

Forum for Preventing Deaths in Custody

ANNUAL REPORT 2007/08

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CHAIR'S REPORT

By the time of publication, well over a year will have passed since we published the Forum's inaugural Annual Report in September 2007. Those with an interest in the Forum will, I hope, nevertheless have been able to keep abreast of the matters which have pre-occupied us since the last Annual Report through a much more up-to-date and comprehensive website. I am pleased to say that this has become a valuable resource to Forum and non-Forum members alike despite no new resources being provided, and I hope this remains the case under the Forum's successor organisation.

This brings me on to the single most significant development which has taken place during this reporting period: the announcement of the establishment of the Ministerial Council on Deaths in Custody. The independent review of the Forum which the government had commissioned at the time of the last Report concluded in December 2007, and was published for consultation in February 2008. The Forum itself, and a number of member organisations individually, responded generally very positively to the recommendations contained in the review, prompting Ministers to announce in July 2008 that the recommendations were to be adopted.

As a result, a new three-tier structure will be set up: a Ministerial Board on Deaths in Custody, chaired by the Justice Minister and made up of service leaders and other senior government and non-government stakeholders, will form the first tier. Its principal source of advice will be an Independent Advisory Panel on Deaths in Custody. This will be a small group of appointed independent experts in relevant fields. Like the Forum, it will also be independently chaired, and is modelled loosely on the Advisory Council on the Misuse of Drugs. At the time of writing, the appointment of Lord Toby Harris as the Panel's inaugural Chair has just been announced, and I take this opportunity to congratulate him on his appointment. As an advisory panel, it will not, of course, have the power to make policy or to bind Ministers, but my hope is that its constitution and status will mean that its recommendations will carry a good deal of weight and will be heeded by policy-makers. The third of the new tiers will be a 'virtual' group, the Practitioner and Stakeholder Group, made up of bodies and agencies which we were not able to accommodate on the Forum, such as NGOs working in relevant fields, and representatives of frontline custody staff. All three of the new tiers will be served by a full-time Secretariat.

Clearly, these new arrangements are still embryonic at this stage, and many of the details have yet to be worked out. It is true that these arrangements still fall short of the kind of body envisaged by the Joint Committee on Human Rights, or of INQUEST's proposal for a Standing Commission on Deaths in Custody. There are also issues around resources: while the new arrangements do involve the provision by government of new resources of around £200,000 per year, my view and that of many Forum members is that the new arrangements would be most effective if they were supported by a dedicated research budget, to enable the Independent Advisory to commission research as they see fit. Despite our overtures, there is no commitment from government to provide this at the time of writing. Nonetheless, these measures do represent progress and I am cautiously optimistic that they will build on the good work of the Forum. They should also help to ensure that the issue of deaths in custody remains high on the public and political agenda.

The fact that we are shortly to be replaced by these arrangements has certainly not caused any complacency among Forum members, and indeed, with key legislation relating to coroners inquests before parliament and a number of test cases before the

House of Lords, it has been a busy time. I alluded, in the last Annual Report, to the changes which we were pushing for to strengthen Coroners' powers to make recommendations to prevent future deaths. Since then, that power has been overhauled in the Coroners' Rules 1984. The Ministry of Justice has also pledged to publish all such recommendations and their responses either verbatim or in summary form, in order to maximise learning opportunities. Both of these are positive developments in which the Forum was heavily involved.

I was particularly pleased to see that the Coroners and Justice Bill featured in the Queen's Speech in December 2008 and is scheduled to be introduced in January 2009. While it is true that certain stakeholders have voiced misgivings or do not feel that the reforms go far enough, I believe that the fundamental reforms to the coronial system contained within it are long overdue and can only be good news to everybody who interacts with the inquest process. I am also pleased that the government abandoned the provisions in the Counter Terrorism Bill which would have ousted juries in cases involving sensitive information. That said, at the time of writing, these provisions have reappeared in a slightly amended form in the recently-published Coroners and Justice Bill. While, overall, this Bill is to be welcomed, it is a shame that these provisions have reappeared: many Forum members have grave reservations about the effect this would have on the learning process, and feel that there are other, better alternatives. I share those reservations and would urge the government to explore the alternatives for the very small number of inquest cases in which sensitive material must be considered.

Another area in which the Forum has been active has been that of near-deaths in custody. All of the custody providers and their investigation bodies are represented on the Forum. We were therefore very well-placed to compare the definitions, policies and procedures which are employed in this area. The results of our research were fairly stark: the systems that are currently in place are, in most cases, inadequate, uncoordinated and patchy. There appears to be no commonality of understanding in terms of the definition of a near-death, nor the investigative obligations which are triggered in the event of one. This has probably not been helped by a relative lack of legal certainty. This is still an evolving area of law and will no doubt generate further litigation.

That said, at the time of writing the House of Lords have just given judgment in the test case of *R ('JL') v Secretary of State for the Home Department*. This judgment confirms that, where an apparent suicide attempt '...comes close to success, and leaves the prisoner with the possibility of serious long-term injury', the same investigative duty under Article 2 ECHR initially arises as in cases where the victim loses their life: there should be a prompt, independent initial enquiry to secure evidence while still fresh and to establish the facts. Whether the investigation then needs to take on further-reaching attributes more akin to a public enquiry will depend on the results of the initial inquiry. Where the course of events appears to be clear and reveals no issues of concern, the initial enquiry may in itself be sufficient to satisfy article 2. Where there are issues of concern, a greater degree of public scrutiny and participation of next-of-kin may be called for, which might more closely resemble the Prisons and Probation Ombudsman's investigation in the now well-known case of 'D', following the judgment in *R ('D') v Secretary of State for the Home Department*.

While this was a prison case, 'JL' is likely to be regarded as good authority for near-death cases in all custodial sectors – another test case, *Savage v South Essex Partnership NHS Foundation Trust* has just confirmed that the same Article 2 duties are owed to detained patients as to other types of detainee – and it is essential that

government departments and the relevant investigation bodies now move to develop timely, effective and human rights-compatible procedures for investigating such cases. In the context of prisons, my suggestion as an intervener in the 'JL' case that the Prisons and Probation Ombudsman should investigate this type of case, and should be provided with appropriate resources to do so, received judicial support. I remain of the view that this would be a commonsense solution.

While the challenges of investigating near-deaths have come to the fore relatively recently, it has long been recognised that actual deaths do require article 2-compliant investigation. Another piece of Forum research this year looked into the extent to which this would happen in practice in England and Wales. The work concluded that, in general, this would take place, but that there are limited circumstances in which it would not (for example, the death of a child detained in a Secure Children's Home). We have drawn the attention of Ministers and the Parliamentary Joint Committee on Human Rights to this in the hope that appropriate procedures will be put in place. Sadly, the long-standing difficulties with the status of the Prisons and Probation Ombudsman (as a non-statutory office within the Ministry of Justice working within a non-statutory remit) remain. The Ombudsman himself has mooted these difficulties in his own Annual Report, and I wholeheartedly echo the concerns he expresses and his wish that legislation guaranteeing his independence is put before parliament as soon as possible.

As will be clear from my earlier comments, what the future holds is currently far from clear. What I can say with greater confidence is that, while the challenges and the room for improvement undoubtedly remain, the direction of travel is the right one, which I believe is an achievement in itself. My tenure will shortly come to an end and the Forum in its current guise will cease to exist, so this is a fitting moment to record how pleased I am that it has been a catalyst for that achievement. I also offer my gratitude to all those who have worked in and alongside the Forum towards it.

John Wadham
Chair

WHAT IS THE FORUM?

The Forum's Terms of Reference

"The forum exists to effect real change to prevent deaths in custody."

The scope of the Forum

The aim of the Forum is to promote and disseminate learning between the custodial sectors to try to prevent future deaths. The Forum covers the custodial sectors which fall within the responsibility of the Home Office, Ministry of Justice and Department of Health. In practice, this means looking at deaths of people detained in the custody of the police and prison services, approved premises (formerly known as probation hostels), the UK Border Agency, Her Majesty's Revenue and Customs, and of patients detained under the Mental Health Act. Deaths which occur after release (or transfer) from custody are also included in the Forum's scope, as are near-deaths, since both can provide important sources of learning.

The Forum consists of senior representatives from the following organisations:

- Association of Chief Police Officers (ACPO)
- Coroners' Society of England and Wales (CSEW)
- Coroner's Unit, Ministry of Justice
- Department of Health
 - High Secure Services
 - Offender Health
 - Investigations and Inquiries Unit
- GSL Global Ltd.
- Her Majesty's Chief Inspectorate of Prisons (HMCIP)
- Her Majesty's Inspectorate of Constabulary (HMIC)
- Her Majesty's Revenue and Customs (HMRC)
- Independent Police Complaints Commission (IPCC)
- INQUEST
- Mental Health Act Commission (MHAC)
- National Offender Management Service (NOMS)
 - Offender Assessment and Management Group (OAMG)
 - National Probation Directorate (NPD)
 - Her Majesty's Prison Service (HMPS)
- National Patient Safety Agency
- Police Powers and Protection Unit, Home Office
- Prisons and Probation Ombudsman (PPO)
- United Kingdom Border Agency (UKBA)
- Youth Justice Board (YJB)

The background to the establishment of the Forum

At the Forum's inception, there had been proposals to set up some kind of body to oversee and monitor deaths in custody for many years. The chief advocate for these was the organisation INQUEST. In March 2003 Liberty published its report '*Deaths in Custody: Redress and Remedies*' in collaboration with others, including INQUEST.

INQUEST itself favoured a completely separate Commission to investigate all forms of deaths in institutions. Liberty agreed, suggesting that:

‘...The mandate [of a Standing Commission on Custodial Deaths] should be to bring together the experiences from the separate investigatory bodies... . Such an over-arching body could identify key issues and problems, develop common programmes, research and disseminate findings where appropriate, and ensure services work together for change. Lessons learned in one institution could be promoted in other institutions, best practice could be promoted, and new policies designed to prevent deaths could be drafted and implemented across all institutions.

‘Except when conducting inquiries, we do not think that this Commission needs substantial resources. We suggest that its membership could include representatives from the other investigatory bodies, although there should also be other independent members who should represent or reflect the interests of people detained in these institutions.’

In July 2003, the Joint Committee on Human Rights (JCHR) launched an inquiry into deaths in custody to which many of the Forum’s members, contributed. The resulting JCHR report recommended that the Home Office (which was still responsible for prisons at the time) and Department of Health should establish a cross-Government expert task force on deaths in custody.

Separately, in July 2004, the Independent Police Complaints Commission (IPCC) suggested the idea of a Forum to capture cross-sector learning following deaths in custody. The proposal met with a positive response from custody providers and other stakeholders. Meetings in March and June 2005 brought together key organisations, and it was quickly established that much could be learned by agencies sharing information and learning across institutions.

In October 2005, the Government responded to the JCHR’s report by outlining its commitment to better co-ordinate the existing processes and to work with the key agencies to consolidate a new multi-agency forum to take this forward. The Forum met for the first time in November 2005 has been meeting three times per year ever since.

Recent developments

In December 2006, the Joint Committee wrote to the Government seeking an update on the Forum’s work. The Forum’s Chair contributed an account of the work that the group had undertaken so far. In May 2007, the Government announced a commitment to strengthen the Forum. It commissioned an independent review of the Forum’s structure, working methods, and its work to date. The Review reported in December 2007 and was published in February 2008, before the government announced in July 2008 that the recommendations in the review were to be adopted (see ‘The Future’ section for further details).

Our work this year

The Forum met in November 2007 and in February, June and October 2008. The following provides an overview of the themes and issues on which the Forum focussed. Further details, and the minutes of Forum meetings, are available at www.preventingcustodydeaths.org.uk

Sharing information and learning

Central to the reasons for the Forum's existence is the promoting and sharing of information and learning between the custodial sectors.

In January 2007, the Independent Police Complaints Commission published the first of what was to become a periodical bulletin capturing the learning points arising from IPCC investigations, the *Learning the Lessons Bulletin*. While the IPCC co-ordinate this publication, its content and dissemination is handled by a multi-agency panel of police service stakeholders known as the Learning the Lessons Committee (more information about the Committee, and previous editions of all of the Bulletins, are now available at www.learningthelessons.org.uk

This initiative was discussed in the Forum, which immediately recognised its value. Shortly afterwards, in December 2007, a meeting was held between the IPCC policy lead responsible for the Bulletin, and members of the National Offender Management Service's Safer Custody Group. This led to the Safer Custody Group (now the Safer Custody and Offender Policy Group) publishing its own, similar publication, based on investigations of fatal incidents by the Prisons and Probation Ombudsman. This publication – the similarly-named *Learning Lessons Bulletin* – also features recommendations by Coroners (known as 'rule 43' recommendations) following inquests into such deaths, and the responses to those recommendations. At the time of writing, the third *Learning Lessons Bulletin* was being prepared.

Both publications are available on the Forum website.

Investigating near-deaths

In 2001, a prisoner at HMP Pentonville known as Mr. 'D' attempted to take his life and suffered lasting injuries. He was a known suicide risk whose suicide attempt might have led to his death under other circumstances. The issue arose as to whether Article 2 was engaged, and its ancillary investigative obligation triggered. Mr. D's representatives challenged the adequacy of the earlier internal investigation which had been carried out, on the basis that in a number of respects, it fell short of the type of inquiry necessary to satisfy Article 2. The Courts found in his favour and the Secretary of State eventually agreed to commission and fund an investigation by an independent person (the Prisons and Probation Ombudsman), to be held in public and in which Mr. D and his representatives were able to participate.

This was significant in that it was the first time that the domestic courts had recognised that, under certain circumstances, the Article 2 obligation could be triggered in the event of a near-death, as well as cases where the victim had in fact died.

This line of reasoning was adhered to in the case of 'JL', the near-suicide of a young man at HMYOI Feltham in 2002. This became the second case into which a public, Article 2-compliant investigation was ordered by the Courts.

Because they broke new ground, neither of these cases was without problems. The 'D' case cost about £500,000 (in the Prisons and Probation Ombudsman's estimation), much of this being legal costs. The challenge was to arrive at an investigative model which did not place a huge financial burden on public resources, but at the same time was sufficiently probative to satisfy the public interest, give effect to the victim's rights under Article 2, and identify any learning from the case that might prevent future deaths.

It was this latter objective that led the Chair to take the view that the issue of near-deaths was an appropriate one for the Forum to focus on. Near-deaths can provide at least as fertile ground for learning as actual deaths, and the learning which could potentially stem from such cases is just as salient in preventing actual deaths. The Chair therefore wrote to each of the detaining authorities and their relevant investigation and oversight bodies to ask about their procedures for handling such cases.

The results of this exercise, which were published on the Forum website, revealed much still to be done: there seemed to be little commonality of understanding between the custodial sectors as to what constituted a near-death, and the minimum investigative requirements in the event of one. The Forum was fortunate to hear a presentation on the case from Saimo Chahal, JL's legal representative, and the Prisons and Probation Ombudsman, who had chaired the 'D' inquiry, is of course a Forum member.

The Court of Appeal and, more recently, the House of Lords decided that any attempt at suicide by a person in custody which (i) comes close to success, and (ii) leaves the prisoner with the possibility of serious long-term injury were capable of triggering the Article 2 obligation. A prompt initial inquiry into the circumstances was required, by a person institutionally and practically independent of the custody provider in whose care the incident happened. Whether the investigation was then required to take on the mantle of a more in-depth inquiry (including, for example, greater next-of-kin involvement, public scrutiny and, if necessary, the power to compel witnesses) would depend on the results of the initial enquiry. If the initial inquiry revealed no issues of concern, it might of itself be sufficient to satisfy Article 2. Where the initial inquiry revealed issues of concern, a broader and more detailed investigation, similar to that conducted by the Prisons and Probation Ombudsman in the 'D' case, would be necessary.

In the Secretary of State's appeal to the House of Lords in the 'JL' case, the Lords accepted the point made by the Chair that:

Whenever a death or near-death occurs it is very important that a decision as to what kind of investigation is made quickly, before any evidence is disturbed or lost and before those who witnessed the events forget the details or have their accounts contaminated by the accounts of others. Obviously the more likely it is that there may be some culpability or some systemic failure associated with those that can give evidence, the more important it is that those investigating are independent of the people they are investigating.

The Lords went on to approve of the Chair's view that, in the context of near-deaths in prison such as the 'JL' case, the Prisons and Probation Ombudsman might be an appropriate independent investigator in such cases:

Mr Wadham suggests that the Prisons and Probation Ombudsman would be an appropriate investigator. Your Lordships were not told much about the resources available to the Ombudsman. But he already carries out a similar function in relation to fatal incidents, and it seems to me that it would be appropriate, if the Ombudsman has or can be furnished with adequate human and other resources, for his oversight to be extended to non-fatal but serious incidents that may call for an Article 2 investigation.

Clearly, this point is sector-specific: nobody suggests that the Prisons and Probation Ombudsman should investigate near-deaths in *all* custodial sectors. That said, it seems likely that this judgment will be interpreted as applying to near-deaths in all custodial settings, and that near-deaths in the circumstances described in the judgment will therefore require initial independent investigation in all cases, whoever the investigator may be. It remains to be seen how the judgment will be translated into changes to practice and procedure. The Lords found it difficult to be prescriptive in general terms about the form and course that the investigation should take, and many of these decisions will be for the independent investigator in any case, so it is possible that near-deaths will generate further litigation. But in terms of identifying and disseminating learning that might prevent future deaths (which is part of the rationale for the enhanced Article 2 investigation in the first place), this case represents a significant and positive development.

Coroners Reform

The Forum has taken an active interest in a number of issues relating to Coroners' inquests which have come to the fore since our last Annual Report.

Changes to Rule 43, Coroners Rules 1984

Annexed to the last Annual Report was a letter from the Chair to the (then) Minister for Constitutional Affairs, Harriet Harman. The letter set out the importance, as the Forum saw it, of the Coroners' inquest as the single most effective juncture for lessons which might prevent future deaths to be learned and disseminated. In particular, it focussed on the Coroner's power under Rule 43, Coroners Rules 1984 to make recommendations to appropriate agencies or bodies which might prevent future, similar deaths.

The Forum view was that this power, potentially a very useful mechanism in promoting learning, was insufficient as it stood at the time: there was no obligation on a person or body which has received a 'Rule 43' recommendation to reply, or to take any action based on the recommendation. There was no mechanism for the implementation of any recommendation to be followed up or monitored. There was also no publicly available record of such recommendations, which prevented them from being disseminated as widely as they might otherwise be. On this basis, the Chair called for the power to be strengthened and to be included in the (then) recently-published Coroners Reform Bill.

It is therefore very pleasing to report that, following a consultation exercise in February 2008 to which the Forum again contributed, amendments were laid before Parliament in June and came into force in July. Their effect is to impose a duty on anybody who receives a 'Rule 43' recommendation to reply within 56 days. The recommendations and their responses will now be made public (either verbatim or in summary form) by the Ministry of Justice, subject to the consent of the Coroner and Lord Chancellor. It is hoped that such recommendations will also be searchable, to maximise learning opportunities.

At the time of writing, it remains to be seen how these new measures will work in practice, but in principle this is a very positive development for which a number of Forum members have long called. It is pleasing to note this positive example of the Government's willingness to work with, and listen to the advice of the Forum.

Counter Terrorism Bill

Another inquest-related development came with the publication of the Counter Terrorism Bill. Part 6 of the Bill originally contained provisions amending the Coroners Act 1988 in respect of inquests in which sensitive material needed to be considered. Among other things, these provisions would have empowered the Secretary of State to order that a case which would normally be heard with a jury should proceed without one, and/or that the usual Coroner should be replaced by a person appointed by the Secretary of State.

A number of Forum members voiced a variety of concerns about this, notably INQUEST, which issued a number of parliamentary briefings on the issue. Whatever the merits of the wider arguments, the Forum's remit is not to monitor the UK's compliance with human rights obligations or to become involved in individual cases. It was clear that, for the Forum, the central questions had to be: would these

provisions have any effect on the process of learning which might prevent future deaths, and, if so, whether there were alternative measures which would allow the inquest to consider all relevant material without hindering the learning process to the same extent? Little time had been available for consultation before these significant changes were included in the Bill, and a number of members had doubts about whether the alternatives had been fully explored.

A number of members argued that these measures would indeed affect the learning process: if learning arose from evidence which could not be made public, disseminating that learning was likely to be difficult or impossible. The balance of opinion among those members who were in a position to express views was that these amendments to the Coroners Act would not be a positive step. The Forum was conscious that the Parliamentary Joint Committee on Human Rights (JCHR) had already expressed grave misgivings about these provisions. The Chair therefore wrote to the Minister with responsibility for Coroners' inquests, and to the Chairs of the JCHR and Home Affairs Select Committee, to advise them of Forum concerns. We also brokered a meeting with the relevant senior Home Office and Ministry of Justice officials to advise them of these concerns and the reasons for them.

While the Forum was very grateful to those who met with our members and listened to their concerns, it is fair to say that the Forum was less successful in convincing the Government to change its mind on this issue. The Minister wrote that '...the proposals allow us to ensure that coroners' inquests will always be fully compliant with Article 2 of the ECHR because the independent finder of fact will always be able to see all relevant material, even if it cannot be made public or disclosed to a jury.' The Forum entirely supported the Government's wish to ensure that all relevant material could be properly considered, but suspected that there were better ways to achieve this end.

In the event, Parliamentarians in both Houses made clear their wish to consider these reforms in the context of a Coroners Bill rather than a Counter Terrorism Bill, and the Government signalled its willingness to remove these provisions from the Bill. The Coroners and Death Certification Bill had, in the meantime, been included in the Draft Legislative Programme for this Parliamentary session, and subsequently featured in the Queen's Speech. At the very least, this should allow time for consultation on these measures, and for alternatives to be properly explored.

Public funding for legal representation for bereaved families at inquests

The Forum also looked at whether or not the current legal aid regime disadvantaged families in terms of their ability to explore all relevant issues in inquests. Many bereaved families express the wish that other families should not have to endure the death of a loved one as they have, and therefore take a keen interest in probing the circumstances of the death to establish whether any lessons can be learned.

While there is limited legal aid available to families under certain circumstances, the current legal aid regime is means-tested and the rules are complex. There also seem to be issues around the quality and extent of the legal representation which the Legal Services Commission is willing to fund. This is potentially problematic when the detaining authorities, who may be seeking to avoid imputations of blame or wrongdoing, enjoy unlimited publicly-funded legal representation, often by specialist lawyers. These imitations and complexities have prompted a number of observers (notably, the JCHR, Baroness Corston and INQUEST) to call for means-testing to be scrapped, and for families to be put on a level playing field with the other 'properly interested persons' in an inquest.

Again, whilst acknowledging that there are other legitimate issues at stake in this debate, the question for the Forum was whether or not this state of affairs might inhibit learning which could prevent future deaths. Almost every Forum member who expressed a view on this issue felt that, potentially, it could. The objective of exploring all relevant issues was felt to be most easily achieved where all the interested parties have the same access to legal representation by representatives who have sufficient experience and expertise. Making the family wholly or partly financially responsible for their own legal representation risked either dissuading them from being represented at all, or else being insufficiently represented. Many Forum members felt that could have a knock-on effect on the ability of the inquest to identify learning opportunities.

The Chair therefore wrote to the Minister responsible to place on record the Forum's endorsement of the recommendation made by the JCHR and others that means-testing for families in these circumstances should be abolished. Based on Forum research in the area, he also made a series of recommendations for interim measures which might improve the situation before the wholesale scrapping of means testing – a significant step – could be achieved. Realistically, there was no expectation that the Minister's reply would announce a significant change in government policy, and indeed she responded by saying there were no plans to change the public funding regime at present. The interim suggestions made in the letter are still believed to be helpful, and it is hoped the government will consider them.

Investigations of deaths and Article 2

In spite of the lack of a research budget, the Forum was able to undertake one significant piece of research during this reporting period: an examination of investigations into deaths in custody, and whether or not such investigations complied with Article 2 in all possible scenarios in which a death could take place.

The resulting work, which at the time of writing is scheduled to be published very shortly, identifies certain scenarios in which the Article 2-compliance of the investigation must be open to doubt, and goes on to consider how those difficulties might be remedied.

While authored and coordinated by the Secretary, this was a long-term piece of work to which many Forum members – particularly those who represent investigation bodies – contributed extensively. This work provides an example of the type cross-sector research which the Forum (and, shortly, the new Ministerial Council) would be ideally placed to undertake if it had the necessary research resources.

The Family Liaison Working Group

This group, the Forum's second working group, is made up both of Forum members and non-members. The group continued to meet throughout 2008 to discuss the challenges of providing sensitive and helpful family liaison services in the unusual and difficult circumstances of a death in custody. Unfortunately, resources and competing priorities mean that the group's final report is unlikely to be published while the Forum is still operating. Some progress towards it has been made, however, and this area of work will remain a critical area within the field of deaths in custody.

The Future

The Independent Review of the Forum for Preventing Deaths in Custody

The Forum's last Annual Report noted that the Government-commissioned independent review of the Forum was due to report to the Justice Minister in December 2007. Since then, the report has been published and consulted on, and in July 2008 the Government committed to implementing its recommendations.

The reforms themselves were significant. The Forum and its sister organisation, the Ministerial Roundtable on Suicide are both to be replaced by a three-tier Ministerial Council on Deaths in Custody. (The Roundtable differs from the Forum in that its ambit does not include the police service, secure hospitals or immigration detention or indeed deaths which are not self-inflicted). A Ministerial Board, chaired by the Justice Minister and made up of the heads of the key agencies, will form the first tier. This will probably be similar to the existing Ministerial Roundtable (although many Forum members are also members of that body). Its membership will be relatively large and not confined to government or official bodies: The Review proposes that a number of NGOs, including INQUEST, a Forum member, will also sit on it. It will meet regularly to discuss issues of concern, as the Ministerial Roundtable currently does.

The principal source of advice to the Ministerial Board will be an Independent Advisory Panel on Deaths in Custody ('IAP') which will form the second tier. The Panel will be smaller, and made up of experts appointed for relevant expertise. It will be independently chaired, and at the time of writing the Ministry of Justice has just announced that the Chair-designate is Lord Toby Harris, who is to be congratulated on his appointment. As IAP Chair, Lord Harris will have the role of representing the Panel on the Ministerial Board, influencing Ministers and helping to shape policy through championing the conclusions of the Panel's expert deliberations.

The third tier will be a Practitioner and Stakeholder Group. This will probably be a 'virtual' group which will not meet regularly, but will provide a vehicle to enable the participation of people or groups who are legitimate stakeholders, but who the Forum was not able to accommodate for reasons of sheer practicality. This may include representatives of frontline staff, bereaved families, and other NGOs and/or official bodies.

These new arrangements will be supported by a full-time secretariat, who will be co-located with the relevant unit of the National Offender Management Service. They will be contracted by the Ministry of Justice, but accountable to the IAP Chair. The new arrangements will be funded up to £220,000 of new resource by the three sponsor departments, namely the Ministry of Justice, Home Office and Department of Health. The review, which contains further details of its recommendations, can be viewed on the Forum website.

Overall, these are positive developments which the Forum enthusiastically welcomed. That said, appropriate machinery alone will not be a panacea: Much will depend on appropriately targeting the resources available, the quality of the relationships between key stakeholders, and Government's willingness to heed the advice of the Independent Advisory Panel.

Aside from these general considerations, there are a number of specific issues which have generated discussion in the Forum, and it is perhaps fitting to take this opportunity to offer the following food for thought to those who will be involved in running the new arrangements.

Research

The independent reviewer of the Forum accepted that its lack of resources placed limits on what it could achieve, particularly with regard to research. While both the Forum Secretary and his predecessor worked hard to ensure that the Forum was well supported and provided with high-quality research and papers, they were never in a position to undertake long-term, specialised research. While the Secretariat under the new arrangements will link in to existing departmental research streams, there will also be limits on what such collaboration can achieve: departmental research tends to be 'vertical' as opposed to cross-sector in its approach, focussing on individual custodial sectors, e.g. the police service.

Many Forum members have suggested that there will still remain a need for thematic, cross-sector research, for which existing departmental research streams are unlikely to be an adequate substitute. The independent reviewer perhaps shared this view, since one of his recommendations was that the Independent Advisory Panel should have a small research budget to independently commission research where it identified research opportunities which had not yet been explored. At the time of the publication of the Review, the Forum was concerned that the level of funding suggested for this purpose –£50,000 per year – would be insufficient to achieve worthwhile results.

Many members were therefore disappointed to learn that Ministers had decided, on further consideration, that *no* research budget should be provided, since existing research resources within those departments would be sufficient (a view with which many disagreed for the reasons set out above). The Chair therefore wrote to the Justice Minister to express this disappointment and to ask for this decision to be re-considered. Her reply did not rule out the possibility of dedicated funding for research, but nor did it commit to providing it (in fairness to the Minister, this is presumably a decision for all three of the sponsor departments).

A dedicated research resource may prove important for two reasons. First, it could be independently deployed by the IAP as it saw fit, which may be preferable to the IAP having to request funding from central Government departments on a project-by-project basis, and without any ultimate guarantee of success. It would be a public demonstration of the IAP's independence, which would help to build confidence in the new structures, and a public token of the Government's faith in the IAP and openness to its advice.

Secondly, the cross-sector approach championed by the Forum in identifying the problems and solutions in the field of deaths in custody is central to the recommendations of the Review. If the theme of deaths in custody is important enough to merit the special, dedicated governmental machinery recommended by the review, that machinery will be most effective if it is supported by special, dedicated research. The Forum has now done and said all it usefully can on the issue, but many members believe that it would amount to a real missed opportunity if the new arrangements are not supported by an appropriate research resource.

Independence

The independent reviewer noted that one of the Forum's strengths was the official bodies' openness to external advice and expertise, as manifested by the participation of INQUEST on the Forum and a number of other NGOs on the Roundtable. Many Forum members agreed with his assessment: it cannot be right to discount any organisation with many years of producing high-quality work in a given field merely because they are not an official body. Indeed, NGOs enjoy a freedom to articulate inconvenient or unfashionable views which official bodies often do not.

The same can be said about the IAP's independent Chair and experts, and for that reason, it will be important for the sponsor departments and others within the Ministerial Council to allow the IAP to operate at 'arm's length' to safeguard its independence (and perceived independence). Ensuring this will probably be a key part of the Chair's role.

Since the secretariat will be principally accountable to the IAP Chair, the same consideration must apply to the secretariat. This should not present an insurmountable challenge: the public sector abounds with examples of independent and quasi-independent organisations who have successfully carved out appropriate relationships with their sponsor bodies despite operating at arm's length from them. A sensible approach will ensure that the IAP is able to operate as independently as its name suggests it should, and thereby as effectively as we would all wish.

Ideas for future work

It is clear that the programme of work which the Ministerial Council chooses to take forward is entirely a matter for those within it. Much like the previous section, the following is offered merely as food for thought. That said, one of the key threads running through the experience of the Forum over the last three years is that more could have been achieved with greater resources. It would be a shame to cease operation without at least recording some of what we might have done under different circumstances.

Restraint

At present, different guidance on the use of restraint exists within different custodial settings, despite the risks to detainees being broadly the same. Despite the potential difficulties for the police in confronting people that they may know nothing about, it may be useful to pool the expertise which exists in this area, and, longer-term, to push for national guidance.

Operation Safeguard

The Forum has publicly articulated its misgivings in terms of the risks associated with holding detainees in police cells. In the long-term, the government hopes to be able to end the practice by increasing prison capacity. In the short-term, it seems likely that Operation Safeguard will continue to be employed. It may be useful to monitor the way Safeguard is applied, including any deaths in which it may have played a contributory part, or instances in which those deemed unsuitable to be held under Safeguard are nevertheless so held.

Near Deaths

Near-deaths provide at least as fertile ground for learning as actually deaths, since the victim will sometimes be able to contribute to their investigation. The Forum has therefore looked at the procedures which the various custody providers and/or investigation bodies follow in a near-death. The results of this work demonstrated

that, in most cases, the systems currently in place are uncoordinated and patchy, with little common understanding of what constitutes a near-death or the investigative procedure to be followed in the event of one. Now that the House of Lords have given judgment in the test case of *R (JL) v Secretary of State for Justice* [2008] UKHL 68, the trigger for the investigation of a near-death (and the investigative obligations to which a near-death gives rise) are clearer, and consideration could usefully be given to the most effective and human-rights compatible way to investigate such incidents. There may also be a case to draw up some standard definitions for use across Government: many of the terms currently employed to categorise near-deaths (e.g. Serious Untoward Incident, Adverse Incident) also have wider meanings, and many such incidents will not require investigation in the same way as near-deaths.

The investigation of the deaths of detained patients

Our research suggests that the regime for the investigation of such deaths may not comply with Article 2 as it currently stands. Subject to any revisions to the National Patient Safety Agency Guidance in light of a number of recent test cases, it may be helpful to consider whether changes could be made to the current regime which might increase transparency and thereby maximise learning opportunities.

The investigation/inspection regime following the death of a child in a Secure Children's Home

There is a range of views as to whether it would be appropriate to extend the remit and resources of the Prisons and Probation Ombudsman (who already investigates deaths which take place in the other two types of juvenile custody) to Secure Children's Homes as well. It could also be argued that establishment inspections following a death should properly be conducted by the Prisons inspectorate rather than Ofsted (whose responsibility this currently is). Happily, there has not been a death in a Secure Children's Home to date. Whatever the IAP's view, it may wish to satisfy itself that the investigation and inspection processes following any such death are effective, human rights-compatible and sufficient to identify any learning.

ANNEX 1

Table 1

Deaths in all forms of custody in England & Wales 2007-2008

	2004/2005	2005/2006	2006/2007	2007/2008
Police	36	28	27	21
Prison	199	164	162	187
Patients detained under the Mental Health Act 1983	327	373	351	351
Immigration Detention	4	3	0	0
Approved Premises ¹	20	17	10	17
Youth Custody	3	1	0	0
Revenue & Customs ²	-	-	-	1
TOTAL	589	586	550³	577

¹ Statistics for deaths of Approved Premises Residents have been provided for calendar years rather than financial reporting years for 2004, 2005 and 2006. Data in the final column (2007/08) includes deaths between January 2007 and March 2008.

² HM Revenue & Customs were not members of the Forum prior to the reporting year 2007/08 and data is therefore only included for the most recent year.

³ Data on the number of deaths in or following police custody during 2006/07 was not available at the time of printing the Forum's previous annual report. This data is now available and has been included in the above table. The overall number of deaths in custody for 2006/07 was therefore 550 rather than 523 (as indicated in the Forum's previous annual report).

² Statistics for deaths in Approved Premises have been provided for calendar years rather than financial reporting years so these statistics are for the calendar years 2004, 2005 and 2006 respectively.

Table 2

Deaths during or following police custody, 2007 - 08

	Self-Inflicted	Natural Causes	Substance Misuse	Other	Awaited	No Cause	TOTAL
Male	1*	7	7	2*	1	2	20
Female	0	0	0	0	1	0	1
TOTAL	1	7	7	2	2	2	21

*The act of self harm did not occur in police custody. The man had consumed a lethal substance prior to being arrested and concern was raised in custody. The man was taken to hospital where he subsequently died.

** Includes one death from a head injury received prior to arrest and one death following asphyxiation on plastic wraps of drugs swallowed during arrest.

Table 3

Deaths of detained patients notified to the Mental Health Act Commission 2007- 08

	Male	Female	Totals
Natural Causes	148	121	269
Self Inflicted	31	14	45
Substance Misuse	2	1	3
Homicide	0	0	0
Unknown	0	0	0
Other*	24	10	34
Total	205	146	351

*See Table 2A

Table 3A

Deaths categorised as 'Other'

	Male	Female	Totals
Awaiting Information	18	7	25
Accidental	5	2	7
Iatrogenic	0	0	0
Drowning	0	1	1
Unsure accident or suicide	0	0	0
Fire	0	0	0
Method Unclear/Other	1	0	1
Total	24	10	34

Table 4

Deaths in Prison Custody 2007/08

AGE/GENDER	Homicide	Natural Causes	Other Non-Natural	Self-inflicted	TOTAL
Adult Female	0	0	1	8	9
Adult Male	1	97	0	71	169
YO Male	0	1	1	6	8
YO Female	0	0	0	0	0
Juvenile Male	0	0	0	1	1
Juvenile Female	0	0	0	0	0
TOTAL	1	98	2	86	187

NOTE: 'YO' = deaths in Young Offenders Institutions. 'Juvenile' = deaths in Secure Training Centres. All classifications are provisional and subject to change following inquests

Table 5

Deaths of Approved Premises Residents 2007/08

GENDER	Self-inflicted	Overdose	Natural Causes	Accident	Other	TOTAL
Male	6	1	9	0	0	16
Female	0	1	0	0	0	1
TOTAL	6	2	9	0	0	17

Table 6

Deaths of HM Revenue and Customs detainees

GENDER	Self-inflicted	Overdose	Natural Causes	Accident	Other	TOTAL
Male	0	0	1	0	0	1
Female	0	0	0	0	0	0
TOTAL	0	0	1	0	0	1

