournment is only until the conclusion of the trial.

In the decision of *Jordan v United Kingdom*[106], the Court stated at Paragraph 108 that:

> A requirement of promptness and reasonable expedition is implicit in this context (see the Yasa v Turkey judgment of 2 September 1998, Reports 1998-IV, pp 2439–2240, §§ 102–104; *Cakici v Turkey* cited above, § 80, 87 and 106; Tanrikulu v Turkey, cited above, § 109; *Mahmut Kaya v Turkey*, no. 22535/93, [Section I] ECHR 2000-III, §§ 106–107). It must be accepted that there may be obstacles or difficulties which prevent progress in an investigation in a particular situation. However, a prompt response by the authorities in investigating a use of lethal force may generally be regarded as essential in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts.

In this decision the Court also refer to Paragraph 9 of the *United Nations Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions*[107] which states *inter alia* that:

> There shall be a thorough, prompt and impartial investigation of all suspected cases of extra legal, arbitrary and summary executions, including cases where complaints by relatives or other reliable reports suggest unnatural death in the above circumstances . . . (emphasis added)

In *Shanaghan v United Kingdom*[108] the Court were highly critical of the delay in the proceedings:

> The inquest opened on 26 March 1996, more than four and a half years after Patrick Shanaghan's death. The Government explained that the delay in the RUC sending the file to the Coroner on 14 January 1994 resulted from their heavy criminal workload. The Court does not find this a satisfactory explanation for failure to carry out a transfer of documents for an important judicial procedure. No explanation, beyond unspecified further enquiries, has been forthcoming for the delay after the transfer of the file. Once the inquest opened, it proceeded without delay, concluding within a month. In the circumstances, the delay in commencing the inquest cannot be regarded as compatible with the State's obligation under Article 2 of the Convention to ensure that investigations into suspicious deaths are carried out promptly.

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[102] For example, The *McKerr* Inquest was not opened for six years and was adjourned in 1988 pending appeal. English practice has also been subject to such criticism. See also British Irish Rights Watch, *Current Developments in Inquests in Britain and Ireland: Record of Proceedings,* (June 1992) which alleges that the average delay in Inquest proceedings is 10 years.

[103] *Coroners (Practice and Procedure) (Northern Ireland)* Rules 1963, Rule 3. In England and Wales this requirement is under Coroners Act 1988, s. 8(1).

[104] *Coroners (Practice and Procedure) Rules 1988.*

[105] *Coroners (Northern Ireland) Act 1959,* Section 13(1) and (6).

[106] Application No 24746/94, Judgment of 4 May 2001. *See* also *Kelly v United Kingdom,* Application No 30054/96, Judgment of 4 May 2001, Paragraph 97, *McKerr v United Kingdom,* Paragraph 114 Application No 28883/95, Judgment of 4 May 2001 *Yasa v Turkey,* Paragraphs 102–104, Reports 1998-IV, Judgment of 2 September 1998, *Çakici v Turkey,* Paragraphs 80, 87, ECHR 1999—IV, *Tanrikulu v Turkey,* Paragraph 109, ECHR 1999—I, Judgment of 8 July 1999, *Kaya v Turkey,* Paragraph 106–107, ECHR 2000—III.

[107] Adopted on 24 May 1989 by the Economic and Social Council Resolution 1989/65.

[108] Paragraph 119–120, Application No 37715/97, Judgment of 4 May 2001.

COMPELLABILITY

Rule 9(2) of the *Coroners (Practice and Procedure) Rules 1963*[109] is an exception to the general rule that all persons who are competent to give evidence at an inquest are compellable to do so. Under this rule a person "suspected of causing the death or has been charged or is likely to be charged with an offence related to the does not have to appear."[110]

The position in Northern Ireland with regard to the non-compellability of key witnesses was specifically criticised in the decision of *Jordan v United Kingdom*[111] at Paragraph 127:

> In inquests in Northern Ireland, any person suspected of causing the death may not be compelled to give evidence (Rule 9(2) of the 1963 Coroners Rules, see paragraph 68 above). In practice, in inquests involving the use of lethal force by members of the security forces in Northern Ireland, the police officers or soldiers concerned do not attend. Instead, written statements or transcripts of interviews are admitted in evidence. At the inquest in this case, Sergeant A informed the Coroner that he would not appear. He has therefore not been subject to examination concerning his account of events. The records of his two interviews with investigating police officers were made available to the Coroner instead (see paragraphs 19 and 20 above). This does not enable any satisfactory assessment to be made of either his reliability or credibility on crucial factual issues. *It detracts from the inquest's capacity to establish the facts immediately relevant to the death, in particular the lawfulness of the use of force and thereby to achieve one of the purposes required by Article 2 of the Convention* (see also paragraph 10 of the United Nations Principles on Extra-Legal Executions cited at paragraph 90 above).

The Court also makes reference to the "soft law" UN United Nations Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions[112], Principle 10 of which states that:

> The investigative authority shall have the power to obtain all the information necessary to the inquiry. Those persons conducting the inquiry . . . shall also have the authority to oblige officials allegedly involved in any such executions to appear and testify.

Rule 9(2) was subjected to similar criticism in the case of *McKerr v United Kingdom*[113] and *Kelly v United Kingdom*[114]. In the domestic case of *In Re: Jordans Application*[115], McKerr J. at Page 6, stated that "the decision clearly called for the removal of the exemption in Rule 9(2), therefore".

In light of the European Court of Human Rights, the Lord Chancellor has since amended Rule 9. The amended Rule 9 reads as follows:

> 9(1) No witness at an inquest shall be obliged to answer any question tending to incriminate himself or his spouse
>
> 9(2) Where it appears to the coroner that a witness has been asked such a question, the Coroner shall inform the witness that he may refuse to answer the question

As is apparent from above, the old rule pertaining to the privilege against self-incrimination, which had always functioned adequately in England and Wales to protect the rights of the potential accused, have been retained. While we welcome the changes in relation to non-compellability, we are concerned that the continued existence of the right against self-incrimination will undermine the changes in that police officers and soldiers will refuse to answer any questions relating to the actual killings or indeed the planning of the security operation which led to the deaths.

We believe there are alternative ways in which the rights of soldiers and police officers can be protected while still ensuring the integrity of the fact finding nature of the inquest. For instance, soldiers giving evidence to the Saville inquiry have been guaranteed that their evidence will not be used against them in any subsequent trials. We believe that this approach could be adopted in relation to article 2 inquests.

[109] Rule 9(2) has since been repealed by the Lord Chancellor.

[110] The formulation of this Rule is in line with the recommendations of the Brodrick Committee which recommended that "where a person is suspected of causing the death he should not be called and put on oath unless he so desires and should not be cross examined". It is noteworthy that this recommendation was not followed with regard to the Coroner's practice in England and Wales.

[111] Application No 24746/94, Judgment of 4 May 2001.

[112] Adopted on 24 May 1989 by the Economic and Social Council Resolution 1989–65.

[113] Paragraph 144. Application No 28883/95, Judgment of 4 May 2001. Sergeant M and officers B and R were therefore not subject to examination concerning their account of events. Their statements were made available to the Coroner instead. This did not enable any satisfactory assessment to be made of either their reliability or credibility on crucial factual issues.

[114] Paragraph 121, Application No 30054/96, Judgment of 4 May 2001. "At the inquest in this case, none of the soldiers A to X appeared. They have therefore not been subject to examination concerning their account of events. The records of their statements taken in interviews with investigating police officers were made available to the Coroner instead (see paragraphs 16 to 23 above). This does not enable any satisfactory assessment to be made of either their reliability or credibility on crucial factual issues".

[115] As yet unreported. See Justice Kerr, *Article 2 and the Future of Inquests in Northern Ireland,* (Transcript from CAJ and British Irish Rights Watch, Inquest Seminar dated 23 February 2002).

INDEPENDENCE OF THE INVESTIGATION

In both a domestic and European context the need for independence of investigation has been addressed and the need highlighted[116]. In the cases of and Guluc v Turkey[117] and Ögur v Turkey[118], it was stated that:

> For an investigation into alleged unlawful killing by State agents to be effective, it may generally be regarded as necessary for the persons responsible for and carrying out the investigation to be independent from those implicated in the events.

This means not only a lack of hierarchical or institutional connection but also a practical independence.[119]

This creates two problems in terms of Article 2 compliance in Northern Ireland. First, it is clear that the police cannot carry out investigations into killings for which police officers were, or were suspected of being responsible. The creation of the Police Ombudsman goes some way to solving this problem. However in light of the Kelly judgment, it is also clear that the police cannot investigate army killings. The Police Ombudsman does not resolve this problem because her powers are limited to the police. She has no power to investigate the army. This applies equally to the situation regarding deaths in prison. In our view it is clear that investigations by the prison service will in no way satisfy the independence requirement of Article 2. It is also our view that a police investigation will similarly fall foul of Article 2 requirements.

Second, Coroners have in the past and continue to rely on the police investigation to obtain relevant evidence. Under Section 11(1) of the Coroners (Northern Ireland) Act 1959 the Coroner is charged with making "such investigations as may be required to enable him to determine whether or not an inquest is necessary". The police act on behalf of the Coroner to obtain relevant evidence. In theory, the coroner may instruct the police, however,

> It may not be appropriate for the Coroner to give such instructions where, for example, the death is the subject of a murder inquiry. Coroners are usually content not to interfere in any criminal investigation of that type, and to rely instead on the senior investigating officer advising on the progress being made by the police.[120]

In the case of Ergi v Turkey[121] a violation of Article 2 was found where the public prosecutor investigating the death of a girl during an alleged clash showed a lack of independence through his heavy reliance on the information provided by the gendarmes implicated in the incident. Thus, excessive reliance on the police or other government bodies during an investigation may result in a finding of a breach of the State's Article 2 obligations.

It is therefore clear that the Coroner can no longer rely on the police to conduct investigations in these cases.

VERDICTS

In England and Wales verdicts are available to Coroners and inquest juries. These include the possibility of an unlawful killing verdict and a range of other possible verdicts.

Northern Ireland was curtailed in this regard in 1981 when the verdict was abolished and replaced with "findings". Therefore it is not open to a jury in Northern Ireland to bring a verdict of "unlawful killing" in the case of a death by a member of the security forces[122].

Rule 15 of the 1963 Rules pertaining to Northern Ireland sets out the precise ambit of the Inquest:

The proceedings and evidence at the inquest shall be directed solely to ascertaining the following matters, namely:

(d) who the deceased was;

(e) how, when and where the deceased came by his death;

(f) the particulars for the time being required by the Births and Deaths Registration (Northern Ireland) Order 1976 to be registered concerning the death.

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[116] *See* also *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials*, Principle 23 "persons affected by the use of force or firearms or their legal representatives shall have access to an independent process, including a judicial process" and *Principles on Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Execution*. Principle 11 "an investigation must be independent and not governed by interests of any agency whose actions are the subject of the scrutiny".

[117] Judgment of 27 July 1998, Reports 1998-IV, Paragraph 81–82.

[118] Application No 21954/93, ECHR 1999-III, Paragraph 91–92.

[119] *See* for example the case of *Ergi v Turkey*, Judgment of 28 July 1998, Reports 1998-IV, Paragraph 83–84 where the public prosecutor investigating the death of a girl during an alleged clash showed a lack of independence through his heavy reliance on the information provided by the gendarmes implicated in the incident.

[120] Leckie & Greer in Coroner's Law and Practice in Northern Ireland 90 (Northern Ireland: SLS Legal Publications) (1998).

[121] Paragraph 83–84, Judgment of 28 July 1998, *Reports* 1998-IV.

[122] The Gibraltar Inquest into the deaths of Mairead Farell, Daniel McCann and Sean Savage was at liberty to return such a verdict in light of the fact that the Inquest was conducted in Gibraltar under Gibraltar Law.

In the Northern Ireland Courts in *In Re: Bradley and Larkens Application*[123] Justice Carswell stated:

> The word "how" means "by what means" rather than "in what broad circumstances". The enquiry must focus on matters directly causative of death . . . It should not embark on a wider inquiry relating to the background circumstances of the death; it is not its function to provide the answers to all the questions which the next of kin may wish to raise . . . I am of the opinion that what was contemplated by the word "findings" in the 1980 Rules was just such a brief encapsulation of the essential facts, and that juries should be encouraged to confine their findings to statements of that nature.

European Jurisprudence

The European Court of Human Rights has specifically indicated that an investigation of the violation of the right to life must have the capacity to make findings indicating those responsible. In Kelly v United Kingdom[124], the Court stated at Paragraph 96 that:

> The investigation must also be effective in the sense that it is capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances (eg Kaya v. Turkey judgment, cited above, p. 324, § 87) and to the identification and punishment of those responsible

Notwithstanding that the European Court specifically condemned the inquest procedure for not permitting any verdict or findings the government and the Lord Chancellor have failed to amend the Rules to enable a Coroner or his jury to bring a verdict.

Public Interest Immunity Certificates

Public Interest Immunity Certificates were specifically criticised in the case of McKerr v United Kingdom[125] in which the Court stated that:

> [t]he Reports in any event dealt with the evidence of obstruction of justice, which was relevant to the wider issues thrown up by the case. The Court finds that the inquest was prevented thereby from reviewing potentially relevant material and was therefore unable to fulfil any useful function in carrying out an effective investigation of matters arising since the criminal trial.

The fundamental issue at hand here is, essentially, the balancing of a set of competing interests both in the name of the public good; on one hand that of national security and on the other hand, the need for full disclosure of evidence to support the proper administration of justice. It would appear, all too often, that the scales have tipped too far the one way, ie national security. It does not serve the public interest when documents, which may be relevant to revealing some systemic deficiencies within the police force, are purposively withheld from determination at Inquest.

In its "package of measures" which it submitted to the Committee of Ministers in Strasbourg in response to the judgments the UK government argued the judge in relevant cases (and presumably the Coroner in inquests) should decide on what should be subject to the PII where the Minister was unsure. In recent hearings in Northern Ireland however lawyers for the police and army have refused to disclose unredacted documents to the Coroner. This in our view is simply unacceptable.

The balance should be in favour of disclosure. In the event that a PII is issued or being considered the situation in relation to Coroners should be the same as obtains in criminal cases under the judgment of *ex parte Wiley*.

International Soft Law Standards

The relevant "soft law" standards applicable to the area of Inquest systems, particularly with regard to controversial deaths at the hands of security forces, are contained in the Basic Principles on the Use of Force and Firearms by Law Enforcement Officials[126] and the United Principles on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions[127] and the UN Manual on the Effective

[123] [1994] NI 279. See also Hutton LCJ in *Re Ministry of Defence's Application*, [1994] NI 279, 307, Simon Brown LJ in *R v HM Coroner for Western District of East Sussex, ex p Homber* (1994) 158 JP 357, 369.

[124] Application No 30054/96, Judgment of 4 May 2001. See also *Jordan v UK*, Paragraph 107, Application No 24746/94, Judgment of 4 May 2001, *McKerr v United Kingdom*, Paragraph 113, Application No 28883/95, Judgment of 4 May 2001, *Ögur v. Turkey*, Paragraph 88, Judgment of 20 May 1999, Application No 21594/93.

[125] Paragraph 151, Application No 28883/95, Judgment of 4 May 2001. Public Interest Immunity Certificates were also referred to in the case of *Shanaghan v United Kingdom*, Application No 37715/97, Judgment of 4 May 2001 at Paragraph 118. However, because no certificate was issued in this case, the Court concluded that "(t)here is therefore no basis for finding that the use of these certificates prevented examination of any circumstances relevant to the death of the applicant's son".

[126] Adopted on 7 September 1990 by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders.

[127] Adopted on 24 May 1989 by the Economic and Social Council Resolution 1989/65.

Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions[128]. The standards contained therein are not strictly legally binding. However, they represent an important yardstick by which a State may judge its adherence to the generally recognised principles applicable in the conduct of an investigation into a suspicious death.

These principles were specifically referred to and given credence by the European Court of Human Rights in the recent cases of Jordan v United Kingdom[129], McKerr v United Kingdom[130], Kelly v United Kingdom[131]: and Shanaghan v United Kingdom[132]. This would certainly add weight to the binding force of these principles, in light of the fact that they have been applied through the mechanism of the European Court.

Conclusion

The judgments from the European Court of Human Rights in May 2001 marked a watershed in the development of Article 2 jurisprudence in Europe. In Northern Ireland we believe they should mark the effective demise of the discredited manner in which deaths caused by the state are investigated. A new independent and effective mechanism to inquire into Article 2 deaths is required.

We believe the most effective way of dealing with such cases in the future may well be the creation of a single entity to investigate such cases. It appears to us that, drawing on some of the thinking done by the Luce Review team, a new level of coronial court might be established to deal with controversial cases while either the old system or a more streamlined administrative model might deal with the less controversial cases. Obviously there would need to be safeguards built into the system to ensure decisions as to which level a particular case has been directed to could be subject to appeal. This new higher level of court could, in our view, be tasked with investigating controversial deaths from the beginning, working in tandem with the family and if necessary external investigators, and also ultimately with the DPP. Powers and resources could be allocated accordingly. Public hearings would remain a central aspect of the investigation of these cases.

One further matter also needs to be addressed which is the failure of the DPP to provide reasons in Article 2 cases. In our view and in the view of the European Court of Human Rights such cases are "crying out for an explanation" of the failure to prosecute.

That specific criticism and the others made by the Court in the European judgments need to be met in full.

- The investigations into article 2 killings need to be independent, carried out either by the Police Ombudsman, another independent investigator for army killings or investigators appointed by the Coroner.
- The DPP need to give reasons for failing to prosecute in Article 2 cases.
- Witnesses suspected of causing death must be compellable and the right against self-incrimination needs to be addressed in order to ensure the integrity of the hearing.
- Verdicts must be possible at inquests.
- Legal aid must be available and witness statements must be made available in advance of the hearing.
- Inquest hearings must be held promptly.
- The scope of the inquest must be such as to allow a broad inquiry into the circumstances surrounding the death.
- If PIIs are to be used they should be narrowly drawn and should apply in inquest courts as they do in ordinary criminal courts.

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[128] United Nations Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions, UN Doc ST/CSDHA/12, UN Sales No 91.IV.1 (1991). The "UN Manual" provides model methods of investigation, purposes, and procedures of an inquiry and processing of the evidence. (Chapter III, 16), requires that all investigations be characterised by competence, thoroughness, promptness, and impartiality, (Chapter III, 16), the scope of the inquiry, the terms of reference should be framed neutrally to avoid suggesting a predetermined outcome, (Chapter III, 18). In cases involving an allegation of government involvement, the Minnesota Protocol recommends the establishment of a commission of inquiry (Chapter III, 21/22), Such commissions require extensive publicity, public hearings, and the involvement of the victims' families, (Chapter III, 21).

[129] Paragraph 87–92, Application No 24746/94, Judgment of 4 May 2001.

[130] Paragraph 144, Application No 28883/95, Judgment of 4 May 2001.

[131] Paragraph 121, Application No 30054/96, Judgment of 4 May 2001.

[132] Application No 37715/97, Judgment of 4 May 2001.

10. Memorandum from The Children's Society

1. Introduction

The Children's Society is a national charity working with children in order to address the problems and injustices that they face. This includes work with children on the streets, children with disabilities, refugee and asylum seeking children, and those in the youth justice system.

The Children's Society has a significant amount of experience of working with children held in prisons, through its Remand Rescue and National Remand Review Initiatives, which between 1997 and 2002 worked with approximately 6,000 children remanded either to local authority secure units or Young Offender Institutions. The work of these Initiatives has been captured in our recent publication "A Beacon of Hope"[133].

This submission is largely based upon this report and a research study conducted on our behalf by Barry Goldson of the University of Liverpool entitled "Vulnerable Inside" (2002)[134]. This study looked at the experiences of children remanded to Young Offender Institutions compared to those of children accommodated in local authority secure units due to welfare concerns. Copies of these publications are submitted with this statement.

The Children's Society has drawn out the key points from these publications in relation to the relevant articles of the European Convention on Human Rights and the issues of suicide and self-harm, poor treatment and protection from harm.

The terms "child" and "children" has been used throughout this report to refer to "every human being below the age of 18 years" in accordance with the UN Convention on the Rights of the Child and the Children Act 1989.

2. Human Rights and Children's Rights

The safeguards, protections and rights conferred upon children by domestic legislation and international conventions, in particular, the Children Act 1989 and the United Nations Convention on the Rights of the Child, should work together with the Human Rights Act 1998, to offer a robust framework for the protection of all children, including those held in prison. In practice, however, this framework offers limited protection to some children, particularly those in the youth justice system and in prisons. The primary piece of child welfare legislation, the Children Act 1989, does not apply to the Prison Service itself despite the recent High Court judgement which held that the Act applies to children held in prison.

3. The Profile of Children Held in Prison Custody

The background of children in prison is depressingly familiar: poverty, poor educational attainment, family difficulties, drug and alcohol problems, mental health and other factors feature heavily in their profiles. The work of The Children's Society bears this out. Of the 4,358 cases the National Remand Review Initiative worked on between 1999–2002, monitoring statistics show children with multiple patterns of disadvantage:

- Half of the children had been involved with social services prior to their remand, with 10% of these children subject to care orders and a further 20% accommodated by the local authority.
- Over 40% of children were not living with a parent prior to their remand—16% of these reported no fixed abode, with a further 15% reporting unstable accommodation.
- Fewer than 20% of school-age children were attending school. Almost 30% of children were excluded from school while a further 34% were long-term non-attendees.
- Of those children beyond school leaving age, two thirds were not working, in training or at college.

As summarised in Goldson (2002):

> "Children whose lives have been damaged and disfigured by disadvantage, neglect and abuse are the very children who occupy the juvenile remand wings of our prisons. These are the children for whom the fabric of life invariably stretches across poverty; family discord; public care; drug and alcohol abuse; mental distress; ill-health; emotional, physical and sexual abuse; self harm; homelessness; isolation; loneliness; circumscribed educational and employment opportunities; and the most pressing sense of distress and alienation". (Goldson, 2002:51)

[133] Moore, S and Peters, E. *A Beacon of Hope: Children and young people on remand* London: The Children's Society 2003.
[134] Goldson, B. *Vulnerable Inside: Children in secure and penal settings* London: The Children's Society 2002.

4. The Inappropriate Use of Custody

Examining the findings of the National Remand Review Initiative for a 12 month period, Goldson (2002) found that a quarter of remanded children had been locked up for property offences, and of those whose final court outcome was known, around one-third had received a community sentence, and a further 5.6% had their cases withdrawn, dismissed or found not guilty. This information is used by Goldson to suggest that custody is being used inappropriately for a significant number of children.

Whilst the Crime and Disorder Act 1998 created powers for courts to remand children between the ages of 12 to 16 directly to local authority secure units, 15 and 16 year old boys are required to fulfil the additional criteria of being designated as "vulnerable" by the courts. This means that a court must find that "by reason of his physical or emotional immaturity or a propensity of his to harm himself, it would be undesirable for him to be remanded to a remand centre or a prison". In addition, a vacancy in a local authority secure unit has to have been identified to enable a boy of 15 or 16 to be thus assessed and remanded. In practice, this has resulted in courts either opting not to carry out the assessment or boys being remanded into a YOI despite being assessed as "vulnerable" on both counts due to the lack of available space.

The last decade has seen an explosion in the use of custody for children, increasingly for younger children and for less serious offences. Most recently Section 130 of the Criminal Justice and Police Act 2001 has actually conferred upon courts greater powers to remand to custody where persistent offending on bail is an issue. Persistence has been defined by case law as meaning "on more than one occasion". Prior to this custodial remands were limited to those cases of children who were perceived to be a serious risk of harm to themselves or others. This new power has increased the use of custodial remand for children and placed significant demands on both on the Prison Service and local authority secure units.

> I have just interviewed a boy on a £9.99 shop theft. They are persistent and a nuisance but no real threat to the public at all. It is the persistence of their offending which now makes the remand legal but it is quite unnecessary. (NRRI practitioner in Goldson, 2002:126)

This measure is contrary to the articles of the UN Convention on the Rights of the Child that states that custody should be used as a "measure of last resort" and for the "shortest possible time".

5. Institutional Racism

Goldson (2002) suggests that racism not only means that black children are more likely (than their white counterparts) to be remanded in custody, but they also face the prospect of less favourable treatment and conditions. A quarter of children people worked with the National Remand Review Initiative were from a black or minority ethnic background—for the children helped through by our London project the figure rises to almost 50%.

The Director General of the Prison Service has recently acknowledged that the prison system is "institutionally racist" (cited in Goldson, 2001:19).

> I have long been concerned that the biggest single problem facing the Director General is the culture that still pervades parts of the prison system . . . It is a culture that adopts an attitude to prisoners that is not only judgmental, but too often includes physical and mental brutality . . . One of its most obvious manifestations is in attitudes to minorities, of whatever, kind, who are treated not as equal but as unequal because of their minority status. There are . . . minority groups whose inequality of treatment concerns me—ethnic or cultural minorities. (Her Majesty's Chief Inspector of Prisons quoted in Goldson, 2002:56)

The Children's Society, in partnership with the Community Fund and the University of Central England, is currently embarked upon a four-year programme of research examining the experiences of black children of the youth justice system, including their experience of prison custody. The first phase of the research, looking at the prison system, is to be launched later this year.

6. Unhealthy Prisons

The physical and mental health needs of children in prisons are significant and as such require sustained attention from an expertly staffed and well-resourced range of health services. HM Chief Inspector of Prisons has noted that over 50% of young prisoners on remand and 30% of sentenced young offenders have a diagnosable mental disorder. The British Medical Association found that 17% of young offenders were not registered with a GP and that the population of Young Offenders Institutions represent a "concentration of unhealthy lifestyles" (Goldson 2002).

> The Prison Service is being consistently starved of adequate funding to meet this clinical and social care agenda . . . the prison medical service has been in an acute crisis for some time . . . because of the general shortage of resources in prisons, prison medical officers often have inadequate support from an appropriately qualified healthcare team . . . unqualified "hospital officers" are given responsibility for aspects of clinical care that in the NHS would only be given to clinical staff with appropriate training. (British Medical Association quoted in Goldson, 2002:57)

Despite the best efforts of health care staff in prisons, children who have compelling health-related needs are exposed to environments in which their health is likely to deteriorate further.

7. Systemic Bullying

Goldson (2002) acknowledges the hold that bullying, in all its forms, has on the Prison Service:

> There can be no doubt that physical assault is commonplace. However, children are also exposed to other forms of bullying, including sexual assault; verbal abuse (name-calling, threats, racist taunting); extortion and theft; and lending and trading cultures—particularly in relation to tobacco—involving extraordinary rates of interest, which accumulate daily . . . Moreover, bullying is contagious. It is entrenched within the fabric of prison life; it is integral to the very incivility of child imprisonment and it is an intrinsic feature of the survival-of-the-fittest machismo that prevails. The bullied child is invariably also a bully; the damaged wreak damage as the victim becomes the aggressor within the corrosive environment that is prison . . . It is of little surprise that within this culture of torment, children's vulnerabilities are compounded and exposed. For all, bullying perpetuates misery and fear. For some, it is literally too much to bear. (Goldson 2002: 58/59)

The children interviewed by Goldson also articulated a sense of hopelessness and a lack of faith in the ability of prison officers to offer them protection:

> It's going on all the time—threatening you, shouting things, calling your mum names. There's nothing you can do about it. You just have to cope with it. I don't know how I do, you just do. My mate was hammered in the showers. When the screws asked him what was wrong he said that he fell over. If he had told him the truth, he'd have got hammered again. Most of the staff are all right but some either ignore you or try to wind you up. They swear at us and that, and call us names, and they threaten to drag us down to the block. Every day . . . bullying happens, there's fight every day. It's getting worser and worser. A lad has just killed himself and I reckon that was through bullying. A 16-year old lad . . . does not kill themself when they have their whole life in front of them, I just picture it in my head and it's bad, it's really bad. (Boy aged 15 in Goldson, 2002:147)

> I was really scared in my pad. They are shouting at you through the windows and that, saying, "I want your breakfast in the morning" and stuff like that. I was lying on my bed proper scared, thinking, "I don't want to go out there in the morning, I don't want to go out at all". (Boy aged 15 in Goldson, 2002:142)

It is hoped that the provision of advocacy services for children in prisons, currently being developed by the Youth Justice Board, will go some way to tackling the issue. To have any real effect, however, this must go hand in hand with reform of the Prison Service's Complaints and Representations Procedures to bring them into line with the Children Act 1989 regulations and procedures.

8. Information Breakdown

> Indeed, the view that prison personnel should take greater individual care of children, and that the prison authorities should raise general standards, has made a very significant policy impression over the last two years. Much of this new emphasis has focused upon improving methods of vulnerability/risk assessment to identify and screen out the most vulnerable children, but this is itself a source of some concern. (Goldson, 2002:63)

The Youth Justice Board and Prison Service have worked together to develop new assessment procedures for children in the youth justice system. The ASSET assessment, created for Youth Offending Teams, is completed at each stage of the youth justice process. These forms should follow children into prisons, along with a post-court report (PCR) completed at court following a remand or sentence of custody. In addition, prison establishments have been given form TV1 to complete at the reception stage for every child.

Goldson (2002) in his study noted that prison officers were very uncomfortable with the responsibility of predicting the young person's vulnerability due to a lack of substantiating information, limited time and resources. Goldson also reported that both post-court reports (PCRs) and the ASSET assessment forms were only received in 28% of cases and as many as one in five children arrived at prison with no information at all:

> If you receive it, it can be adequate, but most of the time you are working cold and it's gut reaction on the basis of an interview, which can be very short, and probably not very accurate. (Prison Officer in Goldson, 2002:135)
>
> We very seldom get all the information and we only have to go on what the prisoner is telling us. We try to pick up on body language, eye contact and the like, but at the end of the day we just have to write down what they tell us. If they say "no" to the history of self-harm question, for example, then I will simply write down "inmate says no". (Prison Officer in Goldson, 2002: 136)
>
> What we need is a private room. Too much is going on at reception. Sometimes at reception you just have to find a corner space, anywhere that is not being occupied. We used to be able to take them into a store cupboard but that's used for something else now. (Prison Officer in Goldson, 2002: 137)
>
> It's usually busy and noisy and rushed at reception. It depends on the time that they arrive. There are times when kids are seen in court at half-ten in the morning and we get them at 10 to 7 at night. We then have to do reception, and everything that goes with it for up to 15 kids before half-eight. (Governor in Goldson, 2002:138)

It is, however, not very surprising that children fail to open up to deeply personal questioning conducted in the manner described above. This leaves staff and children in a highly vulnerable situation. If a young person's history is unknown to the prison officer on reception, then previous suicide and self-harm attempts or mental health problems may go undetected. Therefore a young person may be seen as coping and indicators of vulnerability go unnoticed when, in fact, the young person is at very real risk:

> It follows, therefore, that institutionally expedient, hasty and necessarily cursory assessments, of the type routinely applied to children in prisons, will inevitably carry serious risks. They are not meaningful safeguards and any pretence otherwise is profoundly misguided. (Goldson, 2002:63)

9. The Need for Support and Protection

The need for greater levels of support and protection for children in prison, particularly on the first night, in preventing self-harm and suicide is obvious. Goldson (2002) reports the anxieties of children and prison officers:

> It's really scary—you don't know what to do and where to go. You have a little interview with an officer and a nurse and they ask if you know why you've been remanded, if you're all right, if you have any health problems and if you're suicidal . . . I just said, "I'm all right" but I didn't know if I was all right or not. I was just thinking, "What will it be like?", that's all I could think about. I wasn't really listening to what they were telling me. I kind of wanted to get out of there but I didn't want to go to my cell. It was weird. They just said that if you ever get bullied or feel down, talk to an officer. I was thinking "Will they do owt. What if I do get bullied? If I told them, would it stop?" You hear all these rumours about what happens to grasses and I thought, "There's no way I'm going to be a grass" but I was really scared. (Boy aged 16)
>
> I just felt really alone and down. They just spoke to me like I was a piece of meat. They didn't make you feel like a person. I know I broke the law and that, but they just treated me like a piece of shit. They think 'cos you're in prison, and they're in uniform, they can just tell you to do what they want and treat you as bad as they want. (Boy aged 16 in Goldson, 2002: 139)
>
> There is no real first night support. We might say that there is but it's all about back-covering really . . . If it says check every 15 minutes and I do, I've done my bit, so it's not my fault if it (self-harm or suicide) does happen. That's hardly support though, is it? (Prison Officer)
>
> We have been very lucky here. We have only had one suicide and not that many attempted suicides. Bearing in mind the way that they are treated on the first night, this is more by luck than design. (Prison Officer in Goldson, 2002:141)

Goldson (2002) cites the Personnel Officer scheme as an example of an attempt to address the "incongruous duality of controlling and caring roles" within the role of the prison officers. But even in "the best" of YOIs 49% of children stated that their Personal Officers never met with them, compared with 89% of those in "the worst" YOIs.

The Safeguarding Children report (2002)[135] produced by the Joint Chief Inspectors concluded that:

> 8.19 Young people in YOIs still face the gravest risks to their welfare, and this includes those children who experience the greatest harm from bullying, intimidation and self-harming behaviour.
>
> 8.20 The work of YOTs (Youth Offending Teams) was detached from other services, and there was only limited evidence that they were addressing safeguarding issues. The focus of their work with young offenders was almost exclusively on their offending behaviour, and did not adequately address assessing their needs for protection and safeguarding. (Department of Health 2002:72)

Youth Offending Teams, in most instances, are the agency best placed to facilitate the sharing of information about the child in custody. But figures from the National Remand Review Initiative show that in 13.4% of cases Youth Offending Teams were unaware that the child was in custody prior to NRRI making contact to discuss the remand (The Children's Society 2003).

Given that many these children are held at significant distances from home, despite the commitment of the Youth Justice Board to place children close to home, the sense of isolation and the lack of information available to the prison serve to heighten their vulnerability. The possibility of regular visits from family members and their Youth Offending Team worker is also reduced.

10. Conclusions

> The primary role of the Prison Officer is to maintain discipline, order and institutional security. Set against this is the duty of care, which arguably becomes more sharply focused when the prisoner is also a child. (Goldson, 2002:65)

Whilst the Prison Service has a duty of care to its prisoners, it is currently not required by the Children Act 1989 to promote the welfare and protect the children it accommodates. As a result, the welfare and protection of these children are secondary considerations. In order to address properly the concerns listed above, and to protect children's welfare and human rights, we believe that the Children Act 1989 should apply to the Prison Service itself as well as to the individual child.

The singular purpose of the youth justice system in England and Wales is "to prevent offending" as laid down by the Crime and Disorder Act 1998. If children within this system are to be properly cared for and protected and the risk of suicide and self-harm reduced, then this must change. The Children's Society, as part of a wider coalition of children's charities and penal reform groups, has been lobbying for the Criminal Justice Bill to be amended to include a clause which puts the welfare of children at the heart of the system and places a duty upon all agencies and institutions that deal with them to protect them and promote their welfare. We are deeply concerned that Government has missed an opportunity to properly address this issue in the recently published Green Paper on children at risk (DFES 2003)[136] and its companion paper on youth justice (Home Office 2003)[137].

Finally, it is recommended that the principles and rights bestowed upon children by the United Nations Convention on the Rights of the Child are fully integrated into the youth justice system in England and Wales, in order to ensure that the special protections conferred upon them due to their status as children are fully applied.

The Children's Society would be happy to supply any additional information that is required to support the work of the Committee.

16 September 2003

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11. Memorandum from Doughty Street Chambers

1. We are writing to convey our written evidence on behalf of the above chambers, to you as Chair of the Joint Committee on Human Rights. As part of your inquiry into human rights and deaths in custody, you have asked for evidence upon Article 2 of the ECHR and the "investigation of deaths in custody", which is the question we will address. Members of our chambers have been at the cutting edge of this issue for many years, in the conduct of inquests into "custody deaths", and in challenging their inadequacies by way of judicial review.

2. You will be aware that the Judicial Committee of the House of Lords is due to rule upon much of this territory in the case of "Amin v Home Secretary". It is anticipated that judgement could well be given in October or November. There will also be further relevant rulings by the same Committee in the appeal of "Middleton" and the joined case of "Sacker", both of which more directly concern inquest procedure. The hearing of those appeals will take place in February 2004.

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[135] Chief Inspector of Social Services et al (2002) *Safeguarding Children: A joint Chief Inspectors' Report on Arrangements to Safeguard Children* London: Department of Health.

[136] *Every Child Matters* (2003) London: DFES.

[137] *Youth Justice: The Next Steps* (2003) London: Home Office.

3. We append the text of the critical paragraphs from the two leading ECtHR authorities, which definitively interpret the investigative requirements of Article 2.[138] Those passages are paragraphs 102–109 from *Jordan v UK*, 4 May 2001, which are repeated verbatim at paragraphs 69–73 in *Edwards v UK*, 14 March 2002. More appears from other parts of those judgements, but these are the "general principles" establishing the minimum common safeguards, to be consistently applied in all Convention jurisdictions. It should however be remembered that Convention law provides a "floor, but not a ceiling". There is no impediment to national jurisdictions keeping or even developing more effective safeguards. For example, there is good evidence that through inquest juries, we have had forms of public hearings and investigations into custody deaths for many centuries: see the *Statute de Officio Coronatoris*, 1276, cited in *R v Southwark Coroner* ex p. Hicks [1987] 1 WLR 1624 at 1636: and Hale's History of the Pleas of the Crown, 1736, reprint of 1971, vol II, Chapter VIII, at p 57. The strength of common law protections is not diminished by the passing of the Human Rights Act 1998.

4. In summary, the requirements for a compatible investigation are:

> at the instigation of the state itself: not waiting for complaints or allegations, see paragraph 105;
>
> independent, meaning lack of hierarchical connection with those connected with the events: eg in a police custody death; at least a separate police force would be required: see paragraph 106;
>
> effective: eg gathering eye witness and scientific evidence to maximise the chance of getting at the truth and if necessary founding a prosectution: see paragraph 107;
>
> promptness and reasonable expedition: see paragraph 108. A recent example of unacceptable delays appears in *Finucane v UK*, 1 July 2003;
>
> with sufficient public scrutiny to ensure effective accountability: see paragraph 109. Though this seems to allow for public scrutiny of the "results" of the investigation, rather than the process, this has been significantly fortified by paragraph 83 in *Edwards v UK*. A prison death required "the widest exposure possible" so that a private inquiry, though rigorously conducted, was insufficient for Article 2. The same would apply to police custody deaths;
>
> and participation of the next of kin, sufficient to safeguard their private interests: see paragraph 109. The Court emphasised at paragraphs 133–4, that disclosure of documentation to the family at any inquest was essential to effective participation.

5. The most controversial requirements are the last two above: public scrutiny; and participation of the next of kin. Indeed the Home Secretary is attempting to argue in the Amin appeal, that these are not consistent requirements at all; and even if they are, they are not separate requirements. These arguments are deployed despite the centuries of common law history above. The House of Lords Judicial Committee will have to decide these points.

6. The ECtHR made clear in *Jordan v UK* that, though they were establishing certain minimum safeguards, there was no one uniform method of providing those safeguards. The investigative mechanisms and procedures will vary considerably across the many different Convention jurisdictions: see paragraphs 105 and 143. Indeed it is not necessary for any one procedure to comply with all the requirements.

7. It follows that all the examples of investigative steps given in your question are of relevance to compliance with Article 2. No one mechanism needs to provide all the requirements. However, in the round, they must ultimately satisfy them all. To take one kind of investigation, an internal Prison Service investigation into a prison death could not be "independent" or provide sufficient participation by the family, or public scrutiny. However, provided there is also a prompt, independent and effective police investigation, and a public inquest, it may well contribute somewhat to the gathering of evidence to get at the truth and possibly contribute to founding a prosecution or discipline proceedings, to prevent recurrence. If the Report is served upon the next of kin it may contribute somewhat to providing them with necessary information. Though quite insufficient in itself, an internal prison service investigation is therefore of some relevance to overall compliance.

8. The requirements of the "Jordan" criteria are no innovation, for the normal manner of investigating relevant deaths within this jurisdiction. The combination of an independent police investigation and a Coroner's inquest will generally in practice take place after any death triggering the Article 2 investigative duty.

9. The scheme of section 8 of the Coroners Act 1988 provides that there is a statutory duty to hold an inquest where there is "reasonable cause to suspect":

> any death at all in prison: section 8(1)(c); and
>
> any "violent or unnatural death; or sudden death of which the cause is unknown", see section 8(1)(a) and (b).

10. Although there is no express reference to deaths in police custody, or at the hands of the police in section 8(1), as a matter of practice, and under Home Office Circulars, Coroners always hold inquests with juries in all custody deaths; see *R v Inner London North Coroner, ex parte* Linnane [1989] 3 WLR 395.

[138] Not printed here.

11. An independent police inquiry and an inquest are capable of providing an "effective investigation" within Article 2, and compliance with the "Jordan" requirements. In particular, the inquest combines in one process "public scrutiny" with involvement of next of kin. Providing for both of these requirements is no special burden or innovation. It is the norm under our system, and has been for many centuries.

12. It was held in *McCann v UK*, at paragraphs 162–3, that that particular inquest, despite certain shortcomings, was Article 2 compliant. In *Jordan v UK*, at paragraphs 132–34, the Court expressed reservations about whether in the absence of legal representation and advance disclosure of documents, inquests could so comply. [We here put aside those profound problems, peculiar to the Northern Ireland inquest system, of endemic delays of many years, the unavailability of any "unlawful killing" verdict, and the lack of compellability as witnesses of those who perpetrated the killing.]

13. Until recently the absence of legal representation and advance disclosure of documents, were general problems with our inquest system, arguably preventing compliance. However, under Home Office Circular 20/1999, set out at paragraphs 73–74 in the *Jordan v UK* judgement, there is now provision for advance disclosure. Further, under a scheme similar to that mentioned at paragraph 67 in the same judgement, a limited scheme for funding of legal representation now operates.

14. We have the following reservations about the current ability of our inquest system to comply with the Jordan requirements, and therefore with Article 2:

Lack of resources

We attach a copy of the striking affidavit of the West London Coroner in the "Amin" case, explaining, at paragraphs 6–10, why she simply could not practically hold the kind of inquest required by that case.

Disclosure

There is continuing delay and obstruction in complying with the Home Office Circular.

Representation

While there is generally moderate legal aid in the major high profile cases, there is inconsistency, and no clear principle applying to all death in custody cases.

Verdicts

There is now a possible limited verdict of "system neglect" as a result of the Court of Appeal decision in *Middleton v West Somerset Coroner* [2002] 3 WLR 505. However, in practice Coroners are applying two restrictions, (a) only where the neglect is "gross" and (b) proof must be beyond reasonable doubt. These restrictions are unfounded and prevent findings of many levels of state neglect. The inquest cannot then publicly attribute many instances of state fault.

15. A fundamental Home Office Review into the whole Coronial system has reported in June 2003: CM 5831. It makes 123 recommendations, covering organisation, resources, procedure verdicts and family rights. Some of these proposals have been reinforced by the Report of Dame Janet Smith into the Harold Shipman deaths. It is widely anticipated that there will be changes to substantive and procedural inquest law, as well as to the organisation and resourcing of the system. We commend these as vital to ensuring consistent compliance with Article 2 within our jurisdiction.

16. Until these problems are addressed, Article 2 compliant inquests will not consistently take place; and in some of the most complex cases, inquests may not be possible at all. In the interim therefore, other methods of investigation will be necessary. It is to be noted that the Hutton inquiry is specifically taking the place of the inquest under section 17A to the Coroners Act 1988. Whatever form of alternative inquiry is adopted, its process must be public and there must be provision for participation by the next of kin, with legal representation and advance disclosure of documents.

20 September 2003

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12. Memorandum from The Howard League for Penal Reform

The Howard League for Penal Reform was extremely interested to see that you were undertaking an investigation into this very important area of policy. The Howard League has been campaigning to raise awareness about this issue for more than a decade and there is still a long way to go.

Unfortunately, due to limited staff resources we are not able to make a formal submission, on this occasion. However, I am sending you a copy of the submission we made to the recent Home Office consultation on investigating deaths in prisons and approved premises, and a copy of a letter sent to the

Prison and Probation Ombudsman this week in relation to the on-going investigation into deaths at HMP Styal, for information.[139] Please feel free to circulate this information to other Committee members if you feel it is helpful.

12 September 2003

13. Memorandum from Inquest

1. Introduction

INQUEST is the only non-governmental organisation in England and Wales that works directly with the families and friends of those who die in custody to provide an independent free legal and advice service to bereaved people on inquest procedures and their rights in the Coroner's Court. We provide specialist advice to lawyers, the bereaved, advice agencies, policy makers, the media and the general public on contentious deaths and their investigation. We also monitor deaths in custody where such information is publicly available and identify trends and patterns arising.

INQUEST is unique in working directly with the families of those who die in all forms of state custody—in which we include deaths in prison, young offender institutions, immigration detention centres, police custody or while being detained by police or following pursuit, and those detained under the Mental Health Act as they involve people whose liberty has been taken away.

We have accrued a unique and expert body of knowledge on issues relating to deaths in custody and seek to utilise this towards the goal of proper post-death investigation and the prevention of custodial deaths. INQUEST has been at the forefront of working alongside bereaved people to bring the circumstances of the deaths into the public domain and under public scrutiny and to hold the relevant authorities to account. We have reported our concerns about custodial deaths and their investigation at a national and international level.[140] We were also consultants to the Liberty project on deaths in police custody and many of our recommendations were endorsed in their final report.

There have been a significant number of high profile deaths in custody that have raised public and parliamentary disquiet. This legacy needs to be fully understood if we are to move forward and ensure that the custodians are truly accountable to the community they serve.

INQUEST has supported families' calls for a full public inquiry into the issues raised by deaths in custody for many years but these have received a negative response from government. INQUEST has been frustrated by the failure to learn the lessons from deaths occurring in different custodial settings and the lack of joined up learning between agencies. In our view this has resulted in more deaths occurring because of the failure to approach this serious human rights issue in a holistic way. Many of issues arising from deaths in custody need to be fed into the wider agenda for social inclusion of government, local authorities and voluntary sector. Many of the deaths which occur are part of a pattern which impact on policies on combating racism, drug and alcohol use, homelessness, mental health, crime prevention and policing.

To this end we recommend the setting up of a Standing Commission on Custodial Deaths which would bring together the experiences from the separate investigation bodies set up to deal with the police, prisons, hospital deaths and the others. Such an over-arching body could identify key issues and problems arising out of the investigation and inquest process following deaths and it would monitor the outcomes and progress of any recommendations. It could also look at serious incidents of self-harm or near deaths in custody where there is a need to review and identify any lessons. Arising from this it would develop policy and research, disseminate findings where appropriate and encourage collaborative working. Lessons learnt in one institution could be promoted in the other institutions, best practice could be promoted and new policies designed to prevent deaths could be drafted and implemented across all the institutions. It would play a key role in the promotion of a culture of human rights in regard to the protection of people in custody.

It should also have powers to hold a wider inquiry where it sees a consistent pattern of deaths. Such an inquiry could give voice to and a platform for examination of those broader thematic issues and those issues of democratic accountability, democratic control and redress over systemic management failings that fall outside the scope of the inquest. One of its functions would also be to lay the past to rest and assisting the process of effecting real and meaningful change.

This submission details current concerns arising from our casework and monitoring of the investigation and inquest process following deaths in custody. In the last ten years 1824 men, women and children have died in police and prison custody.[141] Many of these deaths raise concerns about inhuman and degrading

[139] Not printed here.

[140] The Ashworth Inquiry 1992; United Nations Committee on the Elimination of Racial Discrimination 1996 and 2000; Council of Europe Committee on the Prevention of Torture 1997; Home Affairs Select Committee on Police Complaints and Discipline 1997; United Nations Committee Against Torture 1998; Inquiry into the death of Steven Lawrence 1998; Health Select Committee into Adverse Clinical Incidents and Outcomes in Medical Care 1999; Health Select Committee Inquiry into the Provision of Mental Health Services 2000; Attorney General's review of the role of the Crown Prosecution Service in deaths in custody 2002; Fundamental Review of Coroners' Services 2002; Joint Committee on Human Rights—deaths in prison 2002; Independent Inquiry into the death in psychiatric care of David Bennett 2003.

[141] For statistical analysis see appendix 1.

treatment, systemic failings and the unlawful use and abuse of force. Since 1990 there have been nine unlawful killing verdicts returned at inquests into these deaths and no successful prosecution of any police or prison officer.[142]

We draw the committee's attention to:

- The increasing number of deaths in police and prison custody—a disturbing number raising concerns about inhuman and degrading treatment;
- deaths due to alleged drunkenness or drug intoxication;
- deaths involving poor medical care;
- fatal shootings;
- police pursuits—an increasing percentage of police related deaths are following pursuits or otherwise involving police vehicles;
- the lack of accountability and transparency in the investigation process;
- the disproportionate number of deaths of black people following the use of force;
- the poor treatment of the mentally ill in custody and inadequate medical care;
- the lack of central collection and collation of information on deaths of detained patients and monitoring of the issues arising from inquests;
- the poor treatment of bereaved families following a death in custody/psychiatric care;
- the inadequacy of the current investigation and inquest process;
- the inequality of arms of the family compared to the state ;
- the failure of the state to learn from previous deaths and to ensure inter-agency communication and learning; and
- the lack of accountability of state agencies.

And

- An independent public inquiry should be set up to look at all the issues relating to deaths in custody in an open, systematic and inclusive way. We have been frustrated at the government's piecemeal approach to the complex issues of deaths in custody and their investigation and the lack of "joined up government" on this issue.

And

- The need to establish a Standing Commission on Custodial Deaths.

2. Deaths in Prison

2.a *Issues arising from prison deaths:*

- institutionalised attitudes towards prisoners that cause an indifference to pain and distress and help to prevent learning;
- young people in deep distress described as manipulative trouble makers;
- a disturbing number of self-inflicted deaths in prison of people who had a known previous psychiatric history;
- the rise in the number of youth deaths and in particular of remand prisoners, the need for an understanding of the needs of young people;
- a significant rise in the number of deaths of women in custody;
- the link between prison deaths and inadequate or inappropriate health care;
- the increasing number of drug related self-inflicted deaths in prison of prisoners who are not given treatment and support for drug withdrawal;
- the stereotyping of black people with mental health problems;
- the use of prison as a "place of safety" for those with serious mental health problems;
- the number of self-inflicted deaths which occur within Health Care Centres;
- the need for a reduction in the use of imprisonment rather than treatment of vulnerable people, for whom prison is the worst place to be. Prisoners with mental health problems are often a risk more to themselves than to others as the increasing catalogue of self-inflicted deaths in prison reveals;
- inadequate policies to deal with bullying;

[142] *See* appendix 2.

— there has been a pattern of failure to acknowledge self harming behaviour as an expression of distress which has often led to such behaviour being treated as a discipline problem and for clearly distressed people to be placed in segregation rather than receiving appropriate care;

— continuing problems with cell design, access to ligature points; and

— the need for diversion schemes for those suffering from mental health problems, drugs and alcohol problems.

2.b *Women's deaths*

There is a crisis in women's prisons highlighted by the increasing number of deaths and incidents of self-harm and the numbers of women prisoners with mental health and or drug and alcohol problems being sent to prison. This year 14 women have died in prison custody, the highest number ever recorded. 12 out of the 14 have died as a result of hanging themselves, two having taken an overdose of medication.

In response to public concern about the situation at Styal prison where six women died during an eight month period the Prison Minister announced an investigation by the Prison Ombudsman into the death of Julie Walsh. We were concerned at the narrow remit of the review and that it was not reinvestigating the other deaths. There was also concern that families of the other women who died were being asked for their views without having had disclosure of the investigation reports into their relative's death. INQUEST feels that this investigation was a missed opportunity to set up a wide-ranging independent public inquiry that examined all of the recent deaths, any institutional and systemic failings and most importantly involved bereaved families and women prisoners themselves.

INQUEST put in a submission to the investigation about our concerns the treatment of bereaved families following deaths in prison. Our contact with some of the families affected reveal concerns about communication with the Ombudsman's office about the timing and publication of the report. Our concern is also with his use of Prison Service investigators to conduct his investigation.

2.c *Deaths of children and young people*

INQUEST has prioritised work on the deaths of young people and children in custody since 1990, when we advised and supported the family of Philip Knight, a 15 year old boy who took his own life in Swansea prison. We have been frustrated by the large number of cases that have raised similar issues and the apparent failure of the Prison Service to learn the lessons.

We believe that for many young people prison is inappropriate and that their experience of imprisonment has *directly* contributed to their death.

Between January 1990 and December 2003 there have been 177 self-inflicted deaths of young people in prison (21 and under). There have been a total of 947 self-inflicted deaths in prison. These figures are situated in the context of 21,760 reported incidents of self-harm in prison between 1998 and April 2002. Although these are not broken down in detail it is recognised widely that self-harm amongst young prisoners, particularly women, is an urgent problem.

We would like to draw the committee's attention to the case of Joseph Scholes which is illustrative of the concerns these deaths raise about the way in which the criminal justice deals with children. It also reveals the inadequacy of the current inquest system to deal with the complexity of issues by these cases that engage Article 2 of the Human Rights Act.

> Joseph was a deeply disturbed boy who had disclosed a history of alleged sexual abuse from an early age. On 24 March 2002 he hanged himself in his cell at Stoke Heath Young Offender Institution in Shropshire. His death occurred just nine days into his two-year sentence for street robbery.
>
> Joseph's death and other tragedies like it, raise serious issues about the ability of the present system to cope with society's most vulnerable young people and to provide them with a safe as well as a secure environment. The question arises as to how best to identify any systemic failings that do exist and how future tragedies can be avoided.

The case for a public inquiry rather than an inquest

INQUEST, Nacro and Yvonne Scholes, Joseph's mother recently launched[143] a call for a public inquiry into his death.

The narrative of Joseph's life is grim reading and reveals a catalogue of failures by state agencies to provide appropriate care and help to an exceedingly vulnerable child.[144]

[143] Prison suicide of Joseph, 16, a phone thief who fell victim to sentencing policy—Independent 12/11/03.
[144] A child's death in custody—Call for a public inquiry—INQUEST and NACRO Campaign Briefing—November 2003.

Joseph's death raises a number of wider questions about the treatment and care of children in the criminal justice system and the accountability of those agencies responsible, in particular the Youth Justice Board, the Prison Service and Social Services Departments. It asks questions of society and how it should respond when children show clear signs of being disturbed and in need of professional intervention. It raises questions about how agencies and individuals could have intervened in Joseph's case and how we can ensure that we have better systems and better practice in the future.

These are issues of policy, which no inquest—however well conducted—can cover in the way a public inquiry could. A public inquiry into a case like Joseph's would be able to examine the fundamental flaws in our system for dealing with children who break the law—flaws which have led to 25 children aged 15 to 17 taking their own lives in custody since 1990.

The current inquest system is incapable of dealing with the systemic issues highlighted in cases such as Joseph's and consequently fails victims, their families and the wider public interest in seeking to ensure that lessons are learnt to avoid future fatalities. Given the pattern of deaths of children in prison, the number of different state agencies involved in Joseph's care, the systemic and wide-ranging issues involved, and the narrow confines of the coronial system, any inquest into Joseph's death will not be able to fulfil the state's obligations under Article 2 incorporated by the Human Rights Act 1998 to identify faults in the system that might have led or contributed to the death and to enable steps to be taken to prevent the recurrence of such deaths in the future.

Six months before Joseph died 16 year old Kevin Jacobs hung himself from the bars of his cell. He too had been identified by prison staff, social workers and doctors exceptionally vulnerable disturbed and "at risk" young boy. The inquest jury returned a verdict of "system neglect" fining "gross deficiencies within the system and a failure to provide consistent and safe accommodation."[145]

Deaths Involving the use of Force

3.a *The General Issues*

INQUEST has worked with many of the families of those who have died on the most significant and controversial deaths in all forms of custody over the past two decades in particular those involving the use of force.[146] The majority of these involve the police.

INQUEST's work in this area reveals serious shortcomings in the existing mechanisms of legal and democratic accountability, and the consequent impact in particular on community relations has been profound, resulting in a lack of public confidence in the current system. Until recently complacency and inaction have characterised the response from government agencies during the last two decades to these deaths. This indicates a failure and/or unwillingness to ensure that systems are in place to learn the lessons to prevent further deaths and ensure accountability of agencies of the state.

For two decades we have documented our concerns about deaths where the use of restraint by state agents has either caused or played a significant contributory factor in the death of the deceased. Casework[147] in police prison and psychiatric custody has revealed concerns about the excessive use of force generally including the use of CS spray, US style batons, firearms, strip cells and medication as well as the use of dangerous "control and restraint" methods such as body belts, "neck holds, and other restraint techniques resulting in the inhibition of the respiratory system, asphyxia and death."[148]

The recent inquest[149] into the death of Roger Sylvester highlighted the issue of the police using dangerous methods of restraint despite a pattern of previous deaths.

A recurrent theme in these deaths is a quick resort to the use of force in general and restraint in particular among our detaining authorities—even where there are available and practical alternatives, which are not considered. In theory restraint is supposed to be deployed as a means of last resort but is not translated into practice. Regulations governing the use of restraint as a means of last resort appear to remain enshrined only on paper.

While the number of deaths involving the use of force are a small minority of all deaths in custody they have been the most controversial because of what they have revealed about the excessive use of force by functionaries of the state.

There is no central collation of statistical or other information on restraint related deaths—we are dependent on the individual agencies for that information where it is made available, and our own monitoring.

[145] INQUEST press release 26 September 2002.

[146] Forthcoming publication—Deaths in Custody following the use of force—INQUEST 2004.

[147] This means working closely with family members, very soon after the death, referring them to appropriate lawyers, working with the legal team, attending the inquest, raising the issues with relevant agencies and government departments and with MPs and other interested organisations. This gives us a unique body of knowledge from which to comment on the deaths and the issues they raise.

[148] *See* INQUEST reports on the deaths of Denis Stevens, Alton Manning, Kenneth Severin, Harry Stanley, Brian Douglas, Wayne Douglas, Shiji Lapite, Glenn Howard, Roger Sylvester and Giles Freeman.

[149] September 2003.

In 2002 and 2003 our casework on police custody related deaths has seen a disturbing increase in the number of restraint related deaths particularly on those with mental health problems.[150]

3.b *Particular problems with the criminal justice and inquest system in these deaths*

It is extremely rare for there to be a prosecution after a death in custody even where there has been an inquest verdict of unlawful killing.[151]

Despite a pattern of cases where inquest juries have rejected the official version of events and found overwhelming evidence of unlawful use of force and neglect, no police or prison officer or nurse has been held responsible either at an individual level or at a senior management level for the institutional and systemic failures to improve training and other policies.

Our monitoring of the cases has revealed an institutionalised unwillingness and reluctance to approach these deaths as potential homicides. This infects the whole process from the investigation carried out by the police through to the considerations by the Crown Prosecution Service. This serves only to encourage a culture of impunity and sends out a clear message to police and prison officers and other detaining agents that these deaths can occur as a result of their acts or omissions and they will not be called to account. The perception is created that state agents are above the law. This is one of the most contentious issues in relation to the approach of the criminal justice system in relation to all deaths in custody.

Our casework suggests that when the use of certain kinds of violence is embedded in the working culture of any organisation (whether a hospital or the police) it isn't easily eradicated by directives from above. Where there exist no real sanctions for those who abuse restraint and force, it is easy to see how those individuals working in detaining authorities are allowed to feel that they can act with impunity. The bottom line therefore relates essentially to the means by which the use of restraint is regulated and the extent to which such regulation and its implementation is open to public scrutiny as a basic safeguard against the abuse of force.

There are limited opportunities for the public scrutiny of the abuse of restraint and force in our custodial institutions. Within the agencies involved there exist internal investigative and disciplinary processes, which by their very definition are not open to public scrutiny. Guidelines/manuals on the use of restraint have been shrouded in secrecy and not made available. In the absence of criminal proceedings against those responsible for such abuse, we are left with the inquest with all its limitations as the only forum at which the ensuing deaths can be subjected to any semblance of public scrutiny.

We address some of the problems of the inquest system below and these are all the more apparent in dealing with these particularly disturbing deaths.

3.c *Racism and stereotyping*

Since 1990 INQUEST's monitoring has revealed how a disproportionate number of black people and those from minority ethnic groups have died as a result of restraint or serious medical neglect. It is the emergence of statistical information backed by factual accounts about the circumstances of the death that has been crucial to understanding the influence of institutional racism on the treatment of black people in custody. Another group over represented are the mentally ill where "negative imagery" once again informs their treatment—the stereotype of the mentally ill as "mad", "bad" and "dangerous".

These issues have been raised consistently by INQUEST with the United Nations Committee on the Elimination of Racial Discrimination who have commented on their dissatisfaction with the current methods for investigating the deaths. It was also touched upon in the Lawrence Inquiry report. This pattern of deaths in custody feeds the perception and reality of racism within the police and prison service and within the NHS.

Cases have revealed a use of violence on some occasions that is greatly disproportionate to the risks posed involving black and Irish people and the mentally ill, raising questions about the attitudes and assumptions of some state officials and pre-conceived ideas about the propensity to violence of particular groups of people.

There has been considerable public anger particularly amongst the black and Irish communities about what some of these cases have revealed about the unlawful and excessive use of force used against black and minority groups. Frequently at inquests there is an attempt to demonise the person who has died and reference made to their "superhuman" strength, and their "animalistic" behaviour.

The disproportionate number of black deaths in custody following the use of force was an issue that the government was slow to acknowledge despite the fact that INQUEST were documenting this issue at a national and international level.

[150] *See* cases of Giles Freeman, Mikey Powell, Andrew Jordan.

[151] INQUEST/Liberty/Bhatt Murphy submission to Attorney General review of CPS decision making following deaths in custody—2002.

The Home Office Bulletin "Deaths during or following police contact 2002–03 published on 20 November 2003 highlighted the rise in the number of deaths of people from minority ethnic communities. In response to this the Government has announced that it has commissioned research from the PCA in an attempt to discover any common factors underlying these deaths. It is a matter of concern that their response to this situation is to seek research from a discredited organisation in who the public have little or no confidence in given their history of involvement in a number of high profile black deaths in custody. INQUEST has not been contacted as part of this research.

3.d *The failures to learn the lessons*

These deaths show a systemic failure to learn lessons: to review, revise and implement policies, instigate new training, to share and disseminate information and guidance across different state agencies.

Evidence of dangerous practice and culture has emerged but the lessons to be learned have not been applied to the range of organisations that are increasingly involved in restraining people:

- police and prison officers and those working in psychiatric custody;
- immigration officers;
- private security firms detaining asylum seekers;
- security guards; and
- and those working in care homes for children, people with learning disabilities and older people.

In the majority of restraint-related deaths coroners have reiterated their concerns about restraint training and made recommendations but there is no mechanism for monitoring such recommendations and their communication and subsequent implementation across relevant Government departments.

In our view this failure to act and ensure inter-agency communication and collaboration in terms of policy and practice around restraint has resulted in more deaths and serious injury.

3.e *Deaths of detained patients*

The deaths of detained patients remain shrouded in secrecy and are not in the public domain to the extent as those that occur in police and prison custody.

Of particular concern is the failure of government or any of its arms length bodies to collate and publish annual statistical information about deaths of detained patients. The existing internal systems for examining and reporting these deaths are so poor that we believe some contentious deaths could escape any public scrutiny.[152] And in relation to the inquest system there is no requirement for the coroner to sit with a jury—a matter that must be addressed in any forthcoming reform of the inquest system.

INQUEST has been unable to take up the issue of the deaths of detained patients in the same way that is has worked consistently on the deaths of people in other forms of custody. We believe that it has been due to the relentless pressure we have applied in those cases that some change has happened in these settings. This is impossible when even access to information about who has died and in what circumstances is not available.

3.f *What does INQUEST's work reveal about deaths involving use of force?*

- The need for independent investigations into deaths following the use of force. All deaths should be treated as potential homicides until proven otherwise.
- Police related deaths are not being treated with the seriousness they deserve in terms of the investigation process—the Police Complaints Authority are continuing to sanction the same police force investigating itself even in cases where there are clear questions about the possible abuse of force. Very few members pass on our details to families. Families frequently complain about their conduct and that they appear to be a mouthpiece for the police. Families have also complained that Family Liaison Officers have been actively discouraged families from contacting INQUEST or from seeking legal advice and representation.
- Questions about inappropriate restraint, racist treatment, and lack of training and awareness and the failure to review and revise practices in light of deaths.
- Poor implementation, understanding and co-ordination of restraint training, and a lack of joined up thinking across government departments, made worse by the constant introduction of new theories that dilute the importance of training of the dangers of methods of restraint.
- There should be national training standards across different agencies and the establishment of an inter-agency group to share best practice and working with the Health and Safety Executive, to set up and monitor standards for the validation of training modules and courses;

[152] INQUEST written evidence to the Inquiry into the death of David Bennett 2003.

— The persisting ignorance about restraint related health risks—failure to keep watch on the physical well being of a restrained person has played a major part in many deaths.

— The lack of centrally collected and publicly reported information on the deaths of detained patients—following pressure on the police and prison service by INQUEST details are now provided on all deaths in police and prison custody including racial/ethnic group. This should happen as a matter of course.

— Cases have revealed a use of violence disproportionate to the risks posed to officer/nurse, especially involving black people and the mentally ill raising questions about the attitudes and assumptions held by some state officials and systemic and persistent deficiencies in police and prison officer practices. Training must include an understanding of why violence occurs and how to deflect it and use of alternative, non-aggressive techniques rather than the ready resort to the use of force.

— The majority of inquests have seen coroners recommendations but there is no mechanism to monitor recommendations made by inquests and inquiries and their communication and subsequent implementation across relevant government departments.

— Custodians have a difficult and sometimes dangerous job to do, to do their job however they must have the confidence of those they serve, to earn and maintain that confidence there must be a system of accountability that is open and transparent.

— There needs to be an urgent inquiry into the use of restraint across different state agencies.

4. The Inquest System

INQUEST has always argued that the right to an inquest is fundamental but that the current inquest system is failing particularly in relation to deaths that involve questions of state and corporate accountability.

There are severe shortcomings in the current systems for investigating and providing remedies after deaths in custody. These shortcomings violate Article 2 of the European Convention on Human Rights which enshrines the right to and which places a positive duty on the state to secure life. Investigations of deaths in custody are secretive, slow and not independent. The relatives of the deceased are too often excluded and marginalised. To them, the investigation can often appear less a search for truth than an attempt to avoid blame, frustrate disclosure, restrict the remit of the investigation and demonise the deceased.

We gave a detailed submission to the Home Office Fundamental Review of Coroner Services[153] detailing our concerns about the investigation and inquest system based on 21 years of advising bereaved families, monitoring post death investigations and attending inquests around the country.

"Any new system [of investigation] needs to operate within a framework that ensures openness, accountability, compatibility with the Human Rights Act and sensitivity to bereaved people and the public. To establish such a framework there needs to be clear national protocols for all aspects of post-death investigation. Those protocols need to enshrine clearly defined mechanisms of accountability, minimum levels of service delivery and a system of sanctions where practice falls below acceptable standards. The protocols need to set out clearly the rationale for each step that is taken, in a manner that is understood by professionals, bereaved people and the public. Above all it needs to be a system that balances the needs of the State with those of bereaved people and ensures that all participants have an equality of resources and information. Whilst the process will be painful for bereaved people it will be more bearable if it is seen to have legitimacy and meaningful outcomes."[154]

Public campaigns pursued by bereaved families following controversial deaths in custody and following major disasters have focused attention on the investigation process following contentious deaths in custody and the inadequacy of the coroners court as a forum for the examination of deaths where the state is suspected of having some responsibility. INQUEST monitoring has shown how the state uses the inquest and not the criminal prosecution and trial for the public examination of these deaths. These factors have serious consequences for families faced with an unexpected or violent death.

"The narrow focus of the inquiry puts artificial and invidious limits on the scope and style of conduct of the Coroner's inquiry, which often exclude from the inquest the issues of greatest concern to the family. The inquest is usually the only investigation of death to which a family has access. Importantly, for the public interest and democratic accountability it is the only public forum in which contentious deaths will be subject to scrutiny. Inquests are too often at risk, particularly in the absence of legal representation for the family, of being opportunities for official and sanitised versions of deaths to be given judicial approval—rather than being an opportunity for the family to contest the evidence presented, to discover the truth and full circumstances surrounding the death of their loved one."[155]

[153] How the inquest system fails bereaved people—INQUEST's submission to the Fundamental Review of Coroner Services—Deborah Coles and Helen Shaw—INQUEST 2002.

[154] Coles and Shaw *op cit.*

[155] Coles and Shaw *op cit*.

5. Investigations

Accessibility

Too often families are left isolated from the investigation process. They are unable to access the investigators let alone the actual investigation. Frequently families are contacted immediately after the death and asked to co-operate or participate in the investigation of their loved one. At this very early stage they will be going through a whole myriad of emotions. Grieving for their loved one, angry frustrated at the level of information forthcoming. There may also be feelings of guilt and of course shock.

When an investigator who is viewed as part of the Prison or Police Service then asks at this stage of the bereavement process for the family to be involved in the investigation it is not surprising that families are unwilling or more likely, are unable to get involved. This is before they have had chance to clarify in their mind what the issues they feel are relevant and when they are in no mental state to answer fully or accurately. In our view for a family to properly participate in any investigation they need time and space and often support from a third party such as someone from INQUEST or a solicitor/advisor. Their role can be very important in determining the terms of reference and scope of the investigation. Again if they were informed from the outset that they could participate in the investigation with the assistance of a third party and have a say in the terms of reference it might go someway to reassuring them that the death is being taken seriously. Clear issues of sensitivity arise from such interviews. Irrespective of whether or not a family decides to have full participation in the process they should still be kept informed of the progress of the investigation. INQUEST believes that more work needs to be done in this area and that we have an important role to play in this.

The investigators

All the investigators into deaths in prison are currently employees of the Prison Service. These investigators have often been unable to establish a relationship with families who are very often not confident in the way a death is being investigated because it is not seen as independent of the prison service. This of course is multi-factorial but issues of impartiality are paramount. A clear need for independent investigators is required and well documented in previous submissions made by INQUEST. In the recent death at HMP Styal the Prison Ombudsman was asked to investigate. However from the contact we have had with some of the families affected, it has not been clear to them that the PPO is independent from the Prison Service. This needs to be made more explicit. There may well be a need to have prison employees involved in the investigation but the need to demonstrate independence is paramount.

Length of an investigation

It is our experience that investigations into police and prison deaths are not generally released to the family until there is a date for an inquest. The inquest may not be held for 6—12 months, sometimes longer.

> In a recent case involving a restraint related death in police custody the family was informed that although the inquest was unlikely to be heard for at least a year, possibly longer it was unlikely that they would receive disclosure until 28 days before the inquest. This is in line with the pre-inquest disclosure guidance but in view is completely unreasonable. We do not see why the investigation reports are not disclosed immediately on completion. This would also allow the family/family lawyer to raise matters that they do not feel have been addressed in the investigation (see paragraph below on disclosure of information).

Disclosure is not provided as of right, not provided early enough and is too obstructive and allows material to be kept secret. In our experience disclosure is something the family/family lawyer has to fight for. The introduction of the voluntary protocol in April 1999 has brought some clarity to the process of disclosure and was welcomed but many problems still remain, particularly in the most contentious cases. Early disclosure of custody-generated documents is vital if the family and their representatives are to have *effective and constructive participation* in the investigation.

Findings and recommendations arising from investigations and inquests

Funding

It has often been lawyers instructed by families in pushing the boundaries of the inquest system who have helped to expose through their legal representation systemic and practice problems that have contributed to deaths. Indeed many of the changes to police/prison training and guidance or public awareness of health and safety issues have been as a direct result of families representation at inquests and our lobbying work thereafter for change and for lessons to be learnt.

There is unlimited public funding for experienced and quality lawyers to represent the Police while union or association funding is available for the police officers, or medical officers. INQUEST believes that where such a death occurs there should be an automatic right to public funding for legal representation without means testing. Although there has been some progress and all deaths in custody (though not involving deaths following police pursuits) are now recognised as coming within the scope of the funding code. Relatives of the deceased whom the law recognises have a legitimate interest cannot afford to take up that representation unless they are eligible for legal aid which effectively excludes a lot of low and middle income families. The Legal Services Commission has taken a very restrictive interpretation of eligibility.

The recent decision of Khan will improve the situation as it has resulted in a new statutory instrument[156] that gives the power to the Legal Services Commission to ask the Secretary of State at the Department of Constitutional Affairs to waive financial eligibility criteria in requests for funding for representation in inquest cases that engage Article 2.

The narrow remit of the inquest and its dependence on the police/prison investigation prohibits exploration of the wider policy issues or indeed any mention whatsoever of any other death than the one currently being investigated. Indeed the High Court in the Sacker case and the House of Lords in Amin[157] have recently questioned whether the present coronial system is an appropriate means for looking into cases that raise wider issues of concern.

Coroners have very wide discretionary powers to determine the scope of each inquest and although there is case law specific to deaths in custody that requires a "full and fearless investigation", that is open to wide interpretation. There is great variation in their practice and similar deaths in different parts of the country may be treated in very different ways.

The majority of information that has entered the public domain about deaths in custody has arisen only because of the deceased's family and friends full participation in the inquest proceedings facilitated by their legal representation. It is very rare for a coroner in the absence of legal representation on behalf of the deceased to conduct the kind of searching questions that occur when a family is represented. Many coroners are ill-equipped and are unaware of what is happening nationally to clean an understanding of broader policy issues surrounding custody type deaths or have not been provided with all the relevant disclosure by the police because they have not known what to request. The issue of resources is also a serious problem for coroners. This is very relevant when considering the inquest is the only public forum in which these deaths are subjected to any scrutiny and where systemic failings can be exposed. We are aware that there are custody deaths that have not been properly scrutinised because families did not have information and the resources or where the deceased had no interested family.

Our experience of such inquests is that lawyers representing custodial institutions are consistently instructed to take a defensive approach to the proceedings, trying to shroud what has happened or to attack the character of the deceased rather than assisting the court in the exercise of an impartial scrutiny of the death. In addition the approach to the inquest from the authorities as a damage limitation exercise means that there has been a reluctance to learn from these investigations.

> The recent inquest into the death of Roger Sylvester gives a good example. The lawyer acting on behalf of the Metropolitan Commissioner paid for out of the taxpayers purse via the Metropolitan Police Authority did not take a neutral role but launched an attack on the deceased and the lawyers and family campaign accusing us of having a political agenda.

We also see this post death where misleading, inaccurate information is placed into the public domain by police about the death in an attempt to demonise the deceased, blame them for their own death and deflect attention away from the conduct of the police.

6. Implications of the Human Rights Act

The limited ambit of investigations, ineffective inquiries and the failure to prosecute those responsible has all been issues for bereaved families. They have also increasingly become an issuein law both in the ECHR and in the domestic courts.

Where a citizen dies or suffers ill treatment in custody, the reaction of the State raises very serious questions about the protection of human rights. As a public authority the Police/prison service/has to comply with the Human Rights Act and all courts and tribunals including the coroner's court are also under a duty to ensure that convention rights are protected.

[156] The Community Legal Service (Financial) (Amendment No. 2) Regulations 2003. Statutory Instrument 2003 No. 2838.
[157] SSHD *v* Amin 16 October 2003.

There is already in existence case law about the importance of a full inquiry into deaths in custody and indeed under the Coroners Act there is a requirement for an inquest with a jury to sit on such deaths. The problem is that under the Coroners Act 1988 the inquest has a very narrow remit and is manifestly not a public inquiry; it is concerned primarily with establishing the medical cause of death, how the person died, by what means and not in what broader circumstances.

The most significant recent development in coronial law has to be the implementation of the Human Rights Act and the direct incorporation of Article 2 (the right to protect and safeguard life) into domestic law. The obligation on the state to protect the right to life requires the state taking appropriate measures to protect life, to investigate deaths and ill treatment in custody thoroughly and to prosecute where there is sufficient evidence to justify proceedings.

The obligation to take positive steps to protect life also requires some sort of investigation where death has occurred in a way, which engages Article 2 and 3 of the Convention because any fault in the system for protecting the right to life may well lead to further deaths (McCann v UK) and the lack of an effective investigation will in itself constitute a violation of Article 2.

The decision of the House of Lords on 16 October this year in the case of the SSHD ex-parte Amin, establishes once and for all consistent minimum standards for the state's duty to investigate deaths in custody.[158]

> The case arises out of the murder in a cell at Feltham YOI of Zahid Mubarek by his cellmate Robert Stewart. Despite a wealth of evidence warning of the dangers posed by Stewart, from his previous violent conduct in custody, his volatile mental state and racism they had been allocated to share a cell for 6 weeks before his murder. There was a complex history of investigations by the police, the Prison Service and the CRE, However no public hearings had been held and no opportunity arouse for the significant involvement of the next of kin.

The House of Lords ruled that whichever form the investigation takes there are minimum standards, which must be met as, set out in Jordan v UK[159] and Edwards v UK. The Court concluded in Jordan that there were five essential requirements of the investigatory obligation: independence, effectiveness, promptness and reasonable expedition, public scrutiny and accessibility to the family of the deceased. The lack of an investigation which embodies the requisite qualities will and of itself constitute a violation of Article 2.

It ruled that such requirements apply with at least equal force to a "state neglect" or omission case (relevant to deaths in police custody) as to a state 'lethal hands' case.

The approach to the House of Lords to the inquest issue is instructive. The coroner's affidavit explained her exercise of her discretion not to hold an inquest into this case (a discretion coroners have where a criminal trial has taken place) She gave detailed reasons why the resource and procedural restraints to which coroners and inquests are subject make an inquest an unsuitable vehicle for investigating publicly the issues raised by this case.

It was conceded for the family that in principle an independent police investigation and an inquest are capable of fulfilling the "Jordan" requirements and the state's investigative obligations as established by McCann as to the adequacy of the Gibraltar/SAS shootings inquest.

Many of INQUEST's concerns about the inquest process were put forward for the family at the Amin hearing including: inconsistency of disclosure of evidence to the family despite the Home Office circular, inconsistency of funding, the narrow boundaries to the jury's findings, coroners current restrictions upon system neglect. The Amin judgement recognises these concerns as legitimate and these comments are a vindication of our concerns about the inadequacy of the current inquest system in relation to contentious deaths in custody.

The Lords accepted the coroners reasoning both as to the problem of resources and legal restriction and agreed that many of the issues needing investigation 'would be beyond the scope of inquest. Lord Bingham refers to the Home Office review of coroners recommendations indicating that if implemented they would avoid such problems and adding that *"no doubt they are receiving urgent official attention."* (our emphasis).

There is now strong recognition of the need for more effective investigation than can be currently provided by inquests. The issues raised about individual and system neglect in the Amin although rare are sadly not unique. Until substantially reformed there is strong judicial recognition for the need for more effective investigations than can currently be provided by inquests and provides an important incentive to accelerate the programme for inquest reform.

[158] *See* INQUEST Law Winter 2003 Article by Paddy O'Connor QC.
[159] Jordan and ors v. UK (4 May 2001) ECHR.

This legally significant case has been brought about because of the courageous struggle by the family of the deceased whose campaigning will contribute to the future protection of vulnerable prisoners. Lord Bingham recognised this as one of main purposes of the investigation and thereby humanely connected the needs of the bereaved with the duties of the state.[160]

7. The Treatment of Families

Finally we would draw the Committee's attention to the poor treatment of bereaved families following deaths in custody. Despite a wider acknowledgement of the issues faced by bereaved people discussed below this thinking has bypassed families affected by deaths in custody.

In our submission to the Fundamental Review of Coroner Services[161] we wrote:

"In our experience the nature of the circumstances of many of the deaths on which we work inherently attracts prejudice and strong feelings and the majority of families we work with do not experience the system as compassionate. Families feel overwhelmingly excluded, dissatisfied and let down by it as a process for establishing the facts. The coroner's inquest has become an arena for some of the most unsatisfactory rituals that follow a death—accusations, deceit, cover-up, legal chicanery, mystification; everything but a simple and uncontroversial procedure to establish the facts.

There have been some important procedural changes but little substantial systemic change. Some of the more recently appointed coroners do have a different approach to their work but like many institutions what is needed is a culture shift. There are important developments taking place in the wake of the Alder Hey scandal and the beginnings of a greater understanding of the support needs of families following sudden and unnatural death. However, we remain concerned that the mainstream provision of bereavement support is delivered in the absence of evidence-based research on the particular impact of bereavement and the inquest process. It is also clear that those families who suffer the death of a loved one in custody are not considered in any of the initiatives taking place. There seems to be an institutional inability for the authorities to acknowledge that the need of a family whose loved one has died in custody are just as acute as those of someone who has lost a loved one following a death in hospital or a murder. However most new bereavement initiatives do not appear to have considered these families at all."[162]

With custody related deaths the lack of support and appropriate assistance is more acute with families feeling doubly victimised—they have suffered a death and because of its nature they are treated as though they are criminals.

All deaths in custody involve an inquest so the potential role of the Coroner's Service in guaranteeing informed and effective access to appropriate bereavement intervention options for bereaved families must therefore be a central concern in developing a new system.

Finding out how someone has died is a fundamental human right and an essential part of the bereavement process and in coming to terms with the death. All of the families who have sought our assistance have been motivated by a need to establish the truth for their own peace of mind, and to prevent others going through the same experience. Above all, they want an acknowledgement of fault or responsibility where appropriate, an apology where an apology is due, for justice to be seen to be done and for lessons to be learnt.

Maximising the possibility for families and friends to discover the truth is the guiding principle of INQUEST's casework service. The family can have a real information deficit after a death in custody. They have a very steep learning curve to understand the various investigations that are initiated by such a death. Some argue that the family should not be overloaded with information. Access to proper information and advice is crucial in ensuring that people are aware of their rights and it is the responsibility of the State to ensure that this happens at the earliest possible opportunity.

This should include information about access to the body, post-mortems, organ retention, rights regarding disclosure, the inquest process, and legal rights.

"The way families are informed of a death and the treatment they receive from officialdom at this stage can crucially set the tone for the way they are able to interact with the process."[163]

In our submission to the Prison Ombudsman on the treatment of families we documented our concerns about the poor treatment of families by many state agencies and the need for families to receive clear, accessible and accurate information about the circumstances of the death and where they can seek advice and support. It is a matter of real concern that there is still no mandatory requirement on the part of the police/prison service/NHS to give out INQUEST's details and information leaflet. This happens on an ad hoc basis only and is entirely dependent on the individual with contact with the bereaved. Provision of our information would at least give families *the choice* as to whether or not they contact us. We have too many families contacting us at a later stage in the process having been referred by friends/press etc and who would have benefited from specialist advice and emotional support much earlier.

[160] O'Connor *op cit.*
[161] Coles and Shaw *op cit.*
[162] Coles and Shaw *op cit.*
[163] Coles and Shaw *op. cit.*

A recent example of this is the mother of a young woman who took her own life in Styal prison in November 2002. She was given no information about INQUEST from the Prison Service or the Prisons Ombudsman when in contact with her as part of their investigation into Styal.

The mother of the deceased found about us via a small advice service in North Wales and contacted us for help. We have been able to find her a solicitor to assist her with preparing for the inquest which is yet to be heard and to refer her to a family who have been through a similar experience for emotional support. The result of the failure to refer the mother to us a year ago is that she has been alone and unsupported.

December 2003

Name	*Ethnicity*	*Date/type*	*Location/force*	*Prosecution*	*Inquest*	*Verdict*
Oliver Pryce	Black	1990 Police	Cleveland Police	No	Yes	Unlawful killing
Omasase Lumumba	Black	1991 Prison	HMP Pentonville—London	No	Yes	Unlawful killing
Leon Patterson	Black	1992 Police	Manchester Police	No	Yes	Unlawful killing quashed; new inquest 1996 misadventure contributed to by neglect
Joy Gardner	Black	1993 Police/ Immigration officers	Metropolitan Police	Yes—acquitted	No	No inquest
Richard O'Brien	Irish	1994 Police	Metropolitan Police	Yes—acquitted	Yes	Unlawful killing
Shiji Lapite	Black	1994 Police	Metropolitan Police	No	Yes	Unlawful killing
Alton Manning	Black	1995 Prison	HMP Blakenhurst Kidderminster	No	Yes	Unlawful killing
David Ewin	UK White	1995 Police shooting	Metropolitan Police	Yes—hung jury	No	No inquest
Ibrahima Sey	Black	1996 Police	Metropolitan Police	No	Yes	Unlawful killing
Christopher Alder	Black	1998 Police	Humberside Police	Officers charged with and acquitted of manslaughter in 2002	Yes	Unlawful killing
James Ashley	UK White	1997 Police	Sussex Police	Yes—acquitted	No	No inquest
Roger Sylvester	Black	1999 Police	Metropolitan Police	No	Yes	Unlawful killing

Appendix 1

DEATHS IN PRISON CUSTODY 1993–2003

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Self-Inflicted	48	59	59	64	69	83	91	81	72	95	90	811
Non-Self-Inflicted	2	5	7	53	47	45	55	57	50	55	65	441
Homicide (NSI)	1	2	3	2	2	6	0	3	1	0	1	21
Control & Restraint	0	1	3	0	0	0	0	0	0	0	0	4
Awaiting Classification	0	0	0	0	0	0	0	1	1	3	2	7
Total												1284

BLACK DEATHS IN PRISON 1993–2003

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Self-Inflicted	3	3	8	3	6	9	7	8	5	8	6	66
(Percentage)	6%	5%	14%	5%	9%	11%	8%	10%	7%	8%	7%	8%
Non-Self-Inflicted	1	1	0	5	6	5	10	1	2	1	6	38
(Percentage)	50%	20%	0%	9%	13%	11%	18%	2%	4%	2%	9%	9%
Homicide (NSI)	0	1	0	1	0	0	0	1	0	0	0	3
(Percentage)	0%	50%	0%	50%	0%	0%	0%	33%	0%	0%	0%	14%
Control & Restraint	0	0	3	0	0	0	0	0	0	0	0	3
(Percentage)	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%	0%	75%

YOUTH DEATHS (21 AND UNDER) IN PRISON 1993–2003

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Self-Inflicted	3	12	11	14	16	15	19	18	15	16	13	152
(Percentage)	6%	20%	19%	22%	23%	18%	21%	22%	21%	17%	14%	19%
Non-Self-Inflicted	0	2	0	3	1	3	1	0	0	2	2	14
(Percentage)	0%	40%	0%	6%	2%	7%	2%	0%	0%	4%	3%	3%
Homicide (NSI)	0	0	1	0	2	1	0	2	0	0	0	6
(Percentage)	0%	0%	33%	0%	100%	17%	0%	67%	0%	0%	0%	29%

JUVENILE DEATHS IN PRISON 1993–2003 (AGED 17 AND UNDER)

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Homicide (NSI)	0	0	1	0	0	0	0	0	0	0	0	1
	0%	0%	33%	0%	0%	0%	0%	0%	0%	0%	0%	5%
Self-Inflicted	1	2	1	1	1	3	2	3	3	2	0	19
	2%	3%	2%	2%	1%	4%	2%	4%	4%	2%	0%	2%

NB these figures are also included in the table of Youth deaths above

DEATHS OF WOMEN IN PRISON 1993–2003

Classification	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Self-Inflicted	1	1	2	2	3	4	5	8	6	9	14	55
(Percentage)	2%	2%	3%	3%	4%	5%	5%	10%	8%	9%	16%	7%
Non-Self-Inflicted	1	0	0	2	1	1	4	1	1	2	1	14
(Percentage)	50%	0%	0%	4%	2%	2%	7%	2%	2%	4%	2%	3%

DEATHS IN POLICE CUSTODY—ALL FORCES 1993–2003

Type	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Custody deaths	36	52	48	57	58	65	46	36	34	47	38	517
Pursuit	2	1	2	9	17	10	8	24	26	34	22	155
RTA	0	0	2	4	6	8	6	5	9	7	9	56
Shooting	3	1	2	2	0	2	3	2	4	2	2	23

BLACK DEATHS IN POLICE CUSTODY—ALL FORCES 1993–2003

Type	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
Custody	3	8	3	9	11	6	8	4	6	8	6	72
(Percentage)	6%	22%	6%	19%	19%	10%	12%	9%	17%	24%	13%	14%
Shooting	0	0	0	0	0	0	0	0	1	1	0	2
(Percentage)	0%	0%	0%	0%	0%	0%	0%	0%	25%	50%	0%	9%

POLICE CUSTODY DEATHS—RESTRAINT ISSUES RAISED 1993–2003

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	Total
All Forces	2	5	7	5	5	9	6	5	5	5	7	75
(Percentage)	6%	10%	15%	9%	9%	14%	13%	14%	15%	11%	18%	15%

Source for all statistical information: INQUEST monitoring.

* Figures for Black deaths, Youth deaths, restraint-related deaths and deaths of Women are all included in the relevant tables for deaths in Prison and Police custody.

* All percentages refer to the proportion of the total number of that classification of death in that year or total.

14. Memorandum from the Law Society

Thank you for the invitation to provide evidence to the JCHR's inquiry into Human Rights and Deaths in Custody. We would like to take this opportunity to make some particular points about the legal process following a death in custody.

There is a positive obligation on the State to prevent real and immediate risk to life. Article 2 (1) of the European Convention on Human Rights, which has been incorporated into domestic law by the Human Rights Act, emphasises that the right to life "shall be protected by law". This requirement on the State includes both protection from the intentional taking of life as well as the requirement to take "reasonable preventative measures to protect an individual whose life is at risk . . .".[164]

According to data held by the organisation INQUEST, 627 people have died in police custody since 1990. Between 1998–99, 65 people died in police custody, "the largest number of deaths in police care or custody on record", according to the Police Complaints Authority.[165] Although the figures have reported a decrease, this issue is still of serious concern.

According to that data, since 1990 there have been 114 black deaths in prisons in the UK and in the same time period 67 black deaths in police custody. A total of 181 black deaths occurred while individuals were under the custody or care of the State.[166]

The disproportionate disparity in the number of prisoners who are black and from ethnic minorities should not be ignored.

Because of the sensitive nature of death in custody cases, vigorous independence must be demonstrated. Previous reports examining the system from death through the inquest have raised the issue of public perception regarding bias in decision-making of the Crown Prosecution Service (CPS). The number of deaths in police and prison custody and the lack of prosecutions have reinforced the real or perceived bias of the CPS. The obligation of the CPS to produce "cogent reasons for not issuing proceedings"[167] may assist the public in their perception of independence.

The Society welcomes the establishment of the Independent Police Complaints Authority as a positive step towards building confidence in the system, and views the independent investigation of every death in custody as a possible homicide as essential.

In addition to concerns of bias, families of the deceased have had to contend with considerable delays. There are countless examples of delayed cases, and many still awaiting closure, adding much undue stress to already traumatised families. For example, Roger Sylvester, a black man, died in January 1999 following restraint by eight Metropolitan police officers. His inquest began in September 2003, nearly five years after his death.

David "Rocky" Bennett was a 38 year-old black man who died in October 1998 following an incident involving the use of restraint in an NHS medium secure unit. His 2001 inquest returned a verdict of Accidental Death aggravated by Neglect with recommendations from the Coroner on the need for national standards on restraint in psychiatric hospitals, and for staff to be pro-active in dealing with incidents of racist behaviour by and against patients.[168] Following calls for a public inquiry, the Government has agreed to an extended form of the usual inquiry that follows a death in psychiatric detention with a public element looking at the national lessons to be learnt. The inquiry began in March 2003.

The Law Society supports proper initiatives to remedy the delays in investigating deaths and concluding proceedings.

[164] *R (Amin and Middleton) v Secretary of State for the Home Department* [2002] 3 WLR 505.
[165] Police Complaints Authority, "News and PCA Reports – Deaths in Police Care or Custody", 1999.
[166] *See* INQUEST statistics www.inquest.gn.apc.org
[167] Rule 28 of the Coroners Rules 1984.
[168] INQUEST (2003) Press Release: *Public Sessions of the Inquiry into the Death of David "Rocky" Bennett.*

The Law Society has particular concerns about the effect on the ability of bereaved families to participate and feel included in the inquiry into the death. It has been documented that current disclosure arrangements at inquests fall below modern judicial standards in openness, fairness and predictability.[169]

The Law Society supports the disclosure of information to bereaved parties throughout the inquest process.

The ability of families to participate in the inquest process is greatly enhanced by the availability of public funding for representation at inquests. The Law Society welcomes the announcement that exceptional funding will apply to all deaths in custody. However, we are concerned about the practice of means testing wider family members in inquest cases.

The Law Society supports reporting from the Coroner following an inquest to relevant authorities and monitoring to help prevent future deaths.

15 September 2003

15. Memorandum from Liberty

Introduction

1. Liberty welcomes the Joint Committee on Human Rights call for evidence into Human Rights and Deaths in Custody. Liberty published a report in March 2003 *Deaths in Custody: Rights and Remedies*[170]. There is extensive common ground between the contents of that publication and this submission. Many of the comments made will reflect those in our earlier submission.

2. We are not responding to some of the questions on the causes of deaths in custody as we do not have expertise in this area and imagine there are a number of organisations who will be able to provide detailed responses.

Preventing Deaths in Custody

3. We believe a human rights approach to conditions and management of detention can have a significant impact in preventing deaths in prison custody. Human rights are too frequently considered simply in terms of the Human Rights Act 1998. Because of this "human rights" only become an issue when a threshold has been reached. In Article 3 cases the European Court of Human Rights has defined torture as "deliberate inhuman treatment causing very serious and cruel suffering"[171] while in the same case degrading treatment was described by the Commission as ". . . ill treatment designed to arouse in victims feelings of fear, anguish, and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance". Inhuman treatment has been defined by the Commission as ". . . such treatment as deliberately causes severe suffering, mental or physical, which, in the particular situation is unjustifiable."[172] Clearly these are difficult hurdles to overcome and in many cases where a prisoner feels he has been treated in a degrading manner Article 3 will not be engaged.

4. However, the majority of suicides and incidents of self harm in prison will not occur as a result of one particular incident that has breached Article 3 but rather the culmination of a series of minor incidents. Education and training in rights and entitlements for prisoners and prison staff will help identify types of treatment which might be "degrading" but do not engage Article 3.

5. We believe that a "human rights culture" is best achieved through the creation of a statutory joint Equalities and Human Rights body. The government has already indicated its intention to set up a Single Equality Body through consultation exercises early in 2003[173]. This body will be able to provide advice and assistance to prisoners who are concerned over treatment of the grounds of race, sexuality, religion, gender, disability or age. This will necessarily be limited to those situations where equality is an issue. It would not be able to assist when equality did not feature in a complaint. The inclusion of human rights in the remit of a Single Equality Body will "fill in the gaps" between the differing equality strands and (depending on the remit of such a body) provide greater recourse to prisoners. We are also in favour of the proposal to create a statutory Prisons and Probations Ombudsman with powers to investigate complaints and deaths in prison and approved premises. As with any public body with the power to investigate complaints we would emphasise the importance of relevant and adequate human rights training.

[169] Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland (2002) Certifying and Investigating Deaths in England, Wales and Northern Ireland p 13 paragraph 20.2.

[170] *Deaths in Custody: Rights and Remedies* Dr Greta S Vogt & John Wadham. Published by the Civil Liberties Trust and is available from Liberty or at www.liberty-human-rights.org.uk. Danny Friedman at Matrix Chambers drafted much of the text on Article 2 violations.

[171] *Ireland v United Kingdom* (1979–80) 2 EHRR 25.

[172] Greek Case 12 YB 1.

[173] *"Equality and Diversity: The Way Ahead"* and *"Equality and Diversity: Making it happen"*.

INVESTIGATIONS OF DEATHS IN CUSTODY

6. Article 2 ECHR, The Right to Life, is often said to be the most fundamental of Human Rights, the basic pre-condition of the enjoyment of other rights.[174] The first sentence of Article 2(1) emphasises that a persons right to life "shall be protected by law". It has been held that this requires the state not only to refrain from the intentional and unlawful taking of life but also to take steps to safeguard the lives of those within its jurisdiction[175]. In addition the state is required to give appropriate training, instructions and briefings to those agents who may be faced with a situation where death could occur under their control or responsibility.[176] The right has also been identified as extending to taking positive steps to prevent suicides of those in state custody. In *Keenan v UK*[177] the European Court of Human Rights (ECtHR) stated that obligations under Article 2 extended to a duty to prevent self-inflicted deaths in custody where the authorities were on notice of a "real and immediate risk to life". Similarly not receiving proper medical treatment when the prisoner suffers from an illness could amount to a violation[178], and a failure to communicate relevant information could give rise to an Article 2 violation if this failure results in a person not being adequately cared for.[179]

7. The obligation to take positive steps to protect life also requires some form of investigation where death has occurred in a way which engages Article 2 or 3 of the Convention[180]. The lack of an effective investigation will in itself constitute a violation of Article 2. This extends beyond deaths that occur as a result of the actions of those who work for the state to self inflicted deaths in prison[181], and to circumstances that lead to an inmate being placed in a cell with someone who is dangerous[182]. In *Jordan v UK*[183] and *Edwards v UK* the ECtHR held that in order to satisfy the requirements of Article 2, any investigation had to satisfy four criteria (the "Jordan criteria"):

- it must be independent from those implicated in the facts;
- it must be capable of leading to a determination of whether state agents are liable for the death and/or the identification of those responsible and (if appropriate) their punishment;
- it must be prompt;
- it must involve a sufficient element of public scrutiny and must involve the next of kin in the investigative procedure to the extent necessary to protect their legitimate interests.

8. The Court of Appeal in *R (Amin and Middleton) v Secretary of State for the Home Office*[184] unfortunately appears to have taken to view that the Jordan criteria are not binding. It held that Article 2 could not be defined by strict rules and that it is up to domestic courts to decide what is required to determine convention rights on a case-by-case basis, commenting at paragraph 61 "the task of our courts is to develop a domestic jurisprudence of fundamental rights. Drawing on the Strasbourg cases of which by S2 HRA we are enjoined to take account of but by which we are not bound." We feel this approach is flawed for two reasons. It is at odds with House of Lords and Court of Appeal authorities that have warned against departing from clear and recent Strasbourg authority on the basis that it is likely to be overturned in Europe[185]. More importantly, it fails to distinguish between the mandatory terms of the Jordan criteria and the procedural flexibility that is afforded member states in providing safeguards. The ECtHR has indicated on a number of occasions that while the procedure by which due process entitlements are delivered are a matter for individual states, the entitlements themselves are mandatory.

9. Because of this Liberty believes that the Jordan criteria are binding on the UK and the cornerstone of any consideration into the manner in which the following state agents carry out investigations.

10. *The coroner's jurisdiction and the inquest*

We are concerned that there is a lack of public confidence in, and understanding of, the inquest system. According to the Coroners Act 1988, the coroner's inquest is inquisitorial. In cases inquiring into deaths in police or prison custody the coroner must sit with a jury. The coroner is under a duty to ensure that a balanced and representative picture of evidence is available in court. As the system is inquisitorial rather than adversarial it has fundamental differences to the criminal and civil courts. This can create problems, especially for the relatives of the deceased, as to the function, transparency and effectiveness of the system. For example, there are no parties to the hearing and there are no formal allegations or proceedings. Instead the jury will listen to the evidence and may ask questions, as may the coroner. After evidence has been given

[174] *R v Secretary of State for the Home Department,* ex p Bugdaycay (1987) AC 514.
[175] *Osman v UK* (1999) 29 EHRR 245.
[176] *McCann v UK* (1995) 21 EHRR 97.
[177] (2001) 33 EHRR 38.
[178] *McFeeley v UK* (1981) 3 EHRR 161, R (Wright and Bennett) SSHD (2002) HRLR 1.
[179] *Edwards v UK* (2002) 35 EHRR 19.
[180] *McCann v UK. Ibid* 7.
[181] *Keenan v UK* (2001) 33 EHRR.
[182] *Edwards v UK Ibid* 10, R (Amin and Middleton) v SSHD (2002) 3 WLR 2002.
[183] (2001) 33 EHRR 38.
[184] (2002) 3 WLR 505.
[185] *R v Secretary of State for the Environment ex parte* Alconbury (2001) 2 WLR 1389, R *(Anderson) v SSHD* (2002) 2 WLR.

only the coroner can address the jury as to the facts and any legal representative will not be able to make a closing statement as would happen in a criminal case. After summing up the evidence the coroner will set down for the jury those verdicts he considers available and relevant. For a verdict of suicide or unlawful killing the standard of proof is to the criminal level, for all other verdicts the civil standard applies. Importantly, no verdict may determine any form of criminal or civil liability. Once a verdict has been reached the coroner has the power to report the case to an appropriate authority with a view to action being taken. However this recommendation does not have to be made public and the parties do not have a right to be consulted or even to see the report.

11. The difficulty for the family of the deceased is how to make sense of inquest proceedings. It may be quite easy for a lawyer to understand how a verdict of unlawful killing does not apportion blame or lead to criminal liability but relatives do not. The family wish to find out "the truth" and where appropriate see the prosecution of those responsible. Achieving both these aims might not be possible as the compelling of evidence precludes that evidence being used in criminal proceedings, as this would breach the self-incrimination provisions in Article 6. However, we believe much can be done to make the coroners system more compatible with the Jordan criteria. If finding the truth is of paramount importance then the privilege against self-incrimination could be abolished so that police and prison officers could be forced to give evidence and answer questions at the inquest. Any evidence would of course not be permissible in any subsequent criminal proceedings.

12. Generally inquests need clearer rules of procedure. The relatives of the deceased should be made a formal party to proceedings and have a right to representation. They should also have the powers of a party to civil litigation—to cross examine, to address the jury and to call witnesses. The inquest system should be generally adversarial and the coroner should have an adjudicative role (while retaining the power to call witnesses for example). The usual civil rules of disclosure should apply to the inquest. There should be a review of existing verdicts which should include a verdict indicating negligence or a failure of a duty of care. Properly interested persons should have a right to legal representation. This should not be means tested due to the importance of such case and the public interest. The small number of cases involved would not mean this was a significant drain on the public purse. There should be a right to appeal to the High Court on a point of law. Making the inquest system similar to the civil courts procedure will make the process more familiar, comprehendible and acceptable to the families of the deceased.

13. *Investigations by the Prison Service*

Liberty is in favour of the proposal to create a statutory Prisons and Probations Ombudsman (PPO) with powers to investigate deaths in prison and approved premises. We are particularly pleased to see that the PPO will investigate all deaths whatever the apparent cause. We do have some concern that the PPO will be able to decide on the level of investigation required. For example when a prisoner has died due to "natural causes" we would still want to see adequate investigation as death by natural causes does not preclude the possibility of clinical oversight or negligence. We also support the proposal that the PPO should be able to require witnesses to attend an interview and respond to questions about the death. However, as mentioned above, this will certainly preclude the use of such evidence in subsequent criminal proceedings. As the new body has not yet come into being we do not propose to comment in greater detail other that to say that the consultation process into the setting up of the PPO seemed to have taken care to ensure that Article 2 considerations and the Jordan criteria had been taken into account. However, the consultation document did not consider the issue of resources, possibly because it was not felt to be appropriate at that point. Placing the investigation of deaths in prison custody onto a statutory footing is an important step to take and we hope it is successful. It is vital that sufficient resources are made available to the PPO to ensure this. It is important not to underestimate the resources needs for a proper, thorough and effective investigation which complies with the requirements of Article 2.

14. *Investigations by the IPCC*

Liberty has been involved in and supportive of the setting up of the Independent Police Complaints Commission. We are optimistic that the IPCC will bring a public confidence in the independence of complaints against the police that the Police Complaints Authority never enjoyed. As the IPCC will not come into operation until April 2004 we can only base our comments on the proposals as they currently stand. We are members of the Police Complaints Programme Board and have been sent a discussion paper relating to the role of the IPCC in the investigation and supervision of complaints. We are pleased to see this paper recognises the importance of Article 2 obligations at paragraph 4.1, "It is now settled law that Article 2 of the European Convention on Human Rights contains a requirement that an effective and independent investigation be undertaken into any death involving agents of the state . . . Any failure on the part of the IPCC to provide an effective investigation of death, for example in police custody could give rise to a successful Article 2 challenge".

15. While we feel that the IPCC has the potential to act in a manner that will satisfy Article 2 obligations we are concerned about the resources available. The IPCC has stated that it believes that 364 investigators will be required to match the previous police investment in terms of investigator days. However, when the IPCC begins work on 1 April 2004 it will have 70 investigators, approximately one fifth of the number

required. This number will increase with the further appointment of 70 investigators anticipated by September 2004 but it will be several years before the IPCC has the number it regards as necessary. Indeed there is no guarantee that it will ever be given a sufficient number of investigators.

16. This is of particular concern, as the Police Reform Act 2002, which set up the IPCC, does not guarantee independent investigation even in the case of deaths in police custody. Paragraph 6.5 of the investigations discussion document states, "After a few days of independent investigation of a death in custody it may be recognised that the facts have been fully established, the truth of the matter has been determined and there is no longer a need for public concern or IPCC independent investigation. At such a stage any outstanding investigative responsibility could be handed to the police force concerned under the continued management or supervision of the Commission". We would question the impact on the deceased's relatives of an independent commission handing control back to the local force in any situation. Given the current availability of investigators there must be the concern that any decision would by necessity be resource driven. When we have raised these concerns we have been reassured by the IPCC that they would not allow resources to dictate decisions inappropriately and we have no reason to dispute this. Bearing in mind the Jordan requirement of independence from those involved it is vital that the IPCC do not take any such decision lightly.

17. *Criminal Prosecutions*

It is in this area where the greatest concerns lie. As a decision to prosecute is usually taken before an inquest has opened it can be extremely difficult for the family of the deceased if no decision to prosecute is taken, but a subsequent inquest indicates that a crime may have been committed. The coroner can refer a case to the CPS if he comes across a criminal offence or if the jury returns a verdict of unlawful killing, but in practice this is rare. The closeness of the relationship between the CPS and other state agents can be seen as a problem. In practice, no police officer has ever been convicted of any of the homicide offences following a death in custody. Since 1990 there have been eight deaths in custody where inquests have returned unlawful killing verdicts. Seven of these were preceded by and followed by CPS decisions not to prosecute.

18. The Attorney General recently undertook a review of the role of the CPS in relation to custody deaths. He was "impressed by the conscientiousness of the CPS lawyers . . . making the decisions" and found "that they had done so diligently"[186]. However he also accepted that the families of the deceased held no confidence in the decisions. Even if the CPS is acting in a diligent manner there is a clear perception problem. While we are not convinced that there is a justification for setting up a new body, or transferring responsibility to another body such as the IPCC, we believe that there is a need for improved performance of the CPS. For example, a special unit could be directly responsible to the Director of Public Prosecutions and separate from the rest of the CPS. Certainly there needs to be enhanced scrutiny of the decision making process. There should be a statutory requirement to give full reasons behind a decision not to prosecute. Families must be informed throughout the decision making process and during the prosecution itself. An amendment to the Code for Crown Prosecutors could create a presumption that a prosecution would be in the public interest—although this would clearly have to be rebuttable to avoid cases proceeding when not relevant. Certainly all deaths in custody should be initially investigated as homicides so that the principal aim is to secure evidence.

19. *Civil proceedings*

Although a civil action is primarily taken in order to obtain damages, there are distinct advantages over the inquest process for the relatives. As claimants they will be in control of the process and, as disclosure rules are more robust, they will have greater access to documents. As they will be represented, they will also have the chance to call and cross-examine witnesses. Unfortunately, a plaintiff can generally bring an action only if they were in some way dependant on the deceased[187]. It may also be considered unsatisfactory, as a successful civil action has never been followed by a criminal prosecution, and even if successful there is unlikely to be any disciplinary action.

20. A possible improvement to the current situation would be reform of the current civil action provisions, including more recognition (financially and in eligibility of persons) for death in custody cases. As mentioned earlier, the inquest system would benefit from greater similarity to the civil process and it is arguable that the inquests could even be incorporated into the civil system. As well as overcoming many of the problems faced by relatives of the deceased (as identified earlier) it would provide the possibility of a "remedy" (albeit in civil law).

[186] Summary of Conclusions: paragraph 6.1.
[187] Unless there is a surviving course of action such as negligence in which case they do not have to be dependant.

21. *Other avenues*

Public enquiries are not a useful remedy. They are time consuming, expensive and usually only arise after considerable public pressure. We would like to see the inquiry process become less *ad hoc*, but rather being incorporated into an official part of the examination into deaths in custody. To this end Liberty strongly recommends the creation of a separate, over arching, Standing Commission into Custodial Deaths. Its remit would cover deaths both in prison and police custody as well as other institutions such as reception and detention centres for asylum seekers. There are many common concerns that arise with deaths in different custodial settings and separate bodies prevent these concerns being addressed on a more holistic basis. The mandate of such a commission would be to bring together the experiences from the separate investigative bodies which deal with police, prison, hospital deaths and others. While it would not have any investigative role, it should have the power to hold a wider enquiry in circumstances where there was a consistent pattern of deaths. Except when conducting enquiries we do not believe the commission would need substantial resources.

September 2003

16. Memorandum from the Medical Foundation for the Care of Victims of Torture

1. The Medical Foundation for the Care of Victims of Torture has helped more than 35,000 people with medical treatment, psychological support and practical assistance at its north London treatment centre since it was established in 1985. It is the only organisation in Britain dedicated solely to helping survivors of torture and organised violence and their families. The Medical Foundation has a recognised expertise in the documentation of torture. We currently prepare more than 1,000 medico-legal reports per year.

2. The Medical Foundation is an independent charity (company limited by guarantee, registered in England no 2398586, charity reg no 1000340).

3. The Medical Foundation is staffed by approximately 210 volunteers and employees, including medical, clinical and professional support staff. Essential to our services is our team of 95 regular and occasional interpreters, who facilitate communication between staff and clients in some 60 languages.

4. The Medical Foundation will limit its submission to torture survivors who may, because of their past experiences, be more at risk of suicide or self harm. The Committee is referred to our publication *Protection Not Prison: Torture Survivors detained in the UK*[188]. Six main recommendations were made in that study:

- greater use should be made of Port Medical Inspectors to carry out initial medical examination of asylum seekers;
- factors telling against detention should be recorded when the decision to detain is made;
- comprehensive physical and mental health screening should be offered to all on arrival in detention;
- staff in detention facilities should receive training to recognise and deal with health care issues, including those of torture survivors;
- legal representatives should ensure that any medical evidence of torture is sent both to the section of the Home Office that deals with the decision to detain, and to the section that considers the asylum application;
- Home Office officials reviewing a decision to detain should check whether there is any information on the asylum file relating to a history of torture.

5. These recommendations have not or have not adequately been followed up, in the view of the Medical Foundation. Page 17 of the said report deals with our concerns regarding the mental health of the subjects of the report and refers to one particular case where a torture risk had been unobserved:

> The files of seven of the 15 men with psychological problems mentioned that medication was being prescribed, usually sleeping tablets or antidepressants. The fact that something was prescribed does not necessarily mean that the treatment was adequate. There were a few cases where the data suggested that the case was not handled appropriately. One of these (16125) concerned a man who was detained, first in Tinsley House and then in HMP Rochester after his appeal was dismissed. His history of torture is given on page 6. He was receiving medication in Tinsley House and was examined by a GP there on account of his erratic behaviour. The GP reported that it was not in the patient's interest to be sent to a mental hospital, since his detention was only for the purposes of removal to his country of origin. His solicitor believed he was mentally ill and arranged for a consultant psychiatrist to visit. By this time the man had been detained for two months. The consultant reported that he was suffering from paranoid schizophrenia and that inpatient psychiatric care was urgently needed. He was said to be a serious suicide risk and not fit to travel. He was transferred to a secure psychiatric unit. It is clear in this case that Tinsley House failed to deal with the case appropriately. The GP's view that psychiatric treatment should not be pursued for a detainee who was to be removed was patently wrong.

[188] Dell, S & Salinsky, M, Medical Foundation for the Care of Victims of Torture, 2001.

6. The Medical Foundation does not believe that the situation has improved since these case studies were put forward in 2001. The Medical Foundation remains concerned that no mechanism exists (notwithstanding the Detention Centre Rules) to identify torture survivors in detention so as to ensure that adequate consideration be urgently given to the question of their continued detention. Indeed the Immigration Service Detention Services were put on notice of similar issues in HMIP's reports on Removal Centres and specifically Strategic Recommendation 10:

> Protocols should be agreed for the release of medical information, with consent, to the immigration authorities and detainees' representatives, if such information is relevant to fitness to detain or the detainees asylum claim, and the action that should follow.

7. However, while accepting the concerns raised, Detention Services were unable to offer a concrete and immediate solution in the Action Point proposed:

> Rule 35 of the Detention Centre Rules 2001 already provides for the reporting of health matters likely to be affected adversely by detention and on any case where the centre doctor is concerned that the detained person may be a victim of torture. Systems are in place in removal centres and the Immigration Service to ensure that such information is transmitted and taken into account in the context of continued detention or the consideration of the persons asylum claim. There are however, complex issues of disclosure and the Immigration Service is looking at ways in which the flow of information might be improved consistent with the requirements of patient confidentiality.

8. This response concerns the Medical Foundation. Our own report dated 2001 (the year in which the Detention Centre Rules came into force) highlights the very issue that Detention Services is only now turning its attention. It was pointed out to Detention Services at its User Group meeting of 10 June 2003 that:

> . . . the (Detention Services) Operating Standard on Health was insufficiently robust on ensuring that action was taken in Removal Centres in respect of victims of torture . . . the proposed action plan should refer to the EU Directive on Minimum Standards for the Reception of Asylum Seekers[189] (January 2003) which required the Secretary of State to lay down minimum standards and that the Immigration Service would be remiss if it did not take the Directive into account.

9. The Medical Foundation has also offered to discuss the issue of confidentiality and has in the past suggested to detention Services that these issues are fully addressed in the BMA Handbook on Human Rights[190]. Doctors under a dual obligation are examined at length therein. The Medical Foundation considers that, if the will truly existed, the "complex issues of disclosure" could have been addressed some time ago.

10. Unless and until the Immigration Service Detention Services apply themselves to the real risks inherent in maintaining the detention of torture survivors (identified and unidentified) then cases similar to those in our study of 2001 will continue to emerge and the risk of suicide and self harm among torture survivors in detention centres remains a real risk.

16 September 2003

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17. Memorandum submitted by Mind

1. Introduction

2. The Joint Committee on Human Rights has called for evidence relating to human rights and deaths in custody. Mind is concerned about this issue as people with mental health problems account for a large percentage of the total number of people in the custody of the State and the number of people who die in custody. In a recent study, of 172 suicides which had taken place on 1999 and 2000, 72% of people had at least one psychiatric diagnosis identified on entry to prison.[191] Mind believes this inquiry needs to consider people who are detained in the following settings:

(i) *Prisons and police detention*

(ii) *Mental health institutions*. This should include people who are technically detained under the Mental Health Act and those who are in effect unable to leave. This may arise from inability to express a wish either to remain in hospital or be discharged or from being advised that if they attempt to leave, they will be detained under the Mental Health Act. These two groups of people have none of the legal safeguards associated with formal detention. We would therefore suggest that the inquiry encompasses all deaths which take place in psychiatric in-patient settings.

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[189] 203/9/EC of 27 January 2003.

[190] *The Medical Profession and Human Rights: Handbook for a changing agenda.* BMA 2001.

[191] Shaw J, Appleby L and Baker D, (2003) Safer Prisons: A National Study of Prison Suicides 1999–2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness, Department of Health.

3. In addition, the high proportion of people from black and minority ethnic communities detained both in in-patient psychiatric settings and in prisons is a cause for great concern. For example, a study in south London found that black populations had a rate of admission to medium-secure units seven times higher than their white counterparts (28 per 100,000 compared with 4 per 100,000).[192] Following a number of cases of deaths of people from these communities, particularly young black men, (for example the death of David "Rocky" Bennett in 1998), it is evident that the needs of black and minority ethnic people need particular attention.

4. In response to the questions raised by the inquiry, Mind would like to make the following points, many of which apply equally to prisons and in-patient psychiatric settings. This response will cover the following areas:

— what are the main causes of suicide and self-harm in custody;
— what are the main causes of other deaths and injuries in custody;
— cultural issues; and
— investigation of deaths in custody.

The submission concludes with a summary of recommendations.

What are Main Causes of Suicide and Self-harm in Custody?

5. Incidences of suicide and self-harm often arise either due to inadequate care and support available to people whilst in a detained setting, or when conditions a person has been detained in are not conducive to minimising anxiety and ensuring they feel safe. This may result in suicide or self-harm, or alternatively in increased agitation or aggressive behaviour which may lead to physical restraint or increased medication being used which has in the past led to deaths (see section on other deaths in custody). In addition some forms of detention such as the use of police cells as places of safety under the Mental Health Act and the use of seclusion cause particular concern.

6. Inadequate Care and Support

7. Mental healthcare provision in prisons is generally poor. Health provision remains dominated by physical health concerns and the services available for people experiencing mental health problems have been acknowledged as falling far below the standard generally available from the NHS outside prisons.[193]

8. People's general level of mental health tends to deteriorate whilst they are detained in prison. In addition to poor services, a number of factors contribute to this which are detailed below. Many of these also relate to in-patient psychiatric care. The Ninth Biennial report of the Mental Health Act Commission found that there are a number of issues relating to conditions which have human rights implications under Articles 3 and 8, for example, denial of access to correspondence and family visits.[194]

9. Isolation from families. Many prisoners are placed in prisons a long distance from their home and it is often difficult for families to visit. This leads to increased social exclusion and can cause great distress.

10. Overcrowding and staff shortages. When prisons become overcrowded, services which have been put in place to support vulnerable people become overwhelmed with the result that some people cannot access support when they need it. Staff who are overstretched can fail to notice when someone is experiencing distress. In addition, overcrowding leads to frequent relocation of prisoners.

11. Disruption due to relocation. If a prisoner who has mental health problems is moved from prison to prison, any services or support they are receiving stop and relationships which they may have built up with support staff are broken, often at short notice, and similar services may not be available in the prison they are moved to.

12. Staff training. Prison staff generally receive little mental health awareness training and often do not pick up signs that a prison is experiencing distress or be able to deal appropriately with a prisoner in distress.

13. Lack of information sharing. In many cases information from NHS health records relating to a prisoner with mental health needs is not shared when they enter prison, making it difficult to adequately assess their needs and provide adequate services for them.

14. The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (2003)[195] made a number of recommendations, including:

— health screening at reception should be carried out by someone with relevant mental health training;

[192] Guite, H *et al* (1996) Diversion from courts and prisons to psychiatric care in a district. Unpublished report, Department of Health and Epidemiology, Kings College London.
[193] Reed, J L (2000) Inpatient care of mentally ill people in prison: results of a year's programme of semistructured inspections.
[194] Mental Health Act Commission (2001) Ninth Biennial Report, HMSO.
[195] Shaw J, Appleby L and Baker D, (2003), ibid.

— information regarding prisoners with prior mental health service contact should be obtained from GPs, mental health services and others within 24 hours;

— mental health services and GPs should accept responsibility to share information with prisons and should no longer impose charges;

— health and risk related information should be shared with all members of staff within the prison who are responsible for the prisoner;

— a family hotline should be established within each prison to enable family members to obtain and pass on information regarding suicide risk in prisoners; and

— all prisoners who have a history of mental health symptoms suggestive of serious mental illness or a history of self-harm should have a multi-disciplinary care plan initiated at reception.

15. In addition, Mind recommends:

— the quality of mental health care available in prisons should be an equal level to that available generally in the NHS;

— a range of services should be available and prisoners experiencing mental distress should have access to a choice of treatments including talking treatments such as counselling and psychotherapy;

— training for all prison officers should include a mental health awareness component;

— clear procedures should be in place for prisoners to seek advice or assistance with regard to mental distress they are experiencing;

— prisoners engaging with mental health services involving a therapeutic relationship should not be relocated unless this is unavoidable;

— prisoners using mental health services should not be relocated unless it is established that adequate services to meet their needs will be available in the new location.

16. Environment in Which a Person is Detained

17. The physical environment in which a person is detained is a key component of developing a calm atmosphere in which a detained person can feel safe and increased anxiety can be minimised. The Royal College of Psychiatrists has issued guidelines for the design of mental health units with this in mind,[196] which Mind believes should be implemented.

18. These recommendations include:

— all areas are kept clean and tidy;

— reception areas are well planned;

— there are separate/designated areas for patients with police escorts;

— there is adequate natural lighting and fresh air;

— noise levels are controlled and crowding avoided;

— there is a perception of space;

— private space and rooms are provided;

— private toilet, bathroom and single sex areas are provided;

— private staff rest areas are provided;

— ambient temperature and ventilation are adequately controlled;

— safe activities inside and outside are provided, ensuring an access to fresh air;

— non-smoking and smoking areas are provided; and

— personal effects are safe and accessible.

19. Places of Safety

20. Under section 136 of the Mental Health Act (1983), a person who is detained under section 136 may be taken from a public place to a "place of safety" in order that the person can be assessed by a doctor and interviewed by an Approved Social Worker. Local policies should be in place to define how this should take place, and the Code of Practice states that "as a general rule it is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital rather than a police station".[197]

[196] Royal College of Psychiatrists College Research Unit (1998) Management of Imminent Violence: Clinical Practice Guidelines to support mental health services (Occasional Paper OP41) London, Royal College of Psychiatrists.

[197] Mental Health Act 1983 Code of Practice.

21. In research undertaken by the Revolving Doors Agency in 1995, however, even where local agreements had nominated a hospital as the usual location to be used as the place of safety, police cells were still often used.[198] Problems arise as police officers do not have the experience and training to deal with this situation, and police cells are not designed in such a way as to provide a suitable or therapeutic environment for someone experiencing mental distress.

22. Mind recommends that:

23. Police cells are not used as a place of safety under the terms of a new Mental Health Act, and that in all areas, local agreements are made as to which locations are to be used as places of safety. In all cases, individuals requiring a place of safety should be taken to a proper clinical setting.

24. Seclusion

25. Seclusion is the supervised confinement of a person in a room which may be locked. It is highly distressing for individuals being held in this way. The Mental Health Act 1983 Code of Practice gives guidance on how seclusion should be used and in a recent case, it has been established that these guidelines should be followed in in-patient psychiatric care and breach of this could constitute a breach of human rights (Articles 3 and 8).[199] The majority of the guidelines outlined in the Code of Practice are also relevant to prison environments. These include:

26. The sole aim of seclusion should be to contain behaviour which is likely to cause harm to others. It should be used as a last resort and for the shortest possible time. It should not be used:

- as a punishment or threat;
- as part of a treatment programme;
- because of shortage of staff; and
- where there is any risk of suicide or self harm.

27. Mind recommends that in relation to seclusion, hospitals and prisons should:

- have clear written guidelines on the use of seclusion which ensure the safety and well being of the person being detained;
- specify a suitable environment for seclusion to take place;
- set out the roles and responsibilities of staff; and
- set requirements for recording, monitoring and reviewing the use of seclusion.

28. Causes of Other Deaths or Injuries in Custody

29. Mind is aware of a number of cases where death has been linked to management of aggressive behaviour involving restraint or medication. Several of these incidents have taken place when a person has been detained in a police station prior to transfer to another setting, as well as in prisons, special hospitals and other in-patient psychiatric settings.

30. Mind believes that in the management of aggression of people who are detained, and particularly those who are experiencing mental distress, staff should take a holistic and preventative approach. If any intervention is needed then treatment used to prevent violence must be neither hazardous nor irreversible.

31. A holistic approach should address:

- advocacy, support and information provision to detained people and family;
- the environment within which a person is detained;
- risk assessment, taking a multicultural approach;
- staff training on guidelines for carrying out control and restraint;
- documentation of the measures used for the purposes of restraint; and
- debriefing and learning outcomes for staff from each episode.

32. Further explanation of what Mind believes should happen in relation to some of these key areas is given below.

[198] Revolving Doors Agency (1995) The Use of Section 136 Mental Health Act in Three Inner London Police Divisions.
[199] *R (Munjaz) v Mersey Care NHS Trust; R (S) v Airedale NHS Trust* [2003] EWCA Civ 1036, *Times* 25 July 2003.

33. Risk Assessment

34. Mind recommends that guidelines on conducting risk assessments when a person is believed to be experiencing mental distress must take into account:

- an awareness that behaviour is often misinterpreted as aggressive or threatening, while these actions may in reality be about a need to exercise the right to express views about care and treatment;
- the patient or prisoner's personal preferences on how they feel they would be better able to deal with their mental health problem;
- awareness of the patient or prisoner's individual and cultural needs;
- anti-discrimination policies and practice;
- the history of the person's involvement with mental health services; and
- previous diagnoses and medical records.

35. Guidelines on Control and Restraint

36. Existing guidelines give detailed recommendations for the management of control and restraint, such as in the Mental Health Act 1983 Code of Practice which states conditions for intervention. There are further guidelines in the National Institute for Clinical Excellence's Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care.

37. In addition to the measures contained in present guidelines, Mind recommends training should be mandatory for staff who are likely to be involved in using control and restraint and should include:

- conditions under which control and restraint may be used with specific training based on existing guidelines;
- examples of how control and restraint measures can go wrong or have been abused;
- procedures to consult the person's nearest relative or in their absence the person's advocate where they have one; and
- all staff who may be involved in control and restraint should receive training in emergency first aid including CPR which is kept up-to-date.

38. Use of Medication for Control and Restraint Purposes

39. The British National Formulary, National Institute for Clinical Excellence guideline on schizophrenia and the Mental Health Act 1983 Code of Practice together provide a framework for preventing the over-medication of patients. However, the law does not prescribe limits and it is clear that guidance is not enough.

40. There is evidence that:

- polypharmacy (prescription of more than one drug from the same BNF class) is routinely used and BNF levels are regularly exceeded;
- medication is used for the purposes of restraint;
- medication is used as a corrective measure;
- medication is used to compensate for staff shortages; and
- restraint is employed beyond the mandate of the Mental Health Act Code of Practice, that is other than:
  - to save a patient's life;
  - to prevent deterioration;
  - to alleviate suffering; and
  - being the minimum necessary.

41. At present, limits for prescribing are set out in the British National Formulary, and this is reinforced by the Mental Health Act Code of Practice, but there is no legal requirement for medical personnel to prescribe within BNF levels. These levels are generally the doses for which the drugs are licensed to be used, but clinicians may prescribe outside the licence, albeit taking on greater personal responsibility in doing so.

42. It should also be noted that maximum stated doses in the British National Formulary are often well above recommended regular dose levels. With some medications, Mind believes, maximum recommended dose levels have also been shown to be above a therapeutic threshold where an increase in dose does not produce an additional benefit. Furthermore, adverse effects are usually dose related so increases in dose do increase the risk of adverse effects which may be disabling or life-threatening. There is a clear pattern of African Caribbean male patients in secure psychiatric settings who have died having been given emergency

sedative medication which exceed British national Formulary levels or due to polypharmacy. Poor monitoring of the deaths of detained people perpetuates the problems and mistakes which lead to such deaths.

43. Mind believes there are several possible measures which may address this situation:

— the Mental Health Act be amended to prohibit giving doses above BNF levels without informed consent;

— parts of the Code of Practice relating to polypharmacy and maximum BNF levels should be given full statutory force;

— while doses above BNF levels are allowed without consent under the Mental Health Act, a multi-disciplinary second opinion process must approve this treatment, including the input of a mental health pharmacist;

— there should be time limits on high dose therapy with physical checks, and time limits which trigger a full reassessment of treatment in all cases;

— consistent and detailed record keeping and adequate monitoring is needed especially when compulsory powers have been used; and

— documentation of whether medication was prescribed for treatment or restraint and acknowledgement if the "double effect" was intended.

44. Cultural Issues

45. Black and minority ethnic communities are over-represented in all secure settings, including prisons, police cells, remand centres, young offenders institutions, detention centres as well as locked psychiatric wards. They also tend to have more coercive routes into psychiatric care or custody such under Section 136 of the Mental Health Act 1983.

46. Evidence from Inquest, anecdotal evidence and the actual numbers, though they are said to be too small to hold any statistical significance, suggest that people from Black and minority ethnic communities have an increased likelihood of death in custody, whether it be psychiatric, police or prison. In fact, off the 11 verdicts of unlawful killing or prosecutions following deaths in custody since 1990, nine involved the death of a person from the black and minority ethnic community and none of these resulted in a successful prosecution.

47. Several deaths of people from the black and minority ethnic community in psychiatric care or custody have occurred due to the use of control and restraint. These concerns have been raised on several occasions, including on the deaths of David Bennett and Roger Sylvester.

48. It should also be borne in mind that being in psychiatric care or custody is a traumatic experience in itself and the effects of inappropriate interventions, conditions or treatment cannot be underestimated. These conditions may relate to diet, cultural values, religion, language (whether this is about use of terminology or the use of different languages) and family circumstances.

49. Mind recommends that:

— training in specific cultural awareness issues should take place for prison officers and medical staff. This should include:

— an understanding of Trust or prison anti-discrimination policy;

— the history of black and minority ethnic people's involvement with the psychiatric system and their overrepresentation in detained settings;

— an understanding of multicultural and acculturation processes; and

— family liaison workers should be trained in notifying bereaved family members and be aware of culturally specific practices after death.

50. Investigations of Deaths in Custody

51. Mind is particularly concerned about deaths which occur in hospitals, as there is a lack of funding for legal representation for families at inquests. This is in contrast to the extensive resources routinely made available within statutory service providers to ensure they have full representation. Without this funding, it is extremely difficult for relatives to take part in the legal process and in many cases the only information they receive is a letter detailing the outcome of proceedings.

52. Guidance issued by the then Lord Chancellor's department provides that funding should only be available for exceptional cases where it is strictly necessary for evidentiary purposes. This does not take account of the needs of the bereaved family who have a legitimate interest in being included as a matter of course in proceedings. This is an issue under Article 8.

53. Mind recommends that:

54. Guidance be amended to allow access to legal aid funding for relatives to take part in investigations and inquests following the death of a close family member in the custody of the state.

55. SUMMARY

56, It is important that the inquiry should pay particular attention to mental health issues, due to the high proportion of people in detained settings—prisons, police custody as well as in-patient psychiatric settings—who experience mental health problems. Mind's main recommendations are that:

57. Adequate care and support should be available for people experiencing mental distress. Many aspects of the prison system such as isolation from families, overcrowding, relocation can exacerbate the distress experienced, and so these should be addressed.

58. Prison officers should undergo mental health awareness training, and mental health services available in prisons should be on a par with those available outside prison.

59. Environments where people will be detained should be designed to induce as little anxiety as possible. Police cells should not be used as a place of safety under the Mental Health Act, and the use of seclusion needs to be carefully monitored and guidelines adhered to.

60. A preventative approach should be taken towards control and restraint. Where control and restraint is necessary, staff should have been trained in methods used as they can cause injury and death. Restrictions should be placed on the use of polypharmacy and high doses of medication.

61. The particular needs of people from black and minority ethnic communities need to be taken into consideration due to their over-representation in detained settings and the high numbers of deaths of people from these communities which have occurred.

25 September 2003

18. Memorandum from The Prison Reform Trust

INTRODUCTION

1. The Prison Reform Trust (PRT) is an independent charity that works to create a just, effective and humane penal system. We inquire into the system, inform prisoners, staff and the wider public and seek to influence government towards reform. PRT provides the secretariat to the Parliamentary All Party Group on Penal Affairs. Each year we publish a number of reports on all aspects of prison life that receive widespread media attention, inform ministers and officials and lead to changes in policy and practice. Our expertise and experience is recognised by HM Chief Inspector of Prisons for England and Wales. About 4,000 prisoners and their families contact our advice and information service each year. We jointly produce a range of prisoners' information booklets with the Prison Service.

2. PRT is pleased to respond to the Inquiry's request for evidence.

3. This submission primarily focuses on the committees' request for evidence on the issue of preventing deaths in custody. It will draw from research carried out by PRT and information received from our advice and information line, from regular meetings with Prison Service officials and from visits to prisons.

4. It is crucial to bear in mind that there is no single cause of suicide. Any suicide arises from a combination of circumstances, and suicide in custody always includes factors inside and outside prison.

WHAT ARE THE MAIN CAUSES OF DEATHS IN CUSTODY?

1. *Overcrowding*

1.1 A recent PRT publication, *A Measure of Success: An Analysis of the Prison Service's performance against its Key Performance Indicators 2002–03,* (Solomon 2003) highlighted the fact that in 2002–03 there were 105 self-inflicted deaths in prisons in England Wales, the highest ever recorded total for a financial year. It represented a 40% increase compared to 2001–02 when there were 75 self-inflicted deaths. The report noted that the rise in suicides had happened at a time when the Prison Service was dealing with a rapidly rising prison population. During the financial year 2002–03 it rose by nearly 3,000. At the end of March 2003, 94 of the 138 prisons in England and Wales were overcrowded (this means that a prison is holding more prisoners than its uncrowded capacity, known as its certified normal accommodation level).

1.2 Responding to the report in an interview on the BBC's Breakfast with Frost programme, the Director General of the Prison Service, Phil Wheatley, said: "Some of that [the rise in suicides] is because of overcrowding . . . it's just the sheer pressure of numbers which means that we're moving people into a local

prison from the courts and then moving them out very quickly. Large numbers entering and with staff not having sufficient time to try to understand the individual needs of individual prisoners. So that's part of the problem."

1.3 The critical factor that Mr Wheatley was highlighting is what is known in the Prison Service as the "churn", ie the movement of prisoners around the system. Overcrowding results in people being moved much more frequently. Within prisons a remand prisoner can go to court during the day only to find that his or her cell has been re-assigned during the day. The Lord Chief Justice, Lord Woolf, has said that overcrowding is so severe that some prisoners no longer attend their appeals because they fear that by the time they return to prison their cells will be allocated to another prisoner (*The Times* June 2003).

1.4 A study by PRT and the National Advisory Council of the Independent Monitoring Boards (the watchdogs appointed by the Home Secretary to monitor prison conditions) entitled *Prison Overcrowding: The Inside Story* found that many prisoners are being moved around the country at short notice (Levenson 2003). The IMB at Holloway noted: "The practice here is to ship out, even at very short notice, however many prisoners are needed to free up accommodation for the daily intake."

1.5 The Prison Service's Safer Custody group has acknowledged a clear link between the rise in suicides and the high level of movement through the prison system. Its research has shown that 10 of the 20 establishments with the highest incidence of self-inflicted deaths are also in the top 20 for turnover of population (Safer Custody Group August 2003).

1.6 Overcrowding can also result in prisoners being regularly relocated within a prison, especially when so many prisoners in local jails are being moved to and from court on a daily basis. A Prison Service study of suicides among women found that repetitive cell moves was a common factor (Mackenzie, Oram *et al* 2003).

1.7 PRT believes that reducing prison numbers would have a direct impact on the number of prisoners who commit suicide.

2. *Mental health*

2.1 Many prisoners have significant mental health problems. Research by the Office for National Statistics has found that 40% of male and 63% of female sentenced prisoners show symptoms of at least one neurotic disorder, such as depression, anxiety and phobias. Nearly two thirds of male sentenced prisoners and half of female prisoners suffer from a personality disorder. These levels of mental illness are three times higher than among the general population (Singleton, Meltzer *et al* 1998).

2.2 A high proportion of prisoners have been treated in psychiatric hospitals—According to the ONS study one in five male sentenced prisoners and 15% of female prisoners have previously been admitted to a psychiatric hospital.

2.3 Many prisoners have attempted suicide before entering custody. The ONS study reveals that 20% of men and 40% of women entering custody say they have previously attempted suicide.

2.4 It is important to note that a higher proportion of women prisoners than men enter prison with mental health problems. A report by PRT, published in July, *Troubled Inside: Responding to the Mental Health Needs of Women in Prison* stated: "Given the stresses of concerns about families, their housing and finances, and the risk of victimisation inside, it is not surprising that the mental health of many women deteriorates while in prison" (Rickford 2003).

2.5 The *Troubled Inside* report notes that a qualitative analysis of 30 Senior Investigation Officer Reports carried out by the Prison Service in 2002 found that problems in mental health provision played a part in about eight of the 30 prisoner deaths. The identified difficulties related primarily to health care accommodation, staffing levels, skill levels and access to specialists. Health Care staff often faced serious shortfalls in the resources they had available to treat very challenging and complex problems.

2.6 PRT believes that there is a clear link between the high prevalence of mental illness among prisoners and the level of suicides. Mental health problems directly contribute to the risk of suicide. Many prisoners who have suicidal thoughts and those who go on to succeed in taking their own lives will have suffered from a mental disorder.

3. *Drugs, social exclusion and family ties*

3.1 It is important to note that there are the factors in prisoners' lives prior to imprisonment that increase that person's risk of suicide. These include drug dependency, social exclusion and weak family ties.

3.2 Drug dependency is common among many prisoners. Over half of all prisoners say they have a serious drug problem. Around two-thirds use illegal drugs in the year before imprisonment—at least double the level among the general population (Prison Reform Trust Briefing, July 2003).

3.3 Drug use in prison is extensive and rising. All prisoners are subject to random mandatory drug tests. The results reveal that recorded drug use increased for the first time in 2002–03 for five years. Positive tests rose marginally from 11.6% to 11.7%. PRT continues to be provided with anecdotal evidence that drugs are available in most prisons.

3.4 When prisoners first enter custody many will go through a period of detoxification. In 2001–02 there were nearly 48,000 entrants to detoxification programmes for alcohol and drug misuse. But concerns have been raised by HM Inspectorate of Prisons about the uneven distribution and variable quality of detoxification programmes, especially for prisoners who have been dependent on crack cocaine.

3.5 Providing good quality detoxification is critically important given the fact that one in 10 suicides occur within 24 hours of admission to prison and almost a third occur within the first week.

3.6 Many prisoners have experienced a lifetime of social exclusion. This has been clearly documented by the Government's Social Exclusion Unit in its report, *Reducing re-offending by ex-prisoners.* It found that compared to the general population prisoners are 13 times more likely to have been in care as a child, 13 times more likely to have been unemployed and 10 times as likely to have been a regular truant (Social Exclusion Unit July 2002).

3.7 Six out of 10 men in prison and two thirds of women have dependent children. Family relationships can be complicated and difficult. But when entering custody maintaining family ties and links with the outside world becomes very important for prisoners. This is not easy for significant numbers of prisoners who are held a long way from their homes. At the end of February 2003, 27,000 prisoners were held over 50 miles from their committal court town and 12,500 were held over 100 miles away. Research by PRT has found that the number of visits has fallen by a third in the past five years, despite a more than 20% rise in the prison population (Prison Reform Trust 2001).

3.8 Although drug abuse, social exclusion and fractured family ties are not the main causes of deaths in custody they are significant factors that are often prevalent in the personal histories of those who take their own lives.

4. *Staffing*

4.1 Overcrowding puts staff under enormous pressures. This means that they have less time to familiarise themselves with prisoners and therefore less chance of identifying prisoners at risk of suicide or self-harm.

4.2 Staff sickness is at record levels. In 2002–03 the average level of staff sickness was 14.7 days, well above the target of nine days. The Prison Service has not managed to meet its target on staff sickness since it was introduced since 1999 (Solomon 2003). At the end of March a third of all prisons had vacancies for at least 5% of prisoner officer posts (House of Commons, Written Answers, 20 March 2003). According to the Prison Officers Association sickness levels among prison officers are the highest in the public sector.

4.3 High levels of staff sickness mean that officers have to cover the duties of their colleagues on wings where they do not know any of the prisoners and where they need to learn the routine at short notice. In these circumstances prisoners who are at risk of taking their own lives are not always identified and monitored properly.

4.4 Staff shortages also mean that prisons struggle to maintain personal officer schemes that are designed to provide prisoners with a designated member of staff to support them and work through a sentence plan. This means that prisoners do not get the support intended for them or the structure provided by a sentence plan.

4.5 Staff shortages have been exacerbated in recent years by a deliberate policy pursued by the Prison Service to reduce the number of staff who are active on a wing at any one time. The so-called performance improvement process requires prison management to cut costs, and the primary target for savings is in the reduction of staff numbers.

4.6 The Prison Service is also experiencing staffing problems at senior management levels. Research by the Prison Reform Trust has found that in the last five years a third of all prisons have had four or more governors, or acting governors in charge. This level of unstable and inconsistent leadership means that staff training in suicide prevention skills and procedures to monitor prisoners at risk of suicide can be neglected.

What Practical Steps Have Already Been Taken to Prevent Suicides and Self-harm in Prison?

1. *The Prison Service's Safer Custody Strategy*

1.1 The Safer Custody Group was established in April 2001 to deliver a new Safer Custody Strategy. The Group has a broader agenda than the Suicide Awareness Support Group which it replaced. One of its main tasks is to develop a revised suicide and self-harm prevention policy and to communicate and work with other agencies. A Research and Training Group, amongst other things, analyses deaths to ensure that lessons are learnt. A Safer Prisons Group develops safer environment design standards, a local prisons programme and use of technology to help suicide prevention.

1.2 The Safer Custody Strategy is in the process of being refined. However, its general direction is:

— to move from awareness to prevention;

— to invest more resources where the risks are highest;

— to provide a better physical environment for prisoners (particularly when first received into custody);
— to provide more training in mental health and suicide prevention for front line staff in particular;
— to develop better interventions for the management of repetitive self injury;
— to increase numbers of prisoner Listeners in high risk prisons;
— to develop better links with other agencies in the criminal justice system.

1.3 The Safer Custody Group is advocating a pro-active approach, focusing on specific areas of prison practice (rather than on targeting individual prisoners) to improve the services provided. For example, in the context of the known risks associated with drug dependence and mental health, one of the proposals for Safer Local Prisons project is clinical management of substance misuse in a dedicated unit.

1.4 A new Prison Service Order, 2700, on Suicide and Self-harm Prevention, was published in November 2002. PSO 2700 replaces previous guidance with mandatory requirements. The new PSO is to be welcomed and should provide for safer, healthier and more decent prisons provided increased prison numbers do not undermine the best efforts of prison staff.

2. *Samaritans Listener Scheme*

2.1 The Samaritans operate a prisoner peer supporter scheme in prisons, known as Listeners. These are people selected, trained and supported by Samaritans to offer confidential support to their fellow prisoners who may be at risk of suicide, otherwise in crisis, or simply in need of someone to talk to. The scheme's objectives are to assist in preventing suicide, reducing self-harm and to help alleviate the feelings of those in distress.

2.2 The scheme is extremely positive and PRT fully supports the work carried out by Listeners. They play an important role in many prisons and the scheme provides prisoners with an important opportunity to support and assist each other.

2.3 A pilot project is currently underway to extend the ideas behind the Listener scheme to provide prisoners with the opportunity to befriend vulnerable prisoners when they first arrive at a jail and assist with induction and settling into the prison regime. PRT welcomes this development as a positive example of how prisoners can play an active role through volunteering that raises their self-esteem and provides significant benefits to other prisoners.

3. *The transferal of Prison Service healthcare to the Department of Health*

3.1 At the beginning of April financial responsibility for healthcare in prisons transferred over to the Department of Health (DoH). This is the first phase in a gradual transfer of health provision to Primary Care Trusts. It is hoped that this will raise the standard of healthcare in prison and so contribute to improving approaches suicide prevention.

3.2 A commitment has been made to increase the number of mental health in reach teams working in prisons. As of March 2003 there were 42 teams comprising over 155 staff working with prisoners.

What Further Steps Need to be Taken to Prevent Suicide and Self-harm in Prison

1. A reduction in the numbers being held in prisons in England and Wales is imperative in order to prevent a further rise in self-inflicted deaths. Prisoners would not be moved around the system so often and would be able to settle more quickly. They would also be able to maintain better links with family and friends.

2. If prisons were not overcrowded staff would be under less pressure and would be in a better position to assist prisoners at risk of self-harm or suicide. Interventions could also be based on care rather than simply on observation. At present staff are not in a position to provide one to one support to prisoners. The Prision Service needs to move from a culture based on observation and risk-management to one based on care as this could be far more effective in preventing suicides and self-harm.

3. The Prison Service needs to stabilise management and staffing throughout the Service so that there is not a high turn over of staff and there is a reduction in the level of staff shortages.

4. Court diversion schemes need to be available across the country so that offenders who are acutely ill or at risk of suicide can be given hospital places or treatment they need. Unless these schemes operate effectively there will be little hope of reducing the high numbers of mentally ill prisoners who self-harm or commit suicide. It is estimated that there are likely to be up to 500 patients in prison health care centres sufficiently ill to require admission to the NHS (Reed 2003).

5. The suicide rate among remand prisoners is particularly high. Last year 36 prisoners awaiting trial took their own lives which accounted for more than a third of all prison suicides. There needs to be an improvement in the conditions of, and treatment for, remand prisoners and a reduction in the needless use of custodial remand.

INVESTIGATION OF DEATHS IN CUSTODY

1. With the implementation of the Human Rights Act 2000, the Prison Service has faced an increasing number of calls for independent investigations into deaths in custody in accordance with Article 2 of the European Convention on Human Rights. Article 2 not only protects the right to life but also requires an "independent investigation" into the death of any person in the care of the state. At present the Prison Service conducts its own internal investigations into suicides.

2. A recent Appeal Court judgment confirms that the current systems in place for investigating a death in custody are sufficient, if properly followed, to satisfy the requirements of Article 2 (Safer Custody Group, 2002).

3. However there are two key areas where the Prison Service may be deficient in respect of the requirements of Article 2: firstly, the quality of the reports, which should be detailed, thorough, and if necessary critical of the establishment and secondly, the need for greater involvement of the next of kin in the investigation. Legitimate family concerns need to be addressed.

4. The Prison Service recently announced that the Prisons and Probation Ombudsman would carry out an investigation into a suicide at Styal women's prisoner in Cheshire where six prisoners have taken their own lives in the last 12 months. The Prison Reform Trust welcomes this development and believes that the ombudsman or another independent authority should carry out investigations in to all suicides in Prison Service custody. A Prison Service review is currently examining extending the remit of the Prisons and Probation ombudsman to investigate all deaths in custody.

16 September 2003

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19. Memorandum from Mr Tony Ashley

I write with regard to the "call for evidence" in respect of an Inquiry into Human Rights and Deaths in custody. I am the brother of James Ashley who was killed by armed Sussex police on 15 January 1998.

I believe that the United Kingdom should be doing more to meet its obligations under Article 2 of the European convention on human rights especially when the law fails to provide adequate safeguards against wrongdoing by the Police or other public servants by its reliance on outdated and archaic statutes such as "misfeasance".

In our case five officers were originally charged with criminal charges—one was charged with Murder/ Manslaughter and four others with "misfeasance in public office". The trial took over three years to get to court, all the while we were warned not to comment as it could prejudice proceedings, yet Sussex police were allowed to blacken my brothers' character despite not having found a shred of evidence which pointed to James having committed any offence to justify the armed raid on his flat in the first place.

A coroner's inquest was put into abeyance whilst criminal charges were pending. Prior to the trial we attended a committal at Bow Street before a magistrate during which we endured two weeks of legal argument put forward by numerous Barristers for the defence—extensively funded by the Police Federation. When the case finally reached the Old Bailey we had to endure further seemingly endless legal arguments by the defence before we had even heard any evidence.

My primary objection is that the trial Judge—the inappropriately named Justice Rafferty—split the trial in two between a Murder trial—and a second trial centering on the misfeasance aspect. Somewhat conveniently once the trials were split the Judge placed a ban on the press from reporting the trial evidence under the argument that publicity could adversely affect the second trial. I believe this legal manoeuvre obstructed real justice and did not allow for any genuine public scrutiny of the serious misbehaviour undertaken by the officers involved.

The next thing we knew, the judge threw out the case before the defendant in the Murder case—PC Sherwood had even provided testimony, thus robbing us of any chance to hear an explanation of the events from those principally involved and therefore any sense of emotional closure. The fact that a jury were prevented from deliberating on the evidence by the cynical actions of the judge exacerbated the growing sense of injustice. The second trial also collapsed because the Judge decided to rule that there had been "Corporate Failure" on behalf of Sussex Police rather than wilful misconduct by individuals. As far as we were concerned this was a completely unsatisfactory outcome and a mockery of justice.

I believe that the failure of both the criminal cases to actually determine responsibility, other than by vague notions of "corporate failure", led to the eventual watering down of disciplinary action taken by Sussex Police against those involved. What also then materialised was the farcical situation whereby the former Chief Constable Paul Whitehouse actually promoted two of the officers involved. Similarly the Deputy Assistant Chief Constable, Mark Jordan, was somehow allowed to retire on the grounds of ill health. Jordan—who apparently now lectures on human rights—thus avoided disciplinary action. This is despite promises by the present government to end this disgraceful practice of serving officers being allowed to retire prematurely without censure.

All avenues of legal redress having dwindled, the family made concerted representations to the Home Secretary on the basis that a full public inquiry was called for in this case. After deliberation by the Minister John Denham, we were informed that an inquiry would not be the best way forward for the following reasons:

(1) Pending disciplinary action would be halted if a public inquiry was granted.

(2) The Coroners Inquest was due to resume.

(3) The Sussex Police Authority would be formally requested to prepare a report on the events of the killing and how it had responded to its obligations in the aftermath. We were also promised access to the (Wilding report) written by Kent Police and the (Hoddinott) report into the state of the Sussex Police force which had been prepared by Hampshire Police.

In reality, disciplinary procedures against the remaining officers were gradually downgraded and sidelined once the initial bad publicity against Sussex had subsided. The Sussex coroner refused to re-open the inquest stating that it would amount to a re-trial and finally, Sussex Police Authority, who "owned" the Kent and Hampshire reports refused to release them publicly. Instead, they produced a report supposedly specifically for the family which was little more than a rehash of what the Judge had said at the aborted trials.

In summary then, our attempts to gain justice have been thwarted at every turn by the authorities, British Law fails to provide any modern or contemporary statute to counter wrongdoing by the police. Misfeasance cannot be deemed appropriate in the circumstances of this case and there certainly needs to be a new and serious appraisal of the law in this regard. Not only are police officers overly protected by judges but civil proceedings initiated by the victims families are completely out of the question due to the cost—victims families simply do not have the required funds to challenge legal decisions, the financial strains placed on victims relatives fighting for justice simply make matters worse, especially when faced with the "money no object" emphasis of the Police Federation or unsympathetic elements of the criminal justice system.

10 September 2003

20. Memorandum from Dr Leonie Howe

SUMMARY

The report is an extract of a study that investigated and analysed institutional deaths in police and prison custody and the ethnic dimensions of the issues raised. The main empirical work is focused on responses to deaths in custody within the UK and Australia. The comparative study, conducted in Australia, was relevant to highlight particular strengths and weaknesses of our domestic institutions and in suggesting alternatives.

The study began from the hypothesis that, because of the wider political and social significance attached to minority ethnic deaths in custody, the normal institutional mechanisms for investigating them, both in terms of initial fact-finding and subsequent adjudication, may prove or be perceived as inadequate in resolving disputes and grievances arising from such events. This may lead to victim's families and their supporters seeking alternative means of raising their concerns and resolving their grievances. These include political campaigning techniques, private prosecutions, civil actions for damages, and "peoples' tribunals". The study examines the factors, including legal and other limitations and forms of social exclusion, which may influence the choice of these mechanisms and their effectiveness in particular cases.

The research involved a combination of traditional documentary and literature analysis, particularly in relation to mapping the legal and regulatory contexts in which different institutions and mechanisms for responding to deaths in custody operate, and empirical investigations based on detailed case studies. In the UK, both historical and contemporary cases have been drawn from police and prison custodial settings and involving members of different ethnic minority groups. The rationale for this comparative element is that official institutions for investigating deaths in custody in both Australia and the United Kingdom have come under increased political pressure from minority ethnic groups and that it should therefore be valuable to compare how these institutions have adapted in each country. In particular, the Royal Commission in Australia (1991) represented a unique institutional response to Aboriginal deaths in custody. This project is relevant to the ongoing Inquiry in asking whether the UK needs its own Royal Commission to satisfy the requirements of Article 2 ECHR for an effective, prompt and independent investigation of deaths in custody.

THE INVESTIGATION AND PROSECUTION OF DEATHS IN CUSTODY

1. The inadequacies of initial investigations and inquests have led families and others campaigning over deaths in custody increasingly to seek out and use alternative remedies. Some of these alternative remedies, such as the institution of criminal proceedings against the police or prison authorities, have proved to be ineffective. Others, such as civil legal actions for damages, can result in the payment of compensation to relatives of the deceased but may have limited value in otherwise holding the authorities to account. Judicial review is a means for challenging the procedural defects of inquests and other legal remedies and raising

wider issues of concern in the public arena. More recently, the European Convention on Human Rights and the Human Rights Act 1998 have been used to challenge more fundamentally the existing systems for redress when deaths in custody occur.

Criminal Prosecutions Against Police/Prison Officers

1.1 The purpose of the inquest is to find out who died and how. This is incompatible with family's need to see those culpable punished. Usually the case is examined and the decision made as to the viability of a criminal prosecution by the CPS prior to the opening of an inquest. Once the inquest has been opened and a person has been charged with an offence under s16(1) (a) of the Coroners Act, normally the inquest will be adjourned until the criminal proceedings are concluded. With the approval of the CPS, the hearing can proceed prior to the conclusion of the inquest (Dorries:1999). The coroner may also refer a case to the CPS if they determine a criminal act has been committed or if the jury returns an "unlawful killing" verdict. Concern about the close relationship between the police and the CPS has grown due to the lack of criminal prosecutions following deaths in custody. Questions are now being asked if the interests of the police are more important than those of both the public and justice (Howe:2000).

The decision making process of the CPS

1.2 The CPS are bound by the Code for Crown Prosecutors which was issued under s.10 of the Prosecution of Offenders Act 1985. This code states that: There are two stages in the decision to prosecute. The first stage is the evidential test. If the case does not pass the evidential test, it must not go ahead, no matter how important or serious it may be. If the case does pass the evidential test, Crown Prosecutors must decide if a prosecution is needed in the public interest. The second stage is the public interest test. The Crown Prosecution Service will only start or continue a prosecution when the case has passed both tests.

1.3 Following the public outcry at the deaths in custody of Joy Gardner (1993), Shiji Lapite (1994), Wayne Douglas (1995) and Brian Douglas (1995), an *Explanatory Memorandum to the Code for Crown Prosecutors* issued in June 1996 added "If the evidential test is not satisfied, there must not be a prosecution, no matter how great the public interest may seem in having the matter aired in court". Under the revised Code (6.4(d) and (h)), public interest factors that would justify a prosecution include the defendant being in the position of authority or trust.

1.4 It is arguable that, at least in the public's mind, an unlawful killing verdict at an inquest should be followed by a criminal prosecution. Before reaching a particular verdict, the coroner and the jury need to be satisfied on the necessary facts to the required standard of proof. For a verdict of suicide or unlawful killing the standard of proof is at the same level set in a criminal court—"beyond reasonable doubt". For all other verdicts, the lesser civil standard of proof applies—"on the balance of probabilities" (Dorries: 1999:193). The question is, however, why given that the standard of proof for a verdict of "unlawful killing" during an inquest, and the standard of proof for a criminal prosecution are similar, that one does not follow the other? There can be several reasons for this inconsistency including not meeting the evidential test; evidence admissible at the inquest may not be admissible in a criminal trial; the deceased took their own life; or it is unclear which of several people might have caused the death (Dorries: 1999). This is little consolation to the family who are aware that the deceased was unlawfully killed but the law is unable to punish those responsible.

1.5 Another unofficial obstacle to such prosecutions is that it may be felt by the CPS that juries are less likely to convict police officers. There is no available evidence to support this view and the CPS denies it. In addition to the failure to prosecute officers involved in deaths, there is the perception that the criminal justice system discriminates against ethnic minorities.

Case: Alton Manning

Alton Manning was 33 when he collapsed and died on 8 December 1995 at Blakenhurst Prison while on remand. Alton's family was informed a post-mortem had already been carried out, with inconclusive results. The family believe this was deliberate and wanted to know why cuts and bruises were found on his body. A second post-mortem found that Alton died of asphyxia.

The inquest into his death began in January 1998. This is the first death in a private prison resulting from the use of control and restraint procedures. The inquest jury recorded a unanimous verdict of unlawful killing on 25 March 1998. After the verdict seven prison guards were suspended, on full pay, until a decision on whether to prosecute was made by the CPS. The case was referred back to the CPS during the inquest, an unusual step taken by the coroner, but in February 1999 the CPS refused to instigate criminal proceedings due to "insufficient evidence". The decision of the DPP not to prosecute again in May 2000 led to the family seeking redress through judicial review. Although the case was once again referred back to the CPS, in January 2002 they announced that charges would not be brought due to "insufficient evidence" once again[200].

[200] *The Guardian* 26 March 1998; INQUEST press release 26/1/98.

The Police Action Lawyers Group have referred to "an apparent lack of willingness on the part of the Crown Prosecution Service and the DPP to prosecute police officers against whom there is substantial evidence to justify a criminal charge" (HAC:1998:90). This claim has recently been justified by the findings of the Butler Inquiry (1999) into the deaths in police custody of Shiji Lapite and Richard O'Brien, where the initial decisions made by the DPP not to prosecute the officers concerned were made in an "unsound" system (Hopkins:1999:7). The Inquiry was critical of the process of CPS decision making in these cases, finding it involved unnecessary replication of functions with no one person taking responsibility for final decisions.

The Inquiry recommended that all cases of death in police or prison custody be dealt with by the CPS Central Casework department, that the decision maker in each case be clearly identified, that the decision maker would be at an appropriate level and that decisions not to prosecute should be reconsidered after the inquest (CPS: 1999). Although these current shortcomings were identified and recommendations were made, it is too early to see any improvements. On an individual case basis, the Inquiry stated claims of bias in the Lapite and O'Brien cases were unfounded and the cases had been dealt with properly.

R v DPP ex parte Manning became the first opportunity to scrutinize DPP/CPS decision-making following the Butler Report and the Report of the European Committee for the Prevention of Torture in 2000 (CPT). In Manning, the High Court found the DPP's decision not to prosecute any prison officer "unsustainable in law" after the inquest verdict recorded a unanimous unlawful killing verdict in March 1998, illustrating that despite the recommendations, structural problems of the CPS prosecuting these cases remains.

Private Prosecution

1.6 Anyone can bring a prosecution under s6 Prosecution of Offences Act 1985. The right to bring a private prosecution against a police officer is not restricted by this Act. A private prosecution is another way to punish a wrongdoer. The choice of the charge that is preferred is generally in the discretion of the private prosecutor and not the magistrate. A private prosecution is an also option if a wider purpose such as exposing the failure of the police to investigate an incident, the failure of the DPP to bring a prosecution, to prevent the police committing contempt of court, to challenge a prosecutor's interpretation of the law[201] or to expose a pattern of malpractice is being sought. One of the largest obstacles is the expense; no legal aid is available for bringing a private prosecution[202], there may also be difficulties in obtaining enough evidence to meet the criminal standard of proof (*Harrison & Cragg:* 1995).

Judicial Review

2. The process whereby the High Court supervises the lawfulness of the actions and decisions of an inferior court, tribunal, public bodies and individuals who carry out public duties is known as judicial review. This includes those employed by the Police and Prison Services and decisions made by the PCA, coroners, and DPP/CPS.

Judicial Review of Inquests

2.1 With respect to inquests, there are two kinds of judicial review in the High Court. Firstly, there is the statutory procedure under section 13 of the Coroners Act 1988[203]. The application of the power to quash depends on whether the court deems it is "necessary or desirable in the interests of justice" to call a new inquest[204]. Secondly, an option exists for dissatisfied individuals to apply for judicial review. [205] An error of law within the coroner's jurisdiction can be reviewed[206], meaning that a coroner's verdict can be quashed (*Matthew & Foreman:* 1994). However, the reviewing court does not quash the decision just because the court might have decided it differently. It is the question of error in the decision making with which the court is concerned. If no clear error can be found, but the decision is unsatisfactory, the applicant must proceed under the statutory power to quash, and not by way of judicial review (*Matthew & Foreman:* 1994). Where the court considers that an error is found, the first remedy is an order quashing the inquisition, with a further order to hold a new inquest. But the court may grant relief that falls short of quashing the whole inquisition, and ordering a new inquest—the only remedy under section 13 of the Coroners Act 1988[207].

[201] *R v Lemon* [1979] AC 617.

[202] In a successful prosecution the award for costs may not cover the full cost of the prosecution and collection of evidence.

[203] Section 13 of the 1988 Coroners Act, re-enacting section 6 of Coroners Act 1887 (as extended by section 19 of the Coroners (Amendment) Act 1926).

[204] *R v Divine, ex parte Walton* [1930] 2 KB 29, 379, applied in *R v South London Coroner*, ex parte Thompson, *The Times*, 9 July 1982, DC.

[205] Since 1977, Rules of the Supreme Court (RSC) Ord 53.

[206] *Anisminic v Foreign Compensation Commission* [1969] 2 AC 147, HL, concerned a statutory tribunal, not a Coroner's court, but is applicable since *R v Surrey Coroner*, *ex parte Campbell* [1982] QB661.

[207] For example inaccuracies in the coronial may be amended, or deleted a paragraph.

2.2 Where the inquisition is quashed under statutory powers resulting from judicial review, a new inquest is usually ordered under section 13(1) (a) of the Coroners Act 1988, as in the cases of Keita Craig and John Sambells (*Vogt & Wadham:* 2003). In the case Keita Craig who died on 1 February 2000 in Wandsworth Prison, the coroner refused to allow the jury to consider a verdict incorporating neglect, even though his recommendations reflected concerns about the care Keita received. This initial inquest was held during April 2000. Keita was a 22 year-old black male who died within 24 hours of arriving in the prison. On 13 February 2001 the High Court quashed the verdict and ordered a new inquest with a fresh jury, held on 3 October 2001. This inquest recorded a verdict of "killed himself while the balance of his mind was disturbed" and added a rider that neglect played a part in his death[208]. John Sambells died on 29 January 1998. The first inquest was held from 25–27 November 1998. The belated disclosure of video evidence to the family led to the judicial review and the quashing of the original inquisition. Thus, in the Craig case, his family benefited by the fact that all the verdicts were open to the jury and in the Sambell's case, more evidence was disclosed to the family. In this sense, judicial review forms a system of checks and balances on inquests, necessary because of the discretion afforded to coroners.

Judicial Review of Decisions on Prosecution

2.3 Cases where an "unlawful killing" inquest verdict did not result in criminal prosecution have been Alton Manning, Richard O'Brien, Shiji Lapite, and Derek Treadaway. In Lapite the coroner referred the case to the DPP to consider the verdict of manslaughter against the two officers involved in the death. The CPS decided not to prosecute. Similarly, in the case of Treadaway, despite a verdict of "unlawful killing", no prosecution by the CPS followed. This apparent disparity between the inquest verdict and the CPS decision-making led the family members of Richard O'Brien, Shiji Lapite and Derek Treadaway to bring a joint application for judicial review, which came before the Divisional Court on 22 July 1997. This resulted in all three cases being sent back to the CPS for further consideration and to the setting up of the Butler Inquiry (1999). In O'Brien, three officers were charged with manslaughter but were acquitted on 29 July 1999, five years after he died.

2.4 In theory, decisions not to prosecute can be judicially reviewed on the basis that they were made in breach of the CPS Code or are so perverse that no reasonable prosecutor could have made them[209]. Yet practice has shown considerable obstacles to exist when challenging a decision by the CPS not to prosecute. As can be seen from the outcome of *R v DPP,* ex P Manning and Another [2002] 3 WLR 463 even the High Court decision that quashed the decision not to prosecute did not result in a prosecution. The High Court is most useful in cases where there has been a procedural flaw, such as when the failure to prosecute was unreasonable or where cogent reasons were not given. It does not function as a court of appeal. Judicial review cannot overcome obstacles such as lack of evidence or difficulties in meeting the standard of proof in criminal cases.

2.5 The reasons behind lack of evidence and the inability to meet the standard of proof may include the families are prevented from gathering the necessary evidence or proof needed. The latter would involve flaws during the investigation, and the inadmissibility of evidence or witnesses called during the inquest—inquests may use hearsay evidence, whereas the criminal trial cannot—or the different composition of the jury.

2.6 Even where a review is instituted this is not a guarantee that the CPS will subsequently make a different decision, as seen in Manning discussed earlier in this chapter. Despite the obvious limitations of a judicial review, the actual process can be helpful in that it frequently exposes more details as the CPS has to justify its decision in writing and in court, leading to further disclosure.

ECHR and Other International Remedies

3. The Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) is an international treaty that provides basic guarantees of a number of fundamental human rights. These rights are not a traditional construct of English law, but the Convention allows individuals and states to complain about violations. Prior to the Human Rights Act 1998 (see below), it could also be used in English courts to help construe statutes[210]. Neither the Convention nor any secondary legislation made under it directly accords individuals any fundamental rights, but some Articles are applicable to deaths in custody cases.

3.1 Under the rules of Article 25, any "person, non-governmental organisation or group of individuals" can bring complaints. The complainant does not have to be European and age is also irrelevant. They must be within the jurisdiction of a state that has ratified the Convention and the person, organisation or group of individuals must themselves be the victims of a violation, either directly or indirectly. Thus the family of a person who died during the course of a violent arrest would be indirect victims of a violation.

3.2 Under Article 26, the Commission considers complaints about violations when all effective domestic remedies are exhausted. However, if it is obvious that there is no possibility of an effective domestic appeal, then the Commission can deem all domestic remedies exhausted. Thus compensatory damages paid to a

[208] Hptt://inquest.gn.apc.org/caseupdater.html
[209] *R v DPP*, *ex p* C [1995] 1 Cr App R 136.
[210] *R v Sec State Home Dept* ex p Brind and Others [1991] 1 AC 696.

prisoner held for an excess amount of time on remand may be held to be inadequate[211] but damages for physical abuse are generally seen as adequate, unless the violation is a practice that was officially approved of by the prison administration[212]. Judicial review does not constitute effective remedies if the relief it grants is insufficient to meet the violation in all respects[213].

3.3 The procedure for making an application is straightforward though not a quick one, as applications take about five years. Under Article 26 the complaint must be made within six months from the date on which the final domestic decision was taken. Legal Aid is not available for any part of the case. However, the Commission can grant its own form of legal aid which can retrospectively cover the cost of preparing the original application, as well as any subsequent work in preparing the case and for representation at any hearing.

3.4 The government has brought in arrangements for a "no win, no fee" contingency for fees in human rights cases. If an applicant does win, then legal costs can be uplifted by up to 100%[214]. However, even successful cases are unlikely to lead to prosecutions or disciplinary actions against police or prison officers, although compensation for a death might be available, as shown in the case study of Christopher Edwards. Cases in the ECHR rarely involve the disclosure of further information.

Case: Christopher Edwards

Christopher Edwards, who had been tentatively diagnosed as schizophrenic in 1991, was arrested on 27 November 1994 and taken to Colchester police station. He had been approaching young women in the street and making inappropriate suggestions. He was later remanded in custody in Chelmsford Prison, initially on his own (*Edwards:* 2002). On 28 November Richard Linford was placed in the same cell as Christopher Edwards on D landing. Richard Linford had been arrested for assault. He had a history of violence, including a previous assault on a cell-mate in prison. He had been admitted to mental hospital in 1988, and was subsequently diagnosed as schizophrenic. Sometime during that night Christopher was stamped and kicked to death by Richard Linford. Linford plead guilty to the manslaughter of Christopher Edwards by reason of diminished responsibility. He is currently at Rampton Special Hospital, suffering from paranoid schizophrenia. The inquest was closed, following the conviction (Edwards:2002).

In July 1995, a private, non-statutory inquiry was commissioned, reporting on 15 June 1998. It concluded that Christopher Edwards and Richard Linford should not have been in prison and in practice they should not have been sharing a cell. It found "a systemic collapse of the protective mechanisms that ought to have operated" to protect Christopher Edwards. The applicants were advised that there were no civil remedies available to them in the light of the findings of the inquiry. On 25 November 1998, the CPS maintained their previous decision that there was insufficient evidence to proceed with criminal charges.

Christopher's parents lodged an application with the European Court of Human Rights on 14 December 1998. They alleged that the authorities failed to protect the life of their son. On the 14 March 2002, the ECHR in the case of *Paul and Audrey Edwards v the United Kingdom* (no 46477/99) held unanimously that there had been a violation of Article 2 (right to life) as regards the failure to conduct an effective investigation; no separate issue arose under Articles 6 (right to a fair hearing) or 8 (right to respect for private and family life); and that there had been a violation of Article 13 (right to an effective remedy).

Under Article 41 (just satisfaction) of the Convention, the Court awarded the applicants £20,000 pounds for non-pecuniary damage and £20,000 for legal costs and expenses. However, despite the ruling that they were entitled to an effective investigation into Christopher's death, the request for an independent inquiry still has not yet been met and the Edwards' continue to lobby the Government (Edwards:2002).

THE HUMAN RIGHTS ACT 1998

4. It now appears that the incorporation of the European Convention of Human Rights by the Human Rights Act (HRA) 1998 may have a fundamental impact on the inquest system (Thomas et al:2002). The HRA requires coroners to have regard to Articles 2 to 12 and 14 of the ECHR and to read and give effect to all (as far as possible) their statutory powers in a manner that is compatible with convention rights[215]. As a public authority, the coroner's decisions will be subject to appeal if they act in a manner that is incompatible with the convention, except when the wording of a statute necessitates it. [216] The Convention has more precise requirements than UK domestic law regarding the effectiveness of inquiries following a death in custody and as such has already been the source of a fundamental review of inquest law[217].

[211] DR 56/62.
[212] DR 20/184.
[213] DR 42/171.
[214] Conditional Fee Agreements Order 1995 SI No 1674.
[215] Human Rights Act 1998 section 2 and 3.
[216] *Ibid* section 6.
[217] *See* in particular *R (Wright and Bennett) v SSHD* [2001] EWHC Admin 520; *R (Amin) v SSHD* [2001]. EWHC Admin 719; *R (Middleton) v HM Coroner for Western Somerset and SSHD*, 14 December 2001.

Range of an Effective Inquiry

4.1 Under the HRA the scope of the inquest is changing as the investigation focuses on the planning and organisation of the state agency that provided the place of death, as well as those allegedly directly responsible for the death. [218] Therefore, the interpretation of the "how" in Rule 36 Coroners Rules now includes individual actions and systemic deficiencies. Now in cases where the circumstances of the death relate to Article 3, the inquest has to consider those circumstances in so far as they have a contributing link to the death[219]. Under Article 8, the coroner may be forced to put the interests of private and family life first. Although the inquest remains inquisitorial, the burden of proof is now on the state to provide adequate explanations for injury or deaths in custody[220]. This results in shift from the original ambit of coronials (*Thomas et al:* 2002).

4.2 Thus, to be considered an effective investigation the focus must be upon those allegedly directly responsible for the death, and the planning and organisation of the state agency or operation that provided the context in which the death took place. An effective inquiry cannot be limited to the cause of death. Where appropriate, it must also indicate those who were responsible (*Jordan v UK*, paragraph 107). Hence Coroners' Rule 42 forbidding returning a verdict that "appears to determine an issue of criminal liability on the part of a named person or civil liability" may not meet the state's duties under Article 2[221].

4.3 Although Article 13 is not a right directly expressed in the HRA, it is relevant to the redress provided by section 8—the provision of just and appropriate remedies (*Thomas et al* 2002). In Keenan it was found that the requirement to show pecuniary/dependency loss as the basis for a civil action under the Fatal Accidents Act 1976 denied the right to an effective remedy. Later, the ECtHR cited Keenan in *Jordan v UK* to show the necessity for the original inquest to provide an adequate inquiry focussed upon causation and responsibility. While in *R v DPP ex p Manning* and *Melbourne* it was held that where an unlawful killing inquest verdict was given, the expectation is that a criminal prosecution follows. In the absence of a criminal prosecution, the DPP is required to give reasons in order to show that there are concrete reasons for acting contrary to the expectation of Article 2[222]. Prior to the HRA, this was not the case[223].

Independence

4.4 When a death occurs in custody, the independence of an investigation is crucial. In Wright and Bennett at paragraph 60(2) the High Court held that the dependence of the coroner on the prison's chief medical officer did not amount to a sufficiently independent inquiry. *R (Nicholls) v HM Coroner* for *Liverpool* saw the refusal of the coroner to call any other medical witness except the Forensic Medical Examiner whose conduct was being challenged was held not to be a sufficient inquiry[224].

4.5 Although a PCA investigation into alleged police misconduct is not considered an impartial and independent tribunal[225], other ways exist to challenge the independence of the system via challenging the investigative process. As coroners rely on police officers to make the bulk of their inquiries, an interested party should to be allowed to examine the investigating officer about their independence and impartiality (*Thomas et al:* 2002).

Legal Aid and Disclosure

4.6 Under the Convention the investigation into a death must allow the family to have effective access to the investigatory process[226] and in *Jordan v UK*, the Court held that necessary involvement included the provision of legal aid to enable adequate representation.

4.7 Under the Convention all state institutions have a duty to disclose material in order to assist "a proper and effective examination" of Article 2 issues[227]. A failure of a Government to comply may ". . . reflect negatively on the level of compliance by a respondent state . . . but may also give rise to the drawing of an inference as to the well foundedness of the allegations"[228]. A relative of the deceased may be able to claim a violation of Article 3 for mental distress and anguish resulting from the authorities responses to and treatment of them in relation to their inquiries[229]. Article 6 protects a person's "civil rights and obligations".

[218] *McCann v UK* at paragraphs 200–201 and 212–214, *Jordan v UK* at paragraph 101–109, *R (Amin) v SSHD* at paragraphs 27 and 75.

[219] *Assenov v Bulgaria* 28 EHRR 652 paragraph 117; *R v (Wright and Bennett) v SSHD*.

[220] *Salman v Turkey*, paragraph 100; *Cackici v Turkey,* paragraph *85*; *Selmouni v France*, paragraph 87.

[221] For example in cases such as *R (Middleton) v HM Coroner for Western Somerset and SSHD,* 14 December [2001] DC where prisoner has hung himself after staff failed to recognise he was a suicide risk.

[222] *R v DPP ex p Manning and Melbourne* [2000] 3 WLR 463, paragraph 33.

[223] *R v DPP ex p C* [1995] 1 Cr App R 136; *R v DPP ex p Treadaway*.

[224] [2001] EWHC 922.

[225] *Govell v UK* (Application 27237/95); [1999] EHRLR 121 and *Khan v UK* [2000] 8 BHRC 310.

[226] *R v DPP ex p Manning and Melbourne* [2000] 3 WLR 463; *R (Amin) v SSHD* [2001] EWHC Admin 719; *R on the application* of *Wright v Home Secretary* [2002] HRLR1.

[227] *Cackici v Turkey*, 31 EHRR 133, paragraph 85; *Tanrikulu v Turkey* 8 July 1999 (Application 23763/94) paragraph 70.

[228] *Timurtas v Turkey* 33 EHRR 121, paragraph 66.

[229] *Cakici v Turkey* (2001) 31 EHRR 5 paragraph 98.

However, it does not directly apply to coroner's courts because the inquest procedure does not involve the determination of a person's civil rights and obligations. As such, the stated requirements of an effective inquiry provides only the basic standards of justice and fairness.

4.8 Recently the court in *R* (on the application of Bentley) *v HM Coroner for the District of Avon*[230] noted that the decision in *ex p Peach*, is out of step with contemporary practice and cannot be used to prohibit all advanced disclosure. In a death in custody, a coroner will need to forward convincing reasons for refusing disclosure (except in relation to statements that he intends to read). The movement away from *ex p Peach* was also seen in *ex p Leatherhead*. Compliance under Articles 2, 3 and 8 means pre-inquest disclosure should be instituted on a legal basis[231].

4.9 Since the first deaths in custody have come to light in the UK, it has been argued that there is a lack of natural justice and procedural fairness in the inquest system[232]. The obligation stemming from Article 2 for an investigation into a deprivation of life by agents of the state is relevant[233]. In Australia, cases considering the equivalent application of natural justice principles have come to the opposite conclusion. There, individual police officers were seeking pre-inquest disclosure in circumstances where a prisoner's treatment was controversial[234].

Case: Paul Wright

This case has been included as it shows the limitations to the remedies available even after the Human Rights Act 1998. Paul, 33, died at Leeds Prison in 1996 from asthma (Liberty: 2001). He was serving three-and-a-half years for fraud, drugs and driving offences. At the inquest held on 29 April 1997, the Prison Service apologised for the death. The inquest verdict was death by natural causes. A civil suit for damages was settled out of court in November 2000, after the Home Office admitted liability.

A police inquiry into deception, wilful neglect and manslaughter by Dr Singh, the prison doctor, ended without charges. An initial plea for an independent inquiry was rejected by the Home Secretary. But in June 2001 an application was made in the High Court (Liberty: 2001) by his mother and aunt alleging that the Secretary of State for the Home Department was in breach of Article 2 (right to life), Article 3 (inhuman and degrading treatment) and Article 8 (privacy and family life). The application was upheld and on 27 June 2001 the Home Secretary was ordered to institute an independent public investigation within three months. This meant that the inquiry took place more than five years after Paul's death. It was the first public inquiry into a death in custody ordered by a judge under the HRA 1998.

The guilt of any one person involved was not established as the inquiry only sought the medical facts of the death. Published on 11 July 2002, the report stated that Paul died from an asthma attack following months of "substandard" medical treatment at the prison. A key issue at the inquiry was the role of the prison doctor, Dr Singh. Under the Tribunals and Inquiries Act 1992, inquiries into prison deaths are non-statutory meaning that anyone giving evidence does so voluntarily. The non-appearance by Dr Singh has left the Wright family concerned that the Inquiry failed to answer key questions, as they were unable to establish individual responsibility for the death (Liberty: 2002; Wainwright: 2002).

5. In this report we have seen how the remedies available to families seeking answers or some form of redress in death in custody cases overlap. This interaction between remedies can have certain advantages, for example, allowing for progressive (if piecemeal) disclosure of facts about deaths in custody that may have been withheld at earlier stages. Such disclosure within one forum may in turn assist relatives to pursue other forms of redress more effectively. Similarly, the availability of legal aid in some areas, such as for civil legal actions, may alleviate to some extent the denial of such assistance before inquests. However, these different remedies often involve families a long and expensive route through the legal system. They will initially start at the inquest but due to its traditional limited scope often are forced to journey through criminal prosecutions, private prosecutions, civil actions and finally end up seeking redress under the Human Rights Act or through the European Courts. It is only the latter that now holds out the potential for forcing the UK Government to consider more fundamental reform of the whole system of remedies to deaths in custody.

5.1 The significance of this issue for black and ethnic minority communities does not lie in the disproportionate number of their members who die in custodial situations alone but rather because deaths in custody demonstrate wider discrimination felt by these communities in the criminal justice system and society at large. This research has shown how members of black and ethnic minority communities share many of the same problems as families, relatives and supporters of other victims of custodial deaths when it comes to attempting to find redress through existing legal remedies.

[230] [2001] EWHC Admin 170.

[231] *Jordan v UK*, paragraph 109.

[232] *R v HM Coroner for Hammersmith ex p Peach* [1980] 2 WLR 497, 504; *R v HM Coroner for Lincolnshire ex p Hay* [1999] 163 JP 667, 675–6.

[233] *McCann v UK* paragraph 150.

[234] *Annetts v McCann* (1990) 65 ALJR 167.

5.2 As expected, it was found that the existing remedies for deaths in custody are inadequate and need to be reformed, and that there is a need to give greater consideration to the ways in which these different mechanisms interact with one another. This paper started with the proposition that reform directed solely at the existing remedies is not sufficient to meet the wider political concerns of the black and ethnic minority communities. This in turn led to the second part of the research question, of what potential role there may be for a Royal Commission on Deaths in Custody in the UK?

The Politics of Deaths in Custody in Australia and the UK

6. In the UK the official reaction has tended to be one of denial of responsibility and an attempt to blame individuals for their own deaths, thereby diminishing state accountability. It not untypical for a death in custody to be immediately followed by stories being leaked to the press concerning the drug taking, psychotic behaviour, immigration status, super human strength, size, and height of the victims, images which are often linked at least sub-consciously with their race. This can be seen in the UK as far back as David Oluwale's manslaughter case in 1971, where the trial judge called him "a menace to society, a nuisance to the police and a frightening apparition" (IRR:1991:6). By doing that, the victim can be blamed and when many months or even years later, the truth does start to emerge, the waters have been so muddied that the public cannot see the victim beyond their immigration status, criminal record or their drug or mental health problems.

6.1 In Australia, the setting up of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) in 1987 represented a major departure from this individualised response to deaths in custody. Of course, the Royal Commission was the product of a Labor Government under increased pressure about its public image, both nationally and internationally. Cynically, one could argue that the Royal Commission was established precisely in order to deflect this criticism in the build up to the Australian Bicentenary in 1988. It has been noted that Royal Commissions traditionally have the role of managing potentially conflictual issues in society within a seeming democratic consensus, rather than being a real stimulus for political and social change (Thomas: 1982; 1994).

6.2 However, despite some of its harsher critics and more specific failings, the RCIADIC has presented a somewhat different experience. More than a decade after it reported, its findings and recommendations are still a talking point among Aboriginal organisations, the media, academics, and the general public. Moreover, the Commission, by extending its Letters Patent, went beyond the normal expected parameters of such bodies and, by doing so, raised awareness of issues such as systemic failures and the over-policing of certain communities (McDonald: 1999). It has, in turn, helped to collectivise the response to deaths in custody in Australia. Government and Aboriginal organisations have established dozens of bodies responsible for the monitoring and reporting upon the implementation of the Royal Commission's recommendations, such as the various Death Watch Committees, the National Deaths in Custody Monitoring Unit in Canberra, and MUNNCI (national coronial database) in Melbourne. These have provided the Australian system with at least some transparency and consistency. The Commission has furthermore provided a framework for Aboriginal activism in the field of human rights campaigns, criminal justice campaigns and Aboriginal self-determination (McDonald: 1999).

6.3 By contrast, in the UK there has never been an official recognition of black deaths in custody being a collective problem of the criminal justice system or society at large. The Home Office report by the Police Research Group (Leigh *et al* 1998) treated deaths in custody as a technicality of the way individual detainees were treated, without any recognition of the wider concerns raised by campaigning groups and members of the black community. The language of the report was tentative, and didn't call for radical change.

6.4 The earlier Home Office study by Ingram, Johnson and Hayes (1997) again focussed on self-inflicted deaths in police and prison custody. However, many of the recommendations and findings were not innovative or new. Most had already been discussed in depth by other UK academics, such as Liebling and Ward (1994) and Towl (1996; 1999). Thus, suicide and "deliberate self-harm" (DSH) prevention has tended to dominate official discussion on deaths in custody in the UK.

6.5 The nearest the UK has come to achieving official recognition of a collective responsibility for deaths in custody has been the MacPherson Report (1999) which arose, of course, out of a different issue altogether. In similar circumstances to those that led to the establishment of the RCIADIC in Australia, the MacPherson Inquiry was a political response by a newly-elected Labour Government in the UK to growing national and international pressure over black victimisation and the failure of the police to investigate crimes against members of ethnic minority communities effectively. Like the RCIADIC, the MacPherson Inquiry extended its remit beyond the specific case of the racist murder of Stephen Lawrence to examine (albeit much more briefly) wider issues of race and criminal justice. Both reports reached similar conclusions regarding the existence of "institutional racism", of how (in the words of the RCIADIC) racist presumptions are frequently "embodied in ostensibly neutral procedures"[235] Although it dealt with it only tangentially, the MacPherson Report did at least acknowledge deaths in custody and the need for effective redress as a major concern of the ethnic minority communities.

[235] Wootten, H *Report into the Death of Clarence Alec Nean* (1991:72).

6.6 More generally, the issues the Royal Commission uncovered in Australia relating to Aboriginal deaths in custody were startlingly similar to those in the UK surrounding black deaths in custody. In Australia and the UK the number of blacks deaths in police and prison custody are disproportionate to their percentage in the population but not to their proportions of arrestees or the prison population. This points to another commonality—black over-representation in the criminal justice system (Simes & Goodman: 2002:20, ABS: 2002).

6.7 In both Australia and the UK, governments have traditionally used the over-representation of ethnic minorities in the criminal justice system as a means of rationalising the high incidence of Aboriginal/black deaths in custody. This line of rationalisation was reflected, for example, in the 1998 Home Office study on deaths in custody in the UK. By contrast, the Royal Commission in Australia not only concluded that Aboriginal people are more likely to die in custody because they are over-represented in custody[236], but went on from this to link such over-representation to the disadvantaged and unequal position in which Aboriginal people find themselves in the society—socially, economically and culturally. In the UK, there has never been such official recognition of the need to reduce the incidence of black arrests and imprisonment as a means to addressing the issue of black deaths in custody.

6.8 Unfortunately, the political and legislative trend in both Australia and the UK in recent years has been away from de-criminalisation and the reduction in the use of imprisonment. Rather, there has been a distinct shift toward a greater emphasis on the use of criminal sanctions and deterrence. These measures particularly impact on black people because of their greater likelihood of a prior offending history. Much the same can be said of the likely adverse impact on black imprisonment of current shifts in criminal justice and sentencing policy in the UK to target so-called "persistent offenders" (Bridges 2001: 71).

6.9 Given this common shift toward greater use of imprisonment, it seems highly unlikely that the incidence of custodial deaths in either Australia or the UK will be significantly reduced. The statistical evidence from Australia is that any reduction in deaths in police custody are likely to be more than matched by increases in prison deaths. In this context, the issue of deaths in custody is likely to remain a major focus of political concern for ethnic minority communities in both countries, as will the effectiveness of the official remedies available to them.

Reforming Remedies in Deaths in Custody Cases

Initial Investigations

7. For many years the main criticisms surrounding deaths in custody has been the lack of independence regarding police and prison investigations. At present in the UK the PCA investigate deaths in police custody, meaning that the police investigate themselves. The police also conduct an investigation when a death occurs in prison custody. This investigation often runs parallel to the Prison Service's own internal investigation. For a coroner to fully investigate how and why a person died in custody, the initial investigation is crucial. However, this investigation is currently conducted by the police and the coroner's officer, a seconded police officer. As the coroner relies so heavily on the information received from these sources, a persistent criticism has been that the Coroners Court itself is not independent as it is dependent on the police. Similar criticisms lay at the heart of some of RCIADIC's key recommendations on coronial investigations into deaths in custody in that country.

7.1 Over recent years, a significant impetus for reform of the system for investigating complaints against the police has developed. The European Committee for the Prevention of Torture (CPT) has criticised the lack of "independence and impartiality" of investigations into complaints against the police (CPT:2000:17). Both the MacPherson Report (1999) and the Butler Inquiry (1999) called into question the legitimacy of the current investigation system for serious complaints against the police. These criticisms resulted in the Police Reform Act 2002 and the establishment of the Independent Police Complaints Commission (IPCC), which is due to come into operation in April 2004. A major question mark remains as to whether the IPCC will be able to establish a reputation for the independence and robustness of its investigations, especially where a death in custody occurs. Nor are there any plans as yet to establish a similarly independent body to investigate deaths in prison or other forms of custody.

Disclosure and Representation

7.2 Two issues which cannot be separated from either the lack of independence of initial investigations of deaths in custody or the ineffectiveness of inquests are the lack of disclosure to and adequate representation of families of those who have died. Despite recent pledges towards a more open system, any internal investigation statements taken from witnesses are the property of the Prison Service as are documents collected in the course of the PCA investigation. The coroner has no powers to order pre-inquest disclosure. Thus, in reality, pre-inquest disclosure remains a voluntary act by both the Police and Prison Service.

[236] *National Report*, Volume 1 at 1.3.3.

7.3 The need for representation of families of those who have died in custody is not limited to appearances before inquests. Not only is there a need for such representation to be available early enough to enable adequate preparation prior to the inquest, but representation for families from the very beginning of investigations of deaths in custody may be an important element in enhancing the independent status of those investigations. Family representatives can serve to counter adverse publicity about the victim and to raise further issues for investigation. In this respect, it is important that some mechanism is established to identify lawyers who are sufficiently expert in dealing with deaths in custody and to put families in touch with them as soon as a death in custody occurs. Needless to say, such representation should be made available throughout free of charge and regardless of the means of the families concerned.

Inquests

7.4 The coronial system in the UK has many deficiencies when dealing with a death in custody: the undue influence of the police over the coronial process, the major delays in holding an inquest, the lack of independence of coroners and the coronial organizations, the broad and vague powers of coroners, and the barriers to the effective participation of relatives. The core issues of accountability, independence, fairness and efficacy are identical.

7.5 The current inquest system does not provide an effective remedy for families as they want to find out the truth surrounding the death in custody and would like to see those responsible to be held liable. Furthermore, the coronial process itself is flawed. It is not an open, transparent system as disclosure is not a right, it is dependent on goodwill, it is not provided early enough and there are many exclusion clauses preventing full disclosure. Death in custody inquests are formally inquisitorial but adversarial in practice, with both sides with much to lose, and this serves to confuse the unprepared family participants. Coroners do not have sufficient powers to be genuinely independent and lack the skills, training, and independent support necessary to conduct investigations into a death in custody.

7.6 It is essential for public confidence that the strong link between the coroner and the police must be removed. Every death in police custody should be investigated as a potential homicide by the new IPCC, which must not be police dominated. As for prison deaths, more independence could be achieved if the Prison Ombudsman were given the power to investigate and publish their reports into all prison deaths. In order to assist the grieving families, guidelines should be developed to speed up the inquest process and full and prompt pre-inquest disclosure made mandatory. It is inconceivable that bereaved families are still subject to delays of over a year in trying to find out how a loved one has died.

7.7 The jury is too confined in their ability to frame verdicts and they cannot make recommendations and do not name those responsible. The verdicts do not necessarily lead to any form of legal liability creating a lack of consistency. The author recommends that the jury power to add riders should be reinstated. A further reform the researcher advocates is the reinstatement of the coroners' ability to commit someone for trial[237]. At present the inconsistency between "unlawful killing" verdicts and coroners' inability to name individuals responsible and commit them to trial is a major deficiency, as the expectation that a criminal prosecution will follow such a verdict is rarely met.

7.8 This lack of consistency is reinforced as coronial findings and recommendations are not published, monitored or even followed up. Riders have been abolished. In order to reduce this inconsistency, coroners' recommendations should be part of the inquest verdict; their recommendations should be published and monitored. There needs to be some official mechanism for holding the authorities to account for acting upon coroners' recommendations, as it is not enough that the media can draw attention to and cause embarrassment to government agencies if recommendations are ignored and another death follows[238]. If a public inquest database were available and easily accessible families would not feel so left out. They would be aware of the options available to them and how the system actually works. Additionally, if the post of an inquest welfare officer, employed by the coroner, was created to liase and explain the process to families, this would help to create a more independent and less confrontational system.

7.9 In order to strengthen the role of the coroners' court and create a more consistent system, a Chair/Head of Coroners should be created to maintain standards, ensure regular training, provide good practice guidelines and deal with complaints. The final and perhaps most important recommendation to emerge from the research into coronials into deaths in custody is that legal representation should be a right for families without means testing. The importance of such a recommendation cannot be overstated. The undue stress that families are put through in trying to secure financial assistance at such a traumatic time is unforgivable.

7.10 There are currently attempts afoot to institute reforms of the inquest system. Dame Janet Smith is investigating the role and function of investigations in the Shipman Inquiry. The Final Report is due in 2004. The Home Office launched a Fundamental Review of the Coroner's System[239] in 2001 as a result of the Alder

[237] Removed under the Criminal Justice Act 1977.

[238] *Chief Commissioner of Police v Hallenstein* [1996] 2VR 1 at 21.

[239] The Coroners Review Team's terms of reference included: considering the most effective procedure for identifying the deceased, for establishing and certifying the medical cause of death, and having regard to proposals for a system of medical examiners.

Hey and Marchioness Inquiries. The results were published in June 2003. The report recommended that public judicial inquiries be held in all death in custody cases where the death did not arise from natural causes. It does not, however, support coronial verdicts implying either criminal or other liability.

7.11 As yet Ministers are still considering their response to the recommendations made. The HRA 1998 s3 affects the potential to reform coroners' courts in a number of ways. In particular, the limited remit of the coroner's inquiries may need to undergo significant changes, in order for the "how, where and when the deceased came by his death" in the Coroners Act 1988 s11(5) (b) to have the potential to provide for an adequate and effective inquiry. This is because the word "how" potentially no longer excludes a consideration of individual actions and systemic failures. Furthermore, the introduction of the HRA means that coroners are now obliged to put the interests of family and private life in a primary position as directed by Article 8 of the ECHR (*Thomas et al* 2002). In general terms the HRA 1998 may enable coroners to rewrite the Coroners' Rules, but this would be a prolonged exercise conducted on an individual case basis.

Criminal Prosecutions

7.12 At the moment criminal prosecution remains the most appropriate action for holding individual people to account for a death, but such actions are doomed to fail without a reform of the whole investigative process. To date, in both countries there has been no successful criminal prosecutions following a black death in custody. Since 1990 there have been eight deaths in custody where inquests returned unlawful killing verdicts in the UK, all of which were followed by CPS decisions not to prosecute. The CPS decisions were successfully challenged using judicial review in four of these cases (O'Brien, Lapite, Manning and Alder), two of which eventually resulted in unsuccessful prosecutions (O'Brien and Alder). Although the Butler Inquiry (1999) was set up to examine the decision-making process of the Director of Public Prosecutions in relation to deaths in custody, it did not itself result in any new prosecutions or significant changes. Lastly, the Attorney General and the Director of Public Prosecutions have begun a review of the role of the CPS in deaths in prison or police custody. It reported in July 2003 and was limited to key aspects of the CPS role .It did not reopen or reconsider individual cases.

Would a Royal Commission Satisfy Article 2?

8. In 1991 the Institute of Race Relations proposed the establishment of a Royal Commission to investigate all deaths in custody based on their limited knowledge of the RCIADIC at the time. This paper set out to investigate the feasibility of this proposal when set against an analysis of what the Australian Royal Commission achieved and the potential for reform under the Human Rights Act 1998.

8.1 One of the clear lessons to be drawn from the Australian Royal Commission is that such a body is inappropriate for the detailed investigation of individual death in custody cases. Not only did the RCIADIC become bogged down in the controversy and procedural manoeuvring that is bound to surround such investigations, but a permanent body with such a remit could well hamper the reform of existing remedies and the development of investigative expertise in the police, prisons and secure hospitals—arguably where greater expertise is most needed. Also, even if the establishment of a standing Commission guaranteed greater investigative independence, its very existence would limit the progress of creating independence in other institutions, such as the new IPCC. The Institute of Race Relations originally proposed that a Royal Commission would only become involved in individual cases in an appellate capacity, following an inquest. However, the past decade has seen a significant development of judicial review as a means for challenging the findings of inquests and the inadequate working of existing remedies, such as criminal prosecutions. The advent of the Human Rights Act 1998 has a potential for further strengthening such challenges in the future.

8.2 What of the wider political impact of the Australian Royal Commission? As argued earlier, it proved for a period to be a stimulus for both government action and wider political organisation around the issue of deaths in custody. However, its effect in terms of influencing governments in Australia has now largely dissipated with the advent of much harsher "law and order" policies. Arguably, the experience in the UK following the MacPherson Report holds out similar lessons.

8.3 If the analysis presented here leads to scepticism about the potential for a Royal Commission in the UK, there may nevertheless be a role for a differently constituted permanent review body on deaths in custody. Such a body would need to include representation of community and other interest groups and it certainly should not seek to displace them. While there should be a statutory requirement on all custodial and investigative bodies to notify the review body immediately that deaths (and possibly serious injuries) in custody occur, its function should not be to oversee or interfere with the existing processes of investigation of such cases. It might, however, have a role in assisting families in the immediate aftermath of deaths, such as in maintaining a register of lawyers expert in dealing with deaths in custody cases and putting them in touch with families through organisations such as INQUEST.

8.4 The primary role of the review body would come after the investigation and inquest into deaths in custody had been completed. One of the more important and lasting changes brought about by the Royal Commission in Australia was the setting up of the National Deaths in Custody Monitoring Unit in Canberra and the MUNNCI (national coronial database) in Melbourne. Part of the function of a national review body on deaths in custody in the UK would be to replicate the role of these organisations in this country in respect

of death in custody cases, in particular collating information on the findings and recommendations of all investigations and inquests into deaths in custody. But it should also go beyond such a monitoring role and seek to draw out specific lessons for future policy in this field. Its advantage over existing remedies is that its remit and recommendations would not be confined to the circumstances on any one individual death or even to one particular form of custody, but rather it could seek to draw out policy lessons across the full range of cases and custodial situations. It could also serve as a body to review periodically the Government and authorities' implementation (or lack of it) of recommendations of inquests or the review body itself. One could envisage the publication of its annual reports as providing a major focus for a wide range of groups campaigning for reform in relation to deaths in custody.

8.5 Of course, no commission or review body can serve to guarantee reform or as a substitute for political action around such issues as deaths in custody. The issue of deaths in custody will not disappear due to the underlying spectre of racism and current trends in criminal justice policies, such as the drive against "persistent offenders" in the UK. Unless there is a fundamental shift in societal attitude towards ethnic minorities and criminal justice issues (including immigration) then despite the attempts at reforming individual parts of the system, the number of deaths in custody will continue to rise in line with the growing incarceration of members of ethnic minority communities.

25 September 2003

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21. Memorandum from Dr Alice Mills

PREVENTING DEATHS IN CUSTODY

1. *Main causes of deaths in custody*

1.1 Traditionally, suicide in prison has been seen as being caused by individual, internal traits or characteristics, such as psychological defects and many early studies mentioned the high preponderance of mental illness/psychiatric contact and substance misuse among those who commit suicide in prison. However, as prisons tend to "specialise" in people with mental health problems and substance misusers, any prediction made on the basis of these factors is likely to generate a high number of false positives. In order to distinguish those at risk from suicide/self-harm from those who are not, it is necessary to look for other indicators of vulnerability.

1.2 More recently, there has been a shift towards understanding suicide in prison as the result of difficulties coping with imprisonment and the pressures of prison life. Such coping difficulties will vary between individuals as they are seen to arise from an interaction between internal factors such as mental health problems which may affect a prisoner's coping abilities, and environmental pressures, particularly the so-called "pains of imprisonment" such as lack of activity or security or contact with family and friends. For example, in her study of prison suicide, Liebling (1992)[240] found that young inmates who were at risk of suicide or self-harm were those who were less likely to have contact with anyone on the outside, less likely to have anything to occupy them during the day and more likely to have problems with other inmates, and were also unable to cope with the resulting isolation, boredom and fear, as well as having a history of psychological problems and substance abuse.

1.3 Difficulties coping with prison life may also explain other so-called "maladaptive" responses to imprisonment. Inmates who find it difficult to cope in prison may withdraw either physically (by going into protective segregation) or psychologically, and such withdrawal may lead to further problems as they may be seen as "weak" by other prisoners, which may leave them open to bullying and victimisation. They may also be vulnerable to violent outbursts or episodes of "acting out" as a result of their own frustrations with prison life.

2. *Common Factors*

2.1 Research is in general agreement that prison suicides tend to share several common factors. Suicide is more likely to occur in the early stages of a sentence. The Chief Inspector of Prisons (HMCIP 1999)[241] reported that the first 24 hours is a high risk period as about 10% of suicides occur in this period, with 43% occurring within the first month and 80% within the first year. This may be explained by the shock and stress of incarceration which may be even more acute for first-time prisoners. Substance misusers are at particular risk at this time, as they have to cope with the shock of imprisonment, whilst withdrawing from the substance that they have previously been dependent upon.

2.2 Prisoners on remand are also disproportionately represented in the figures. This has largely been attributed to the stress of the remand period, as prisoners face the uncertainty of the court case and sentencing as well as the shock of being in prison, poor conditions, limited activities and overcrowding on

[240] Liebling, A (1992) *Suicides in Prison*, London, Routledge.

[241] HM Chief Inspector of Prisons (HMCIP) (1999) *Suicide is Everyone's Concern: A Thematic Review by HM Chief Inspector of Prisons for England and Wales*, London, Home Office.

remand wings. However, as the remand population has a high turnover, any suicide rate based on the average daily population may be slightly biased towards remand prisoners, and if calculated on the basis on receptions, the suicide rates of sentenced and remand prisoners are roughly similar (Liebling 1999)[242].

2.3 Prisoners who have committed violent and sexual offences may be more at risk of suicide and self-harm. In 1998, 34% of those who committed suicide were charged with violence against the person, but this group made up only 21% of the prison population. Those charged with sexual offences made up 10% of suicide, but 8% of the population (HMCIP 1999).[243] Those serving sentences of four years or more, particularly lifers, are at high risk and this may be due to guilt about the offence, and uncertainty and despair about the prospect of long periods of imprisonment.

2.4 Due to the fact that a large proportion of prison suicides are carried out by those on remand or in the early stage of a sentence, the majority of suicides and incidents of self-harm take place in local prisons, as these are where such prisoners are accommodated.

3. *Particular aspects of conditions of detention, or the treatment of detainees, or the cultural background of prisoners or prison officers that contribute to suicide and self-harm*

3.1 Prison pressures or the so-called "pains of imprisonment" such as isolation from family and friends, and the lack of constructive activity may contribute to suicide and self-harm if prisoners feel that they are unable to cope with them. For example, the lack of any opportunity to sort out family problems or alleviate anxieties over a relationship due to the constraints of imprisonment may lead to feelings of hopelessness and despair, which may eventually lead to suicide. In the current climate of overcrowding, contact with family may be even harder to maintain if a prisoner is moved far away from their home area due to population pressures, and visits from family can become difficult if not impossible. Prisoners who have difficulty coping with the boredom and inactivity of prison life are more vulnerable to self-destructive acts, and therefore such risk is likely to be more acute in local prisons which tend to have a high prisoner turnover and high levels of overcrowding. This may lead to a large proportion of the population being left with no opportunities for work, education or other activities and being locked in their cells for up to 23 hours a day, as well as less opportunities to arrange visits or make phone calls, and more pressure on facilities such as health care, drug treatment etc. Furthermore, staff may have less time to conduct assessments and offer care to individual prisoners.

3.2 Feeling unsafe or fearful may also contribute to suicide in prison, particularly if prisoners do not see any other way out of a situation where they are being bullied, threatened etc. This risk may be higher if they are in prison for the first time or at the beginning of their imprisonment and have not had any time or opportunity to build up any kind of supportive network, or learnt the skills to avoid threatening situations.

3.3 The masculinity of a male prison environment and the prisoner subculture may discourage inmates from discussing their personal difficulties, as showing that they have problems and particularly talking to staff about them may be seen as a sign of weakness, potentially leaving prisoners more susceptible to victimisation.

3.4 Despite the fact that a history of self-harm can be a strong indicator of vulnerability to suicide, self-harm or suicide attempts are sometimes seen by staff and other prisoners as manipulative, attention-seeking, "gestures" which are deliberately carried out by prisoners for their own gain such as to obtain transfer to a better setting, escape problems with others or be given a phone call to loved ones. Such attitudes may lead staff to dismiss the severity of the prisoners' distress and they may be treated with contempt and disapproval rather than support and help. Viewing these acts as attention seeking or manipulation tends to ignore the real problems that motivate prisoners to commit self-destructive acts, and if there is no response to an act of self-harm, suicide may ensue (Liebling 2001)[244].

3.5 Staff shortages, lack of staff continuity and lack of information sharing can all impair staff ability to identify and care for prisoners at risk of suicide/self-harm. Although personal officer schemes (where one officer is responsible for the welfare of a small group of inmates) may facilitate trust and understanding between inmates and staff, thereby putting them in the best position to notice any problems that prisoners may be having, the effectiveness of such schemes varies between establishments, and they are particularly less likely to be running in local prisons and remand centres, despite the heightened risk of suicide there (HMCIP 1999)[245].

[242] Liebling, A (1999) "Prison Suicide and Prisoner Coping", in Tonry M and Petersilia, J (eds) *Prisons*, Crime and Justice: A Review of Research, Vol 26, Chicago, University of Chicago Press.
[243] *op cit*.
[244] Liebling A (2001) "Suicides in Prison: Ten Years On", *Prison Service Journal*, No 138, pp 35–41.
[245] *op cit*.

4. *Particular aspects of conditions of detention, or the treatment of detainees, or the cultural background of prisoners or prison officers that contribute to other deaths or injuries in custody*

4.1 The subculture of prisons and the prisoner hierarchy ensures that certain groups of inmates are at a much higher risk of victimisation and therefore injuries and possibly even deaths in custody. Probably the most "at risk" group, at the bottom of the hierarchy, is made up of sex offenders, particularly child molesters or killers. Many prisoners see the victimisation of sex offenders as legitimate and such attitudes can be reinforced by staff who may tolerate expressions of such hostility. Other vulnerable groups include "grasses" who are seen to have broken a key rule of the inmate subculture, police informers or those in debt to other prisoners.

4.2 Prisoners who have difficulties coping in prison may also be at an increased risk of victimisation and therefore death or other injuries. They may not have the social skills to avoid dangerous situations such as borrowing tobacco from others and being unable to pay this back, particularly when double the initial amount is demanded. In the masculine prison environment, where prisoners and staff are expected to solve their problems through being tough and using violence and aggression, those who show fear, weakness or resourcelessness or fail to stand up for themselves may be more vulnerable to attack by other prisoners. Any attempt to reduce violence may therefore be difficult as prisoners may wish to "save face" to prove their strength and status when faced with aggression. Furthermore, because the inmate subculture clearly rejects any notion of "grassing", informing staff that they are being bullied or intimidated may not be an option for many prisoners as they may fear the repercussions of this more than the initial victimisation.

4.3 Various aspects of the prison environment, particularly relative deprivation and the limited access to material goods, as well as overcrowding and limited supervision may explain why bullying and taxing (intimidation designed to persuade someone to part with goods or money) can flourish within prisons.

5. *Practical steps that have already been taken and further steps that need to be taken to prevent suicide and self-harm in custody*

5.1 The most recent Prison Service suicide policy (introduced in 2001) places an emphasis on preventing suicide through caring for prisoners who are seen to be at high risk of self-destructive behaviour. Resources are to be concentrated on local prisons through the Safer Locals Programme, and care for prisoners on reception and induction is to be improved to ensure that the early stages of custody are less stressful, prisoners have adequate support and contact with others, and any risk factors can be identified.

5.2 This policy also borrows the concept of a "healthy prison" from the Chief Inspector of Prisons' thematic review of suicide and self-harm (HMCIP 1999)[246] and aims to promote a supportive culture where prisoners are less likely to commit suicide, although it is not really made clear how this might be done. Such a culture should be a key element in any approach to reducing deaths in custody as there is a need to break down ideas that only weak prisoners talk about their difficulties, and ensure that prisoners feel comfortable about approaching staff to discuss their distress.

5.3 Additionally, the policy suggests that mental health staff can help to identify and care for at risk prisoners and support wing staff, and recommends the establishment of detoxification units to reduce the risk of substance misusers committing suicide/self-harm in the early stages of their imprisonment. However, many prisoners may be denied access to such a controlled detoxification if prison medical staff feel that it is unsuitable or do not believe in giving prisoners what they see as "more drugs". Detoxification can also take up to 12 weeks and if a prisoner is moved within this time or released, it may not be possible to complete the programme which can be worse than no programme at all.

5.4 Whilst these measures are helpful not only in terms of reducing the risk of suicide, but also in promoting better mental health, there is a danger that the focus of suicide prevention is moving back towards a medical model, with an emphasis on mental disorder and substance misuse, rather than a multi-disciplinary approach. Although the policy stresses the role of the whole prison community in creating a supportive environment, it does not discuss the role of other staff such as teachers, instructors and probation officers, despite the fact that they spend a considerable amount of time with prisoners, and inmates may choose to confide in them, particularly if they are in distress whilst away from the wing. Such staff therefore also need to be supported to ensure that they are confident in taking measures to prevent suicide/self-harm, and the role of activities such as education in ameliorating prisoners' coping difficulties should not be underestimated (see paragraph 7.8 below).

5.5 Mental health and enhanced suicide awareness training for front line staff in local prisons is also recommended in the suicide prevention policy, and since 2001, all new prison officer recruits have been given training in identifying mental health problems. Whilst this is a positive step, it is not clear why this should not be received by existing officers, particularly as there is a danger that when trainees start training "on the job", they will accumulate negative attitudes from more experienced officers who have not received mental health training.

[246] *op cit*.

5.6 In 1999 the Prison Service announced that the use of strip cells for suicidal prisoners would be abolished by April 2000, as this practice was likely to be challenged under Article 3 of the European Convention of Human Rights, which protects the right to freedom from torture or inhuman or degrading treatment or punishment. Strip cells have been widely recognised as unsuitable accommodation for suicidal prisoners, as inmates are deprived of human contact, and they may actually serve to intensify a sense of hopelessness and increase suicidal ideas rather than relieving prisoners' distress.

5.7 Since the abolition of strip cells, "safe cells"; that is, cells that minimise ligature points, have been installed in health care centres and induction and detoxification units. Although such cells may ensure compliance with Article 2 and 3 of the European Convention of Human Rights, they, along with other situational measures such as observation cells with CCTV, may be used as an excuse not to maintain active, supportive contact with the inmate, and may therefore leave prisoners isolated from others, which is likely to exacerbate any feelings of hopelessness and any consequent risk of suicide.

5.8 Prisoners who are vulnerable to suicide/self-harm may also be placed in a prison health care centre for short periods of time in order for staff to observe them and to take them away from the pressures of the normal prison environment. However, prisoners accommodated in health care centres tend not to have access to a range of constructive activity, and being placed there may therefore serve to exacerbate a prisoner's feelings of boredom and isolation. Some commentators have argued that suicidal inmates should be placed in shared accommodation in as normal an environment as possible (Medlicott 1999)[247]. This would ensure that the suicidal prisoner can receive help from their cell mate (who may or may not be a Listener), is less likely to feel isolated and would still be able to participate in the prison regime. Alternatively, vulnerable prisoners could be placed in the facilities for prisoners with special needs which are described in section 7 below.

5.9 Most prisons in England and Wales operate a Listener scheme, where prisoners are selected and trained, usually by the local Samaritans group, to befriend other inmates and support those in distress, using sympathetic but active listening techniques. All discussions are completely confidential, and there is an emphasis on helping prisoners to help themselves, whilst Listeners remain supported by the Samaritans through regular feedback sessions. Listener schemes are designed to supplement the work of staff, as it was seen that prisoners would be better informed about how to cope with periods of despair and would be more likely to recognise the distress of others (HM Prison Service 1997).[248] Although the number of Listeners in high risk prisons has recently been increased, it should be noted that it may be more difficult for schemes to operate in local prisons and remand centres where there is a high turnover of inmates. Additionally, the issue of confidentiality remains contentious, not only because staff resent the idea that they may not be informed if prisoners intend to commit self-harm, but also as prisoners may distrust Listeners fearing they may discuss their problems with staff (HM Prison Service 2001)[249].

5.10 Families and friends also need to be included in caring for those at risk of suicide/self-harm. They may be able to pass on any relevant information or concerns that they may have about an individual prisoner, and they should be kept informed of any changes in a prisoner's mental state. Although the latest Prison Service Order (PSO 2700, issued in November 2002) on suicide and self-harm prevention recommends that after serious incidents of self-harm, prisoners may be given a phone call or an extra visit, it is not clear whether the same provisions would exist for those who are clearly in a state of acute distress, but have not actually self-harmed.

6. *Practical steps that have already been taken and further steps that need to be taken to prevent other deaths or injuries in custody*

6.1 In 1993, the first national anti-bullying strategy stressed the need for a "whole prison approach" in which staff, prisoners and visitors show a commitment to reduce and prevent bullying. This includes identifying circumstances that are conducive to bullying, constantly reinforcing the strategy to prisoners as soon as they enter an establishment, and challenging bullies and supporting victims of bullying in an effort to change the prison culture. Every establishment is required to have its own anti-bullying policy, and an anti-bullying co-ordinator to regularly review the symptoms of bullying. Policies may include measures such as those to encourage prisoners to report victimisation without fear of being seen as a "grass", and segregating aggressors rather than victims and ensuring they go through an anti-bullying programme. However, not all staff members may be aware of the policies which may lead to wide variations in their effectiveness (Edgar and O'Donnell 1997)[250], and thus there is a need to ensure that all levels of staff are committed to anti-bullying measures.

6.2 Vulnerable prisoners can ask to be placed on voluntary segregation for their own protection (under Rule 45), but this may have several negative consequences. Conditions on segregation wings are seen to be substandard in comparison to those that prevail in the rest of the prisons, and inmates may have little or no

[247] Medlicott, D (1999) "Researching the Prison: Prisoners as Knowledgeable Agents", unpublished paper presented to the British Criminology Conference 1999, Liverpool, 13–16 July.
[248] HM Prison Service (1997) *Caring for the Suicidal in Custody*, London, Prison Service.
[249] HM Prison Service (2001) *Prevention of Suicide and Self-Harm in the Prison Service,* London, Prison Service.
[250] Edgar, K and O'Donnell, I (1997) "Responding to Victimisation", *Prison Service Journal*, No 109, pp 15–19.

access to institutional activities such as work, education and gym. Many vulnerable prisoners, particularly in local prisons, may therefore spend approximately 23 hours a day locked up in their cells, a situation which may increase a sense of boredom and isolation and psychological problems such as severe anger, sleep disturbances and depression, thus potentially enhancing the risk of suicide. In some prisons, Vulnerable Prisoner Units (VPUs) have been developed which offer the prisoners accommodated there conditions which are at least approximate to those on normal location. Work, education and association is provided within the units and prisoners are able to mix more freely amongst themselves. Yet providing separate facilities for work, exercise, education and visiting may be beyond the budgetary and other resources of most establishments.

6.3 Protective segregation may also contribute to the identification of weak and vulnerable groups in the prison, thus adding to their scapegoating and victimisation. It does not address aspects of the prison subculture which stigmatise and persecute such inmates and prisoners who chose to go on protective segregation risk being stigmatised as sex offenders even when they are not, which may make any return to normal location problematic. Such stigmatisation can be dehumanising and cause great distress.

6.4 In order to counter this stigmatisation, challenge the negative subculture and provide better conditions for vulnerable prisoners, some prisons have integrated vulnerable prisoners into the main prison population. At HMP Littlehey vulnerable prisoners are accommodated separately from the rest of the prison, but are encouraged to participate in work, education and exercise with inmates from the main population, and eventually move onto normal location. Staff will not tolerate persecution and as the regime at Littlehey is relatively relaxed, inmates are dissuaded from causing trouble or they risk being transferred. Vulnerable prisoners could certainly be accommodated with ordinary inmates in small units, containing no more than 50 to 70 prisoners, as recommended by Woolf (1991)[251]. Such units would have a liberal regime so that prisoners would not want to risk being moved off the unit and would therefore be less inclined to cause trouble. They may offer improved standards of surveillance and control and can encourage better interpersonal relations between staff and prisoners, and may also have the effect of creating a better sense of community amongst the prisoners accommodated there, which could discourage them from victimising others, and encourage them to support those who are being victimised.

7. *Facilities for vulnerable prisoners with coping difficulties/special needs*

7.1 In some prisons in England and Wales, distinctive units have been set up for prisoners who have a variety of different problems or "special needs", such as mental disorders, learning difficulties, or substance misuse, which make it difficult for them to cope with prison life. These facilities aim to help such prisoners to cope by keeping them in a sheltered environment such as a separate landing or wing, where they can receive assistance with their individual difficulties and be kept away from other prisoners who may seek to harm them due to their vulnerability. They act as "halfway houses" between the normal prison wings and more specialist locations where vulnerable prisoners are often placed, such as the Rule 45 unit or the health care centre. Such facilities accommodate approximately 40 prisoners and are staffed by small teams of supportive officers who receive little or no extra training for this role, but are specially selected for their more understanding, tolerant approach.

7.2 My doctoral research on the effectiveness and operation of two of these facilities (B1 at HMP Cardiff and St Patrick's wing at HMP Camp Hill) found that they could help prisoners cope in several different ways (Mills 2003)[252]. Firstly, the prisoners accommodated there particularly seemed to appreciate being kept in a more sheltered subsetting, away from the rest of the prison. The facilities ameliorated prison pressures by reducing the unpredictability of prison life and offering a more supportive environment free from the constraints of the masculine prison culture and its need to demonstrate toughness, and the majority of prisoners reported feeling safer there than in other areas of the prison. Furthermore, although both facilities protected the prisoners from others, B1 encouraged inmates to integrate with other prisoners at work, education, association etc, whilst St Patrick's provided opportunities for education and association on the wing, which meant that these prisoners were able to access constructive regimes which they may not be able to do on other specialist locations.

7.3 Secondly, staff played a significant role in creating such an ameliorative environment. Having regular staff working on the facilities meant that better staff-prisoner relations could be built up and officers were well placed to notice any changes or differences in a prisoner's mental or physical state. Staff also seemed to recognise the need to try to understand prisoners' complex problems and be tolerant of their behaviour rather than resorting to disciplinary responses. Many encouraged prisoners to talk to them about their concerns in the hope of alleviating their distress and reducing the isolation of prison life, and during the fieldwork, it became evident that many inmates appreciated the regular officers' approachable, friendly manner. Approximately 40% of prisoners on B1 and 25% of prisoners on St Patrick's reported that they would talk to staff working on the facilities about personal problems. Although these figures do not appear to be high, one study of prison suicide found that only a fifth of prisoners would discuss a problem with

[251] Woolf, Lord Justice (1991) *Prison Disturbances April 1990: Report of an Inquiry by the Rt Hon Lord Justice Woolf (Parts I and II) and His Honour Stephen Tumin (Part II)*, London, HMSO.

[252] Mills, A (2003) *Coping, Vulnerability and disruption: Facilities for Prisoners with Special Needs*, unpublished PhD thesis, University of Wales, Cardiff, June 2003.

someone (including staff, prisoners and others) (Liebling 1992 *op cit*). Additionally, when asked what they would do if they had a problem with another prisoner, most inmates on both facilities said that they would tell an officer, which suggests that the facilities were able to create a safe environment where inmates feel comfortable about approaching staff about such matters, as suggested in the Prison Service's anti-bullying strategy.

7.4 The research has also shown that there is a need to understand how a prisoner's "special needs" can affect their coping difficulties. The thesis looked at four specific areas of special need found amongst the prisoners accommodated on the facilities—health problems, substance misuse, educational difficulties and physical disabilities—and found that some could have a considerable impact on prisoners' ability to cope. Prisoners with mental health problems may feel too ill to participate in constructive activity due to their medication, which may leave them feeling unable to alleviate any feelings of boredom. Substance misusers who may have previously depended on a substance to cope with life outside of prison, may find it difficult to cope without this in prison and any physical or psychological withdrawal symptoms may also leave them unable to participate in prison life and with an enhanced sense of anxiety and fear. Finally, those with educational difficulties or learning disabilities may be more limited in the way that they can keep themselves occupied whilst in prison and may be more susceptible to feelings of isolation due to greater communication difficulties with family and friends.

7.5 The facilities did, however, provide some specialist assistance to help to meet prisoners' special needs and thus try to alleviate their coping difficulties. For example, St Patrick's wing holds specialist education classes to improve prisoners' basic and life skills as well as giving them some form of constructive activity, and offers access to a community psychiatric nurse who works on the wing three days a week. All staff working on the wing also attend a weekly meeting where individual prisoners are discussed to monitor their progress and note any problems that they may be having.

7.6 In order to help prisoners cope with prison life and thus reduce vulnerability to suicide/self-harm and victimisation, these facilities could be replicated across the prison estate, as they appear to offer a more constructive alternative to situational suicide and victimisation prevention measures. However, they do need to be developed and improved, and as these prisoners have a variety of different problems, a multi-disciplinary approach is necessary with more services to help them with their special needs and thus their difficulties coping in prison. This could be based around the multi-disciplinary mental health in-reach teams which are to be introduced into prisons. These consist of a range of mental health professionals from the community who will provide services to prisoners accommodated on normal prison wings in the same way that they do to patients in the community, and the facilities seem to be an ideal setting for these services. Such mental health teams may also include occupational therapists who can play a significant role in helping prisoners to cope with their imprisonment. Occupational therapy or day care may allow them to express feelings that they are unable to discuss, as well as providing them with constructive activity. In order to best meet the variety of needs that these inmates have, day care could cover a number of different subjects and could be carried out by a team of different staff including officers, teachers, psychiatric nurses, psychologists and drug/alcohol counsellors, particularly as recruiting forensic occupational therapists to run such provision may be difficult due to a shortage of staff specialising in this area.

7.7 Such a multi-disciplinary approach also needs to include comprehensive drug treatment ranging from suitable detox medication, awareness courses and more intensive treatment programmes. Although new detoxification units will go some way towards providing this help, the evidence suggests that current drug treatment provision is unable to cope with the extremely high demand for it, particularly in local prisons. Furthermore, as mental health problems and substance misuse are two issues which may exacerbate any difficulties coping with prison life, there is also a need to ensure that services are provided for prisoners with a "dual diagnosis"; that is, a mental disorder and substance misuse problem. Such prisoners have traditionally fallen through the gap in provision, as mental health services have refused to treat them due to their substance misuse and drug agencies have turned them away due to their mental health problems. The Department of Health (2002)[253] has recently introduced a dual diagnosis strategy which suggests that mental health services will take primary responsibility for patients with a severe mental illness and substance misuse problem, with drug agencies providing them with specialist training and support. Conversely, mental health services should offer support to drug and alcohol agencies to enable them to deal effectively with those with less severe mental health problems, and there is no reason why such a strategy could not be introduced into prisons to provide appropriate care for these prisoners.

7.8 Other agencies and groups could also be involved in providing multi-disciplinary care to prisoners with special needs. The training in mental health awareness which is now given to new prison officer recruits could be given to the staff working in these facilities so that they can identify anyone showing signs of stress or anxiety and give appropriate support. Furthermore, education classes like those provided on St Patrick's wing can provide a forum for prisoners to discuss their concerns with others, including the teachers, within a "humanising" environment, which may go some way to ameliorate the coping difficulties that these prisoners have. However, in order to do this, education should be more broad than the current rather narrow

[253] Department of Health (2002) *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*, London, Department of Health.

emphasis on basic skills and should include subjects such as art, which may not necessarily lead to a vocational qualification, but may improve prisoners' self-esteem and general attitudes towards themselves and others.

8. *Fostering a greater human rights culture*

8.1 Fostering a human rights culture in prison is difficult when a negative view of prisoners' rights is likely to be reinforced by those in the outside community to which staff return every day. Among staff, "rights" talk may generate suspicion as they may believe that it will mean that prisoners have more scope to litigate against them. Fear of being blamed for a breach of human rights, particularly in terms of preventing deaths in custody, may lead to an overcautious approach as staff may be tempted to resort to situational measures such as "safe" cells or encouraging prisoners to go onto Rule 45 rather than attempting to reduce their vulnerability by offering them personal support and improving their coping abilities. Furthermore, a human rights approach may generate resentment among staff as they may feel that more attention is being placed on improving conditions for prisoners rather than their own working conditions.

8.2 There is therefore a real need for management commitment to support staff in order to encourage them to adopt a human rights approach. This might include not only training, but also supporting staff initiatives which do promote human rights. The staff working on the facilities discussed in section 7 had many ideas as to how the units could be developed, but these were often ignored due to budgetary constraints, overcrowding and lack of management commitment, leaving staff feeling disappointed and demoralised. If such measures do not receive the appropriate commitment and financial resources, they can be vulnerable to being closed down when, for example, a new governor is appointed, or when a key individual leaves the project, and no-one can be found to take their place.

8.3 Finally, there is also a need to act in the interests of prisoners in order to promote humanity and care in prisons, rather than in the interests of prisons who may wish to simply avoid legal action under the Human Rights Act 1998. This could include utilising more social measures to prevent deaths in custody, such as the facilities for special needs prisoners which attempt to tackle vulnerability, rather than situational approaches which deal in terms of risk and simply trying to manage risk predictors.

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