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Human Rights

Deaths in Custody

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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.

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Summary

When the state takes away a person's liberty, it assumes full responsibility for protecting their human rights. The most fundamental of these is the right to life. Each year, however, many people die in custody. This report examines the causes of deaths in custody, and considers what may be done to prevent these deaths, and to better protect the right to life, and other human rights, of vulnerable people held in the custody of the state.

The report begins by considering the human rights standards which apply. Article 2 of the European Convention on Human Rights guarantees the right to life and places duties on the state to take steps to prevent deaths of people in detention, and to establish independent investigations into deaths in custody. The freedom from inhuman and degrading treatment also protects detained people from violence or serious neglect. These rights must be guaranteed, not through excessive control, but in the context of a system which also respects rights to privacy, personal identity and physical integrity.

The report assesses the scale of the problem, and the numbers of people dying in each form of state detention. It looks at the wider system in which these deaths occur, and concludes that measures to reduce deaths in custody are being implemented within a system where there are many acutely vulnerable people detained, especially in prison, who simply should not be there. Overcrowding in the prison system further hampers efforts to reduce deaths in custody. The principal reason for the increase in the prison population is sentencing practice, and the report considers the availability and recourse to alternatives to prison for vulnerable offenders, in light of the Article 2 right to life.

In the long-term, increased resources and a reduction in the use of imprisonment is needed to address the problem of deaths in custody. However, significant improvements can be made within the context of the present system. The report considers risk assessment of detainees, especially on admission to custody. It also assesses the provision of physical and mental healthcare in detention, and the human rights implications of inadequate healthcare. The report stresses the importance of maintaining a standard of healthcare equivalent to that available in the community. The provision of adequate treatment for drug and alcohol addiction in detention is essential in order to protect the rights to life and to freedom from inhuman and degrading treatment. The report also raises concerns about the detention of mentally ill people in inappropriate forms of detention, whether in prison, in police cells, or in immigration removal centres.

Although deaths in custody from the use of control and restraint are relatively rare, they are a cause for serious concern. The report examines policy and practice in the use of physical restraint in all forms of custody, and its compliance with human rights standards. It also examines the use of seclusion in Mental Health Act detention, in light of patients' human rights.

Training of those responsible for the safety of detainees is vital if deaths in custody are to be effectively prevented. Adequate levels of staffing are also a prerequisite of a safe custodial environment. The report makes recommendations on training of police custody officers, and on the training in control and restraint in all forms of detention.

Finally, the report considers how the state responds following a death in custody. The state has a duty, under Article 2 ECHR, to provide a thorough and independent investigation into each death in custody. This independent inquiry must allow for the full participation of the family of the person who has died, and the report emphasises the need to ensure that families are informed, supported and involved immediately following a death, and at all stages of the investigation. The report assesses recent changes in the inquest system, new mechanisms designed to allow for greater independence in the investigation of deaths in police and prison custody, and the reasons for the low rate of prosecutions following deaths in custody.

The report concludes by recommending the establishment of a cross-departmental expert task-force on deaths in custody, supported by human rights expertise, with the functions of: sharing information on good practice and developing guidelines in relation to the prevention of deaths in custody; reviewing the systems for conducting investigations into deaths in custody; developing good practice standards on training; reviewing recommendations from coroners, public inquiries and research and monitoring progress in their implementation; collecting and publishing information on deaths in custody; and commissioning research and making recommendations to Government.

1 Introduction

Our approach

1. When the state takes away the liberty of an individual and places him or her in custody, it assumes full responsibility for protecting that person's human rights—the most fundamental of which is the right to life. This right, and other human rights which protect people detained by the State, now form part of our law under the Human Rights Act 1998. Yet at a time when we have finally abolished the death penalty in the United Kingdom and few of our prisoners serve whole-life sentences, too many still die in custody. Some of these die, of course, from natural causes. A few are killed by fellow inmates. Others die as a result of actions of officers of the state, often without charges being brought or an effective remedy being made available to family and friends. Most deaths are 'self-inflicted', with yet more people in custody, especially women, inflicting upon themselves life-threatening injuries, but surviving.

2. Each and every death in state custody is a death too many, regardless of the circumstances of the person who dies. But we must recognize the harsh reality that many of those who die in state custody have been convicted of no criminal offence and are held only on remand, either in prison or in police custody, or are detained under the Mental Health Act.

3. As this report shows the majority of people entering custody are extremely vulnerable individuals. Many of those who die in custody are young. Most of those who die are vulnerable or sick, with histories of mental illness and drug and alcohol problems. It must be recognised that by taking people into custody the state takes upon itself a particular duty of care, because of their vulnerability, and a special responsibility to ensure their protection and to uphold their human rights.

4. We have undertaken this inquiry in order to discover some of the reasons that lie behind deaths in custody and to propose what might be done to reduce them. We approach the issue of deaths in custody through looking at the right to life and other rights protected in the Human Rights Act and seeking to expand on what they mean. In order to do this it is necessary to go beyond the abstract legal texts and shed light on what practical implications they have for our custodial institutions and authorities which run them. A marked improvement in preventing deaths in custody will not come about by a defensive approach which seeks to only protect the rights but by a much more proactive approach which seeks positively to promote and to ensure the human rights of people in custody. By doing this we can take the Human Rights Act out of a purely legalistic context and make it relevant to the daily practice of people who work for and run our custodial institutions. This positive approach can only have benefits for the working practices of our custodial institutions and the health and well-being of those in custody.

5. This inquiry has considered issues relating to deaths in all forms of state detention, including deaths in prison, police custody, immigration detention and Mental Health Act detention. We have not considered issues relating to other deaths following contact with the police or other state agents, such as deaths following police pursuit, or police shootings.

6. We have taken oral evidence from numerous witnesses with expertise and experience in the causes, prevention and investigation of deaths in custody. We have also received substantial written evidence and visited several institutions of detention. Some of our discoveries during the course of this inquiry have shocked us. At times we have been exposed to the frustration of staff whose attempts to address detainees' human rights are thwarted by an under-resourced and ramshackle physical and administrative environment. We also held a private meeting with members of the families of people who had died in custody. They provided us with compelling evidence of failings throughout our systems of detention, and of the grievous personal consequences of those failings. The family members with whom we met, primarily parents whose sons and daughters had died, told us of their belief that the state had failed them in its duty of care. State institutions had taken into custody people who, in many cases, were depressed, ill, or troubled, and were known by their families to be in need of particular care. Although these vulnerabilities were in most cases also well known to the detaining institutions, or should have been, they had failed in their responsibility to protect the people in their charge from harm. In some cases, there had been failures to provide essential healthcare, support or counselling. In other cases, a family member had died violently, following the use of control and restraint. The families' distress and concern was compounded by uncertainty and secrecy surrounding the circumstances of these deaths and by delays in inquiries, which were often seen to be less than independent. In some cases, it was also compounded by the discourtesy with which the family was treated immediately following their bereavement, including off-hand thoughtlessness in the means used to notify next-of-kin of the death. All of these factors had led the families we met to lose confidence in the capacity of the state to protect people in its care and to deliver justice. It is a loss of confidence which can only be widely shared, and there is an urgent obligation on the Government to reverse it.

7. During our inquiry we were encouraged by examples of good practice which, if adopted more widely throughout our detention system, would go some way towards ensuring respect for the human rights of prisoners and detained mental health patients. There is much theoretical understanding of ways to manage our prisons and mental health units in order to minimise the risks of deaths in custody, and in some cases this understanding has been put into practice, creating an institutional culture which promotes and protects the rights of even the most disturbed people, and which manages incidents of violence in a humane and ethical manner. We draw attention to such examples of good practice throughout our Report.

8. This inquiry has considered problems relating to deaths in prison, in police custody, in immigration service removal centres (formerly known as detention centres) and in Mental Health Act detention. Each form of state custody presents its own difficulties in securing the safety of detainees. Police custody functions as an emergency service, detaining people about whom very little information may be available. These problems are not present to the same extent in the prison service, where, nevertheless, the pressures of overcrowding and of an overstretched prison service affect prisoners' safety.

9. Across all forms of state detention, however, there are common factors present in deaths in custody. The multiple vulnerabilities of the people detained, the acute need for medical treatment and drug and alcohol detoxification facilities, low educational achievement and poor communication skills, and the high rate of mental illness, are all found to a greater or

lesser extent in all forms of state detention. The use of physical restraint by the detaining authorities, and its consequences for the safety of those detained, is also a common issue, though the circumstances in which such force is used may vary.

Structure of our Report

10. The duty of the state to protect the life of those in its care provides the framework in which we have placed our examination of the issues raised by this inquiry. This Report seeks to address the challenge of preventing deaths in all forms of state custody, in the context of the right to life, and the related duty to protect other rights of detained people under the European Convention on Human Rights. An integrated human rights approach to deaths in custody requires that the safety of detained people should be protected, not through the exercise of excessive or intrusive control, but in the context of a system which also respects rights to privacy, personal identity and physical integrity. We give a full explanation of the human rights framework in Chapter 2. In Chapter 3 we go on to give an overview of the scale of the problem of deaths in custody, and an explanation of the factors behind the problem.

11. Policy to reduce deaths in custody operates, as we have said, in a context where there are many people detained, especially in prisons, *who quite simply should not be there*. The decision to hold a person in state detention is an assumption of a heavy responsibility to ensure the safety of someone who may already be at risk, and it is a decision which should be taken in light of the duty to protect the right to life. The problem of self-inflicted deaths in custody therefore cannot be considered in isolation from prison overcrowding and sentencing practice, and the availability to sentencers of alternatives to custodial sentences. We address these background issues in Chapter 4, while remaining conscious that, in overall policy terms, parliamentary scrutiny of such matters is the responsibility of members of the Commons Home Affairs Committee.¹

12. It is our conviction that, in the long-term, sustainable solutions to the problem of deaths in custody can only be achieved in the context of increased resources and a reduction in the numbers of prisoners and other detainees held in the UK. But significant improvements can be made even within the constraints of the current system. In Chapters 5 to 9, we go on to look at some of the practical aspects of preventing self-inflicted deaths, as well as deaths resulting from neglect. Chapter 5 considers the issues surrounding risk assessment and management of detainees, especially in the crucial early hours, days and weeks following their admission into custody. Individualised risk assessment and clear communication of information in this regard between the various state authorities provides the indispensable bedrock for an effective policy to prevent self-inflicted deaths in custody.

13. In Chapters 6 and 7 we consider the provision of healthcare, physical and mental, in the different detention settings. We then consider issues surrounding the use of physical restraint and seclusion (Chapter 8) and staffing and training issues (Chapter 9). These issues affect both self-inflicted deaths, and deaths resulting from actions of police, prison officers or other staff.

¹ See, for example, their recent Fifth Report of Session 2003–04, *Draft Sentencing Guidelines 1 and 2*, HC 1207

14. Finally, in Chapter 10, we consider the important question of the mechanisms that are in place to investigate deaths in custody. It has been established by jurisprudence of the European Court of Human Rights that the Article 2 ECHR duty to protect life requires a thorough and independent investigation of all deaths in custody. The State has a duty to ensure that the families of those who died are provided with a full explanation of the circumstances of the death and are fully involved in the investigation into those circumstances. It also has a duty to ensure that the investigation is capable of leading to the identification and punishment of those responsible for a death. Our main conclusions and recommendations are set out in Chapter 11.

15. We are most grateful to all those who have assisted us throughout the course of this inquiry. We also record our thanks to our two specialist advisers in the inquiry, Professor Kevin Gournay of the Institute of Psychiatry at King's College London, and Joe Levenson.

2 Human rights standards and deaths in custody

The European Convention of Human Rights

16. Every unnatural death in custody presents a human rights issue. In this report, we examine the problem of deaths in custody in light of the human rights obligations of the institutions which compulsorily detain people, and those which investigate deaths of people who are so detained. These institutions are subject to a number of obligations. Under the Human Rights Act 1998, the police and prison service are “public authorities” with obligations to comply with rights under the European Convention on Human Rights, including the right to life.² Private contractors operating prisons, immigration removal centres and mental health detention facilities are also considered to be public authorities when exercising powers of detention delegated to them by the state, and are therefore also required to comply with Convention rights. In international law, the state, in protecting people in its custody and in investigating deaths, has obligations to comply with international standards, including those under the European Convention on Human Rights, and United Nations human rights treaties.

17. Article 2 ECHR establishes the right to life, the most fundamental of the Convention rights, and a core protection against deaths in custody. It provides—

1. Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary—
 - a. in defence of any person from unlawful violence
 - b. in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
 - c. in action lawfully taken for the purpose of quelling a riot or insurrection

18. A number of other Convention rights are also important in protecting against ill-treatment that may lead to deaths in custody. Article 3 provides—

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

19. Article 8 also protects against physical ill-treatment or neglect which may not attain the severity of treatment which would be contrary to Article 3. It provides—

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society. ...

The right to respect for private life has been interpreted by the European Court of Human Rights as including a right to physical integrity.

20. The Convention also protects against unjustified discrimination in the way in which other Convention rights are protected. Article 14 provides—

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground ...

The International Framework

21. In addition to the ECHR rights taking effect in UK law under the Human Rights Act, a number of other international human rights instruments, as well as non-binding standards and guidelines, are of particular relevance to the protection of rights in prisons.

22. The International Covenant on Civil and Political Rights (ICCPR) states in Article 10 that all detained persons are to be treated with humanity and respect for their dignity. The United Nations Convention on the Rights of the Child (CRC) repeats this principle in Article 37, and adds that “Every child deprived of liberty shall be treated ... in a manner which takes into account the needs of persons of his or her age”.³

23. The UN Convention Against Torture requires states to “keep under systematic review ... arrangements for the custody and treatment of persons subject to any form of arrest, detention, or imprisonment ... with a view to preventing any cases of torture”⁴ and preventing cruel, inhuman or degrading treatment.⁵

24. A number of United Nations “soft law” standards set out comprehensive rules for the treatment of prisoners. These include the UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment 1988; the UN Standard Minimum Rules for the Treatment of Prisoners 1977; and the UN Basic Rules for the Protection of Juveniles deprived of their Liberty 1990. The UN Basic Principles for the Treatment of Prisoners 1990 state amongst other things that—

1. All prisoners shall be treated with the respect due to their inherent dignity and value as human beings.

...

9. Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.⁶

3 We have already commented on issues arising from juvenile detention in our Tenth Report of Session 2002–03, *The UN Convention on the Rights of the Child*, HL Paper 117, HC 81

4 Article 11

5 Article 16

6 General Assembly resolution 45/111 of 14 December 1990

The right to life: Article 2 ECHR

25. The standard against which law and practice in preventing and investigating deaths in custody must be measured is Article 2 ECHR, as interpreted in the case-law of the European Court of Human Rights. Crucially, Article 2 imposes on States, not only a negative duty not to take life intentionally or negligently, but also a positive duty to safeguard life. The Article 2 negative duty not to deprive an individual of life may be breached by excessive or unnecessary use of force against a detainee. It may also be breached as a result of systemic failings which fail to provide adequate procedures or adequately trained or qualified staff, to ensure safety.

26. The positive duty has two aspects. First, it places positive obligations on the detaining authorities to take steps to protect individuals whose lives are known, or should be known, to be at risk. Second, it requires the police, Coroners, the Crown Prosecution Service and other investigating bodies to ensure that deaths in custody are appropriately investigated.

27. The Article 2 positive obligation to protect life arises wherever the authorities know or ought to know of a real and immediate risk to the life of a particular person or group of people.⁷ Article 2 is breached if, in these circumstances, the responsible authorities fail to take reasonable measures within the scope of their powers to avert the risk.⁸ Where there is a threat to the life of someone in the custody of the state, there is a heightened responsibility to provide protection.⁹ The case-law makes clear that the positive obligation arises where the threat to life comes from a third party, such as a cell-mate,¹⁰ or the detained person themselves.¹¹ Where a death does occur in state custody, the burden is on the detaining authorities to provide a satisfactory and convincing explanation for the death. In the absence of such explanation, Article 2 is breached.¹²

28. The Article 2 obligation to protect life is not an unlimited one, however. In particular, where a detainee takes their own life, Article 2 will be breached only where it can be shown that the authorities knew or ought to have known that the detainee posed a real risk of suicide. Where the authorities have taken reasonable steps to protect a detainee, having regard to the nature of the risk of suicide, or where there are no indications that a detainee is at risk of suicide, the death will not result in a breach of Article 2.¹³

Article 2 privacy and autonomy

29. The duty to protect the right to life under Article 2 must be viewed in the context of the ECHR as a whole, and of the other human rights standards it guarantees. In particular, the Article 2 positive duty will not justify extreme or disproportionate measures of control

7 *Osman v UK* (2000) 29 EHRR 245

8 *Edwards v UK* (2002) 35 EHRR 19; *Anguelova v Bulgaria*, App. No 38361/97, 13/06/2002

9 *Salman v Turkey* (2002) 34 EHRR 17

10 *Edwards v UK*, op cit.; *R (on the application of Amin) v Secretary of State for the Home Department* [2003] UKHL 51, [2004] HRLR 3, in which the House of Lords observed (Lord Bingham at para. 21) that the case of *Edwards* was important because in it the European Court of Human Rights for the first time applied to a case of negligent failure to protect the life of a prisoner the same principles as it had developed in the context of killing by state agents.

11 *Keenan v UK* (2001) 33 EHRR 913, in which the European Court of Human Rights recognised for the first time, at paras 89-92, that a positive obligation under Article 2 may arise “where the risk to a person derives from self-harm.”

12 *Anguelova v Bulgaria*, op cit

13 *Keenan v UK* (2001) 33 EHRR 38 paras. 92–101

intended to deprive the individual of any opportunity to self-harm. In *Keenan v UK*, the European Court of Human Rights set out the principle that—

The prison authorities must discharge their duties [to protect Article 2 rights] in a manner compatible with the rights and freedoms of the individual concerned. There are general measures and precautions which will be available to diminish the opportunities for self-harm, without infringing personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case.¹⁴

30. This affirms the principle of proportionality, which requires that measures which interfere with the right to respect for private life, personal autonomy and physical integrity, must be confined to those necessary to achieve the legitimate aim of protecting a detainee from self-harm, and must be appropriate to the particular circumstances of the individual case. Blanket measures which for example apply intrusive surveillance, or require the removal of items of clothing, for large groups of detainees, may amount to disproportionate interferences with the right to respect for private life under Article 8 ECHR, where they cannot be justified as necessary and proportionate measures to protect an individual detainee from a risk of suicide or self-harm.

31. The need to protect the right to life within a culture of respect for all of the Convention rights, including the right to respect for private life and personal autonomy under Article 8, therefore embraces an emphasis on “relational” security—established through the environment of detention, access to necessary support and healthcare, and supportive relationships with staff—rather than on a more narrow “physical” security which is confined to removal of the means for self-harm, and surveillance of detainees at risk. It also puts a premium on effective risk assessment of each person detained, so that measures taken can be tailored to that person’s individual needs.

Article 2 and the duty to investigate

32. Article 2 also places a positive duty on the state to investigate following any death in state custody, whether or not involving agents of the State (*Edwards v UK*). In order to satisfy Article 2, the investigation must be effective. The ECtHR has held that it must be—

- on the state's own initiative (e.g. not civil proceedings);
- independent, both institutionally and in practice;
- capable of leading to a determination of responsibility and the punishment of those responsible;
- prompt;
- allow for sufficient public scrutiny to ensure accountability;
- allow the next of kin to participate.¹⁵

¹⁴ *ibid.*, para. 91

¹⁵ *Jordan v UK* (2003) 37 EHRR 2

These principles have now been approved by the House of Lords in the case of *ex parte Amin* (the Zahid Mubarek case).¹⁶ Their application in the UK system is discussed further in Chapter 10. For present purposes, however, it is important to point out that the House of Lords in *Amin* was unanimous in rejecting the Government's argument, successful before the Court of Appeal, that "an allegation of negligence leading to death in custody, though grave enough in all conscience, bears a different quality from a case where it is said the state has laid on lethal hands." The Court of Appeal had held that in cases where a death was due to systemic neglect, the "minimum requirements" of the procedural obligation could be applied more flexibly. The House of Lords adjudged that to be directly contrary to the decision of the Court of Human Rights in *Edwards v UK*. It held that systemic failures leading to deaths called for *even greater* scrutiny. Lord Bingham, for example, said "a systemic failure to protect the lives of persons detained in custody may well call for even more anxious consideration and raise even more intractable problems".¹⁷

Article 14 discrimination and Article 2

33. Article 14 requires particular sensitivity and attention to questions of racial prejudice in an Article 2 investigation. This sensitivity must take account of the complex range of racist attitudes and behaviour, including prejudice against those of Irish descent and members of the Gypsy and Traveller community. Since ethnically motivated killings may be particularly pernicious in undermining democratic societies they require "particular vigilance and an effective response from the authorities".¹⁸ In terms of the investigation into a death in which state agents may be implicated, this means that there is an additional duty to take all reasonable steps to unmask any racist motive.¹⁹ In particular, any evidence of racist verbal abuse by law enforcement agents in an operation involving the use of force must be fully investigated.²⁰ Where evidence of possible racist motivation is not pursued in a state investigation, then the Strasbourg Court will place the burden of proof on the state to establish that the death did not arise from discriminatory motives of state agents.²¹

34. The Court has expressly left open the possibility that a use of force may be considered as discriminatory on the basis of evidence of its disproportionate impact on a particular group even where it is not specifically directed at that group. Nevertheless statistics alone, which appear to show that one section of the population are disproportionately affected, cannot establish discrimination.²²

16 [2003] UKHL 51, [2004] HRLR 3. See Chapter 10 Inquiries into Deaths in Custody

17 [2003] UKHL 51, para. 21. See also Lord Steyn at para 50 "... the investigation of cases of negligence resulting in the death of prisoners may often be more complex and may require more elaborate investigation. Systemic failures also affect more prisoners." and Lord Hope at para 62 "... failures by the prison service which lead to a prisoner's death at the hands of another prisoner are no less demanding of investigation, and of 'the widest exposure possible', than lethal acts which state agents have deliberately perpetrated. Indeed there is a strong case for saying that an even more rigorous investigation is needed if those who are responsible for such failures are to be identified and made accountable and the right to life is to be protected by subjecting the system itself to effective public scrutiny."

18 *Nachova v Bulgaria* App Nos 43577/98 and 43579/98 para. 155

19 *ibid.*, para. 158

20 *ibid.*, para. 162

21 *ibid.*, para. 171

22 *Jordan v UK*, (2003) 37 EHRR 2 para. 154

Article 3 Freedom from inhuman or degrading treatment

35. The Article 3 protection against inhuman and degrading treatment and torture applies with particular stringency in the context of detention. There is a presumption that, where a person in custody is subjected to treatment considered to be in breach of Article 3, responsibility for the treatment can be attributed to the State.²³ Furthermore, any use of physical force against a person in detention is presumed to breach Article 3, unless it can be shown to be strictly necessary.²⁴ The use of control and restraint, in particular where it leads to the death of a detainee, may breach Article 3.²⁵

36. Inadequate medical, mental health or drug detoxification treatment leading to the death of a detainee may breach Article 3.²⁶ In *Keenan v UK*,²⁷ the suicide in custody of a mentally ill prisoner was found to result, not in a breach of Article 2, but of breach of Article 3 by reason of neglect. There had been a lack of monitoring of the prisoner's condition and of sufficient psychiatric assessment, and he had been inappropriately detained in segregation in a punishment block.²⁸

37. Article 3 is also relevant to the conditions which may form the background to some self-inflicted deaths in custody. Unsatisfactory prison conditions may give rise to breaches of Article 3. In *Napier v Scottish Ministers*,²⁹ a breach of Article 3 was found where a remand prisoner was held in a cell without a toilet, and confined in a cell for very long periods with inadequate lighting, space and ventilation. Whether conditions are adequate may depend on the particular physical or mental condition of the detainee. In *Price v UK*,³⁰ for example, it was held that detaining a severely physically disabled woman in prison conditions unsuited to her needs breached Article 3.

23 *Tomassi v France* [1993] 15 EHRR 1

24 *Keenan v UK*, *op cit*.

25 *Herczegfalvy v Austria* (1993) 15 EHRR 437. See Chapter 8 Physical Restraint and Seclusion

26 *McGlinchey v UK* App No 50390/99 29/04/2003. See Chapter 6 Physical Healthcare

27 [2001] 33 EHRR 38

28 The UN Human Rights Committee found prison conditions to amount to inhuman treatment in *Estrella v Uruguay*, Application 79/1980.

29 The Times, 15 November 2001 (Court of Session, Outer House)

30 App No 33394/96, 10/7/2001

3 Scale of the problem

38. The number of people dying in custody, particularly by their own hand, is extremely shocking and concerning. The number attempting suicide is on average twice that of those dying in custody, and the number carrying out incidents of self-harm should be a cause of huge concern. Moreover, close analysis of the figures reveals not only that many in custody have mental health problems or drug and alcohol dependencies, but that they have presented themselves to the authorities with these problems before they have offended. This begs two fundamental questions; first, whether intervention earlier could avoid custody later, secondly whether prison is the most appropriate place for them to be kept in custody if custody is necessary. But it also highlights certain straightforward practical concerns—such as the vital importance of prisoners receiving close supervision and observation at the beginning of their sentence, a topic that will be returned to in Chapter 5.

39. It is within this context that the positive duties of Article 2 become of extreme relevance and importance. A pro-active approach is vital in order to reduce the rate of self-inflicted deaths among people in custody and help the state meet its obligations under the Human Rights Act.

40. There is a great deal of information about the incidence of deaths in custody, much of which we summarise below. However, we also note some serious deficiencies in the information which is collected, rectification of which could assist in preventing deaths in custody. In these cases it could be argued that the relevant authorities are neglecting their duty to take all reasonable steps in furtherance of their positive obligation to protect detainees' right to life under Article 2 ECHR.

Prisons

41. In the five-year period between 1999 and 2003, a total of 434 prisoners in England and Wales took their own lives, equivalent to *one every four days*. During 2003 there were a total of 94 self-inflicted deaths in prisons in England and Wales, of which 80 were men and 14 women. In addition, in 2003 one prisoner was killed by a fellow inmate and 76 died of natural causes.³¹

42. In addition, as we shall see, around eighty people every year die from unnatural causes whilst detained under the Mental Health Act. Overall then, someone is either killed, kills themselves or dies in otherwise questionable circumstances—every other day. That—quite frankly—is shocking.

The extent of self-inflicted deaths

43. The Prison Service uses the term “self-inflicted death” rather than “suicide” when referring to those prisoners who take their own lives while imprisoned. This is because it does not differentiate between the occasions where there is an official Coroner’s verdict of suicide and other occasions where people die at their own hand, for example through

31 First Report of Session 2003–04, *Deaths in Custody: Interim Report*, HL Paper 12, HC 134, Ev 26

misadventure. As a result, the Prison Service records around a third more self-inflicted deaths than it would if it measured only suicide verdicts given by Coroners.

44. The 94 self-inflicted deaths in England and Wales in 2003 compare with 95 in 2002, 73 in 2001, 81 in 2000 and 91 in 1999. Figures from 2004 so far suggest that the total will increase this year.³² In Northern Ireland, there were four self-inflicted deaths in 2003–04, 2 in 2002–03, none in 2001–02, 2 in 2000–01 and 5 in 1999–2000. In Scotland, there were 6 self-inflicted deaths in prison in 2003, 10 in 2002, 11 in 2001, 14 in 2000 and 13 in 1999.³³

45. While there have been increases in the numbers of self-inflicted deaths in prisons, this must be set in the context of an increasing prison population. The Prison Service asserts that the rate of self-inflicted deaths is not increasing but has remained fairly stable. In 2002–2003 the rate of self-inflicted deaths in prisons in England and Wales was 146.9 per 100,000—significantly above the Prison Service’s own Key Performance Indicator of 105 per 100,000. However, we were told by the Prison Service that the indicator that they regarded as the most reliable measure of the progress that they were making in reducing self-inflicted deaths was a three-year rolling average. This rate is currently running at 129 per 100,000.³⁴

46. The majority of the organisations and individuals from whom we heard during the course of our inquiry expressed serious concern at the high levels of self-inflicted deaths amongst prisoners. In their evidence to us, the Royal College of Psychiatrists—which, in February 2002, published a comprehensive report ‘Suicide in prisons’—stated that: “These rates are unacceptably high and the trend is alarming, especially given the amount of time and effort that has been spent in trying to reverse the trend”.³⁵

47. The Royal College also presented us with evidence making comparisons between the suicide rates of prisoners, offenders in the community and the general population. They told us that—

[P]risoners cannot be compared with the general community as the prison population is characterised by younger age, lower social-economic status, histories of serious disadvantage and high rates of mental disorder—all of which make a population much more likely to have high rates of suicide. High levels of self-inflicted deaths in prisons could therefore be fully explained by the fact that prisons are simply importing a highly vulnerable population, who commit suicide at higher rates than other individuals wherever they happen to be.³⁶

48. The Royal College told us that while some attempts have been made to compare prisoners with offenders who are supervised in the community, these attempts are unfortunately not really valid because prisons have high rates of turnover whereas community groups, even of offenders, are relatively stable. Moreover, prisons take the more serious offenders and community and offender groups may have a different age and sex profile, and different rates of drug and alcohol abuse.

32 Figures for the first 11 months of 2004 are 94 self-inflicted deaths in prisons www.inquest.org.uk

33 HL Deb, 3 February 2004, col. 94WA. 3 Coroners’ verdicts were being waited on for 2003, 1 in 2001 and 1 in 2000.

34 Q 322

35 Ev 185

36 *ibid*

49. The Royal College also drew our attention to a Home Office research study which found that offenders in the community had an overall death rate of about double that of prisoners and four times the male general population. The accidental death rate for offenders in the community was more than five times that of prisoners, and the homicide rate was as much as nine times higher. What evidence there is—at least superficially—might suggest that prison is a protective factor for a highly vulnerable and suicidal population. However, the Royal College again noted that such conclusions can be misleading as community studies are not satisfactory comparisons for the general population.

50. Whilst we accept that overall *rates* of self-inflicted deaths in prisons are not rising, increased reliance on imprisonment means that the total number of self-inflicted deaths in prisons each year is unacceptably high. This is despite the high priority that has been given to the issue and must be seen in the context of suicides in the general population having fallen to an all-time low.

Who dies in prison?

51. Prisoners who take their own lives are disproportionately drawn from certain sections of the prison population. An understanding of the profile of these statistically vulnerable groups is essential to any strategy to reduce deaths in prisons, provided that it is underpinned by individual risk assessments.³⁷

- **Age.** Most deaths during 2003 occurred in the 25–39 age groups. In all, more than a third (36 per cent) were in the 30–39 age group. The youngest prisoner to take his own life was 18 and the oldest 62. No juveniles (15–17 year olds) died but 11 young offenders (18–20 year olds) did. This is similar to the age-profile of those who died in previous years and broadly reflects the age-profile of the general prison population. Between January 1990 and December 2003, there were 177 self-inflicted deaths of young people in prison—19 per cent of the total of all self-inflicted deaths for that period.
- **Gender.** Despite making up just over 6 per cent of the prison population, 15 per cent of self-inflicted deaths in 2003 were of female prisoners.
- **Ethnicity.** A disproportionate number of self-inflicted deaths occurred amongst white prisoners. In all, 86 of the 94 prisoners who died in 2003 were white (91 per cent), even though white prisoners comprised around 78 per cent of the prison population. Four of those who died were Asian (4 per cent), three of those who died were Black (3 per cent) and one was Chinese. These figures are consistent with previous research findings which indicate that white prisoners are more likely to take their own lives.
- **Nationality.** Eight of the 94 self-inflicted deaths in 2003 were of foreign national prisoners.

37 These figures are from HM Prison Service, see Ev 104–106

- **Offence-type.** Those who take their own lives in prison are more likely than the general prison population to be imprisoned for violence-related offences. The most common offence-type of those who died during 2003 was violence against the person—accounting for 29 per cent of self-inflicted deaths in that year.
- **Legal status.** Although unsentenced prisoners account for less than 20 per cent of the prison population, they comprise the majority of self-inflicted deaths (54 per cent). While 43 of those who died in 2003 were sentenced (46 per cent), the remainder were either on remand (36), convicted but unsentenced (10), in prison awaiting further reports (2) or detainees (3).
- **Previous history of self-harm.** The majority of prisoners who take their own lives were not considered at risk of self-harm or suicide at the time of their death. Prison Service statistics show that in 2003, just 27 of the 94 self-inflicted deaths (29 per cent) were subject to an open F2052SH or ACCT (mechanisms for caring for those at risk of suicide or self-harm) at the time of their death.³⁸ Of those prisoners who were not considered to be at risk of suicide or self-harm at the time of their death, 62 per cent had also not previously been considered to be at risk during their current time in custody. However, in 8 cases a previous F2052SH had been closed within 4 weeks of their death, and in a further 12 cases it had been closed between 1 and 6 months before their death.
- **Length of detention.** A consistent finding is that the majority of prisoners who die have been in the establishment for relatively short periods at the time of their death. Just under half (46 per cent) of prisoners who died in 2003 spent less than a month in custody (down from 54 per cent in 2002 and 52 per cent in 2001). In all, one in four prisoners who took their own lives had spent less than a week in the establishment at the time of their death.
- **Type of prison.** In 2003, as in previous years, the majority of self-inflicted deaths (50 per cent) occurred in Category B Local prisons. This is consistent with the fact that newly sentenced and remand prisoners—who are largely held in local prisons—are most likely to take their own lives. It has been found that male local prisons that experience a self-inflicted death are statistically more likely to experience further deaths. In 2003, 49 establishments and one court experienced a self-inflicted death. Two prisons experienced five deaths and four prisons experienced four deaths.

52. The Prison Service does not collect information on whether prisoners who took their own lives had undergone or were undergoing at the time of their death mental health assessments, psychiatric treatment, drug or alcohol detoxification or drug and alcohol treatment. Similarly, no information is collected on how many prisoners who die in custody had a history of substance misuse prior to entering prison.

38 F2052SH is the Prison Service Self-Harm At Risk Form. Prisoners with an 'open' F2052SH are considered to be at risk of self harm

53. As part of the National Confidential Inquiry into Suicides and Homicides by Mentally Ill People, a study of prison suicides between 1999 and 2000 was published.³⁹ The study collected data held by the Prison Service's Safer Custody Group, and covered 172 suicides. Of these self-inflicted deaths, 72 per cent were of people who had one psychiatric diagnosis identified at reception. The most common diagnosis was drug dependency. In all, 32 per cent had a second diagnosis of a mental health problem, indicating more complex treatment needs. Over half (53 per cent) had a history of self-harm, 57 per cent had symptoms of psychiatric disturbance on reception to prison, and, of these, 72 per cent were referred to a healthcare professional in prison. Thirty per cent of people who took their own lives had a history of contact with NHS mental health services. One in six self-inflicted deaths (17 per cent) were among inpatients in the prison healthcare centre at the time of death, and 15 per cent of suicides were seen by health staff as preventable with closer supervision, better training and an increased use of shared cells. Respondents also indicated that a higher percentage of suicides could have been made less likely with closer supervision, better staff training in risk assessment, placement in a double cell or with a Listener, an increase in staff numbers, better ongoing support and clinical management, and better communication.

54. The statistics revealed in the above report are extremely concerning. The evidence demonstrates a clear link between drug dependency, mental illness, length of stay in prison and an increased risk of self-inflicted death. This highlights the areas where the Government must act if it is to meet the duty of care it owes to the most vulnerable people in its custody. Presently, however, it is clear that the Government is failing many of these people, leading to an unacceptably high level of self-inflicted death.

55. Moreover, the sheer numbers of people in custody with mental health problems and/or drug and alcohol dependency once again calls into question whether these people should be sent to prison in the first place—an environment that does not best address their medical needs and the likely causes of their criminal behaviour.

56. We recommend that the Prison Service should routinely collect information on whether prisoners who take their own lives, or attempt to, had received mental health or substance misuse treatment before or during their imprisonment. This would be invaluable in shedding more light on the broader circumstances of self-inflicted deaths in prisons and would highlight ways better to fulfil the Service's duty of care to prisoners and uphold their right to life.

Attempted suicide and self-harm

57. There is no agreed definition within prisons of what constitutes “attempted suicide”. Data recording incidents of “attempted suicide” are effectively subsumed within those for self-harm, which covers all reported acts of self-injury, however serious.

58. However, information is available on the number of resuscitations that took place. In 2003, 211 prisoners were successfully resuscitated by staff following serious self-harm

39 J Shaw, L Appleby and D Baker, *Safer Prisons: A National Study of Prison Suicides 1999-2000*, The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness, May 2003

incidents. Of these, over half (126) were women—a strikingly high figure when it is borne in mind that women make up such a small proportion of the prison population.

59. In 2003, there were a total of 16,223 recorded incidents of self-harm in prisons in England and Wales.⁴⁰ Many of these are likely to be accounted for by some individuals repeatedly self-harming—separate data is not available on the number of individuals who self-harm as opposed to self-harm incidents. However, these figures are likely to significantly underestimate the true extent of self-harm as they only include instances which come to the attention of the prison authorities and which are then recorded.

Women

60. As noted above, self-harm is a particular problem amongst women prisoners—largely due to the significant and often imported vulnerability of many women in custody. In 2003, 30 per cent of women prisoners harmed themselves, compared with 6 per cent of men. At New Hall women’s prison in Yorkshire, 100 of the jail’s 365 prisoners were considered at risk of self-harm or suicide and had been made subject to the “Self-Harm At Risk Form” F2052SH procedures as of April 2004.⁴¹ On our visit to Holloway, we were told that of Holloway’s 444 prisoners at the time, 57 were at risk of suicide, and 8 women were on 24 hour watch. The evidence which we heard, supported by our visit to Holloway, indicates that women prisoners are placed at special risk. Not only do a disproportionate number of women self-harm in custody, we were told that several women are cut down from ligatures almost every night in Holloway Prison alone.

61. Moreover, there is a confluence of six factors that combine to put women prisoners at especial risk in the first few hours of being placed in custody.

- Women prisoners are often especially vulnerable in any event—not only having mental health or drug dependency problems, but also being the victims of abuse—physical and sexual.
- Many women prisoners are mothers, and have been taken away from their children—of itself a traumatising factor.
- For the following reasons, women prisoners often arrive at prison very late in the evening—
 - There are so few women’s prisons that they often have to travel longer distances from court to custody in any event;
 - In addition, there is a financial incentive to those responsible for transferring prisoners into custody to deliver men to prison before women.
- It is only when they arrive at prison late at night that some are even asked whether they have dependent children at home or whether they are being looked after, leading to yet further maternal anxiety.

40 HC Deb., 5 May 2004, col. 1549W

41 HC Deb., 8 June 2004, col. 327W

- Many of the women prisoners that we met were sentenced—
 - for very short periods of time—often a week or less,
 - for very minor offences—for example, stealing coffee to sell to neighbours to buy drugs, and
 - very frequently—four or five times a year,

meaning that their lives and families were disrupted in this way repeatedly, and yet without any realistic chance of addressing the causes of their criminality.

- The very design of women's prisons can exacerbate the risk of self-harm or suicide of these especially vulnerable prisoners. Holloway—for example—is designed as a hospital, making it especially difficult for prison officers to observe the women in their custody.

Homicides

62. Homicides in prisons in England and Wales are rare—an undoubtedly impressive achievement given the relative freedom of movement that the vast majority of prisoners have within a prison, the inherently claustrophobic and pressure-cooker existence of prison life and the violent offence profile of many prisoners.

63. However, whilst rare, homicides do still happen in our prisons. There was one homicide in 2003. The death of Zahid Mubarek, killed by his mentally-ill cellmate Robert Stewart at Feltham Young Offender Institution in March 2000, was the subject of an inquiry by the Commission for Racial Equality which found 20 areas of failure in the management systems at Feltham either to identify the violent and racist nature of Robert Stewart or to protect Zahid Mubarek from him. A further independent inquiry into Zahid Mubarek's death has now begun.⁴²

64. The Home Office has recently published research on homicides in prisons in England and Wales.⁴³ Amongst the report's main findings were—

- There was an average of two homicides per year in the period 1990 to 2001 (26 in general)
- Two-thirds of the homicides occurred in high security or local prisons
- Twelve victims were in shared cells and 11 had been killed by their cellmate
- Victims were likely to be young, white, male repeat offenders, serving sentences for violence, robbery or drugs offences, and sharing a cell.

⁴² The inquiry, chaired by Mr Justice Keith, began hearing evidence in November 2004. It was established following the ruling of the House of Lords (in *ex parte Amin*, *op cit*) that previous investigations of the case did not satisfy the Article 2 ECHR right to a full independent inquiry.

⁴³ G Sattar, 2004, *Prisoner-on-prisoner homicide in England and Wales*, Home Office Findings 250

The Prison Service has a strategy of using shared accommodation in their strategy for caring for prisoners at risk of self-harming. However, the finding that almost one-half of prisoners who were killed died at the hands of their cellmate suggests that this policy may need to be implemented more carefully.

65. Each year there are many other serious violent assaults which do not result in death. The Prison Service has recently introduced a new measure of violence towards prisoners, based on the number of reported serious assaults. Between April and December 2003, there were 611 serious prisoner-on-prisoner assaults.⁴⁴

Deaths through control and restraint

66. Between 1996 and 2003 there were no deaths in prisons through the use of control and restraint techniques. However, on 19 April 2004, 15-year-old Gareth Myatt died after losing consciousness while being restrained by staff at Rainsbrook Secure Training Centre.

Death by natural causes

67. In 2003, there were 76 deaths of prisoners through “natural causes”. While the overwhelming majority of these were undoubtedly completely unrelated to the person’s imprisonment, the standard of prison healthcare has attracted major criticism from, amongst others, NGOs, Independent Monitoring Boards (formerly Boards of Visitors) and the Prisons Inspectorate.⁴⁵

European comparisons

68. There is considerable variation across Europe in levels of deaths in penal institutions. Latest figures for deaths in custody in 2002 from the Council of Europe show that the mortality rate in prisons in England and Wales was 23.3 per 10,000 prisoners and the suicide rate was 13.2 per 10,000. England and Wales had the joint ninth highest suicide rate amongst the 46 Council of Europe Member States.⁴⁶ However, a note of caution should be added when trying to make international comparisons of this kind, because of the risk that definitions may vary from one country to another.

Measures taken to address deaths in prison

69. The Prison Service has placed a great deal of emphasis in recent years on trying to reduce deaths in custody. When he was Director General of the Prison Service Martin Narey, now Chief Executive of the National Offender Management Service, announced that preventing deaths in custody was his top priority. This sentiment was echoed by the Prison Service’s current Director General Phil Wheatley who told us that suicide prevention “is an important priority and something that is crucial for the service if we are to deliver a humane and decent service”.⁴⁷

44 HC Deb., 10 February 2004, col. 1435W

45 See Chapter 6 Physical Healthcare and Chapter 7 Mental Healthcare

46 M Aebi, Space I, *Council of Europe Annual Penal Statistics*, Survey 2003, Strasbourg, 17 May 2004

47 Q 324

70. A proactive three-year programme to develop policies and practices to reduce self-inflicted deaths in prisons began in April 2001. The programme included improvements in reception and induction arrangements, better inter-agency information exchange, changes in detoxification facilities, changes in procedures for identifying and managing prisoners at risk, the training and appointment of suicide prevention coordinators in the majority of prisons, the increased provision of prisoner-peer support, an investment of £21 million in six “Safer Local” prisons (Feltham, Leeds, Wandsworth, Winchester, Eastwood Park and Birmingham) and projects to develop safer prison design, including safer cells.

71. On 31 March 2004 a new outline suicide prevention strategy was announced to apply across all types of prisons and to all prisoners. In addition, women prisoners are to benefit from a specifically targeted and separate suicide prevention and self-harm management strategy being developed for them. This builds upon a number of interventions including: individual crisis counselling for women prisoners who self-harm; the continued development and evaluation of Dialectic Behaviour Therapy, which is currently being trialled at Durham, Bulwood Hall and Holloway prisons; investment and planning to ensure progress on the detoxification strategy in women’s prisons; and the introduction of a new training pack for all staff working with women in custody. In addition, £1 million from the Department of Health is being spent on the recruitment of psychiatric nurses in women’s prisons.⁴⁸

72. We welcome the introduction of this scheme on a trial basis. If it is proven to be effective we strongly urge the Government to extend it nationwide as quickly as possible. In particular we welcome the individual crisis counselling for women and programmes specifically targeted at women. We recommend further analysis of the experiences of women and in particular reasons why they have a far greater tendency to self-harm than men. The individualisation of the treatment process and drawing up of specific courses of action concerning specific groups of people is a welcome step towards helping meet the positive obligations of a duty of care imposed by Article 2.

Children and young persons

73. Deaths in custody of children and young people are especially distressing, and we therefore highlight them for specific comment. The Youth Justice Board has implemented a number of practical measures to minimise the risk of self harm and suicide among children in custody. These measures include the provision of safer cells, funding for 24 hour healthcare in all establishments that take young people, the provision of ‘First night’ packs for all young people entering custody, the commissioning of a regular survey of all young people in Young Offender Institutions (YOIs) and the commissioning of advocacy services for young people in prisons.⁴⁹ Nevertheless, there have been some deeply worrying cases of children and young people who have died while in the care of the state. Between 1990 and August 4 2004, 25 children have taken their own lives in prison and 2 children have died in secure training centres. An especially worrying case is that of Joseph Scholes, who hanged himself from the bars of his cell in Stoke Heath Young Offender Institution in

⁴⁸ HC Deb., 8 June 2004, col. 328W

⁴⁹ Ev 130–131

March 2002 at the age of just 16. The death of Joseph Scholes highlights successive failures within the criminal justice system in meeting the needs of a highly vulnerable child.

74. At the time of his arrest for involvement in a series of robberies—albeit peripherally—Joseph Scholes was depressed, had begun to self-harm and have periodic suicidal thoughts. Two weeks before his court appearance, he slashed his face with a knife over 30 times. Prior to sentencing, the trial judge was alerted to Joseph’s vulnerability, his experience of sexual abuse and history of suicidal and self-harming behaviour. Despite this he was sentenced to a two-year detention and training order, although the judge stated that he wanted the warnings about Joseph’s self-harming and history of sexual abuse “most expressly drawn to the attention of the authorities.” Nevertheless, Joseph Scholes was placed in prison service custody rather than local authority secure accommodation. Just nine days into his time at Stoke Heath Joseph Scholes hanged himself [I/S] in his cell, where he had been kept in virtual seclusion.⁵⁰

75. The inquest jury returned a verdict of “accidental death in part contributed to because the risk was not properly recognised and appropriate precautions were not taken to prevent it”.⁵¹ The coroner who presided over the inquest wrote to the Home Secretary calling for a public inquiry to be held. **This is a call that we support. There has never been a public inquiry into the death of a child in custody. We recommend that the Home Secretary order a public inquiry into the death of Joseph Scholes in order that lessons can be fully learnt from the circumstances that led up to his tragic death. We also recommend that local authority secure accommodation should be used wherever possible for children, with use of prison service custody reduced to an absolute minimum.**

76. In light of this disturbing case we would also like to draw attention to the recent comments of Jaap Doek, the Chairman of the UN Committee on the Rights of the Child, regarding the unnecessary jailing of juveniles in the UK.⁵² His comments were made in light of the death of two children in custody this year. He also highlighted the recent report from the Children’s Rights Alliance which voices concern at the under-funding of community support projects for teenagers, the imprisonment of child asylum-seekers and the disproportionate number of black people in prison. When addressing the custodial care of children it is extremely important to bear in mind Article 3 of the Convention on the Rights of the Child—to which the UK is a signatory—in which any action of the state regarding children must always have the best interest of the child at its core. This raises the crucial question of to what extent imprisonment can ever be deemed to be in the best interests of the child.

Police Custody

77. Home Office figures show that, between April 2003 and March 2004, there were 38 deaths in police custody in England and Wales, of which 7 were in police stations, 22 were in hospital, and the remainder were at the scene of arrest or following arrest.⁵³ None of the

50 INQUEST, *Why are children dying in custody?*, November 2004

51 *ibid*

52 Britain violates rights of child say UN, *The Guardian*, 29 November 2004

53 Home Office, *Deaths During or Following Police Contact, Statistics for England and Wales April 2003 to March 2004*

deaths at police stations involved the use of restraint, although six of those who died in hospital had been restrained by the police shortly prior to death.⁵⁴ All of those who died at police stations were white; one of those who died in hospital having earlier been restrained was black. In 2002–03, there were 8 deaths in police custody in Scotland.⁵⁵ In 2001, there were 5 deaths in police custody in Northern Ireland.⁵⁶

78. A research study by the Police Complaints Authority (PCA)⁵⁷ illustrates the extreme vulnerability of those who die in police custody. The PCA found that, in the period between 1998–2003, there was an over-representation of ethnic minorities in deaths in police custody (17.6% of those who died were non-white, compared with 9% of the general population, and 13% of arrestees). The study also found that there were restraint issues in a higher proportion of the deaths involving non-white individuals (21.7%) than among white individuals (12.3%).

79. There are very high rates of drug and alcohol dependency, and of mental illness, amongst those held in police custody, and those who die there. The PCA's research⁵⁸ found that, of 153 deaths in police custody (including deaths in police custody suites, police vans, in hospital or in a public place following arrest) between 1998 and 2003, 43.8% had consumed alcohol prior to arrest, 17.6% cocaine; 12.4% heroin; 20.3% benzodiazepines; 8.5% ecstasy; and 13.7% cannabis. "Toxicity" was cited as a cause of death in 31.8% of the cases.

80. The PCA survey found that just over half of those who died had prior indications of mental health problems. Three of the 60 deaths surveyed by the PCA were of persons detained to be brought to a place of safety under section 136 of the Mental Health Act 1983.

Measures taken to address police custody deaths

81. A number of initiatives have sought to address problems related to deaths in police custody. The Standing Committee on Learning the Lessons from Adverse Incidents was established by the Home Office under the Chairmanship of ACPO in 2002. It reviews "adverse incidents" including deaths or injuries in police custody, and makes recommendations arising from this review. Its work resulted in guidance on the physical characteristics of police cells.⁵⁹ The National Custody Forum, together with the National Centre for Policing Excellence, is working towards developing practice to ensure safer detention in police cells.⁶⁰ The Metropolitan Police Service under its Professional Standards Directorate has established a Deaths in Custody Group dedicated to prevention and reduction of death following police contact.⁶¹ These valuable initiatives appear to be limited

54 Inquest verdicts are still awaited in a number of the cases recorded

55 Response by the UK to issues raised by the United Nations Committee Against Torture for Discussion at the Committee's 33rd Session in November 2004, Appendix 2

56 *ibid.*, Appendix 4

57 See our First Report of Session 2003–04, *Deaths in Custody: Interim Report*, HL Paper 12, HC 134, Ev 64

58 *ibid.*, Ev 60

59 Home Office Circular 18/2002

60 Q 406

61 First Report of Session 2003–04, *op cit.*, Ev 11–14

to some extent, however, by the decentralised policing system, and by the wide variation in practice between police forces.

Immigration Detention

82. Although levels of deaths in immigration detention have historically been low, there is now increased resort to detention (from 250 places in immigration detention a decade ago to between 1,500 and 2,000 currently). Those detained are likely to be highly vulnerable, with high rates of mental illness and distress, and sometimes with past experience of imprisonment, ill-treatment or torture.⁶² We are concerned that there appears to be a recent increase in deaths in immigration detention. The Home Office records 5 deaths in immigration removal (previously detention) centres between 1989 and mid-2003, 4 of which were self-inflicted.⁶³ In 2004, three apparently self-inflicted deaths have so far been recorded. In July 2004, a disturbance at Harmondsworth immigration removal centre was triggered when a detainee was found hanged.⁶⁴ A second detainee was found hanged at Dungavel removal centre a few days later, having been transferred from Harmondsworth after the disturbance.⁶⁵ An immigration detainee died in hospital following a suicide attempt at Colnbrook Immigration Removal Centre in November.⁶⁶ A fourth death of a detainee at Haslar removal centre, apparently from natural causes, was followed by allegations that he had been ill-treated at another immigration centre in the days before his death.⁶⁷ Evidence we have received from NGOs reports numerous incidents of self-harm in immigration detention. There were two deaths of immigration detainees in prison in 2002, two in 2003, and none in the first 11 months of 2004.⁶⁸

Mental Health Act detention

83. The last comprehensive statistical survey undertaken by the Mental Health Act Commission, for the period between 1997 and 2000,⁶⁹ shows that in that period there were 233 deaths from unnatural causes of people detained under the Act.⁷⁰ Its evidence notes that the majority of these deaths were suicides, and that four deaths were directly related to the use of control and restraint powers, whilst 22 of those who died had been subjected to control and restraint in the previous week.

84. The most recent outline figures provided by the Mental Health Act Commission show that there were 304 deaths of detained patients in 2003. In 9 of these cases, control or restraint had been used in the 7 days preceding the death. In one case, restraint had been

62 First Report of 2003–04, *Deaths in Custody: Interim Report*, HL Paper 12, HC 134, Ev 68–73 and Ev 106–107

63 Ev 14

64 Riot at fast-track asylum removal centre, *The Guardian*, 21 July 2004

65 Harmit Athwal, Institute of Race Relations, *Death Trap: the Human cost of the war on asylum*, 2004

66 Kenny Peter died on 4 November 2004

67 Harmit Athwal, *op cit*

68 *ibid.* On the detention of immigration detainees in prison see para. 128 below

69 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*. See our First Report of Session 2003–04, *op cit.*, Ev 37–46

70 Only one third of these deaths occurred whilst actually in detention; the remainder occurred whilst absent from the place of detention, or in a general hospital. The Commission collated these figures according to the cause of death determined at inquests.

used within 24 hours of the death.⁷¹ The MHAC estimated that one patient per annum over the last seven years had died whilst under restraint.⁷²

85. INQUEST was concerned that some deaths where use of restraint was implicated might be inaccurately recorded as deaths by natural causes. The Chief Executive of the Mental Health Act Commission told us—

We do not have really good data on any of this area. The Commission's collation of these statistics began essentially because no one else was doing it and it is quite possible that data collection might be improved in the coming years ... I cannot be too sanguine that we know that all either natural deaths or unnatural deaths which apparently do not feature control and restraint did not, in fact, feature control and restraint because the data quality is not as good as we would want.⁷³

86. The Report into the Death of David Bennett found that the lack of sufficient statistics made it difficult to draw general conclusions on deaths in psychiatric hospitals. It recommended that more detailed statistics should be kept, to enable analysis of how many detained patients died under restraint or shortly thereafter, and on how many such patients were from an ethnic minority.⁷⁴ Following this recommendation, the Director of Mental Health for the Department of Health has been made responsible for the collection of these data as part of the Confidential Inquiry into homicides and suicides by the mentally ill. **We recommend that annual statistics should be published by the Department of Health, recording the numbers of natural and self-inflicted deaths, homicides and deaths which are restraint-related, as well as attempted suicides, and detailing the age, gender and ethnicity of those who died or attempted suicide.**

71 Ev 120

72 Q 169

73 Q 170

74 Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, *Independent inquiry into the death of David Bennett*, December 2003, page 63

4 Prison overcrowding and sentencing

87. It has become clear to us in the course of this inquiry that the levels and characteristics of the detained population are inextricably bound up with the high levels of deaths in custody, and in particular in prison. Overcrowding in the prison system undermines the many initiatives taken to address the vulnerabilities of prisoners at risk of suicide and self-harm. Whilst the detail of sentencing practice is outside the scope of this report, the fact that too many highly vulnerable people are being cared for not in the community, but in prison or police cells, which are not appropriately equipped to take on the role asked of them, is at the root of the problem of Article 2 compliance.

88. It is clear to us from our inquiry and prison visits that many highly vulnerable people are being imprisoned unnecessarily, for minor offences. Detentions of already very vulnerable people confront an ill-resourced and overcrowded prison service with a formidable task in ensuring prisoners' safety. Ensuring prisoner safety is a fundamental responsibility of the state under Article 2. It is difficult to see how this is being upheld when the state continues the bad practice of sending such vulnerable people to prison for minor offences. Indeed, this represents a systemic failure to positively promote and enforce the human rights of these people and grave failure by the state to fulfil its positive obligations under the ECHR.

Characteristics of the prison population

89. Many prisoners, notwithstanding their imprisonment, have a number of characteristics which mark them out as being at disproportionately high risk of self-harm or suicide. In their written evidence to us, the Prison Service stated that—

An increasing number of vulnerable people are passing through the criminal justice system and the prison population contains very large numbers of prisoners who enter custody already struggling to cope with a range of difficult issues.⁷⁵

90. This is certainly supported by research evidence. The Social Exclusion Unit's report 'Reducing Reoffending by Ex-prisoners' found that—

- 72 per cent of male and 70 per cent of female prisoners suffer from two or more mental health disorders—14 and 35 times the level in the general population respectively. 95 per cent of young prisoners aged 15 to 21 suffer from a mental disorder, 80 per cent suffer from at least two.
- 40 per cent of male and 63 per cent of female sentenced prisoners have a neurotic disorder—over three times the level in the general population
- 7 per cent of male and 14 per cent of female sentenced prisoners have a psychotic disorder—14 and 23 times the level in the general population respectively

⁷⁵ First Report of Session 2003–04, op cit., Ev 26

- 64 per cent of male and 50 per cent of female sentenced prisoners have a personality disorder—12 and 14 times the level in the general population respectively
- 20 per cent of male and 15 per cent of female sentenced prisoners have previously been admitted to a mental hospital
- Nearly 10 per cent of female sentenced young offenders reported already having been admitted to a mental hospital at some time⁷⁶

91. These factors increase the likelihood of self-harm and suicide and indeed self-harming and suicidal behaviour often pre-date custody and may have started early in life. Statistics show that 20 per cent of sentenced men and 44 per cent of women on remand report having attempted suicide in their lifetime.

92. We found broad agreement that there were very severe limitations on treatment of people with mental health problems in a prison environment. Anne Owers, the Chief Inspector of Prisons, told the Committee that it was “verging on the impossible to provide the right kind of environment” in prisons for people who are seriously mentally ill because: “Prisons are not by their nature therapeutic environments. They are not places where prisoners can compulsorily be treated ...”⁷⁷

93. MIND were also quite clear about the inappropriateness and risks of holding the acutely mentally ill in prisons. They told us that: “If you are seriously ill to the extent that in any other circumstances you should be in hospital, then you absolutely should not be in prison”.⁷⁸ Home Office Minister Paul Goggins MP agreed that: “Anyone who requires acute mental health care should be in hospital rather than prison”.⁷⁹

94. The words used by MIND in their oral evidence were particularly stark—

From the evidence it appears that [people with serious mental health problems] become more ill and it would appear that people who have less severe mental health problems in prison develop more severe mental health problems. *Prison appears to be a good greenhouse for developing mental health problems.* (our italics)⁸⁰

The Revolving Doors Agency told us that “Prison is not a therapeutic environment”, and that “In many cases the prison environment is likely to exacerbate previously existing mental health problems”.⁸¹

95. Mr Goggins conceded that for some people, time spent in prison could have a negative impact on their mental health, but also said that he had seen evidence that people who entered prison with significant problems could be helped while locked up. On the other hand, Health Minister Stephen Ladyman MP told us that prisons “are bound to exacerbate

76 Social Exclusion Unit, 2002, *Reducing Re-offending by ex-prisoners*, London

77 Q 74

78 Q 143

79 Q 296

80 Q 145

81 Ev 183

any underlying mental health problem” and to expose any that had not previously been spotted.⁸²

96. The Royal College of Psychiatrists stated that—

The risks to mental health ... remain high. Separation from family and friends, entry into an alien environment, sudden withdrawal from drugs and alcohol, an uncertain future, loss of job and income, the rupture of many social relationships and supports, all induce mental distress and disorder. It follows logically from this that the reduction of the prison population may be the single most effective means of improving the mental health of prisoners, and thereby reducing the levels of self-inflicted harm.⁸³

97. Research by Dr Alison Liebling at the Cambridge Institute of Criminology, which used the General Health Questionnaire to assess levels of mental distress in prisons, has found that in the majority of prisons the rate of distress was far above that which would be found in the community.

98. We are profoundly concerned that the prison population contains some of the most vulnerable and troubled people in the country, many of whom have a history of having attempted suicide. Prisons, however well-resourced or well-intentioned, cannot be an effective environment in which to care for mentally-ill or disturbed people who have been failed by mainstream public services.

99. More than this, the evidence we have gathered suggests that prison actually leads to an acute worsening of mental health problems. By sending people with a history of attempted suicide and mental health problems to prison for minor offences the state is placing them in an environment that is proven to be dangerous to their health and well-being. Positive promotion of a person’s right to life requires that vulnerable people in the state’s care are closely supervised and adequately treated. It is a sad reflection on our society that we appear to be using prison as a place to offload the individuals that are classed as too difficult for mainstream public services. By criminalising their mental illness through unnecessary imprisonment we are creating a situation where far too many people take their own lives. This is a clear example of how the Human Rights Act has not been taken out of its legal context and made relevant to courts and mainstream service provision through awareness raising of the implications for service provision that the positive obligations of Article 2 give.

Prison overcrowding

100. As the Prison Service noted, people with grave vulnerabilities which may be exacerbated by imprisonment are being imprisoned in ever greater numbers. Whilst our inquiry into deaths in custody has been taking place, the prison population has reached record levels—

82 Q 226

83 Ev 186

- On 10 September 2004 there were 74,661 people in prison in England and Wales. This represents an increase of 15,000 since May 1997 and an increase of 30,000 since 1993.
- The rate of imprisonment in England and Wales—141 per 100,000—is significantly higher than our western European neighbours. It is 44 per cent higher than Germany (98 per 100,000) and 52 per cent higher than France (93 per 100,000). It has significantly risen over the last five years from 125 per 100,000 in 1999.
- The number of women in prison has almost trebled over the past decade. On 2 July 2004, the women's prison population stood at 4,475. Ten years ago in 1994 the average female prison population was 1,811. Five years ago in 1999 it stood at 3,247.
- On 2 July 2004 there were 10,821 under 21 year olds in prisons in England and Wales. Of these, 2,586 were under 18.
- On 31 March 2004 there were 12,936 remand prisoners in England and Wales.⁸⁴

101. The rapid and largely unanticipated rise in the prison population has led to the majority of prisons becoming overcrowded, despite the fact that since 1995 over 15,000 additional prison places have been provided at a cost of more than £2 billion. At the end of May 2004, 91 of the 138 prisons in England and Wales were overcrowded. At the same time, 17,000 prisoners were held two to a cell designed for one. Of even greater concern, some prisons have been so overcrowded that they have been operating at population levels that are above their operational capacity (the so-called 'safe' level of overcrowding).

The impact of overcrowding

102. It has become clear to us just how significant issues related to overcrowding are to the ability of the Prison Service to fulfil Article 2 obligations to protect the right to life. The overwhelming weight of evidence that we received identified the pressure of prison numbers and the resulting overcrowding and increased movement of prisoners as fundamental problems facing the Prison Service and as factors that are contributing to high levels of deaths in Prison Service custody.⁸⁵ This analysis was reinforced during the course of the Committee's prison visits to Winchester, Feltham Young Offender Institution, Holloway and Pentonville, where staff and prisoners alike expressed grave concerns about the negative implications of overcrowding on all aspects of prison life, including health and personal safety. Our visits and discussion have suggested to us that overcrowding has at times delayed and frustrated implementation of the safer custody strategy, and other initiatives to address prisoner safety and suicide prevention.

103. Overcrowding has also resulted in changes such as the re-designation of some women's prisons as male establishments to deal with increases in the number of men in

⁸⁴ Statistics from the Prison Reform Trust, see www.prisonreformtrust.org.uk

⁸⁵ Concerns about the harmful effects of overcrowding were echoed in evidence from Prison Reform Trust (First Report of Session 2003–04, op cit., Ev 113), Howard League for Penal Reform (ibid., 87), INQUEST (ibid., 88) and the Royal College of Psychiatrists (Ev 183)

prison. At Winchester prison, which we visited, a women's unit which had housed particularly vulnerable prisoners had been "re-roled" as a men's prison at very short notice, and we were told that staff had been extremely concerned for the safety of the women prisoners moved as a result of the re-designation.

104. The Chief Inspector of Prisons Anne Owers told us that overcrowding "is not the only factor [behind deaths in Prison Service custody] but it is certainly something that inhibits prisons' ability to provide a secure environment, particularly for vulnerable prisoners." Ms Owers also raised concerns that pressure on prison numbers had meant that prisoners could spend up to 23 hours a day in their cells, which "is unlikely to add to their safety and their mental condition".⁸⁶

105. Both adults and children in prison are being affected by overcrowding. The Youth Justice Board (YJB) for England and Wales, an executive non-departmental public body which commissions and purchases places for children and young people remanded or sentenced to secure facilities, told us that—

While there may not be firm evidence of a link between overcrowding and levels of self-inflicted deaths and self-harm, it is clear that overcrowding can destabilise establishments, limit the ability to place young people close to home, and can lead to transfers around the juvenile estate (overcrowding drafts), undermining constructive work with young people. Transfers for overcrowding can also result in young people arriving at establishments without appropriate documentation to inform assessments of vulnerability.⁸⁷

106. The Prison Reform Trust has argued that: "There is a direct link between overcrowding and the number of suicides", and has reported that "research by the Prison Service has found that 10 of the 20 establishments that have the highest incidence of self-inflicted deaths are also in the top 20 for turnover of population".⁸⁸ But this is disputed by the Prison Service, who, in their written evidence to us, stated that—

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 the 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.⁸⁹

107. While it is difficult to demonstrate direct causal links between prison numbers and deaths in custody, on the basis of the evidence presented to us it certainly appears to be the case that the combination of the sheer number of prisoners with which prisons have to deal, and the increased movement of prisoners around the system are contributing to the vulnerability of significant numbers of prisoners.

⁸⁶ Q 60

⁸⁷ Q 130

⁸⁸ First Report of Session 2003–04, op cit., Ev 114

⁸⁹ First Report of Session 2003–04, op cit., Ev 29

Movement of Prisoners

108. We found a consensus that it was not so much overcrowding in the sense of prisoners being held in overcrowded cells that was the major problem, as the resulting movement of prisoners around the country to deal with the issue—something referred to by a number of witnesses as ‘the churn’. Indeed both the Director General of the Prison Service Phil Wheatley and the Prisons and Probation Ombudsman Stephen Shaw told the Committee that while overcrowding presented major problems, cell-sharing itself could be a protective factor, both because it is more difficult to take your own life if you have a cellmate who can sound the alarm and because cell-sharing means there is someone to talk to.

109. The statistics reveal the huge scale of the task facing the Prison Service in its work and in its obligation to exercise a duty of care to all prisoners. Mr Goggins told us that in 2003 there were 250,000 individual receptions into prisons—“Movement which obviously does not help if a particular individual prisoner is vulnerable.” He also stated that “if we could stabilise the prison population then we would be in a better position to stabilise the movement of prisoners within the system”.⁹⁰

110. This viewpoint was supported by the Director General of the Prison Service, Mr Phil Wheatley, who told the Committee that—

The big problem for us is sheer numbers. What we tend to call ‘churn’... the fact that we have large numbers of prisoners arriving in reception, very often late in the evening, does not help individual risk assessment of prisoners.⁹¹

Because prisons have an obligation to take all of those sentenced or remanded by the courts, however, there is only so much the Prison Service can do to minimise the movement of prisoners in its care.

111. Mr Wheatley also told us that the need to move prisoners around the system to make room for new arrivals “does not help us to concentrate on people who need additional support”.⁹² Similarly the Prisons and Probation Ombudsman Stephen Shaw told the Committee that the churn “means that individual needs are simply not picked upon”.⁹³

112. A consistent theme in the evidence was that rising prison numbers were significantly impacting upon the ability of prisons to adequately risk-assess prisoners when they enter a prison, and also on the time that could be spent meeting the individual needs of prisoners. In turn, this appears to be leading to a situation where prisoners are becoming more vulnerable, more isolated and more prone to self-harm and suicide. During our visit to Feltham YOI we were told that overcrowding had led to problems retaining Listeners—Samaritan-trained prisoners who support distressed prisoners—as they had been transferred on overcrowding drafts to other establishments.

113. Overcrowding is also leading to prisoners being held a long way from their homes—a major cause of distress. Although there is no specific research on the effects of transferring

90 Q 284

91 Q 340

92 Q 340

93 Q 100

people between prisons, nor on the mental health effects of being located far from home, the Prison Service has begun research with Oxford University's Public Health Department on the effects of imprisonment on women's health. The effects of women's locations in relation to their families and the effects of transfers between prisons are expected to be examined as part of that work, with preliminary results expected by the end of 2005.⁹⁴

114. We are concerned that there is much truth in Inquest's assertion that: "Suicide prevention and prison overcrowding are simply incompatible".⁹⁵ **It is an unavoidable conclusion that until overcrowding is significantly reduced, prisons, despite their best efforts, will find it extremely difficult to make any real inroads in reducing deaths in custody. This is a matter of the most serious concern and one which requires the utmost effort on the part of everyone involved in the criminal justice system to address.**

115. **We recommend that the certified normal accommodation of each prison should be based on the availability of drug and alcohol treatment, healthcare provision and regime activities and not just physical cell space. We also recommend that there should be an independent review of the Operational Capacity (the 'safe' upper limit) of each prison and that it should be forbidden to breach this limit under any circumstances.**

116. **We further recommend that a protocol should be introduced in all prisons stating that prisoners with specific health or psychiatric needs should not be selected for transfer unless the receiving establishment's medical officer has agreed the transfer. Listeners should not be transferred on overcrowding drafts.**

Rising prison numbers and sentencing

117. Even the most modest prison population projections forecast a continued growth in prison numbers. According to the Government's review of Correctional Services, the Government's plans for transforming the management of offenders, a substantial revitalisation in the use of fines, more demanding community penalties than at present and a step-change in sentencing would mean that it would be possible to check the projected increase in prison numbers to 80,000 by 2009, rather than the 93,000 currently projected.⁹⁶ However, this would still mean that the Prison Service would have to find capacity to accommodate a further 5,000 prisoners.

118. Most of the increase in the prison population in recent years can be explained by significant increases in the proportion of offenders sent to prison and the length of sentences given. The number of men serving sentences of four years or more has doubled in the last ten years and currently stands at more than half of the sentenced male prison population. In terms of custody rates, in the magistrates' courts offenders are three times more likely to go to prison compared to ten years ago and in the Crown Court almost twice as likely. First time domestic burglars are almost twice as likely to go to prison today as they were eight years ago.⁹⁷

94 HC Deb., 15 June 2004, col. 879W

95 See www.inquest.org.uk

96 Home Office, *Reducing Crime—Changing Lives, The Government's plan for transforming the management of offenders*, January 2004

97 Patrick Carter, 2003, *Managing Offenders Reducing Crime A new approach*, Home Office Strategy Unit, London

119. The number of prisoners serving short sentences has also increased. Between 1992 and 2002 the number of adults sent to prison for sentences of less than 12 months more than doubled from 18,500 to nearly 48,000. In 2002, over half of those sent to prison were there for jail terms of six months or less.

120. Our visits to prisons confirmed the particular problems caused by short-term sentences. At Holloway, we were told of the destructive impact of the very short-term sentences served by many prisoners, including many likely to self-harm, often for very minor offences including non-payment of small fines, or petty theft that was a consequence of drug addiction. Women were regularly sentenced to one week's imprisonment, which in practice, depending on the day of the week on which they were sentenced, could mean that they served as little as one night in prison. Short-term sentences were extremely disruptive and distressing both for the prisoner and for her family, and did not provide sufficient time for the prison to help or support the prisoner, for example through detoxification or counselling. **We are convinced that inappropriate reliance on the prison system is at the root of many deaths in custody. Many very vulnerable people are being held in prison unnecessarily, with no benefit to society and at great risk to their own safety. The overcrowding of the prison system due to this over-reliance places people with drug and alcohol dependencies as well as mental illness in a system that is at breaking-point and unable to meet its duty of care to them. There is a responsibility on the Government to address this by developing workable alternatives to prison, and on sentencers to make full use of the alternatives that are available. Only when this problem is addressed will the state begin to be able to meet its positive obligations under Article 2 effectively.**

121. During the course of the inquiry, sentencing practice by judges and magistrates, rather than changed crime rates, was highlighted by both the Government and NGOs as being behind much of the pressure that prisons faced. Mr Goggins told us that "The increase in severity in sentencing bears no relation whatsoever to an increase in criminality or seriousness of offending; it is simply an increase in the seriousness of penalties that are meted out, and we have to tackle that because there is no evidence that it is reducing reoffending rates." This is a view supported in *Crime, Courts and Confidence*, the report of an independent inquiry into alternatives to prison chaired by Lord Coulsfield,⁹⁸ and by research carried out on behalf of Rethinking Crime and Punishment.⁹⁹

Judicial and magistrate confidence in alternatives to prison

122. In light of the impact that the decisions of sentencers have had on the size of the prison population and the ability of prisons to provide a safe and healthy environment in which to hold prisoners, we decided to seek evidence on whether magistrates and judges had confidence in alternatives to prison. Our intention was to see whether pressure could be freed on prisons so that they could better meet their Article 2 obligations.

98 Lord Coulsfield, 2004, *Crime, Courts and Confidence, Report of an Independent Inquiry into Alternatives to Prison*, Esmeé Fairburn Foundation, London

99 Mike Hough et al, 2003, *The Decision to Imprison*, Prison Reform Trust, London

123. A number of witnesses told us that they felt the judiciary was not sufficiently well-informed about either prison conditions or alternatives to custody. The Prison Reform Trust said that an explanation for the rise in custody rates was that the judiciary did not have confidence in the services available in the community. The Howard League for Penal Reform put some of the responsibility for this at the door of sentencers themselves, with Frances Crook, Director of the Howard League stating that “quite a lot of the time, the sentencers do not know about alternatives and that is the problem”.¹⁰⁰ Only when this problem is addressed will the state begin to be able to meet its positive obligations under Article 2 effectively.

124. We received written evidence from the Lord Chancellor, the Lord Chief Justice, the Magistrates’ Association, the Judicial Studies Board and the National Association of Probation Officers (NAPO) on these points. Their evidence made reference to the extensive programmes of training and information provision to judges and magistrates on sentencing options, sentencing guidelines including on the impact of a sentence on an individual offender and the recently established Sentencing Guidelines Council and new sentencing options under the Criminal Justice Act 2003. The Lord Chief Justice noted that—

Probation officers prepare pre-sentence reports in most cases, and all cases where an alternative to custody can be considered, [and] they also regularly speak to the judiciary about options available to them in their areas.¹⁰¹

125. Information provision on locally available options appears to be more problematic however. Both NAPO and the Magistrates’ Association pointed out that during the 1990s there had been liaison between local probation services and sentencers, coordinated by Magistrates’ Liaison Committees.¹⁰² However, the duty of liaison was abolished by the Criminal Justice and Court Services Act 2001, and since that time there has been no formal mechanism for sentencers to be made aware of locally available alternatives to prison, though informal contacts continue in some areas. Both NAPO and the Magistrates’ Association favoured the reintroduction of the statutory duty of liaison. NAPO pointed to lack of resources within the probation service as the main reason for failure to advise sentencers on sentencing options for vulnerable offenders. **We consider it to be essential that sentencers are well-informed about the range of non-custodial sentences that they have at their disposal, because current sentencing trends are placing great strain on the ability of the Prison Service to meet its Article 2 and other human rights obligations.**

126. Evidence from NAPO, the Magistrates’ Association and the Judicial Studies Board makes clear that there is no routine provision of information to judges on the outcome of sentences they had imposed, although individual judges could request such information.¹⁰³ The JSB stated that: “the view has been expressed very clearly by judges attending the Continuation Seminars that they would welcome regular feedback on the outcomes of the sentences they pass”.¹⁰⁴ Following the death of Joseph Scholes, the Home Office has asked

¹⁰⁰ Q 32

¹⁰¹ Ev 113

¹⁰² Magistrates’ Association Ev 158–159; NAPO Ev 161–162

¹⁰³ Judicial Studies Board Ev 115–116

¹⁰⁴ Ev 116

the Sentencing Guidelines Council to consider the issues raised by that case in relation to custodial sentences for vulnerable young offenders. **We recommend that the Sentencing Guidelines Council should issue guidance to courts to consider the risk of defendants harming themselves if they were to receive a custodial sentence. Magistrates and judges should receive feedback on their sentencing decisions, including information on when someone they have sentenced to custody self-harms, or commits or attempts suicide.**

127. Concern was also raised that magistrates and judges were not adequately informed about either the vulnerabilities of individual offenders or the realities of life inside prison. Deborah Coles of Inquest told us that she thought there had been “a number of cases, some quite high-profile cases involving children, where judges were well aware of the high risk of suicide and self harm that those young people presented but chose to ignore it and sent them to establishments knowing that it was impossible for the prison staff to properly care for those young people given the high levels of disturbance they presented”.¹⁰⁵ The case, discussed above, of Joseph Scholes, a highly vulnerable and disturbed 16-year-old boy who hanged himself in Stoke Heath Young Offenders Institution in 2002 after serving nine days of a two-year sentence, highlights this problem.

128. It was significant in the case of Joseph Scholes that the court had no power to determine whether Joseph was held in prison service or in local authority accommodation. In an attempt to address this issue, amendments were tabled to the recent Children Bill in the House of Lords to allow the Youth Justice Board the power to vary the placement of a child following sentence when an assessment of vulnerability is made. This would provide a mechanism to avoid inappropriate placement of particularly vulnerable children in prison service custody. Although the amendments to the Children Bill were rejected, Baroness Ashton assured the House that the Home Office would give further consideration to legislation to this effect.¹⁰⁶ The forthcoming draft Youth Justice Bill would provide an opportunity for such legislation. **We recommend that the government should take the opportunity afforded by the Youth Justice Bill to empower the Youth Justice Board to direct the form of custody of a sentenced child who has been assessed as particularly vulnerable. Such powers must be accompanied by adequate funding for suitable forms of accommodation for vulnerable children, both on remand and following sentence.**

129. **The number of cases where judges have sent people to prison despite prior knowledge of their potential for suicide and self-harm is a cause for serious concern.** It is of particular concern that many youngsters now imprisoned have previously presented themselves to authorities in respect of their health care needs. They needed healthcare before they offended, not custody after—especially when the evidence demonstrates that custody often exacerbates their medical problems.

Immigration detainees in prison

130. In relation to Immigration Act detention in prisons, Mr Goggins told us that although 205 people were detained in prison under the Immigration Act,¹⁰⁷ these were exceptional

¹⁰⁵ Q 19

¹⁰⁶ HL Deb., 20 May 2004, col. 984

¹⁰⁷ Ev 97 (as of 27 December 2003)

cases and detention in prison had “in policy terms” been ended. Of the 205 people detained in prison, the majority were detained on completion of a prison sentence and pending deportation, though some were held on transfer from removal centres “for reasons of security and control”. No figures were available for the number of people within the group of 205, with serious mental health problems, or a history of torture. In Northern Ireland, immigration detainees continue to be routinely held in prison.¹⁰⁸ It is a matter of concern that despite a Home Office policy decision, a relatively significant number of potentially vulnerable people, who are either unconvicted or have completed any sentence of imprisonment, are being held in an inappropriate prison environment. Unofficial figures indicate that there were two deaths of immigration detainees in prison in 2003, and two in 2002.¹⁰⁹ Two detainees transferred to prison after the Yarl’s Wood fire of 2002 are reported to have attempted suicide.¹¹⁰ **We recommend that detention of immigration detainees in prisons should be urgently reviewed with a view to reducing the numbers of such detainees held in prison, with particular reference to those who may be at risk of suicide or self-harm.**

108 NIHRC, Comments of the NIHRC on the Fourth Periodic Report of the UK to the UN Committee Against Torture, November 2004

109 Ev 142

110 *Asylum pair attempt suicide*, BBC news, 7 March 2002, www.bbc.co.uk

5 Risk Assessment and Management

131. The imprisonment of large numbers of highly vulnerable people is a reality of the present system which places a significant burden on institutions of detention to assess and respond to the risks that detainees pose to themselves or others. As we have mentioned previously, this is an extremely unsatisfactory situation. However, basic steps are needed in order to limit the risk to those vulnerable people in custody. Accurate and informed risk assessment at the time a person first enters custody, or is transferred from one custodial institution to another, is essential for the management of the risk that that person may commit or attempt suicide. With such a large proportion of prisoners who take their own lives doing so within their first few days or weeks in prison, it is essential that appropriate and comprehensive reception and induction arrangements are in place to identify any health or support needs that prisoners have, and to make the transition to imprisonment, or the move to a new prison, less disturbing. Effective information exchange, in accordance with privacy rights, between the police, prison, immigration service and health services, on the vulnerability of a detainee to suicide or mental illness, or the threat which he or she may pose to others, is also crucial to establishing an individual approach to detainee care in accordance with the positive obligations under Article 2.¹¹¹

132. Therefore, in our analysis of the problems which authorities face in minimising deaths in custody, and the strategies which they may use to this end, we deal first with the question of risk assessment and management.

Prison reception, induction and assessment arrangements

133. Currently, guidance requires prisons, generally with the prisoner's consent, to request any information required from a prisoner's general practitioner or other relevant service with which the prisoner has recently been in contact. It also sets out the circumstances in which information may be requested and disclosed without consent. **We wish to highlight the importance of prisons obtaining medical records about a prisoner's mental and physical health from clinicians who have provided treatment prior to imprisonment and to ensure that this is monitored rigorously by Prison Service headquarters.**

134. This is all the more important because at present – according to MIND and a number of other witnesses—prisons are not always aware of someone's mental health needs on reception. This appears to be part of a wider, though not universal, problem about the comprehensiveness and quality of the information available to prisons on reception. The situation appears to have been compounded by the fact that overcrowding has led to prisoners frequently being moved around the prison system at very short notice.¹¹² **It is essential that all new arrivals to a prison are properly assessed by fully trained staff for mental and physical health problems and for any risk of self-harm or suicide. This assessment would be a great step towards helping the Prison Service adequately provide the duty of care prescribed under Article 2.**

¹¹¹ *Edwards v UK* (2002) 35 EHRR 19

¹¹² Q 340. And see Chapter 4 Prison Overcrowding and Sentencing

135. The problem appears to be particularly acute in women's prisons. At Holloway prison we were told that it was common for prisoners to arrive at reception very late at night, often accompanied by only very poor information on their health and circumstances. Often it was only at a late hour that it was discovered that the prisoner's children were not being cared for. The problem was compounded by the fact that many of the women imprisoned at Holloway had had little prior contact with services in the community, so information about their background was not easily accessible. Staff expressed great concern at the lack of information on new prisoners, and the difficulties this caused in managing risk, in particular since prisoners at Holloway tended to be highly distressed and at risk.

136. Also at Holloway, medical staff found that the late reception of prisoners caused considerable problems for the service they sought to provide. On the day we visited, prison doctors had been assessing newly arrived prisoners until midnight the previous evening. It was pointed out that this placed considerable strain on prisoners as well as on medical staff. **We consider it completely unacceptable, in the context of preventing deaths in custody, that new prisoners should arrive at prison reception too late to allow full assessment at a reasonable hour. It is essential that all new arrivals to a prison are properly assessed by fully trained staff for mental and physical health problems and for any risk of self-harm or suicide. Prisoners should arrive at prison accompanied by essential information on their state of physical and mental health and on their outside circumstances, and should arrive in good time for a full health check to be made at a reasonable hour on the first evening in custody.**

137. During the evidence that we took—and our own prison visits—we were struck by the need to provide comprehensive support to prisoners in their very early hours and days in a prison. Many remand prisoners in particular may not have expected a custodial sentence and will need practical as well as emotional support to deal with the upheaval and distress caused by imprisonment.

138. The Prisoners Advice and Care Trust (PACT) runs a First Night in Custody project at Holloway Prison, which was set up in September 2000. The service's aim is to work with the most distressed women who come into Holloway Prison to spend their first night ever in custody. According to PACT, "the main objectives are the reduction of anxiety felt by this group, and to ensure that information about all the resources available to new prisoners, both inside and outside of the prison, is given at reception".¹¹³

139. The First Night in Custody project was proposed in response to a number of reviews, which highlighted the gaps in the service provision to women when they enter custody for the first time. In particular—as the Prisons Inspectorate report, 'Unjust Desserts' found—between a third and two-thirds of unsentenced prisoners had not expected to be sent to prison and so were especially vulnerable on reception.¹¹⁴

140. The First Night in Custody project at Holloway has been the subject of an evaluation by the Centre for Crime and Justice Studies at King's College, London. This found that—

¹¹³ J King et al, 2002, *Evaluation of the First Night in Custody Project HMP Holloway*, PACT/CWS, London

¹¹⁴ HM Inspectorate of Prisons, *Unjust Desserts, A Thematic Review by HM Chief Inspector of Prisons of the Treatment and Conditions for Unsensenced Prisoners in England and Wales*, December 2000

- 75 per cent of new receptions to the prison felt ‘anxious’ or ‘worried’
- 65 per cent were ‘very concerned’ about notifying their family of their whereabouts
- Nearly half (47 per cent) of the women sampled had received previous treatment for depression
- Half had a self-confessed problem with alcohol or drugs
- 69 per cent feared losing their home as a result of imprisonment
- It was acknowledged in all the interviews with reception staff and the various Governors and Heads of Department that the First Night in Custody project reduced the anxiety felt by people in prison for the first time.¹¹⁵

141. We commend the work done by first night in custody schemes and recommend that all prisons introduce similar schemes to support prisoners received into custody for the first time. We also recommend that new prisoner receptions should receive a minimum of a week of close observation and assessment in a dedicated area. This would provide prisoners with time to acclimatise to their new environment and would allow staff to carry out proper risk and health assessments.

142. There is also a need for ongoing assessment of prisoners—both in case mental health needs were overlooked during initial reception screening, and in case mental health problems develop during the course of someone’s time in prison. In their evidence to us, the Revolving Doors Agency expressed concern about the extent of hidden mental health problems in prisons. They told us that there is a “clear reluctance” among inmates to be labelled mentally ill—which although it reflects the situation in the wider community, is likely to be intensified by the added stigma associated with having a mental health problem among the prison population. Revolving Doors stated that: “It is clear that bullying problems exist throughout the prison system and in many cases it will be those labelled mentally ill who are subjected to bullying. The persistence of such problems helps to create and sustain an environment in which inmates are unwilling to access services”.¹¹⁶ **Prison staff must receive training in mental health awareness and should be alert to warning signs such as prisoners becoming withdrawn or aggressive and refer them to mental health in-reach teams if appropriate.**

Reception in Police Custody

143. On reception in police custody suites, custody officers undertake an assessment of risk, which include questioning of detainees on their state of health or mental health. This assessment may form the basis for referral to a Forensic Medical Examiner (FME), also known as police surgeons. ACPO pointed out that there was a need for effective flow of information from the prison service to the police, as well as from police to prisons. They referred to a lack of procedures in this regard—

¹¹⁵ J King et al, 2002, *Evaluation of the First Night in Custody Project HMP Holloway*, PACT/CWS, London

¹¹⁶ Ev 183

if a person has attempted to self-harm whilst in police custody, there are existing procedures in place to notify the prison service of this fact. However, if a person attempts to self-harm whilst in prison, there is no mechanism to notify the police. Hence if the same person upon release from prison re-enters police custody they could self-harm in an identical manner, without the previous attempt being known to the police. If the appropriate information exchange had occurred this might have prevented a death or injury.¹¹⁷

We recommend that provision should be made for exchange of information on suicide risk from prisons to the police in appropriate cases.

Immigration detention

144. Evidence suggests that provision of information has also been unsatisfactory in relation to those held in immigration removal centres, who may have particular healthcare or mental health needs, and in particular may have experienced torture or ill-treatment abroad.¹¹⁸ We were provided with evidence of cases where immigration detention centre medical staff did not pass on medical information to the centre managers, contrary to the Detention Centre Rules¹¹⁹ and Operating Standards. The Chief Inspector of Prisons has recommended that 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 to the detainee's asylum claim, and for the action that should follow.¹²⁰

145. The Home Office's written evidence to the inquiry states that "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".¹²¹ The Detention Centre Operating Standards on Healthcare¹²² require medical staff to report to the centre manager and the immigration service cases where a detainee's health is likely to be harmed by continued detention, or if a detainee has suicidal tendencies. In doing so, however, they are required to take account of medical confidentiality, unless the patient has given consent to disclosure of information.

146. Medical confidentiality is supported by the right to respect for private life under Article 8 ECHR. However, medical confidentiality should not prevent limited disclosure of information to detention centre managers, in order to protect a detainee's rights under Articles 2, 3 and 8, where a detainee may be at risk of suicide or self-harm. **Information on the risk of suicide or self-harm should be used to inform decisions on whether an individual is detained in immigration detention, and how he or she is cared for in detention. We are concerned that, despite guidelines, this may not be happening effectively in practice.**

117 Ev 135

118 See our First Report of Session 2003–04, op cit., Ev 106–107 and Ev 68–73

119 Rule 35 of the Detention Centre Rules 2001 (S.I., 2001, No. 238)

120 Her Majesty's Chief Inspector of Prisons, *Introduction and Summary: Inspection of Five Immigration Service Establishments*, April 2003

121 First Report of Session 2003–04, op cit., Ev 14

122 Her Majesty's Chief Inspector of Prisons, op cit., paras. 16 and 17

Safer cells and surveillance

147. Evidence from all forms of detention cited problems related to the physical condition of detention facilities, in particular the existence of ligature points.¹²³ This was a particular problem where older, many 19th century, buildings continued to accommodate detainees. At Broadmoor for example, we visited one of the women's wards where patients at high risk of suicide were accommodated in 19th century buildings which retain ligature points, and which do not provide acceptable modern standards of accommodation for many seriously ill patients. The Mental Health Act Commission have suggested that "poor therapeutic conditions" including in some hospitals 200% bed-occupancy and an inappropriate mix of patients, may be a cause of self-harm or suicide.¹²⁴ Wards are often "substandard, frightening and even dangerous".¹²⁵ In November 2003, the Commission for Health Improvement¹²⁶ found that the majority of wards at Broadmoor were lacking in basic standards of dignity, privacy, cleanliness and amenities, and concluded that "the overwhelming majority of ward areas cannot be considered an appropriate, humane environment".¹²⁷ The Mental Health Act Commission has also raised concerns about the physical condition of high secure hospitals, and in particular has stated that it is "not possible to deliver a safe and therapeutic environment" within the older wings at Broadmoor hospital.¹²⁸ **Sub-standard or unsafe conditions of detention may violate Article 3 ECHR, as well as Article 8. We recommend that funding should be made available to ensure that people at risk of self-harm or suicide are held in decent conditions of detention.**

148. Research has consistently shown that if a given method of suicide is no longer available, although some displacement may take place, overall suicide levels fall. This has led to the Prison Service making use of situational suicide prevention strategies such as safer cells, where obvious ligature points are eliminated. Safer cells were first introduced in HMP Belmarsh in 1997 with the aim of reducing hanging. In a safer cell, all the corners are rounded, the pipes are covered, the light fittings are modified, and a safe ventilator is placed instead of windows that open and could therefore be used to attach a ligature. Programmes to remove ligature points and to provide "safer cells" are in place in the prison service, police forces, and in secure hospitals.¹²⁹ We were consistently told however, that much remains to be done to extend this programme to provide sufficient safe cells, and to deal with the many problems posed by holding detainees in older buildings. Measures were also being taken in many police forces to install CCTV in cells as a means of ensuring safety; but the high costs involved have meant that CCTV remains installed in only a small number of cells.¹³⁰

123 Fixed points capable of bearing sufficient weight for a person to be able hang himself or herself from them.

124 First Report of Session 2003–04, op cit., Ev 38

125 *ibid.*, Ev 45

126 Whose functions have now been taken over by the Health Commission

127 Commission for Health Improvement, Clinical Governance Review, West London Mental Health NHS Trust, November 2003, p. 29

128 10th Biennial Report, 2001–03, para. 12.6

129 The Department of Health has provided funding for, and issued targets on, removal of ligature points. See our First Report of Session 2003–04, op cit., Ev 18 and Ev 43

130 Meeting with the Metropolitan Police Force. The MPS is aiming for 50% CCTV coverage in its cells.

149. A preliminary evaluation of the use of safer cells has been carried out by the Jill Dando Institute of Crime Science at University College London. This found that “safer cells were likely to be useful in preventing suicides if implemented correctly. For example, of the 27 at-risk prisoners who were interviewed, three spontaneously stated that they would have hanged themselves had they not been in a safer cell (one of them having tried and failed). Although some displacement took place, the evaluation found that these alternative methods such as cutting are less lethal and leave more time for staff intervention. It is therefore concerning that the evaluation found that “quite often there are not enough safer cells within the unit, and prisoners may have to be prioritised or moved to other locations in order to be in a safer cell”.¹³¹ **We consider that safer cells should be widely available in all prisons and should be used to hold at-risk prisoners. However, they should be used alongside, and not as a substitute for, other suicide prevention strategies such as comprehensive mental health care, good staff-prisoner relationships, comprehensive risk assessments and provision of support through Psychology, the Samaritans or Listeners.**

150. Suicide prevention is of course a much more complex matter than the removal of ligature points and the imposition of rigorous surveillance; and the safety of detainees is a matter not just of immediate suicide prevention, but of what is sometimes termed “relational security”,¹³² safety achieved through well-being and quality of life. **It is important to note that the Article 2 positive obligation to protect life requires that reasonable measures be taken to protect detainees who are vulnerable to suicide. It does not require the authorities to impose absolute safety by draconian means. There are limits to the positive obligation to protect, which must also be balanced with other Convention rights which protect the quality of life of a detainee, in particular the right to respect for private life and personal autonomy (Article 8), and the right to respect for physical integrity and to freedom from inhuman or degrading treatment (Article 8, Article 3).**¹³³ **As the ECtHR stressed in *Keenan v UK*, protection of the Article 2 right to life must be conducted in a manner compatible with the other Convention rights of a detainee, and in particular the principle of personal autonomy.**

151. A detention regime that respects a detainee’s human rights, rights to respect for private life, alongside, and balanced with, measures to prevent suicides, is an important element in detainee safety. **We recommend that strategies for suicide prevention in all forms of detention should take into account the need to respect the privacy and physical integrity of people in detention. Excessive focus on control, at the expense of detainees’ well-being, will not prevent deaths in the long term, and will not assure compatibility with the Convention rights.**

131 Summers L, 2003, *Reducing Self-Harm and Suicide in Prisons: Advice for Prison Staff on Using Safer Cells*, Jill Dando Institute of Crime Science

132 First Report of Session 2003–04, op cit., Ev 46. Mental Health Act Commission quoting Kinsley: 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 ... “. We were impressed during our visit to Caswell Clinic medium-secure unit in Bridgend by the positive effect resulting from a culture of relational security embracing all these factors.

133 See Chapter 2 Human rights standards and deaths in custody

152. Nevertheless, we support moves to provide safe cells in prison and police custody, and to provide similarly safe accommodation in secure hospitals. **It is a particular concern in relation to deaths in custody that detainees at known risk of suicide may be held in an environment which includes ligature points. We recommend that efforts should continue to provide safe accommodation in all forms of detention.**

6 Physical healthcare

153. The sufficiency of medical care available in prisons, in immigration removal centres, and in police cells has been repeatedly questioned in evidence to this inquiry. In psychiatric hospitals, very different issues arise. There, human rights concerns are principally raised by the prescription of unusually high levels of drugs to detained patients, beyond recognised limits. These issues, and their human rights implications, are considered below.

The human rights context

154. The provision of adequate, timely and appropriate medical care to people in detention is an essential element of Article 2, 3 and 8 compliance. Questions of ECHR compliance may arise where a patient's death arises from inadequate medical care,¹³⁴ or following a self-inflicted death where psychiatric assessment and treatment has been inadequate.¹³⁵ In particular, failures in healthcare or in the response to drug overdoses may breach the detaining authorities' positive obligation under Article 2 ECHR to protect the right to life of those they detain. The Article 2 positive obligation to protect life arises wherever the authorities know or ought to know of a real and immediate risk to the life of a particular person or group of people.¹³⁶ This obligation, which is particularly strong in respect of detained persons, is breached if the responsible authorities fail to take reasonable measures within the scope of their powers to avert a real or immediate risk.¹³⁷

155. Medical shortcomings may also breach the right to freedom from inhuman and degrading treatment, under Article 3 ECHR,¹³⁸ and the right to physical integrity under Article 8. Inadequate medical treatment provided to a prisoner recovering from heroin addiction was found to breach Article 3 in *McGlinchey v UK*.¹³⁹ In that case, a misdiagnosis resulted in inappropriate treatment, and the patient died shortly after being admitted to hospital. The case makes clear that seriously negligent medical treatment of a detained person, even in the absence of any deliberate mistreatment, may lead to a breach of Article 3.

156. The vulnerability of mentally ill detainees, and the difficulty they may have in articulating their needs or distress, mean that Article 3 will apply with particular stringency to their treatment.¹⁴⁰ In *Keenan v UK*,¹⁴¹ the suicide in custody of a mentally ill prisoner was found to breach Article 3, since there had been insufficient monitoring and psychiatric assessment, and the prisoner had been inappropriately detained in segregation in a punishment block.

134 *Anguelova v Bulgaria*, App No 38361/97, 13/06/2002— the failure to provide timely medical care in police custody breached Article 2; *McGlinchey v UK* App No 50390/99, 29/04/2003

135 *Keenan v UK* (2001) 33 EHRR 38

136 *Keenan v UK*, *op cit*; *Osman v UK* (2000) 29 EHRR 245

137 *McFeeley v UK* (1980) 3 EHRR 161

138 *McGlinchey v UK* App No 50390/99, 29/04/2003

139 App No 50390/99, 29/04/2003

140 *Keenan v UK*, *op cit*; *Herczegfalvy v Austria* App No 10533/83, 24/09/2002

141 [2001] 33 EHRR 38

Police custody healthcare: drug- and alcohol-addicted detainees

157. Medical care in police detention is generally provided by Forensic Medical Examiners.¹⁴² More recently, some police forces have employed “custody nurses” to provide on-site medical care in police cells. Oral evidence from the Police Complaints Authority (PCA) suggests inconsistencies in the standard of healthcare available in police cells, and inadequacies in the knowledge and training both of custody officers and of police surgeons.¹⁴³ Custody sergeants themselves have expressed concern at the paucity of their training.¹⁴⁴

158. Care of vulnerable detainees is now well provided for in guidelines, since the revised PACE Codes of Practice came into force in April 2003.¹⁴⁵ This Revised Code requires a custody officer to ensure that a detainee receives appropriate clinical attention where necessary, and prescribes urgent healthcare intervention where an arrested person fails to meet the following criteria—

- the detainee can be woken;
- the detainee can respond to questions;
- the detainee can respond appropriately to simple commands.

The Code also states that custody officers should take account of illnesses that may be masked by alcohol.¹⁴⁶ It requires detainees to be visited every hour, and for those suspected of intoxication through drink or drugs to be visited every half hour.

159. Grave concerns were expressed by the PCA that these standards and procedures were not adequately applied in practice. These concerns were highlighted in a recent report which found that a significant proportion of custody sergeants had not received adequate custody training in relation to drugs, alcohol and mental health.¹⁴⁷ In a number of the cases studied, custody officers had not been able to assess accurately whether a detainee was intoxicated. Police were also ill-equipped to identify illness which might be masked by alcohol. In a number of cases alcohol-affected detainees were not checked frequently enough, and when they were checked, they were sometimes not sufficiently roused, in breach of PACE Code C requirements and sometimes in breach of instructions given by the Forensic Medical Examiner (FME). The PCA’s analysis showed that “by the time police notice illness among drinkers, they are far closer to life being pronounced extinct than among the non-drinking group of cases examined”.¹⁴⁸

160. The PCA report concluded—

142 Formerly known as police surgeons

143 Q 381

144 Dr David Best and Amakai Kefas, *The Role of Alcohol in Police Related Deaths*, Police Complaints Authority, March 2004

145 Home Office, *Police and Criminal Evidence Act 1984 Codes of Practice A–E*, Revised Edition, April 2003

146 including diabetes, epilepsy, head injury, drug intoxication or overdose; or stroke

147 Dr David Best and Amakai Kefas, *The Role of Alcohol in Police-Related Deaths*, Police Complaints Authority, March 2004.

148 *ibid.*, p. 18

The police service is simply not equipped to deal with the complexity of extreme alcohol intoxication, and does not have the systems in place to offer adequate care to this population. Unless there are vast improvements in custody staff training, detainee risk assessment, the extent and quality of medical support and organisations' commitments to effective detainee management, there is no alternative but to conclude that drunken detainees should not be taken to police stations in other than the most extreme circumstances.¹⁴⁹

161. The PCA Report stressed that the responsibility lay with police managers to provide custody officers with the tools to comply with PACE, and to provide adequate medical cover. Police forces' obligations under the Human Rights Act serve to reinforce this. Management failures in planning and inadequate provision of training to officers required to deal with these situations, may lead to breaches of Article 2.¹⁵⁰

162. Medical care in police cells may also be hampered by lack of equipment and resources. The absence of defibrillators in custody suites may be one such problem. The Metropolitan Police Service calculate that a defibrillator would have helped police officers in 8 recent cases.¹⁵¹ They are however expensive and officers must be trained to use them.

163. One means of ensuring that detainees receive prompt medical attention by qualified personnel is to employ "custody nurses" in the custody suite, rather than to rely on FMEs who may take some time to arrive on site. A number of forces are now employing custody nurses, although these remain pilot projects.¹⁵² ACPO's view was that the presence of custody nurses, though they could not cater for all the medical needs of a police custody suite, was beneficial in providing medical back-up to custody officers.¹⁵³

164. If drug- and alcohol-dependent people, and the mentally ill including those detained under the Mental Health Act, continue to be held in police custody suites, it would greatly assist police forces in complying with Articles 2, 3, and 8 ECHR to have custody nurses on-site and able to provide timely, regular and dependable medical care, to assess risk to detainees and to identify more serious cases that might require transfer to hospital. This requires close co-operation between the police and health and mental health services at both national and local level to ensure this. ACPO identify: "a need for consistent national policy, which sets out the roles and responsibilities for healthcare in custody".¹⁵⁴ ACPO told us in oral evidence that—

a more robust approach is probably necessary in terms of establishing where the responsibilities lie in relation to the treatment and support of individuals who come to the attention of the police or other agencies and require healthcare.¹⁵⁵

149 *ibid.*, p. 25

150 *McCann v UK* (1996) 21 EHRR 97

151 Meeting with the Metropolitan Police Service Professional Standards Directorate, 7 July 2004

152 First Report of Session 2003–04, *op cit*, Ev 7. A recent Home Office report reviewed the operation of a pilot project in Kent found that the scheme had been successful and made recommendations for further development of the role of custody nurses, in partnership between police forces and health authorities (Gannon S, *Assessment of the Kent Custody Nurse Scheme*, Home Office, November 2002).

153 Q 415

154 Ev 135

155 Q 413

165. In our view, the clear principle that healthcare in custody should be equal to that in the community needs to be rigorously enforced, including in relation to police detention. Where possible some minimal level of qualified medical care should be made available on-site in police custody suites. It is vital to people's well-being and to the realisation of their Convention rights that police custody officers are well equipped to assess on reception the risk detainees pose to themselves or others. It should be ensured that all custody officers receive regularly updated training in basic first-aid and in dealing with drug and alcohol addiction and mental health matters.

166. Difficulties in providing for the often acute healthcare and mental healthcare needs of detainees raise questions of the suitability of the facilities in which they are held. It is clear that police cells are used as an emergency resource to contain people with severe and diverse problems. An alternative solution to one aspect of this problem, the care of intoxicated detainees, favoured by the PCA amongst others, is specialist alcohol treatment centres. The Home Office told the Committee that they saw alcohol treatment centres as having "considerable potential" and that they were studying a pilot centre of this type with interest.¹⁵⁶ **We would support the establishment of drug and alcohol treatment centres as an effective means of treating the effects of alcohol abuse and drug use among those in police custody. This would be an effective means of ensuring the well-being of these people whilst in custody and would protect their Convention rights through positive action.**

Prison Healthcare: NHS equivalence

167. Prison healthcare has attracted considerable criticism in the past, including from successive Chief Inspectors of Prisons. The Prisons and Probation Ombudsman, in a judgement made on 22 December 2003, upheld two complaints on behalf of the late John Tero, who had been jailed at the age of 72 and who died of a cancer that went undetected while he was in prison. The acting Ombudsman recommended that the governors of the two prisons in question apologise to Mr Tero's family.¹⁵⁷

168. The Chief Inspector of Prisons' latest Annual Report considers that prison healthcare is improving following transfer of responsibility to the NHS but expresses grave concern about drug and alcohol detoxification and continuing concern about the adequacy of mental healthcare services.¹⁵⁸

169. Since 1 April 2003 the Department of Health has been responsible for funding prison healthcare in English public-sector prisons. Responsibility for commissioning health services in all publicly-run prisons in England will transfer to local Primary Care Trusts by 1 April 2006. **This is a very welcome development and should go a long way to addressing the healthcare deficit that is to be found in so many prisons at present.**

170. **We recommend that as a general principle physical and mental healthcare in prisons must be of the same standard as provided by the NHS in the community.** As the

156 Q 259

157 Prisons censured over cancer inmate, *The Guardian*, 23 December 2003

158 HM Inspectorate of Prisons for England and Wales, 2004, *Annual Report of HM Chief Inspector of Prisons for England and Wales 2002-2003*, TSO, London

Royal College of Psychiatrists told us, “A right of access to standard health care is no right if the resources to provide that healthcare are not forthcoming”.¹⁵⁹ **New funding arrangements must ensure that prisons have appropriate and adequate resources to ensure that this equivalence is achieved.**

Drug and alcohol treatment and detoxification in prison

171. Published data such as that from the Criminality Survey and the Office for National Statistics shows between 40 and 55 per cent of new receptions into prison to be problematic drug misusers. The Prison Service told us that indicative feedback shows some prisons reporting up to 80 per cent testing positive for opiates on reception. They also reported that they have “the greatest concentration—assessed to be as high as 60 per cent—of problem drug misusers present in one place at one time either in the healthcare or criminal justice systems. With an annual through-flow of around 130,000 offenders, an average 70,000 problem drug-misusing prisoners may be in custody during the course of a year—with around 39,000 being present at any one time”.¹⁶⁰

172. The Prison Service noted that drug misuse amongst offenders received into custody is on the increase, reflecting the continuing high levels of drug misuse generally in the community. This was echoed by Stephen Shaw, the Prisons and Probation Ombudsman, who said that: “The levels of opiate addiction and the use of crack cocaine amongst offenders and therefore amongst those entering prison is on a scale which was simply not known ... 15 years ago”.¹⁶¹

173. Drug misuse and the detoxification process has implications for Convention human rights in two ways. Firstly, inadequacies in detoxification treatment may lead to breaches of Article 2 or Article 3 ECHR. The human rights implications of failures in treatment for drug addiction were made clear in *McGlinchey v UK*,¹⁶² where a breach of Article 3 ECHR was found when a prisoner died as a result of inadequacies in drug detoxification treatment.

174. Secondly, the care and treatment of drug-addicted prisoners is an important element of the positive obligation to protect against self-harm and suicide of vulnerable prisoners. While the Prison Service does not collect information on the proportion of self-inflicted deaths who had been problem drug misusers, it does appear both that drug misusers are more vulnerable to self-harm and suicide, and that the process of detoxification itself can be particularly stressful and make people especially vulnerable and at risk of self-harm.

175. The Confidential Inquiry into Suicides in Prisons 1999–2000 found that 62 per cent of those who died had a history of drug misuse and 30 per cent had a history of alcohol misuse.¹⁶³ The Royal College of Psychiatrists, in a 2002 report, stated that “drug withdrawal

159 Ev 186

160 Ev 100

161 Q 100

162 App No 50390/99, 29/04/2003

163 J Shaw, L Appleby and D Baker, *Safer Prisons: A National Study of Prison Suicides 1999-2000*, The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness, May 2003

occurs when prisoners with problems of substance misuse are admitted to prison and this may play an important part in generating suicidal behaviour”.¹⁶⁴

176. The Prison Service’s review of prevention of suicide and self-harm in prisons recommended that special attention be paid to the safe management of prisoners in the early stages of custody in a prison—including detoxification units. The Prison Service also told us that: “[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 amongst those most at risk: particularly prisoners with co-existent drug and mental health problems”.¹⁶⁵

177. We were told by the Prison Service that they intended to introduce a wider range of treatment options, including “the expansion of maintenance prescribing for opiate-dependency to those prisoners for whom management of withdrawal symptoms alone is unrealistic”.¹⁶⁶ As we have seen previously the links between those on short sentences with drug or alcohol problems and potential for suicide are strong. **In order to reduce deaths in custody and adequately care for those imprisoned we fully endorse the expansion of drug maintenance programmes in prison for addicts to help relieve the distress of getting off drugs and the risk of overdose on release. We recommend that high quality drug maintenance programmes are readily available in all prisons in England and Wales to all those prisoners who require such a programme.**

178. While there was widespread recognition of the challenges faced by the Prison Service and the progress made in expanding the provision of prison drug treatment, concerns were also raised about the adequacy of drug and alcohol treatment. We make recommendations on this point above. The issue of treatment for short-term prisoners was also raised. The Revolving Doors Agency made the point to us that: “People on short-term sentences or remand, who are significantly over-represented in suicide figures, are particularly badly served by the Prison Service. They are excluded from many of the core aspects of the regime ... One key concern is that short-term prisoners are frequently unable to access drug and alcohol treatment programmes”.¹⁶⁷ **We recommend that if people are sent to prison on short sentences or on remand, drug and alcohol treatment must be made readily available for them.**

179. The Prison Reform Trust was particularly concerned about the lack of alcohol treatment in prisons and the absence of ring-fenced funding for such treatment. This concern was shared by the Chief Inspector of Prisons who told the Committee that she thought “alcohol withdrawal is a significant cause of distress that can lead to suicide and self-harm”.¹⁶⁸ The issue of alcohol addiction is often overlooked in prisons. **We recommend that there should be an expansion of alcohol misuse treatment with ring-fenced funding, and that standards should be set for the provision of alcohol detoxification and treatment in custodial settings.**

¹⁶⁴ Royal College of Psychiatrists, *Suicide in Prisons*, Council Report CR 99, February 2002, London

¹⁶⁵ Ev 102

¹⁶⁶ Ev 102

¹⁶⁷ Ev 183

¹⁶⁸ Q 86

180. The issue of high levels of deaths, often due to drug overdose, amongst newly released prisoners was also raised with us. Frances Crook of the Howard League for Penal Reform stated that people who have undergone detoxification in prison are at risk of overdose if they come out and go straight back onto drugs and that as a group “they are hugely neglected, very vulnerable people who desperately need services [and] support”.¹⁶⁹ **Although this inquiry deals with deaths in custody, rather than following release, the Convention human rights obligations of detaining authorities do not end on release. The positive obligation to protect life under Article 2 ECHR requires that reasonable steps should be taken to protect those whose lives are known to be at risk. Newly-released prisoners with known vulnerabilities should therefore be afforded appropriate support. We also recommend that the Prison Service should collect statistics on whether prisoners who undergo detoxification while in prison go on to commence and complete drug treatment.**

Communicable diseases

181. Because a high proportion of prisoners have a history of injecting drug use, there are disproportionately high incidences of communicable diseases amongst the prison population. According to the Social Exclusion Unit, HIV infection of adult male prisoners is 15 times higher than in the general population and Hepatitis B and C infection of female prisoners is 40 and 28 times higher than in the general population respectively.

182. We asked witnesses about the adequacy of measures to prevent the spread of communicable diseases in prisons. Mr Goggins told us that “[t]he Prison Service’s drug strategy and other measures have achieved considerable success in reducing drug misuse in prison”.¹⁷⁰ One of these measures is the reintroduction of disinfecting tablets for injecting drug users to use in order to clean needles. Disinfecting tablets were initially distributed in Prison Service establishments in England and Wales in September 1995 but were withdrawn later that year after concerns were raised about their safety. Following tests by the Health and Safety Executive, the Prison Service re-introduced disinfecting tablets on a trial basis in 11 sites in 1998/99. This pilot project was evaluated by the London School of Hygiene and Tropical Medicine, which judged it to have been successful. Disinfecting tablets are being introduced at all prisons under a rolling programme.

183. There are not currently any needle exchanges in prisons. Mr Ladyman told the Committee that he was open minded about the idea of needle exchanges, though previous experience had not been particularly successful.¹⁷¹ The Director General of the Prison Service, Mr Phil Wheatley, stated that needles were rarely used in prisons and that the introduction of needle exchanges could do more harm than good, though he added that the Prison Service was committed to monitoring developments both at home and abroad, including existing practice in the community, policy and practice in custodial settings and the effectiveness of needle exchanges over other harm minimisation measures.¹⁷²

¹⁶⁹ Q 44

¹⁷⁰ Ev 98

¹⁷¹ Q 237

¹⁷² Q 374

184. The Scottish Prison Service is currently considering proposals to introduce needle exchanges in order to reduce communicable diseases—a proposal which would require a change in prison rules but not a change in the law. **We recommend that the Prison Service and the Department of Health should give further consideration to whether needle exchanges could be effective in reducing the spread of communicable diseases in prisons.**

185. There are no reliable statistics on the number of gay prisoners in England and Wales, or numbers engaging in homosexual sex while in prison. At present, any prisoner who wants access to condoms has to get them from healthcare. The Prison Service confirmed that they had no plans to make condoms available to prisoners other than through healthcare professionals. However, prisoners may be concerned about implications of going to see a healthcare professional for condoms and may therefore be more likely to engage in unsafe sex. **The Prison Service should commission an independent review into whether its current policy on the availability of condoms is doing enough to prevent the spread of HIV/AIDS amongst the prison population and therefore to protect the right to life.**

Prescription of medication in Mental Health Act detention

186. Concern has been expressed that medication is being administered inappropriately and at excessive levels, and sometimes without adequate medical authorisation, to those detained under the Mental Health Act, contrary to guidelines set by the British National Formulary (BNF). The BNF sets limits on the levels of drugs that may be prescribed, though these are not legally binding on medical personnel. MIND's written evidence states that these recommended levels are routinely exceeded in the treatment of detained patients, for purposes of restraint or correction, and in some cases to compensate for staff shortages. It expresses particular concern about the simultaneous prescription of several different drugs (polypharmacy) at high doses and about the higher doses of medication administered to Afro-Caribbean men. MIND warns that excessive medication is being used in such a way as to “increase the risk of adverse effects which may be disabling or life threatening”.¹⁷³

187. MIND raises particular concern that 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”.¹⁷⁴ It suggests that such discrepancies may result from racial stereotyping and unjustified perceptions of dangerousness and aggression in black male patients.¹⁷⁵

188. Expert evidence to the inquiry into the death of David Bennett raised similar concerns about the over-medication of black patients, and stressed the need for further research on the nature and extent of the problem.¹⁷⁶ The Mental Health Act Commission also expressed particular concern that emergency medication was being administered in some

173 First Report of Session 2003–04, op cit., Ev 111

174 *ibid.*, Ev 111–112, QQ 140–141

175 QQ 139–141

176 Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, *Independent inquiry into the death of David Bennett*, December 2003, p. 49

cases without the authorisation of a doctor as required by the Mental Health Act, and supported strict adherence to recommended dosage limits in emergency situations.¹⁷⁷

189. In response to concerns about prescription of medication, Mr Ladyman doubted that such practices were widespread.¹⁷⁸ Our impression, however, is that, in practice, although BNF limits are only rarely exceeded in respect of the dosage of a single drug, limits are routinely exceeded as a result of the administration of several drugs simultaneously. At Broadmoor, for example, at the time of our visit,¹⁷⁹ only four patients were being prescribed a single dosage in excess of BNF limits, but staff estimated that in the region of 80 patients were receiving drugs in excess of BNF limits as a result of combinations of drugs.¹⁸⁰ We were assured that patients on such high levels of medication were very closely monitored, and the combination of drugs and changes in prescription were carefully recorded, and incorporated in the patient's care plan.¹⁸¹

190. Mr Ladyman pointed out that the new Commission for Health Audit and Inspection would have a role in ensuring that guidance was complied with.¹⁸² In regard to current practice, however, the Mental Health Act Commission (MHAC) pointed to limitations in its mandate and resources which prevented it from exercising a very careful scrutiny of the administration of medication. It was not in a position to monitor the levels of medication in individual cases, since it did not have a continuous presence in hospitals. Asked whether he considered that the MHAC should have the remit and specialist staff to review prescription of medication, the Chief Executive of the MHAC, Chris Heginbotham, was cautious about the MHAC challenging clinical judgment, stating that further consideration would need to be given to this.¹⁸³ However, he recognised that the absence of scrutiny of medication levels limited the MHAC's effectiveness in protecting Convention rights.

191. MIND argued that “there should be absolutely no reason why somebody should go over a BNF maximum [in prescribing medication to detained patients]. Going over that should make an individual accountable”.¹⁸⁴ It recommended legislative provision to make it unlawful to administer doses above the maximum recommended within the British National Formulary Guidelines, pointing out that these maxima were often already well above the recommended dose.¹⁸⁵

192. Against this it may be argued that considerations of flexibility, and the need to tailor prescriptions to the particular needs of a patient, may require that BNF limits be exceeded in some cases. The draft NICE guidelines on the Short Term Management of Disturbed Behaviour in Psychiatric Inpatient Settings accept that BNF limits may legitimately be exceeded in some cases, for example, where rapid tranquillisation is used to restrain a patient. The Guidelines state that the rationale for exceeding the recommended limits

177 First Report of Session 2003–04, *op cit.*, Ev 42–43

178 Q 211

179 16 September 2004

180 Out of a total of about 222 patients

181 This is in accordance with West London Mental Health Trust's Medicines Policy, 2004

182 Which is to absorb the functions of the Mental Health Act Commission

183 Q 193

184 Q 142

185 Q 158

should be recorded in the care plan, and the patient should be frequently and intensively monitored where BNF limits are exceeded.¹⁸⁶

193. Excessive or unregulated administration of medication, in particular where it is administered without consent for purposes of restraint or correction, raises issues under Article 8 (the right to physical integrity); Article 3 (freedom from inhuman or degrading treatment);¹⁸⁷ and potentially the right to life under Article 2. Any clearly established difference in the level of drugs prescribed to patients of one ethnic group, would be discriminatory in breach of Article 8 and Article 14 ECHR, unless the difference could be objectively justified in regard to the needs of each patient.

194. Proportionate interference with Article 8 rights requires that standard medical practice should not be departed from in actions such as the administration of medication without consent which impinge on the physical integrity of the patient. Where carefully defined departures from BNF limits are permitted by guidance such as that issued by NICE, this should not lead to a breach of Article 8. Any such departures from BNF limits would however need to be closely justified as necessary and proportionate in the particular circumstances of the case, in order to comply with Article 8. There is a particular need for such close justification, in light of the perception (which remains statistically unproven) that drugs may be disproportionately administered to patients from some ethnic minorities.

195. Whether prescription in excess of BNF limits will breach Convention rights will depend on the circumstances of the individual case. Where such medication can be shown to be a therapeutic necessity in the circumstances of the case, then it is unlikely to breach Article 3 or Article 8. However, in our view, the departure from accepted guidelines set by the BNF would require very close justification, in particular in any case where such medication is implicated in the death of a detained patient. There will be a risk of Article 2 violation where medication is prescribed in excess of BNF limits, either through a combination of drugs or a single dosage, as a matter of routine or without clear justification on the basis of exceptional circumstances. **We recommend that levels of prescription should be closely monitored by health authorities in light of these human rights considerations, and that the Commission for Health Audit and Inspection should have a role on review of levels of medication. We recommend that there should be a statutory obligation to record and report on dosage over BNF limits. Under the Race Relations (Amendment) Act 2000 there is a positive obligation on NHS authorities to ensure race equality, including in the administration of medication. We recommend that health authorities should monitor prescription of medication to detained patients having regard to ethnicity, and should take steps to address any discrepancies found.**

¹⁸⁶ National Institute for Clinical Excellence, *Draft guidelines on the short term management of disturbed (violent) behaviour in in-patient psychiatric settings*, para 1.10.29

¹⁸⁷ *R (Wilkinson) v Broadmoor Special Hospital* [2002] 1 WLR 419

7 Mental healthcare

Mental health and prisons: the Government's approach

196. Three main elements of the Government's general approach to the issue of mental health in prisons were set out by Mr Ladyman. These elements are—

- to try to ensure, through court diversion schemes and the development of wider sentencing options for the courts, that people with mental health problems are not sent to prison inappropriately;
- to make substantial improvements to the mental health services that are provided within prisons;
- to take steps to ensure that people who have been assessed as too ill to remain in prison are transferred for in-patient treatment in hospital as quickly as possible.¹⁸⁸

197. In addition, the Minister told us that the Department of Health was working to ensure that the best use was made of capacity in high secure mental health facilities, so that those beds were available to those who genuinely needed that level of security and supervision. **We urge the Government to ensure that it continues to make major inroads in diverting mentally ill offenders from the courts and prisons, and efficiently transferring the seriously mentally ill from prison to hospital.**

Provision of mental healthcare in prisons

198. The basic principle underpinning the Department of Health's 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. According to the Department of Health's evidence to us, this means that prisoners, who, were they not in prison, would be treated in their own homes under the care of Community Mental Health Teams 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 prisoners requiring specialist in-patient treatment to hospital. **The principle of equal treatment is the fundamental underlying notion of human rights. That equality of treatment should be upheld in relation to mental healthcare as well as in relation to physical healthcare is, therefore, not only an unsurprising, but a necessary component of compliance with the positive obligation to protect Convention rights under Articles 8, 3 and 2 ECHR.**

199. Over 60 prisons are now benefiting from the provision of additional resources to deal with mental health issues by providing "prison in-reach" by NHS staff. Thus, staff normally employed in the NHS, including doctors, nurses, psychologists and others, are currently working in increasing numbers in prisons, to fulfil a range of functions, including direct treatment services and training. While the in-reach initiative is to be commended for dealing with a very substantial problem and for helping to open up the closed world of the

prison, there is a danger that it will become acceptable for mentally ill people to receive care and treatment in prison that they should really be receiving in NHS facilities. We comment below on arrangements for transfer of mentally ill prisoners to hospitals, but we record here our view that mental health prison in-reach should not be used as a substitute for care and treatment in NHS facilities.

200. We were concerned to hear about some of the problems that prisons were facing in managing disruptive prisoners with personality disorders, many of whom are likely to be highly vulnerable as well as problematic to other prisoners and staff.

201. The management of these prisoners was raised as a concern by the Chief Inspector of Prisons, and she highlighted in particular what is described as “sale or return”, whereby problematic prisoners are transferred from prison to prison if they continue to misbehave.¹⁸⁹ While we understand the Prison Service’s perspective that this approach can be effective in finding an environment in which someone can settle, we have concerns about this policy in the light of the fact that a quarter of all prisoners who take their own life do so within the first week of reception into a new prison. **We recommend that the Prison Service examines ways of restricting the transfer of disruptive prisoners, many of whom are also deeply vulnerable.**

202. Just as prisons transfer prisoners to another prison if they are disruptive, so it appears that—understandably—such prisoners are also transferred within prisons. During our visit to Feltham YOI we saw a fight break out involving a young offender who had been held with vulnerable prisoners, despite having a track record of being problematic. However, as he had been moved all around the prison and had not settled, he was placed in a unit where it had been felt staff could observe him closely. **Prisoners known to be problematic and aggressive towards other prisoners should not be placed on vulnerable prisoner units.**

Transfers of mentally-ill people from prisons

203. It is the stated policy of the Government to transfer prisoners who need in-patient treatment for their mental disorders to hospitals as soon as possible. The number of prisoners transferred to hospital as restricted patients under sections 47 and 48 of the Mental Health Act rose from 180 in 1987 to 785 in 1994 and then remained relatively stable, at an average of 745 each year, up to 1999. In 2001, 635 prisoners were transferred to hospital and in 2002, the latest year for which statistics have been published, 639.¹⁹⁰

204. The Chief Inspector of Prisons told us that such transfers were “undoubtedly getting easier and better”, and that transfers could usually happen within three months of diagnosis. However, she expressed concern that even in this period of time a prisoner with such acute needs can deteriorate “quite dramatically”.¹⁹¹ At the same time, MIND was concerned about the fact that the number of transfers from prisons to hospital had actually reduced in recent years.¹⁹²

189 Q 93

190 Q 296

191 Q 74

192 Q 148

205. In our visits to both prisons and secure hospitals, it was confirmed to us that the waiting times for transfers were improving. We were told, however, that on occasion there was under-diagnosis, or belated diagnosis, of serious mental illness in prison, on the understanding that such a diagnosis would be futile until places in secure hospitals became available.

206. At any one time there are around 40 prisoners who will have been waiting longer than three months for a hospital place following acceptance by the NHS. Mr Ladyman acknowledged that “problems of apparently excessive delays can still occur in some individual cases” and that “some prisoners still have to wait some time before they can be transferred to hospital”, but told us that he believed “the arrangements for assessment and transfer worked smoothly and that very many mentally disordered prisoners can be transferred to hospital quickly”.¹⁹³ He also assured us that tighter monitoring had been introduced along with a protocol setting out the actions required of both the Prison Service and the NHS when a prisoner reaches the three-month deadline. **We welcome ongoing efforts to speed up arrangements for the transfer of mentally ill people from prisons to hospitals. Prison, despite improved psychiatric provision, is not an appropriate place for people with serious mental health problems and transferring these vulnerable people to NHS settings must be given high priority.**

The need for more provision in NHS mental health settings

207. With over 600 prisoners awaiting transfer to NHS in-patient care, and many more prisoners with mental health problems who have not been assessed as needing a transfer but who could arguably benefit from being cared for in a therapeutic environment, there appears to be a clear need for more places to be available in NHS forensic facilities—in the high secure facilities, medium secure units and local psychiatric intensive care units.

208. The shortage of secure NHS psychiatric beds is, in our view, the central reason why there is such a problem concerning the number of mentally-ill people who are inappropriately placed. We are also concerned about those vulnerable prisoners who are assessed as having personality disorders, rather than being mentally ill, and who therefore do not meet the criteria for detention and treatment in an NHS psychiatric setting.

209. This was a particular concern of the Chief Inspector of Prisons, who raised the issue of the many very seriously mentally-ill prisoners who cannot be sectioned because, having personality disorders, they are not considered to be treatable. As a result they remain in prison. Ms Owers also told us about people who had been transferred to a psychiatric hospital but were then returned to prison because they were considered too dangerous. In response to this issue, and the high numbers of prisoners with mental health problems who did not meet the criteria for such a transfer, she has proposed the establishment of new psychiatric units which could provide appropriate care to mentally-ill people currently held in prison.¹⁹⁴

193 Ev 93

194 QQ 74–76

210. The Department of Health told us that this was not an approach favoured by the Government as it felt that considerable progress was being made with regard to mental health provision in prisons. The Government was also concerned that such a proposal could lead to the re-creation of the kind of institutional system that existed in the old asylums. These concerns were also echoed by MIND, which felt that an additional parallel system to prisons for the mentally-ill was not needed.¹⁹⁵ We share Ms Owers' concerns and believe that an informed and detailed debate on the issue is urgently required in order to reach an early conclusion on what is to be done. **In the meantime, we are in no doubt that too many vulnerable people with mental health problems are wrongly being held in prisons. Funding decisions for NHS high and medium secure hospitals must invariably take into account the imperative to address this.**

211. **If the Dangerous and Severe Personality Disorder Initiative jointly run by the Department of Health and Home Office is shown to be successful, consideration should be given to extending this as an alternative to prison for offenders with severe personality disorders.**

Police cells as “places of safety”

212. Under section 136 of the Mental Health Act 1983 (MHA), someone found to be suffering from a mental disorder and to be in immediate need of care and control may be removed by the police to a “place of safety” if this is necessary in the interests of that person or for the protection of others. The place of safety may be either a police station or a hospital, and there is no legal obligation on NHS trusts to accommodate persons detained under section 136. The MHA Code of Practice of 1983 states however 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”.¹⁹⁶

213. The Police Complaints Authority confirmed to us that, although the level of suicides in police cells was generally low, there was a real concern about suicide in regard to place of safety detentions in police cells. In the PCA study on alcohol-related deaths in police custody, three out of the 60 deaths studied were of persons detained under the Mental Health Act.¹⁹⁷

214. Witnesses generally agreed that the use of police cells as places of safety was undesirable.¹⁹⁸ The extent to which it may compromise the safety of patients is clear from the Coroner's Rule 43 report into the death of Roger Sylvester,¹⁹⁹ which acknowledges that, in practical terms, the restraint imposed by a police officer on a s.136 detainee may need to differ from that imposed by medical staff—

Situations faced by police officers in a section 136 situation are different to those faced by healthcare professionals. ... Usually, officers have no prior knowledge of the

¹⁹⁵ Q 147

¹⁹⁶ Mental Health Act 1983 Code of Practice, para 10.5

¹⁹⁷ Dr David Best & Amakai Kefas, *The Role of Alcohol in Police Related Deaths*, Police Complaints Authority, March 2004

¹⁹⁸ Mental Health Act 1983 Code of Practice, para 10.5

¹⁹⁹ Inquest into the Death of Mr Roger Sylvester, Report under Rule 43 of the Coroner's Rules 1984, April 2004, HM Coroner's Court St. Pancras

person’s psychiatric or medical history or the same clinical skills for determining competence and cognitive ability, which may be fluctuating in any event. There is therefore a gulf between what can be implemented in the healthcare setting and what can be implemented by police officers between responding to the presentation of a patient and transferring them into health care.²⁰⁰

215. Mr Sylvester’s death, under restraint by police officers whilst arrested under s.136, which resulted in an unlawful killing verdict in the Coroner’s Court later quashed on appeal, illustrates the dangers of the use of police cells for these purposes.

216. The Home Office acknowledged that use of police cells as places of safety was unsatisfactory and states that they were used only as a last resort.²⁰¹ MIND expressed concern however that “last resort” should not be interpreted loosely as “where there are insufficient resources to do otherwise”.²⁰²

217. It emerged from oral evidence that although use of police cells as places of safety was regarded by all witnesses except the Home Office to be “widespread” there were no official figures on the number of place of safety detentions in police cells. In response to our questioning, the Home Office contacted 23 police forces to enquire about practice in the use of police cells as places of safety. They found that 17 police forces used cells as places of safety under section 136, because no alternative could be found in the area—within these 17 forces, an average of 328 people were detained in police cells under section 136 each year.²⁰³ The Home Office noted that it was shortly to provide guidance for local protocols between police forces and local health services.²⁰⁴

218. ACPO was sceptical about the reliability of protocols to address the problem. They considered that a “more robust approach” was necessary that would identify where responsibilities lay, and establish clearly that detainees such as those held under section 136 were not solely the responsibility of the police but that this was a “multi-agency issue”.²⁰⁵

219. The Coroner in the Roger Sylvester case recommended that priority should be given in the allocation of beds to people who were highly disturbed and could not be managed without the use of restraint. The Coroner’s report also recommended that procedures should be put in place within the NHS for clinical decision making so that a section 136 detainee’s transfer from police to NHS custody took place “as a matter of utmost priority with time of the essence”.²⁰⁶

220. For as long as police cells continue to be used for these purposes, even in rare cases, the police have obligations under Articles 2, 3, and 8 to protect the safety of people detained in this way by addressing their particular needs. Compliance with Article 2 in the detention of a person known to be seriously mentally ill, and who may be at risk of suicide,

200 Inquest into the Death of Mr Roger Sylvester, op cit., Section 3, p. 8

201 Q 265

202 Ev 160

203 Ev 96

204 Ev 96

205 QQ 412–413

206 Inquest into the Death of Mr Roger Sylvester, op cit., Part 3, p. 9

requires informed psychiatric assessment and treatment, and expert monitoring.²⁰⁷ These are standards which it will be extremely difficult for police custody suites, even the best equipped, to meet. **People requiring detention under the Mental Health Act should not be held in police cells. Police custody suites, however well resourced and staffed they may be, will not be suitable or safe for this purpose, and their use for this purpose may lead to breaches of Convention rights. In our view, there should be a statutory obligation on healthcare trusts to provide places of safety, accompanied by provision of sufficient resources for this by the Government.**

221. Ensuring the safety of people detained by the police is not a single agency problem that can be addressed by the police alone. It also involves the responsibilities of health authorities, and requires good co-ordination between health authorities and the police. **Transfers from police cells to hospital must operate more effectively. We recommend that a statutory duty be placed on healthcare trusts to take responsibility for people detained under section 136 of the Mental Health Act**

Detention in immigration removal centres

222. Concerns have also been raised about the detention of vulnerable and mentally-ill people in immigration removal centres. The Operational Enforcement Manual, which sets out policy on immigration detention, lists categories of people “normally considered suitable for detention in only very exceptional circumstances”.²⁰⁸ These include people suffering from serious medical conditions or the mentally ill, and people about whom there is independent evidence that they have been tortured.

223. The Medical Foundation for the Care of Victims of Torture, and Bail for Immigration Detainees (BID), reported that the “exceptional circumstances” standard is not being applied to all those falling within these categories, and that torture survivors and the seriously mentally ill are in practice detained, even where this is recorded in medical reports.²⁰⁹ Medical Foundation research shows the particularly detrimental effects of detention on torture survivors in immigration detention.²¹⁰ BID provided us with details of cases of serious mental illness, attempted suicide and self-harm in immigration detention, including cases where detention continued against medical advice, and in cases where medical advice was that detention was exacerbating mental illness. They also reported that in some cases, medical staff’s failure to pass on medical information to managers of detention centres meant that detainees’ vulnerabilities might not be known.²¹¹ **Decisions on continued detention under the Immigration Act must be fully informed by any relevant medical and in particular psychiatric information. Where detaining authorities know, or ought to know (given adequate information exchange) that an immigration detainee is at risk of suicide, serious self-harm or severe mental illness as a direct result of continued detention, they will need to clearly justify such continued detention as compliant with Articles 2, 3 and 8.**

207 *Keenan v UK*, op cit., para. 115

208 First Report of Session 2003–04, op cit., Ev 69

209 First Report of Session 2003–04, op cit., Ev 106–107 and Ev 70

210 Mary Sallinski and Susi Dell, *Protection not prison: torture survivors detained in the UK*, 2001, Medical Foundation for the Care of Victims of Torture

211 First Report of Session 2003–04, op cit., Ev 70

8 Physical restraint and seclusion

Restraint and seclusion in detention

224. Although deaths in custody resulting from control and restraint appear to be relatively rare, they are a cause for serious concern. A reliable, comprehensive assessment of the number of deaths attributable to control and restraint in custody is difficult, in particular in relation to psychiatric detention. The MHAC estimates that one patient per annum over the last seven years died whilst control and restraint was being administered.²¹² However, there is no national database of figures for patient deaths connected to the use of restraint, and the cause of death of detained patients is often unclear, as the use of restraint may lead, for example, to heart failure.²¹³ There is therefore concern that some deaths recorded as being from natural causes may in fact be attributable to restraint. INQUEST state that: “the existing internal systems for examining and reporting these deaths are so poor that we believe some contentious deaths could escape any public scrutiny”.²¹⁴

225. In police custody, although the evidence of both the PCA and the Home Office suggest that deaths directly attributable to control and restraint are relatively rare, the PCA stressed that such deaths were preventable, and as such were a matter of serious concern. The PCA noted that 10% of complaints to them of assault in custody were upheld.²¹⁵ INQUEST reported that their casework showed an increase in the number of restraint-related deaths in police custody in recent years.

226. There has recently been one death following restraint in a young offenders’ institution, following a number of years without any such deaths in prisons.²¹⁶

227. Despite the dearth of statistics in this area, it is clear that the unsafe use of restraint is an ongoing problem across all forms of detention. Evidence from the MHAC and INQUEST cites a number of recent deaths involving control and restraint.²¹⁷ The report of the Inquiry into the Death of David (“Rocky”) Bennett, a detained psychiatric patient who died after having been restrained in a prone position for 25 minutes, contained strong criticism of control and restraint procedures,²¹⁸ as did the Report of the Inquest into the Death of Roger Sylvester, who died in police custody following the use of restraint.²¹⁹

The human rights framework

228. The use of physical restraint by State employees raises an acute issue of Article 2 compliance. Used excessively or inappropriately so as to cause the death of a detainee,

²¹² Q 169

²¹³ Ev 190

²¹⁴ First Report of Session 2003–04, op cit., Ev 93

²¹⁵ Q 383

²¹⁶ The death of Gareth Myatt at Rainsbrook secure training centre. See Ev 143

²¹⁷ See Ev 121 and Ev 142–146

²¹⁸ Norfolk, Suffolk and Cambridgeshire Health Authority, *Independent Inquiry into the Death of David Bennett*, December 2003, pp. 28–29

²¹⁹ Inquest into the Death of Mr Roger Sylvester, Report under Rule 43 of the Coroner’s Rules 1984, April 2004, HM Coroner’s Court St. Pancras

restraint may breach the State's most fundamental duty not to deprive the individual of life. Any death that occurs during or following restraint places a heavy onus on the responsible authorities to justify their action as Article 2 compliant. Where they fail to do so satisfactorily, not only is public confidence in the health or criminal justice systems seriously undermined, but the responsible authorities are likely to be held in breach of their obligations under the Human Rights Act.

229. Article 2 is violated not only where deliberate or negligent acts of police, nurses or prison officers involved in restraint lead to the death of a detainee, but also where systemic failings, in management, instruction and training, may combine to lead to an unnecessary or excessive use of force.²²⁰ Planning and control of action which may endanger life, information provision regarding the threat to which there must be a response, and the training of officials in the use of physical force which may endanger life may, in combination, lead to a breach of Article 2, where they are not tailored to minimise risk to life.²²¹ We consider the particular issues involved in the training of staff in control and restraint in Chapter 9 below.

230. A number of other Convention rights provide a framework in which Article 2 rights must be protected in the use of restraint. Use of physical restraint engages Article 8, the right to physical integrity, and Article 3, the freedom from inhuman and degrading treatment. Article 3 provides particularly strong protection for people in detention, and there is a presumption that unnecessary physical force against a detainee reaches the otherwise high threshold required to establish inhuman and degrading treatment.²²² In *Keenan v UK*, the European Court of Human Rights set down this general principle—

... in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3.²²³

231. As a general rule, a measure which can be convincingly established to be a therapeutic necessity cannot be regarded as inhuman and degrading treatment in contravention of Article 3.²²⁴ The onus is on the applicant to disprove any assertion that medical necessity justified the use of restraint against him in the particular circumstances of the case.²²⁵ Whether restraint amounts to inhuman and degrading treatment under Article 3 may also depend on the characteristics of the person concerned. Age, sex and health will be relevant, as will the physical and mental effects on the person restrained.²²⁶ Particular vulnerabilities of which the detaining authorities knew or ought to have known, such as a history of past physical abuse, may therefore contribute to a finding of an Article 3 violation in the use of restraint.

220 *McCann v UK* [1996] 21 EHRR 97, where the planning and control of an operation to arrest terrorist suspects, which led to the death of the suspects, was held to breach Article 2, though no blame was attached to the officers operating on the ground.

221 *ibid*

222 *Ribbich v Austria* [1995] 21 EHRR 573

223 (2001) 33 EHRR 38, para. 112

224 *Herczegfalvy v Austria* App No 10533/83 24/09/1992

225 *ibid.*, para. 83

226 *Ireland v UK* [1979–1980] 2 EHRR 25

232. Article 8, which protects the right to physical integrity, requires that action that interferes with physical integrity should be in accordance with established law and guidelines, that it should be for a legitimate purpose, and that it should be necessary for and proportionate to that purpose. For a physical intervention to be considered proportionate, it must be the least intrusive measure possible in the circumstances. Proportionality therefore requires both that any form of restraint should be a last resort only; and that where there must be recourse to restraint it is the minimum necessary, and applied for the shortest time necessary, to ensure safety.

233. Finally, and significantly given the issues of racial bias that have been raised in this inquiry, Article 14 ECHR, which requires that there must be no discrimination in the protection of Convention rights, makes the principle of equality central to the obligations to protect life and physical integrity under Articles 2, 3, and 8 in the use of restraint against detained persons. Where any of these rights are engaged, a difference in treatment which cannot be objectively and reasonably justified in the circumstances, will breach Article 14.

234. Human rights standards and the principle of proportionality require that any form of physical restraint should be a last resort. Staff should therefore be equipped with a range of skills to deal with and de-escalate potentially violent situations, as well as a range of restraint techniques that will allow for use of the minimum level of force possible. Restraint in detention should be a rare event, and should never be used as a matter of routine.

235. Alternatives to physical restraint, comprehensively explored in research and policy in mental healthcare, include techniques of de-escalation and the use of seclusion. Seclusion—the supervised confinement of a patient for the protection of others—engages Articles 3 and 8 ECHR. Where it is used in respect of a patient at risk of suicide, it may also engage Article 2. A recent decision of the Court of Appeal has confirmed that, in order to protect the Convention rights, the provisions in the MHA Code of Practice limiting its use must be complied with unless there is a good reason to depart from them.²²⁷

236. The principles of necessity and proportionality in the recourse to restraint and seclusion are echoed, in the mental health context, in principle 11 of the UN Principles for the protection of persons with mental illness and the improvement of mental health care.²²⁸ It provides—

Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose.

²²⁷ *Munjaz v Mersey Care NHS Trust* [2003] ECA Civ 1036

²²⁸ Adopted by General Assembly Resolution 46/119 of 17 December 1991

Restraint and seclusion in Mental Health Act detention: The regulatory framework

237. Powers of control and restraint in Mental Health Act detention are exercised in accordance with the Mental Health Act 1983 Code of Practice, as well as other non-binding guidelines.²²⁹ The Code of Practice requires that use of control and restraint should be used only as a last resort, that it should be considered in each patient's care plan, and that incidents of control and restraint should be recorded in patients' notes. The Mental Health Act Commission's written evidence observes that there is a "raft" of guidance on the use of control and restraint, and lists eight different sources of guidance.²³⁰ The Mental Health Act Commission, MIND and INQUEST amongst others have raised concerns about excessive or unregulated use of control and restraint, contrary to the terms of the Code of Practice.²³¹ There is concern that Code of Practice requirements that restraint should be used only as a last resort are not implemented in practice; that those who have died in custody as a result of restraint are disproportionately from ethnic minority groups; and that there is insufficient recording and monitoring of the use of control and restraint.

238. The evidence we received consistently maintains that this body of guidance is not effective in preventing the misapplication of restraint in practice, potentially in breach of Article 2 and other ECHR rights. The MHAC considers that this "requires consolidation and official sanction, so that detailed guidance with formal status and legal weight underlies statutory regulation".²³²

239. There is no provision for powers of seclusion in the Mental Health Act 1983, but such powers are provided for under the 1983 Code of Practice which requires that seclusion should only be used as a last resort and should be used for the shortest possible time. It should not be used as a punishment, as a means of coping with staff shortages, or where there is a risk of suicide or self-harm.²³³ The status of the Code of Practice, in relation to both seclusion and control and restraint, has been elevated by the recent case of *R v Ashworth Hospital, ex parte Munjaz*,²³⁴ where the Court of Appeal found that it was unlawful for Ashworth Special Hospital to use seclusion contrary to the Code of Practice. It found that, in order to protect rights under Article 8 and Article 3 ECHR, departure from the code of practice in relation to seclusion was only lawful where it could be shown to be necessary in a particular case, in the best interests of the patient. The Department of Health, responding to the judgment, stated that good practice required any departure from the Code to be recorded, and noted that the Mental Health Act Commission's policy is to treat unsubstantiated departures from the Code to be *prima facie* evidence of poor practice. The case is currently under appeal to the House of Lords.

229 Ev 41, para. 5.10

230 *ibid*

231 See Ev 116–121 (Mental Health Act Commission), Ev 161 (MIND) and Ev 147 (INQUEST)

232 First Report of Session 2003–04, *op cit.*, Ev 41

233 Mental Health Act 1983 Code of Practice, Chapter 19, Patients presenting particular management problems

234 [2003] ECA Civ 1036

Compliance with the Code of Practice

240. Whether, following *Munjaz*, the Code of Practice is now satisfactorily complied with in relation to seclusion, and control and restraint, is disputed. Mr Ladyman told us in his oral evidence that he was “broadly content” that it was.²³⁵ Both the MHAC and MIND contested this, maintaining that the Code of Practice was being departed from, not incidentally, but as a matter of policy, in a number of hospitals.²³⁶ The MHAC’s review of seclusion practice in its recent Biennial Report in particular found that 68% of hospitals surveyed did not provide safe seclusion facilities for detainees.²³⁷ MIND pointed out that it was very difficult to be certain that the Code of Practice was complied with, given the dearth of central data on compliance.²³⁸

241. Practice on seclusion appears to vary significantly. Seclusion policy at Broadmoor, for example, does envisage departure from the Code of Practice through the use of long-term seclusion for “a small number of patients” who remain “extremely resistant to all currently available treatments and present a continuing high risk of significant harm to others”.²³⁹ To be Convention-compliant, long-term seclusion in contravention of the Code of Practice must be used in the most exceptional cases only, where it can be shown to be necessary, and not in response to difficulties of management or staffing. By contrast, at the Caswell Clinic, a medium-secure unit which we also visited, seclusion is not used at all. This suggests a high onus on those units which do use seclusion to justify it closely as human rights compliant.

242. Failure to justify a departure from the Code of Practice as a necessary and proportionate response to the exceptional circumstances of a specific case is likely to lead to the responsible health authority being found in breach of the Human Rights Act. We remain concerned at the evidence we have received, including from the statutory body responsible for review of mental health services, attesting to the low level of compliance with guidelines on the use of seclusion and of physical force against vulnerable people who have been deprived of their liberty. This situation carries a serious risk of breach of rights under Article 2, Article 3 and Article 8 of the Convention. **We recommend that the Department of Health should take further steps to ensure that health authorities are aware of their responsibilities under the Human Rights Act following the *Munjaz* case, and that health authorities should implement the necessary changes to seclusion policies and apply them in practice.**

243. The MHAC argues that, whilst considerations of flexibility mean that the Code of Practice as a whole should remain non-binding, clear statutory requirements should be set in relation to a number of matters: staff training on control and restraint; staff and patient debriefings following the use of restraint; and record-keeping of control and restraint incidents. Within this framework, guidelines, fortified by the Convention requirements as applied in *Munjaz*, could continue to regulate control and restraint. The MHAC pointed out that “such regulation could provide real benefit to patients and staff alike, particularly

235 Q 198

236 Mental Health Act Commission (Q 187) and MIND (Ev 161)

237 10th Biennial Report 2001–2003, op cit

238 Ev 161

239 Section 12 of the Seclusion Policy

in relation to ensuring and promoting human rights based practice and removing the current uncertainties over legal powers and practice”.²⁴⁰ The draft Mental Health Bill provides the opportunity to bolster the Code of Practice, by giving elements of the Code statutory force. However, Mr Ladyman indicated that he was not minded to give statutory force to any elements of the Code, while stressing that no final decisions had been taken.

244. The forthcoming draft NICE guidelines on the Short-Term Management of Disturbed/Violent Behaviour in Psychiatric In-patient settings and accident and emergency settings are designed to provide a firmer foundation for good practice in this area.²⁴¹ The Guidelines set out detailed standards for risk assessment, training, patient liaison, application of de-escalation techniques, patient observation, and the use of physical restraint and seclusion. They also set out procedures for recording and review of violent incidents. The Draft Guidelines provide that where physical force is used, the level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.²⁴²

245. **We welcome the enhanced standards and transparency that these guidelines will bring.** We also note that, as discussed above, following the *Munjaz* case, there is a legal duty on health authorities to comply with guidelines or justify any departure from them in exceptional circumstances. Positive initiatives have also followed the publication of the David Bennett report. The Secretary of State for Health announced the establishment of a Cross-Government Group on the Management of Aggression and Violence, and a programme of work in conjunction with the National Patient Safety Agency (NPSA) to improve the organisation and quality of training for staff. Nevertheless, **we remain concerned at the under-enforcement of guidance in this highly human rights-sensitive area. We are not confident that Convention compliance can be effectively and comprehensively ensured without some statutory obligations in this area. This should include statutory obligations on all health authorities to keep comprehensive records of all violent incidents.**

Restraint in the prone position

246. Restraint in the prone position has been particularly controversial because of the dangers it carries to the patient, and it has been implicated in a number of deaths. At present there is no guidance on a maximum time for restraint in this position, in either police or Mental Health Act detention. The NICE guidance currently in draft form does not prescribe a time limit for prone restraint, but the Report into the Death of David Bennett, who died following prolonged prone restraint, recommended that detainees should not be restrained in a prone position for longer than three minutes. The Rule 43 Report of the Inquest into the Death of Roger Sylvester also favoured a time limit following which a detainee held in prone restraint would have to be repositioned: “If a mandatory repositioning after 10 minutes was accepted as well as dangers inherent in repositioning after 10 minutes then this would encourage a focus upon obtaining the necessary medical

240 Ev 119, para 3.9

241 National Institute for Clinical Excellence, *Draft Guidelines on the short term management of disturbed (violent) behaviour in in-patient psychiatric settings and accident and emergency settings*, July 2004

242 *ibid.*, para. 1.8.7

assessment and intervention within that 10 minutes”.²⁴³ The report, although noting that there may be dangers involved in mandatory repositioning of a detainee at a fixed time limit, concluded that: “risks of any injury or harm as a result of repositioning are undesirable results which however avoid a worse one if an apparently mentally ill person dies suddenly during prolonged resistance against prone restraint”.²⁴⁴

247. In our visits to secure hospitals, it was confirmed to us that staff did not observe any fixed limit, such as three or ten minutes, on the amount of time a patient could be restrained in the prone position, but that their training emphasised the risks of asphyxiation in this position, and the aim was to raise the patient as quickly as possible.

248. Reliance on prone restraint is a matter of concern for compliance with Article 2, given the known dangers of this position, evidenced by previous deaths. Whilst we appreciate that an inflexible time limit may cause difficulties in practice, we emphasise that Article 2 requires that patients and detainees should not be placed at risk by use of this position unless absolutely necessary to avert a greater risk to themselves or others, and that they should be restrained in this position for the shortest possible time necessary. **In our view use of the prone position, and in particular prolonged use, needs to be very closely justified against the circumstances of the case, and this should be reflected in guidance. There is a case for guidance prescribing time-limits for prone restraint, departure from which would have to be justified by individual circumstances. Equally importantly, those restraining a detainee should be capable of minimising the risks to him or her, through techniques to ensure, amongst other things, that airways are not blocked. They should be appropriately trained to do so.**

Pain Compliance

249. The purpose of restraint is to bring a dangerous situation under control, and restraint will only be justified as human rights compliant to the extent that it is necessary to achieve that. Restraint which deliberately causes pain to the person under restraint in order to bring them under control is particularly difficult to justify in human rights terms.

250. MIND cited “anecdotal evidence of people within mental health settings being given restraint training which relies on the use of pain rather than on de-escalation techniques”.²⁴⁵ This is confirmed by a survey carried out by the UK Central Council for Nursing, Midwifery and Health Visiting, which found that 61% of those trained in control and restraint had received training on the use of pain to induce compliance.²⁴⁶ On visits to secure hospitals, we were told that training was provided on the use of pain to induce compliance with restraint, but that this was on the understanding that pain compliance would be used only as a last resort, and to the minimum degree necessary to defuse a dangerous, violent situation.

²⁴³ Report in to the Death of Mr Roger Sylvester, op cit., Section 3, p. 5

²⁴⁴ *ibid.*, Section 3, p. 10

²⁴⁵ Q 136

²⁴⁶ United Kingdom Central Council for Nursing, Midwifery and Health Visiting, *Report on the Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care*, February 2002

251. Our understanding is that where pain is used to induce compliance, it is minimal and non-life threatening (for example, bending back a thumb). Such methods are unlikely to engage Article 2, additionally to any use of control and restraint. However, it is not clear that this is the case in every instance where pain compliance is used. Furthermore, the use of pain in restraint, even where the pain is minimal, risks amounting to inhuman and degrading treatment in breach of Article 3.

252. Draft NICE guidance suggests that such techniques should be permitted only in exceptional circumstances where no other means of control are available.²⁴⁷ We support the draft NICE guidance that pain compliance should only be used where necessary in exceptional circumstances, but consider that, in order to be human rights compliant, it will need to be very narrowly construed. **In the most exceptional circumstances where the use of pain is considered necessary to avoid a threat to the life of or threat of serious injury to the person being restrained, or others, it would need to be very carefully justified, and be used to the minimum degree necessary. Training should emphasise these points, and should draw attention to the human rights aspects of this technique.**

Discriminatory use of control and restraint

253. A serious concern expressed in relation to restraint, in police as in mental health custody, is that it is used in a racially discriminatory way, in potential breach of both Article 14 ECHR (read with Article 8 or Article 3 ECHR) and of the Race Relations Acts. However, a systemic problem of race-related restraint deaths in any custodial setting is difficult to establish. In the case of police custody, for example, the PCA told us that, although rates of deaths in police custody were higher for those from ethnic minorities, discrimination was very difficult to prove in individual cases. They did not discount the possibility of it, but considered that more detailed research was needed. The PCA also pointed out that, for the future, the increased transparency in the new IPCC system of investigations should assist in exposing any discrimination in individual cases. The Home Office cited independent research which it recently commissioned which found no issues of discrimination against ethnic minorities or racial stereotyping in relation to deaths in police custody.²⁴⁸ ACPO confirmed that there is no consistent monitoring across all police forces for ethnicity in the use of control and restraint.²⁴⁹

254. In relation to Mental Health Act detention, the Report on the Death of David Bennett supported evidence from INQUEST and others of the discriminatory use of control and restraint against ethnic minorities.²⁵⁰ The MHAC told us that 28% of restraint-related deaths in the last seven years had been of ethnic minority patients, in contrast to an ethnic minority patient population of about 5–6%. The Commission found it difficult to draw conclusions from this research, however, as the numbers were so small.²⁵¹ Mr Ladyman told the Committee in oral evidence that there was a lack of research in this area to clearly

247 National Institute for Clinical Excellence, *Draft guidelines on the short term management of disturbed (violent) behaviour in in-patient psychiatric settings and accident and emergency settings*, July 2004, para. 1.8.7

248 Ev 95

249 Q 419

250 Ev 147 (INQUEST) and Q 134 (MIND)

251 Q 180

establish race discrimination.²⁵² This may shortly be addressed: the MHAC referred to its ongoing research, carried out in conjunction with the National Institute of Mental Health in England, to assess mental health services for minority patients. Furthermore, the Department of Health's response to the David Bennett inquiry accepted the need to address racism in the NHS and announced a programme of work, to be directed by the MHAC, to combat this.²⁵³ Draft NICE guidance, soon to be finalised, recommends training for all staff in cultural awareness.²⁵⁴

255. The positive duty to promote race equality, under the Race Relations (Amendment) Act 2000, places a substantial obligation on the Home Office, and on individual police forces, to proactively ensure that human rights intrusive powers such as control and restraint are not used in a discriminatory way. The government drew attention to a number of initiatives taken in light of this responsibility to promote equality.²⁵⁵ Each police force is required to have a Race Equality Scheme in place, and CENTREX, the organisation responsible for police training, has introduced a training programme designed to meet this obligation. ACPO's Race Diversity Strategy also provides guidance to forces on race equality issues. The Home Office also told us that Guidance had been issued in response to the findings of the David Bennett inquiry²⁵⁶ and assured us that "every police force will be expected to develop local protocols that reflect the kinds of concerns highlighted in the report".²⁵⁷

256. **The possibility that racial stereotyping has been a contributory factor in at least some deaths in custody resulting from restraint should be taken seriously, by both police forces and NHS trusts, as an alert to the risk of a breach of Article 2 ECHR, of Article 14 ECHR read with Articles 2, 3 and 8, and of the obligations of police forces under the Race Relations Acts.** The perception of discriminatory use of restraint is supported by what is generally acknowledged to be patchy compliance with ACPO guidelines on restraint, and variation in the training in restraint techniques provided to police officers. **Race equality schemes under the Race Relations (Amendment) Act need to provide for measures to prevent discrimination in the use of restraint. We emphasise the need for training of all staff who may be involved in control and restraint, to include cultural awareness in its use. This obligation arises both under the Human Rights Act and under the positive duty to promote race equality in the Race Relations (Amendment) Act 2000. Such training should be to national standards and delivered by accredited trainers, as recommended above.**

Detainee Involvement

257. One means by which appropriate and proportionate use of restraint can be ensured is by involving a patient or prisoner who may become violent, in advance, in deciding on the responses to be taken to such violence, for example as part of a care plan in Mental Health

252 Q 203

253 Written Ministerial Statement of Rosie Winterton MP, HC Deb., 12 February 2004, cols. 77–78WS

254 National Institute for Clinical Excellence, *Draft guidelines on the short-term management of disturbed (violent) behaviour in in-patient psychiatric settings and accident and emergency settings*, July 2004, para. 1.3.5

255 Ev 95–96

256 Home Office Circular 17/2004

257 Q 255

Act detention. This can assist in establishing a culture which is not solely or primarily one of control or force, but one in which a detainee's human rights and the safety of others are balanced and respected. A Mental Health Act detainee might, for example, express an advance preference to be dealt with by seclusion, control and restraint, or rapid tranquillisation if he or she were to become violent. A personal choice expressed by a detainee would not of course absolve prison or mental health staff from the duty to apply measures proportionately and in a human rights compliant manner if the situation arose.

9 Staffing and training

258. Failures in the assessment of healthcare needs and the provision of healthcare, and excesses in the use of restraint, raise questions about the training provided for those with responsibility for ensuring the safety of detainees. Inadequacies of training have been found to contribute to breaches of the Article 2 positive obligation to take preventative measures to protect those whose lives are at risk. In *Edwards v UK*,²⁵⁸ which concerned the murder of a remand prisoner by his mentally ill cellmate, the European Court of Human Rights' finding of a violation of Article 2 was based in part on the screening of prisoners by a health worker who was inadequately trained for that purpose. This, combined with defects in information provision to the prison on arrival of prisoners, led to a breach of Article 2.

Staffing of police custody suites and staff training

259. We have already referred to concerns about the adequacy of training for police custody officers (see paragraphs 155 et seq). The extent and quality of such training appears to vary considerably as between police forces, despite the existence of a CENTREX national training programme for custody officers.²⁵⁹ Implementation of this national programme is a matter for individual police forces. Although the Home Office stated that many forces provide two to three weeks' training before officers are appointed to custody duties,²⁶⁰ it conceded that this was not consistent across all forces. We were told that some custody officers began work before they had received any training at all in custody officer duties.²⁶¹

260. The dearth of training for custody officers does not appear to reflect any lack of demand for training from custody officers themselves.²⁶² A pilot programme in the Metropolitan Police Service's Professional Standards Directorate, on the Prevention and Reduction of Death Following Contact with the Police, whose work has included a series of seminars for police custody officers and other staff, reported a demand for improved training amongst police officers working in custody suites.²⁶³

261. Evidence to the inquiry put forward proposals for establishing high and consistent standards of custody officer training. The Police Federation considered that—

the only way to ensure this acute under-investment in training is properly addressed is to make training part of the national competency framework and accredit custody sergeant training ... custody training is a prime example where there should be no variation between forces.²⁶⁴

258 *Edwards v UK* (2002) 35 EHRR 19

259 Q 139

260 Ev 96

261 Q 426 and Q 379

262 QQ 428–429

263 Meeting with the Metropolitan Police Service Professional Standards Directorate, 7 July 2004

264 Ev 163

Furthermore the Police Federation strongly supported “the introduction and monitoring of compulsory refresher and re-qualifying training for police officers working in custody suites”.²⁶⁵

262. ACPO considered that—

The introduction of a requirement to use and follow a structured, centrally produced training programme addressing core and critical competencies for the roles of Constable Gaoler, Designated Detention / Escort Officer and Custody Officer would promote a common approach, with common standards ... The transference of knowledge could be done through a nationally recognised accreditation programme, through a recognised body, with in built quality and content controls, inspections and audits ...²⁶⁶

263. In our view, the significant responsibilities of custody officers, not least their responsibilities under the Human Rights Act, and the skilled nature of their work, should be recognised. Expecting inadequately trained or wholly untrained staff to take responsibility for the custody of detainees who may be physically or mentally ill, disturbed, violent, or affected by a range of drug or alcohol addiction, places detainees at most risk, and may lead to breaches of the police force’s positive obligations to protect Convention rights under Articles 2, 3, and 8, through failure to identify risk, to ensure the provision of appropriate and adequate healthcare, or to prevent suicide or self-harm. Management of police custody should be supported by a more reliable training structure than the present model. **As a minimum requirement to ensure Human Rights Act compliance, we recommend that police forces should ensure that no custody officer should start work without training for this specialised role. Reliable human rights protection and the safety of detainees requires a standardised training programme for custody officers, consistently applied across all police forces, and including regular follow-up training. This could be facilitated by a national accreditation scheme for custody officers. Training should cover first aid and control and restraint, identifying and responding to drug and alcohol intake, and identifying and responding to mental disorder, risk of suicide and self-harm. It should also include training on cultural awareness, in fulfilment of police forces’ obligations under the Race Relations (Amendment) Act, as well as under the Human Rights Act.**

Prison officer training

264. Concerns have also been expressed to us about training for prison officers. We were particularly concerned to learn that there is no requirement for prison staff to undergo ongoing suicide prevention training. At Pentonville, we were told that although there was now some suicide awareness training for the new intake of officers, there was no refresher training for these or other officers. We were told of the difficulties in finding staff time for training, given the pressures on the prison and prison staff, in a prison that was overcrowded and had a very high turnover of prisoners. In discussion our experience has been that many prison officers would appreciate the opportunity for more and better

²⁶⁵ Ev 164

²⁶⁶ Ev 134

training. We are also concerned that the quality and depth of suicide prevention training is insufficient to equip prison officers with the skills they need.

265. Helen Shaw of Inquest told us that at inquests—

We have heard prison officer after prison officer answer questions to say they have not had refresher training on the implementation of some very good guidance the Prison Service has issued, and our sense is that there is no proper system for ensuring that there is learning from deaths that occur in similar situations.²⁶⁷

266. We recommend that both initial and ongoing training in suicide prevention, including first aid, resuscitation, and mental health awareness should be made mandatory for all prison staff, along with regularly updated training on the use of control and restraint and on cultural awareness.

Control and restraint training

In hospitals

267. Comprehensive training in control and restraint does take place for staff in some secure hospitals.²⁶⁸ But research indicates that significant numbers of mental healthcare staff, including nurses, had received no training in control and restraint as part of their undergraduate training; many had received no in-service training and no refresher training, and those staff who had been trained had little confidence in their ability to use restraint safely or to manage violence without recourse to restraint.²⁶⁹ The Report into the Death of David Bennett found a “serious failure of training” in control and restraint techniques, which contributed to the excessive and dangerous level of restraint used against Mr Bennett, and recommended that there should be a national system of training in control and restraint.²⁷⁰

268. Draft NICE Guidance states that all service providers must have a policy for training employees and staff-in-training in relation to the short-term management of violence, and that training relating to the management of violence should be subject to the national accreditation and regulation scheme being established by the National Institute for Mental Health in England (NIMHE) and the Security Management Service (SMS).²⁷¹ It also provides that there should be an ongoing programme of training for all staff in racial, cultural, spiritual and social issues.²⁷²

267 Q 11

268 Meeting with staff at Broadmoor hospital, where training for all staff in the use of restraint, and annual refresher training, is compulsory. Training included 5 days of training in using restraint as part of a team of three people, and training in “breakaway” techniques to allow staff to disengage from an aggressor.

269 UK Central Council for Nursing Midwifery and Health Visiting, *The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care*, February 2002

270 Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, *Independent Inquiry into the Death of David Bennett*, December 2003, p 29

271 National Institute for Clinical Excellence, *Draft guidelines on the short term management of disturbed (violent) behaviour in in-patient psychiatric settings and accident and emergency settings*, July 2004, para. 1.3.2

272 *ibid.*, para. 1.3.5

269. It is vital that staff should be qualified to assess risk accurately and respond proportionately to it. **As a basic principle, and in order to ensure compliance with Article 2, no member of staff should be involved in the use of control and restraint unless they have been trained in its use. There should be a statutory obligation on health authorities to ensure that all staff who may be involved in control and restraint are trained in its use, and to provide mandatory annual refresher training for all staff. Training should be carried out using nationally accredited trainers. It should include cultural awareness and gender issues, and should include an explanation of the obligations imposed under the Human Rights Act.**

In Police Custody

270. There is no statutory regulation of police powers of control and restraint. A training manual, the Personal Safety Manual of Guidance, produced by ACPO and CENTREX, lays down a national basis for training in control and restraint, but the extent to which this model is adopted is a matter for individual police forces. The decentralised nature of the policing system means that there is little consistency in practice of control and restraint, or in training of police officers in control and restraint, across different police forces. This is a feature of a number of aspects of police custody practice, as we discuss further below. A number of witnesses expressed specific concern about the variation of training in control and restraint.²⁷³

271. ACPO confirmed that there was no consistent monitoring or recording across all police forces of the use of control and restraint.

272. However, ACPO stated—

There is specific guidance and training for all officers, with refresher training on a regular basis, that actually identifies issues such as positional asphyxia and problems in relation to excited delirium, and all officers are made aware of this from their initial training and right through their refresher training, and also the problems ... in relation to the way that people should not be held in prone positions.²⁷⁴

273. However, the Home Office conceded that, although the ACPO/CENTREX Manual of Guidance provided a basis for restraint training nationally, the extent of training on the basis of the manual was a matter for individual police forces, and the amount of time allocated to restraint training varied considerably between police forces, "from as little as 4 hours annually to up to 4 days annually."²⁷⁵

274. The recent Report of the Inquest into the Death of Roger Sylvester expressed concern that, in relation to the training offered by the Metropolitan Police Service "there does not appear to be any specific training or any specific procedures for continuing to restrain a non-compliant person with ABD [Acute Behavioural Disturbance] on their side or in a kneeling or sitting or in a standing position" despite the increased risk of asphyxiation that

273 Ev 163–164 (Police Federation), Ev 133–134 (ACPO) and Ev 190 (Professor Gournay)

274 Q 421

275 First Report of Session 2003–04, *op cit.*, Ev 8

resulted from restraint of such a person in a prone or semi-prone position.²⁷⁶ The Coroner also concluded that police officers needed training in the specific techniques appropriate to restraint of persons arrested under section 136 of the Mental Health Act.²⁷⁷

275. ACPO noted that under the Police Reform Act 2002 there was potential for guidance to be developed across the police service on key issues, in the form of codes of practice. The under-regulation of control and restraint, and inconsistency in its practice raise concerns of human rights compliance similar to those that arise in the mental health context. **In our view, there should be a national Code of Practice on restraint in police custody, which takes account of the Convention rights. The Code of Practice should be backed up by statutory obligations which mirror those we have recommended in relation to Mental Health Act detention: to record all incidents of the use of force, and to train on the basis of the Code of Practice. Training, including mandatory annual refresher training, which reflects human rights standards, should be conducted by nationally accredited trainers. Police policy and training on control and restraint should draw on experience and standards in the mental health sector.**

Co-ordination of policy and training on restraint

276. The circumstances in which restraint is used vary, and the techniques used to ensure safety in one custodial environment are not necessarily directly or universally applicable in another. Nevertheless, there are common issues in the use of restraint in all forms of detention,²⁷⁸ in particular the use of restraint against disturbed and mentally ill people, and the possibility of disproportionate use of restraint against people of particular ethnic groups. The recent death in a juvenile detention centre following restraint has highlighted the need for review of prison service policy and training on restraint. In this, the prison service might benefit from discussions on training and techniques with the police and healthcare sectors.

277. Practice and policy in restraint techniques appears to vary widely between different forms of custody—for example, whilst we understand that mechanical restraints are regularly used in police custody, the practice in Mental Health Act detention is to use such restraints only in the most exceptional situations, if at all. Special hospitals may however rely on restraint through medication, or on seclusion.

278. There is a strong case for exchange of expertise and good practice on restraint between the police, prison service and NHS. This is particularly so given the wealth of recent initiatives to improve safety in the use of restraint, in particular in mental health settings. Exchange of information will assist in the development of consistent guidance across all settings where restraint may be used, and in the development of consistent and comprehensive training models to a high standard. It should also assist in devising

276 Inquest into the Death of Roger Sylvester, Section 2, pp. 7–8. Following this the Metropolitan Police Service published a Report on restraint and Mental Health, September 2004, which recommended, amongst other things, that the Department of Health should commission research to provide practical guidance on restraint of people with Acute Behavioural Disturbance (Recommendation 8)

277 *ibid.*, Section 2, p. 18; Section 3, p. 6

278 The report of the coroner in the inquest into the death of Roger Sylvester suggested that police officers could usefully learn from the experiences of psychiatric nurses in using de-escalation techniques to avoid physical restraint. This would particularly be so in respect of persons detained under section 136 of the Mental Health Act (p. 18).

proportionate and flexible responses to violence, which are human rights compliant. INQUEST proposes that—

[t]here 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.²⁷⁹

279. We understand that some of this joint development is already taking place, in particular within the cross-government group on the management of violence, which is working towards the production of joint guidance applicable across prison, police, and mental health act detention. The guidance is to cover local protocols and will address training needs in relation to restraint. **We welcome the establishment of the cross-government group on the management of violence. We recommend that further joint working should take place to ensure that high standards of safety are set and maintained wherever restraint is used against detainees. A permanent body should be established to ensure that these standards are maintained and kept under review.**

280. Ensuring the safety of detainees also requires that detainees who must be restrained are restrained in the environment and by the people who are best qualified to protect them from harm. This is a particular issue in relation to highly mentally disturbed people who are detained in police custody, in particular under section 136 of the Mental Health Act 1983. The Report into the Death of Roger Sylvester addressed this issue and concluded that NHS bodies should give priority to treatment of patients with acute behavioural disturbance who are being restrained by the police, and that local protocols should reflect this. It emphasised that an acutely disturbed and non-compliant detainee in restraint constituted a medical emergency, and should be treated as such and be given priority in transfer to hospital.²⁸⁰

Staffing Levels

281. On visits to a number of institutions, and in written evidence and discussions, we have seen that serious understaffing is hindering capacity to protect vulnerable people, in many prisons, special hospitals, and police custody suites. At Broadmoor, for example, we were told that staff shortages were a chronic problem, a product of both lack of resources and problems in recruiting, which gave rise to concerns about both staff and patient safety. On several of our prison visits we were told that staff shortages made observation of prisoners more difficult, and prevented staff from being released for training. We were also told in evidence that staff shortages were a problem in some police cells. Detention and care of people at risk of self-harm and suicide is inevitably resource intensive. Chronically understaffed detention facilities create conditions in which deaths in custody can more easily occur. **In our view, adequate staffing is a necessary precondition to safety and Article 2 protection.**

279 First Report of Session 2003–04, op cit., Ev 93

280 Inquest into the Death of Mr Roger Sylvester, op cit., p. 16

10 Inquiries into deaths in custody

282. The Article 2 positive duty to protect the right to life implies a duty to investigate any unnatural death of which the State is made aware, including but not confined to deaths in which State agents may be implicated.²⁸¹ An effective system of investigation which ensures accountability for unlawful killings is seen as essential to the practical protection of the right to life. Such investigations are particularly vital in cases where there may be State involvement, as the European Commission of Human Rights pointed out in *McCann v UK*—

A general legal prohibition of arbitrary killing by state authorities would be rendered nugatory if, in practice, there was no mechanism for reviewing the action of the state agents. It must often be the case where state agents have used lethal force against an individual that the factual circumstances and the motivation for the killing lie largely, if not wholly, within the knowledge of the state authorities and that the victims' families are unlikely to be in a position to assess whether the use of force was in fact justified. It is essential both for the relatives and for public confidence in the administration of justice and in the state's adherence to principles of the rule of law that a killing by the state is subject to some form of open and objective oversight.²⁸²

But the duty to investigate is no less strong in cases involving not the use of lethal force but a negligent failure to protect life. Indeed, as pointed out in chapter 2, the House of Lords in *Amin* held that such cases of systemic failure may require even more elaborate investigation than cases of deliberate killing by state agents.

283. The procedural obligation which therefore arises under Article 2, to conduct an effective investigation, applies to any unnatural death which occurs in State detention.²⁸³ The European Court of Human Rights has established a number of criteria for an effective investigation which will satisfy Article 2, summarised in *Jordan v UK*:²⁸⁴

- **State initiative.** The State authorities must act of their own motion to initiate an investigation into the death, rather than leaving it to the next of kin to bring proceedings.
- **Independence.** Those carrying out the investigation must be independent from those implicated in the death. They must be institutionally independent, and must also demonstrate their independence in practice.
- **Effectiveness.** The investigation must be capable of leading to a determination of whether the action taken by State officials was justified in the circumstances, to a determination of the culpability of those responsible²⁸⁵ for the death. This is an

281 *McCann v UK* (1996) 21 EHRR 97; *Ergi v Turkey* (2001) 32 EHRR 18; *Yasa v Turkey* (1999) 28 EHRR 408

282 *McCann v UK*, op cit., para. 191

283 *Edwards v UK*, op cit., para. 74

284 *Jordan v UK* (2003) 37 EHRR 2, paras 105–109

285 *ibid.*, para. 107: The investigation must be: “capable of leading to a determination of whether the force used in such cases was or was not justified, and to the identification and punishment of those responsible”.

obligation of means rather than result, so that steps must be taken to secure all relevant evidence in relation to the death.

- **Promptness.** The investigation must take place promptly and must proceed with reasonable expedition.
- **Transparency.** The investigation must be open to public scrutiny to a degree sufficient to provide accountability in the circumstances of the case.
- **Family Participation.** The next of kin of the deceased must be involved in the inquiry to the extent necessary to safeguard his or her legitimate interests.

284. Within these criteria, the form which the investigation takes may vary. Article 2 need not be satisfied through any one single process. For example, an internal inquiry, though lacking in independence, may contribute towards gathering evidence which may assist the inquest and any subsequent prosecution.²⁸⁶ In the UK, the Article 2 duty is fulfilled through the inquest system, through systems of independent inquiry, either *ad hoc* or systematic, and (albeit rarely) through prosecutions. Since Article 2 also requires that the investigation should be at the instigation of the State, rather than any private person, civil proceedings brought by family members do not contribute to Article 2 compliance.²⁸⁷

285. Article 13, the right to an effective remedy for breaches of Convention rights, requires that mechanisms should be in place for establishing any responsibility on the part of state bodies or agents for a death, and that the system should allow the next of kin an enforceable right of compensation in respect of the death.²⁸⁸ Article 13 does not require that an inquiry should be on the initiative of the state, and therefore civil proceedings, which may lead to an award of damages, may be sufficient to satisfy Article 13.

Informing and involving families

286. A death in custody, once it has occurred, requires respect for the rights of the family of the person who has died. During this inquiry we met family and relatives of people who had died in custody, who raised serious concerns about the authorities' response to the death, the information provided to the family, and the extent to which they had been involved in inquiries. Several of the families had been informed of a death in ways that were highly insensitive, and several had been given insufficient information about what had happened, or had been obstructed in their attempts to obtain information. In a number of cases we were told of, parents were informed of the death of a son by telephone. Some families had not been informed of their right to have a medical representative present at the post mortem.

287. We were told by a number of the public bodies responsible for inquiring into deaths in custody of a new emphasis in family liaison in investigations, in the coroners' courts and in the CPS. We welcome these measures, which we discuss further below, and hope that they will lead to changes in practice. We are concerned, however, that in the immediate

286 Ev 86

287 *Jordan v UK*, para. 105

288 *Edwards v UK*, paras. 96–102

aftermath of a death, families are not always treated with the respect and consideration that they deserve. **All institutions of detention should develop and implement procedures to inform family members of a death promptly and sensitively, to provide them with appropriate support, advise them on how the post-mortem investigation will proceed, and to provide them, promptly, with information on the circumstances of the death and seek agreement with the family on procedures to be used for the return or disposal of the possessions and personal effects of the deceased. Staff members should be trained in effective liaison with families in these circumstances. Contact details of the next-of-kin of detainees should be kept as comprehensively as possible to ensure that they can be informed in as sensitive a way as possible. Wherever possible, staff should visit the family to inform them in person of the death.**

Inquests

288. The Inquest is the main forum in which the Article 2 investigatory duty is discharged in the majority of deaths in custody cases in England, Wales and Northern Ireland. The Coroners Act 1988, in section 8(1), requires that an inquest *must* be held where a death takes place in prison. In practice, an inquest with a jury is held in every case of death in police or prison custody,²⁸⁹ although there is not always a jury in inquests following deaths in Mental Health Act detention. The Mental Health Act Commission regrets this, pointing out that the presence of a jury can lead to a more detailed examination of the circumstances of the death.²⁹⁰ Under rule 43 of the Coroners' Rules, a Coroner may make recommendations to any appropriate authority on steps that should be taken to prevent similar deaths.²⁹¹

289. In Scotland, there is no inquest system; initial investigation of deaths is by the Procurator Fiscal, who reports to the Lord Advocate. This is followed by a Fatal Accident Inquiry, a public judicial inquiry, in all deaths in custody cases.²⁹² The inquiry looks to all the circumstances of the death, including any systemic problems which may have contributed to it.²⁹³

290. Under the ECHR, a sufficiently thorough coroner's inquest may satisfy the Article 2 procedural requirement of an independent investigation.²⁹⁴ Whether it does, however, depends on whether, in the circumstances of a particular case, it satisfies all the requirements which have now been spelled out of Article 2, and serves the purpose of being both an effective investigation into the circumstances surrounding the death and capable of leading to the identification and prosecution of those responsible for the death.

291. There are a number of respects in which an inquest may fall short of satisfying the Article 2 duty of investigation. The main problem is the limited purpose and scope of a coroner's inquest under the current legal framework. The relevant legal provisions defining the purpose and scope of an inquest have traditionally been interpreted to mean that the

289 Ev 86, para. 10

290 Ev 117

291 See for example, the report into the Death of Mr Roger Sylvester, *op cit.*, See also Ev 136–139

292 in the majority of other cases a Fatal Accident Inquiry is held only at the discretion of the Lord Advocate

293 Fatal accident and Sudden Death Inquiry (Scotland) Act 1976

294 *McCann v UK*, *op cit.*, para. 162

inquest has a narrow fact-finding role, and does not extend to looking at the “broad circumstances” in which the death occurred. This means that, on the traditional approach to the purpose and scope of inquests, systemic neglect was not a proper matter for investigation. In *Amin*, the House of Lords unanimously agreed that a coroner’s inquest would not satisfy the procedural obligation in Article 2 because of the various legal restraints contained in the Coroners Act 1988 and the Coroners Rules 1984. No inquest had been held in the case, because the coroner had adjourned the inquest into the death of the deceased pending the trial of the murder charge against the cell-mate, and then subsequently declined to resume it. In the proceedings the coroner put in an affidavit giving detailed reasons why the constraints to which coroners and inquests are subject would make an inquest an unsuitable vehicle for investigating publicly the issues raised by the case, and the House of Lords accepted that evidence. As Lord Hope put it the coroner is restricted to a simple short verdict.²⁹⁵ She cannot make recommendations, and many of the issues which still need to be investigated in public would be beyond the scope of her inquest. Lord Bingham noted that it would overcome the problems exposed by this appeal if effect were given to the recommendations of the Fundamental Review (considered below).²⁹⁶ However, since the implementation of those fundamental changes required legislation, the only alternative in the meantime was to order the holding of an independent public inquiry into the circumstances which led to the death of Mr. Mubarek at the hands of his cell-mate.

292. Another problem in relation to Article 2 compliance arises where the inquest is suspended pending a prosecution.²⁹⁷ If at the subsequent trial there is a guilty plea and therefore no evidence is heard regarding the circumstances of the death, and following the conviction, the inquest is not re-opened, Article 2 will not be satisfied, in the absence of another form of independent inquiry. Families of those who died may be left with many unanswered questions regarding the circumstances of the death.

293. Particular problems of compliance have also arisen in relation to the Northern Ireland inquest system, due in part to delays, and in part to the narrow range of findings open to an inquest under the Northern Ireland system.²⁹⁸

The Luce Report

294. That the purpose and scope of a coroner’s inquest under the current legal framework is too narrow to satisfy the procedural obligation in Article 2 in cases concerning system neglect has now been recognised by the fundamental review of death certification and investigation in England, Wales and Northern Ireland (“the Luce Report”) published in June 2003.²⁹⁹ It recommended that the inquest should be the principal means of conducting an Article 2 compliant investigation. The Luce Report made a series of recommendations for reform of the inquest system. Amongst the recommendations were—

295 *McCann v UK*, *op cit.*, para. 64

296 *ibid.*, para. 33

297 This was the context in which breaches of Article 2 were found in *Edwards v UK*, *McKerr v UK*, and in the *Amin* case.

298 *Ev* 73–80

299 *Death Certification in England, Wales and Northern Ireland, Report of a Fundamental Review*, Cm 5831, HMSO, 2003 (“The Luce Report”)

- A broader remit for inquests, encompassing the cause and circumstances of the death and an analysis of whether there were any systemic failings that contributed to it; and whether there was a real and immediate risk to life which the authorities did not take reasonable steps to prevent;
- The inquiry should extend to whether any regulatory or safety regimes were properly observed;
- In cases where Article 2 ECHR is engaged, the inquest should remain the main forum of inquiry;
- There should be a new set of rules on disclosure reflecting a presumption in its favour but containing necessary safeguards;
- The coroner's office should be required to make contact with the family at an early stage and provide them with information and support throughout the process;
- There should be regular audits of inquest and investigation timings;
- There should be a Family Charter for the coroners' courts.

295. The Home Office responded to the Luce Report in a Position Paper of March 2004.³⁰⁰ It proposed a reorganisation of the coroner and death certification services, with the creation of an office of Chief Coroner for England and Wales, a system of inspections, and an advisory Coronial Council.³⁰¹ Consideration is also to be given to a right of appeal from inquest verdicts.³⁰² The paper makes a commitment to securing better premises for Coroners' Courts, and supports consistent staffing of coroners offices from central funds.³⁰³ It supports the wider scope of inquest verdicts now required in appropriate cases by the House of Lords (see below). The paper also suggests that Rule 43 reports should be more widely disseminated and systematically monitored, and that the recommendations of all such reports, and their implementation, should be reviewed in an annual report of the Chief Coroner.³⁰⁴ The Home Office paper accepts the recommendations of the Luce report regarding the involvement of families, making a commitment to a family charter to be displayed in all coroners' offices.³⁰⁵ **We welcome the Home Office commitment to implement the Luce Report, in particular the establishment of a Family Charter for the coroners' court. We hope that the commitment to family involvement will be made a reality through full provision of information and documentation.**

296. The Home Office paper makes wide-ranging recommendations for the modernisation of the administrative and funding structures of the coroners' courts. It states that a White Paper and draft Bill on reform of the inquest system will be published by spring 2005.³⁰⁶

300 Home Office, *Reforming the Coroner and Death Certification Service, A position paper*, Cm 6159, March 2004

301 The Luce Report, paras. 45–52

302 *ibid.*, para. 53

303 The Luce Report, paras. 55–59

304 *Reforming the Coroner and Death Certification Service, A position paper*, Cm 6159, March 2004, para. 76

305 *ibid.*, para. 25

306 *ibid.*, Annex 3

The inquest verdict

297. The potential scope of an inquest has been widened by recent decisions of the House of Lords in *R v HM Coroner for the Western District of Somerset ex parte Middleton*³⁰⁷ and *R v HM coroner for West Yorkshire ex parte Sacker*³⁰⁸ on 11 March 2004. Prior to these judgments, the inquest verdict was confined to identifying the immediate means of death. Its task was to determine “how, when and where the deceased came by his death”,³⁰⁹ which was interpreted as a determination of the immediate cause, rather than the background to and reasons for the death. In Northern Ireland, where inquests issue “findings” rather than verdicts, particular restrictions have applied which, most significantly, have prevented inquests from returning a verdict of unlawful killing.³¹⁰

298. *Middleton* and *Sacker* make clear that Article 2 ECHR requires that an inquest jury should be permitted to issue conclusions on the surrounding facts of a case. The power to issue a verdict on “how” the deceased came by his death should be interpreted broadly as meaning “by what means and in what circumstances”.³¹¹ This includes, in the case of a death in custody, whether and to what extent systemic failings were a factor in the death. In cases where a traditional short form verdict is not sufficient to establish this, the coroner at his or her discretion should decide on a means to elicit the jury’s decision on the key factual issues in the case. The coroner may, for example, invite a narrative verdict or invite the jury to answer a series of factual questions. The form of the verdict should not, however, contain any finding of civil or criminal liability on the part of any named person.³¹² The Northern Ireland Court of Appeal has applied the principles set out in *Middleton* in *In Re Jordan*,³¹³ where it was held that, although a verdict of “unlawful killing” remained unavailable to coroners in Northern Ireland, the inquest should be able to consider the background circumstances of a death, and make findings of fact on the actions of agents of the state relating to it.³¹⁴

299. Narrative verdicts will be of particular importance in deaths in custody cases where the causes of death may be complex, for example, where a death may have been self-inflicted but contributed to by neglect, or lack of effective healthcare. As the Home Office position paper, issued prior to *Middleton*, noted—

The most effective outcome for inquests would ... be a narrative verdict, as current short-form verdicts do not always give an adequate explanation and are used inconsistently. Narrative verdicts can be more helpful and informative than simple verdicts such as “accident” or “misadventure”. The latter can be used inconsistently

307 *R v HM Coroner for the Western District of Somerset ex parte Middleton* [2004] UKHL 10

308 *R v HM Coroner for West Yorkshire ex parte Sacker* [2004] UKHL 11

309 Section 11(5)(i) of the Coroners Act; Rule 36 (1)(b) of the Coroners Rules

310 Ev 78

311 *Middleton*, *op cit.*, para. 35

312 *ibid.*, paras. 36–37

313 [2004] NICA 30

314 The Court of Appeal considered that if the jury is entitled to make findings of fact and reach conclusions of fact on the central issue in this case, namely, whether the force used was unjustified, a verdict of “unlawful killing” is unnecessary. Para. 36.

and are sometimes without any clear distinction. They can also imply that no-one was responsible for a death rather than that the death was not intended.³¹⁵

300. Recent inquests into deaths in custody have made use of narrative verdicts to provide a fuller picture of the circumstances of a death and the systemic failings which formed the background to it. The inquest into the death of Terry Doyle recorded a verdict of suicide, contributed to by failures in the prison's system of observation and risk-assessment. The inquest into the death of Joseph Scholes recorded a verdict of accidental death in part contributed to by failure to assess the risks and to take appropriate steps to prevent his death. **We welcome the introduction of narrative verdicts in inquest proceedings, as enabling a fuller explanation of the causes of deaths in custody. We emphasise the need for coroners in the exercise of their discretion to make full use of narrative verdicts in deaths in custody cases, in order to provide a full explanation of the case as required by Article 2.**

301. The wider scope of inquests in Article 2 cases has resource implications for the Coroners' Courts. In an additional written submission following the *Amin* case, the Coroner's Society of England and Wales, whilst welcoming the clarification of the law in that case, noted that "judicial decisions do not provide the resources with which to put them into effect. We have grave doubts whether the manpower resources or jury suitable courts are available to deliver the widened scope of inquests required. In some cases they clearly are not".³¹⁶ **We recommend that the resource implications of the House of Lords' ruling that fuller inquiry and a narrative verdict is required in some inquests where Article 2 is engaged, must be taken into consideration in the Government's response to the Luce report.**

Production and disclosure of documents to families

302. One difficulty with the current system relates to disclosure of documents. Failure to disclose relevant documents to families in advance of the inquest was one of the reasons for non-compliance with Article 2 in *Jordan v UK*. Pre-inquest disclosure of documents to relatives of the deceased now takes place, but is on a voluntary basis only.³¹⁷ Although policy is to disclose documents and information to the greatest extent possible without compromising the inquest, INQUEST, Doughty St Chambers, and the Mental Health Act Commission all pointed in their evidence to delays or obstruction in the disclosure of documents.³¹⁸ The Luce report recommended that the rules of disclosure should reflect a presumption in favour of disclosure, subject to certain safeguards.³¹⁹ Where the disclosure of documents has been granted, it is the policy of the Court Service to recover expenses incurred in photocopying by levying a charge of £1.10 + VAT per sheet. This policy does not take into account reductions of cost as a result of improvements in reproductive print technology and appears in conflict with the goal of equality of access. **For disclosure to the**

315 Home Office, *Reforming the Coroner and Death Certification Service, A position paper*, Cm 6159, March 2004, para. 74

316 Ev 139

317 Home Office Circular 20/1999

318 INQUEST (First Report of Session 2003–04, op cit, Ev 95); Doughty Street Chambers (ibid., Ev 87); Mental Health Act Commission, (ibid., Ev 117)

319 The Luce Report, p. 105

family to support real and effective participation in the inquiry, as required by Article 2, it must be thorough, prompt and affordable. We recommend that the fullest possible disclosure should be made to the family well in advance of the inquest. We recommend the Court Service review its arrangements for levying disclosure charges with a view to providing a free or at least an affordable alternative for bereaved families.

303. Furthermore, the Coroner has no statutory power to compel production of documents at the inquest. The Luce report recommended that coroners should be given express powers to obtain any document, statement or report.³²⁰ **We recommend that Coroners should have statutory power to compel the production of documents.**

Delays and Resources

304. The Article 2 obligation to hold a prompt investigation is at risk of breach due to significant delays in the inquest system. INQUEST cite delays of more than two years in a number of recent deaths in custody cases.³²¹ There are particularly acute delays in the Northern Ireland inquest system, due largely to the practice of waiting until all other investigations and inquiries are concluded, before proceeding with the inquest.³²² As the CAJ point out in their evidence, such delays are particularly disturbing in cases where systemic failings are in issue, and may remain unaddressed pending the inquest.³²³ We note that the Northern Ireland Court Service has recently begun a consultation process on reform of the Northern Ireland Coroners' System.³²⁴ **Where the inquest is the means by which the Article 2 duty of investigation is satisfied following a death in custody, then significant delays may breach Article 2, which requires that an investigation into a death be prompt. We are concerned that current delays may in some instances lead to breaches of Article 2. We emphasise the need for the reviews of the coronial system, both in England and Wales and in particular in Northern Ireland, to address delays in the system.**

305. Another practical problem which may have real consequences for Article 2 compliance is lack of resources. The funding provision for coroners' offices is complex and variable, with the main sources of funding being police authorities and local authorities.³²⁵ Written evidence from Doughty St Chambers, and INQUEST, points to a serious problem of lack of resources in the coroners' courts. Doughty St Chambers annexed to their written evidence an affidavit of the coroner in the *Amin* case, Alison Thompson, which contains an account of the resources problems affecting her office, and notes that—

The extent of funding and staffing varies enormously between jurisdictions in England and Wales. The Borough provides no secretarial nor administrative staff for the

320 The Luce Report, p. 74

321 Ev 144

322 The Luce Report, p. 209

323 First Report of Session 2003–04, op cit., Ev 76

324 Northern Ireland Court Service, Consultation Paper, *The Coroners Service of Northern Ireland: Proposals for Administrative Redesign*, February 2004

325 Home Office, *Reforming the Coroner and Death Certification Service, A Position Paper*, Cm 6159, March 2004, para. 16. Local Authority funding is provided through the Office of the Deputy Prime Minister, although policy responsibility for the coroner service is with the Home Office, and the Coroners Rules are the responsibility of the Department of Constitutional Affairs (para. 17).

Coroner and there is no IT facility for the 12 Coroner's offices who still use manual typewriters.

306. Such examples of under-resourcing are a matter of particular concern given the reported delays in inquest proceedings. **We emphasise the need for the government response to the Luce report to address the adequate resourcing of coroners' offices in order to ensure Article 2 compliance.**

Legal Aid and Family Participation

307. Effective family participation in the inquest is likely to depend on the availability of legal assistance. Following the case of *R (Khan) v Secretary of State for Health*³²⁶ in 2002, new regulations were introduced governing the grant of legal aid to families of the deceased in inquest proceedings. Under the new regulations, the Legal Services Commission may, where it considers it equitable to do so, request the Secretary of State to disapply the normal eligibility limits for legal aid. The Legal Services Commission is required to have particular regard to the Convention rights in deciding whether to make such a request.³²⁷

308. In many cases, it appears that, under the new regulations, funding for legal representation for families at inquests continues to pose a problem. INQUEST have raised concerns that the new system is not uniformly applied across different LSC offices. INQUEST argue that the LSC have misinterpreted the construction of Article 2 in *R (Khan) v Secretary of State for Health*, to confine the requirement of legal aid to "exceptional" cases. They argue instead for the application of a form of merits test which would grant legal aid based on a likelihood of a finding that state agents were implicated in a death, directly or indirectly.³²⁸

309. Lack of funding for families' legal assistance is a matter of particular concern for families, given that funding for legal representation at the inquest is generally available to any state employees implicated in the death.³²⁹ The Luce Report recommended that funding for legal representation should be available to families in all cases where a public authority is also legally represented. The Home Office has not undertaken to ensure this, though it has undertaken to give further consideration to "finding an equitable and affordable formula that will provide relatives and others affected by an inquest with the level of legal support they need".³³⁰ **Participation of the next-of-kin in the investigation into a death in custody is an essential ingredient of Article 2 compliance. We recommend that, in all cases of deaths in custody, funding for legal assistance should be provided to the next-of-kin.**

326 [2003] EWCA Civ 1129

327 The Community Legal Service (Financial) (Amendment No.2) Regulations 2003

328 Ev 149–150

329 *ibid*

330 Home Office, *Reforming the Coroner and Death Certification Service, A position paper*, Cm 6159, March 2004, para. 75

Investigations of deaths in police custody

310. Investigations of deaths in police custody in England and Wales are now the responsibility of the Independent Police Complaints Commission (IPCC), which was established under the Police Reform Act 2002 and began work in April 2004. A more robust system of independent investigation applies in Northern Ireland under the Police (Northern Ireland) Act 1998 which established the Police Ombudsman for Northern Ireland. In Scotland, consultation is underway on the establishment of an independent policy complaints body.³³¹ As the IPCC stressed in its evidence, its role is not only to conduct and oversee investigations but also to act as a guardian of the investigations system as a whole. In pursuit of this it will “set standards, inspect performance, identify and spread best practice and ensure the appropriate lessons are learnt at both a national and local level when mistakes are made”.³³²

311. The Police Reform Act provides a statutory framework for independent inquiries into deaths in police custody which are capable of full compliance with Article 2 ECHR. Inquiries may be carried out by independent investigators employed by the IPCC, with powers to enter relevant premises, and require the production of evidence.³³³ Provision is also made in the legislation for full involvement of family members and other appropriate persons.³³⁴ However, the application of the Act in practice, and the resourcing of the IPCC, are crucial to achieving Article 2 compliance.

312. Although the 2002 Act provides a framework for an independent investigation, there remains no assurance of an independent investigation in every case. Following a death in custody, the IPCC has four options: to investigate the death itself; to manage a police investigation; to supervise a police investigation; or to allow an unsupervised police investigation.³³⁵

313. The IPCC made clear to us that it did not yet have the capacity to independently investigate all cases of deaths in police custody where Article 2 might apply.³³⁶ They calculated that in order to do so they would need 160 investigators; at the time of giving evidence they had 72. With this level of staffing, the IPCC envisaged that—

... there may be circumstances surrounding a death in custody which would suggest an independent investigation but which the IPCC would decide to manage or supervise. Where police officers are used for investigations the IPCC will need to determine whether they are taken from the force that is being investigated or from an external force.³³⁷

314. The IPCC’s criteria for investigations envisage that an investigation will be either conducted or managed by the IPCC in most but not all death in custody cases. Where the investigation concerns “a death or serious injury that has occurred as a consequence of

331 Scottish Executive, News Release, Next Steps on Police Complaints, 24/06/2004

332 Ev 109, para. 5

333 Police Reform Act 2002 Sections 17–18

334 Police Reform Act 2002 Sections 20–21

335 Police Reform Act 2002 Schedule 3, para. 15.4

336 Q 450

337 Ev 111

either a positive or a negative action by a person serving with the police”³³⁸ then it is likely that the investigation will be conducted or managed by the IPCC.

315. Where, following a death or serious injury resulting from contact with the police, Articles 2 and 3 ECHR may be engaged, the criteria note that—

The IPCC, as a public authority under the Human Rights Act 1998, has an obligation to determine a form of investigation that is an effective independent investigation that does not have any hierarchical or institutional connection with those implicated in the events.

316. The guidance takes the view that either an investigation conducted by the IPCC, or an investigation managed by the IPCC and conducted by an external police force, would satisfy the Article 2 requirement of independence. It allows the IPCC to take into account the competing demands for resources in its casework, in considering what form the investigation may take, so long as those competing demands do not compromise its human rights obligations.³³⁹ These obligations, however, can only be fulfilled to the extent that the IPCC has sufficient investigators to fulfil them.

317. The IPCC was optimistic that this under-resourcing was temporary. Nevertheless, it was stressed that lack of resources created both administrative problems, and problems for the public perception of independence which could affect the credibility of the IPCC system as a whole.³⁴⁰ The IPCC expressed particular concern that, as a result of the current heavy reliance on investigations by external police forces, police officers were frequently “criss-crossing the country” to investigate each other. This the IPCC judged to be wasteful of resources, and a potential threat to independence and the perception of independence, where, as had happened in certain cases, two police forces found themselves simultaneously investigating each other.

318. The controversies surrounding the investigation into the death of Kebba Jobe, shortly after the IPCC’s establishment, illustrate the problems that may arise if the under-resourcing of the IPCC continues beyond its start-up phase. The initial decision to allow an internal investigation by the Metropolitan Police, followed by transfer of the investigation to an external police force, was criticised by INQUEST.³⁴¹ However, the case was later taken over for investigation by the IPCC. The IPCC made clear that they would have preferred to have investigated this case independently from the start, but that in the early months of the organisation’s operation it had not had the capacity to conduct the investigation itself. They accepted the legitimate concern of the family and agreed that such a case would be the subject of direct investigation by the IPCC, now that the organisation was operating at full capacity.

319. We are concerned that Article 2 compliant independent investigations following deaths in police custody may be limited by resource constraints on the IPCC. The strong statutory basis of the police investigation system, and its capacity to comply with

338 IPCC criteria for investigations para. 18 See www.ipcc.gov.uk

339 *ibid.*, para. 22

340 *ibid*

341 Ev 146

Article 2 ECHR, will be undermined if the IPCC cannot employ sufficient investigators to carry out its statutory mandate appropriately.

Powers

320. Where the IPCC conducts an independent investigation, its investigators may make use of a full panoply of investigative powers. Investigators have powers of entry onto police premises, and powers to seize and retain relevant documents or evidence.³⁴² Chief Officers of Police have a duty to provide documents or information required by IPCC investigators.³⁴³ The Secretary of State may also order the use of surveillance or of covert human intelligence sources for IPCC purposes.³⁴⁴ These powers may also be exercised by police investigators where the IPCC manages or supervises an investigation.

Family liaison

321. The IPCC has adopted a policy of disclosure of the investigating officer's report to the family, subject to a harm test. The presumption in the IPCC system is to be that all relevant information will be disclosed to the family, "unless there are very exceptional reasons" why this should not happen. Family liaison officers have been appointed and trained: the IPCC was "trying to inculcate the culture in the organisation where responding sensitively and appropriately to the needs of the family is at the forefront of all our thinking from the first".³⁴⁵ Our own discussions with families of those who have died in custody have highlighted the need for investigating authorities to communicate effectively and fully with families from the outset. We welcome the priority being given to family liaison by the IPCC.

Co-operation with the CPS

322. Part of the importance of the investigation process to Article 2 compliance is its capacity to attribute responsibility for a death where this may be appropriate, and to provide evidence which may lead to prosecutions of those responsible. This is facilitated by close co-operation between investigators and prosecutors. A recently agreed protocol between the Crown Prosecution Service and the IPCC is intended to facilitate early and continued involvement of the CPS in the investigation. The procedures agreed under the protocol aim to ensure early CPS advice on legal and evidential issues in any investigation, whether undertaken by the IPCC itself, or managed or supervised by it. The protocol provides that early consultation and advice will always be considered in deaths in custody cases.³⁴⁶ The DPP stressed to us that under the new protocol his office would be "working with the IPCC in the closest way from the start of these investigations".³⁴⁷

³⁴² Police Reform Act 2002 Section 17

³⁴³ Police Reform Act 2002 Section 18

³⁴⁴ Police Reform Act 2002 Section 19

³⁴⁵ Q 454

³⁴⁶ Protocol between the Crown Prosecution Service Casework Directorate and the Independent Police Complaints Commission, July 2004, para. 5.1, www.cps.gov.uk

³⁴⁷ Q 16

323. The protocol is also designed to integrate family involvement into the investigation and the work of the CPS. Following a death in police custody, the IPCC is to notify the CPS of the case at the earliest possible date, so that, where the case may lead to a prosecution, a CPS lawyer can make early contact with the family to brief them on the CPS's role.³⁴⁸ The CPS and the IPCC family liaison officer are then to meet with the family.³⁴⁹ This is the first in a series of meetings specified by the protocol, designed to keep the family fully informed of the investigation process and decisions on prosecution. The IPCC investigator and CPS lawyer nominated to the case are to make early contact and together will identify the issues in the case and consider the likely offences and potential lines of inquiry.³⁵⁰

324. The protocol's effective operation depends on the development of good working relationships between the IPCC and the CPS, and both the DPP and the IPCC expressed confidence in this system. More assertive statutory powers for the IPCC, such as the power to recommend a prosecution, were not regarded as necessary by either organisation. The IPCC took the view that its close working relationship with the CPS would be the best guarantee of achieving prosecutions in appropriate cases.³⁵¹ The DPP similarly considered that such a power "would not work because of the nature of the relationship between us which is going to be determined by the protocol"³⁵² although he stressed that the CPS would be happy to receive the views and recommendations of the IPCC in relation to prosecutions in any particular case.³⁵³ **We welcome the new protocol between the IPCC and the CPS and hope that it will be used to the full to support prosecutions in appropriate cases.**

The limits of the IPCC mandate

325. The IPCC has pointed to a number of apparent gaps in its jurisdiction, which mean that, for example, it cannot investigate incidents where police detainees are harmed having been passed on to the custody of the court service or to private undertakings working on behalf of the court service.³⁵⁴ The IPCC also lacks the power to investigate the actions of immigration staff.³⁵⁵

326. These gaps illustrate the limitations of a sectoral approach to investigations of deaths in custody. This approach means that investigations are organised with reference to the institution responsible for custody, rather than with reference to the nature of the harm. Deaths occur in all forms of state custody and carry the same Article 2 obligation to investigate. The gaps in the jurisdiction of the IPCC suggest that a more integrated approach to investigations of deaths in custody may be required.

348 Protocol between the Crown Prosecution Service Casework Directorate and the Independent Police Complaints Commission, July 2004, para. 9.3

349 Protocol between the Crown Prosecution Service Casework Directorate and the Independent Police Complaints Commission, July 2004, para. 9.7

350 Protocol between the Crown Prosecution Service Casework Directorate and the Independent Police Complaints Commission, July 2004, para. 9.6

351 Q 461–462

352 Q 16

353 Q 20

354 Q 465

355 Q 465

327. Such an integrated approach can most immediately be pursued through joint work between the IPCC and other agencies, in particular the Prisons Ombudsman, an aim which the IPCC agreed was important to pursue.³⁵⁶ **We recommend that the Home Office should work with the IPCC to identify any gaps in its jurisdiction, in particular where such gaps may cause problems for Article 2 compliance, and that amendment of the IPCC mandate should be considered to close these gaps.**

328. **The IPCC and the Prisons and Probation Ombudsman should establish procedures for co-operation and information sharing so as to develop best practice in their work on deaths in custody.**

Inquiries into deaths in prison

329. Since 1 April 2004 the Prisons and Probation Ombudsman has been responsible for conducting independent inquiries into all deaths in prisons, probation hostels and immigration detention in England and Wales. The transfer of the investigations function from the Prison Service to the Ombudsman was designed to comply with the requirements of an independent investigation under Article 2 of the Human Rights Act. Initially the Ombudsman's investigatory function will be exercised on a non-statutory basis and, pending legislation, the Ombudsman will have no powers to compel the production of evidence.

330. In written evidence to the Committee, NGOs including the Howard League for Penal Reform and Inquest raised some concerns about the Ombudsman's new role, arguing that the Ombudsman would not be sufficiently independent of Government, that he would need significant additional resources, that he did not have experience of on-the-ground investigations and that there might be conflict between the Ombudsman's wider investigatory role and the management of deaths in custody. Inquest also raised concerns about information provision to families in two early *ad hoc* investigations into deaths in custody conducted by the Ombudsman, and about the reliance on prison service investigators in these inquiries. The Ombudsman rejected these criticisms in oral evidence.³⁵⁷ Mr Shaw stressed that his office would give priority to family liaison in its inquiries into deaths in custody.

331. In both written and oral evidence we were overwhelmingly met with concern that the Prisons and Probation Ombudsman was still not on a statutory footing, and that this would undermine the independence, and perception of independence, of inquiries into deaths in custody. In oral evidence the Ombudsman said that he believed all of his responsibilities should be backed up by legislation, and that: "The judgement as to whether or not an investigation of mine has met Article 2 or not is not a matter for me but for the courts, but my own feeling is that in itself it manifestly does not".³⁵⁸ He added that, even with a statutory basis, Ombudsman investigations alone would not necessarily meet Article 2, but would supply an Article 2 compliant investigation in combination with the inquest, where evidence could be tested in public hearings.³⁵⁹ Mr Shaw also said that he agreed with

356 Q 463

357 Q 129

358 Q 112

359 Q 124

the Howard League's evidence that the Ombudsman's appearance of independence was undermined by being sponsored by the Home Office, and said that "I think one of the very important benefits of independent investigations of deaths is to enhance public confidence and I have not the slightest doubt that public confidence would be still further enhanced were I to enjoy a basis in statute."

332. Mr Goggins agreed that the Prisons and Probation Ombudsman should be on a statutory footing and that this could be accomplished as soon as possible. However, no timescale for legislation has been provided. **As a matter of priority parliamentary time should be set aside to bring in legislation giving a statutory basis to the Prisons and Probation Ombudsman, and providing him with investigatory powers equivalent to those of the Independent Police Complaints Commission. Until such a statutory basis is provided, investigations by the Ombudsman are unlikely to meet the obligation to investigate under Article 2 ECHR.**

333. The Northern Ireland Human Rights Commission raised a concern that, since the remit of the Ombudsman did not extend to Northern Ireland, there was no provision for independent investigations of deaths in prison in Northern Ireland.³⁶⁰ The CAJ also pointed to a potential breach of Article 2 where deaths in prison were investigated either by prison investigators or by the police.³⁶¹ The Ombudsman confirmed to us in oral evidence that there was a gap in the system in this regard. In September 2004 the Northern Ireland Office announced the establishment of a new office of Prisoner Ombudsman for Northern Ireland.³⁶² **We welcome the decision to appoint a Prisoner Ombudsman for Northern Ireland, but we note that no express provision has been made for the Ombudsman to investigate deaths in prison custody. We recommend that the Prisoner Ombudsman for Northern Ireland should have statutory powers to conduct independent investigations into deaths in prison custody in Northern Ireland, in line with the powers of the IPCC and with the powers exercised on a non-statutory basis by the Prisons Ombudsman of England and Wales.**

334. Inquest suggested that there was a need for investigations into deaths in custody to address the significance of sentencing policy and the role that the courts play when making decisions about sentencing. We noted above (see paragraphs 108 to 113) problems with ensuring that judges and magistrates were in possession of reliable information about alternatives to custodial sentencing and the vulnerability of individual offenders committed to prison. **We recommend that investigations into deaths in custody should address whether non-custodial options had been available and whether the sentencing court had ascertained whether the person they sentenced was at risk of suicide.**

Inquiries into deaths in Mental Health Act detention

335. Mental Health Act detention is now anomalous in lacking a framework for systematic independent investigations into individual deaths in custody, equivalent to those that now operate under the IPCC and the Prisons and Probation Ombudsman. Where a death

360 Ev 122

361 Ev 78

362 NIO Press Release, 21 September 2004

occurs of a person detained under the Mental Health Act, then, in addition to an internal inquiry by the Health Authority, there is provision, under the Health Service Guidelines,³⁶³ for independent inquiries to be established; however such inquiries are “fairly infrequent”.³⁶⁴ Currently, such inquiries do not have investigatory powers to require the attendance of witnesses or the production of documents. The Inquiry into the Death of David Bennett recommended that these guidelines should be reviewed to provide such powers, to require involvement of the family, and to require the inquiry to address any ethnic issues relevant to the case.

336. The MHAC reviews deaths in psychiatric detention, although the review stops short of a full investigation, and is geared towards learning lessons for systemic improvement and good practice from individual cases, rather than finding the cause of death in the individual case. It does not (nor does it seek to) provide a full, Article 2 compliant, inquiry. The MHAC deliberately does not seek to replicate the work of NHS inquiries. In its review, the Commission obtains information from the service provider and the coroner, and it attends the inquest, where it may have “properly interested person” status and may ask questions. The Commission writes to the service provider with the results of the review of the case, sometimes making recommendations for changes to practice.

337. The MHAC was not wholeheartedly supportive of an independent inquiry system. They took the view that—

A balance needs to be struck between holding independent inquiries where there is cause for specific concern and holding inquiries in every case irrespective of whether inquiries can be of use.

338. However they suggested that there might be a role for the new Commission for Health Audit and Inspection (CHAI) in conjunction with the National Patient Safety Agency (NPSA) in developing a “flexible response system” of inquiries, with inquiries being held into the most controversial cases, such as those involving restraint. Mr Ladyman told us that the situation in regard to inquiries into deaths in MHA detention was “not starkly anomalous” and that the Department of Health was confident of Article 2 compliance.³⁶⁵

339. **We are not assured that Article 2 standards are met in relation to all deaths of detained patients, in particular where the inquest is not sufficiently thorough to itself satisfy Article 2.** The inquest may not be equipped to sufficiently inquire into the background to the death, including for example the issues of systemic racism that were unearthed in the David Bennett inquiry. In such circumstances Article 2 compliance depends on the establishment of an independent inquiry under the Health Service Guidelines. Prosecutions are very rare.

340. Where an independent inquiry into a death of a detained patient is established, its nature, procedures and scope may vary widely. There appears to be no consistency in the formality or informality of the proceedings, the extent to which the inquiry is held in public, or the extent to which the family may be involved. This inconsistency risks leaving

363 Health Service Guideline (94)27

364 Norfolk, Suffolk and Cambridgeshire Health Authority, *Independent inquiry into the death of David Bennett report*, December 2003, p. 62

365 Q 218

Article 2 rights unprotected. Given the many concerns surrounding deaths in Mental Health Act detention, discussed above, and in particular concerns about lack of accurate information on the circumstances and causes of such deaths, and the possibility that some deaths may be inaccurately recorded as the result of “natural causes”, consistent and reliable investigation of these deaths should be a priority. **In our view there is a case for a permanent investigatory body, with some level of overview of all cases, rather than *ad hoc* investigations in a few cases, in order to support Article 2 compliance. Since the case for such a body has been accepted in relation to police detention (with the establishment of the IPCC) and prison and immigration detention (with powers of inquiry, albeit for the moment on a non-statutory basis, allocated to the Prisons Ombudsman) we can see no reason why deaths amongst this particularly vulnerable group of detained people should not be subject to a similar safeguard.**

341. It is important that any such investigatory body should have powers to require the attendance of witnesses. The absence of such a power would significantly hamper the ability of inquiries to provide, to the family in particular, a full picture of the circumstances of the death, and could inhibit allocation of responsibility for the death in appropriate cases, a problem which was highlighted in evidence to us. The report of the Inquiry into the death of David Bennett noted with regret that, since it had no power to require witnesses to attend, the inquiry had been unable to secure the attendance of a number of witnesses, although it did not in that case consider that the absence of witnesses had deprived the inquiry of essential information.³⁶⁶

Prosecutions of police or prison officers

342. Article 2 ECHR imposes a duty to provide an independent investigation which is capable in an appropriate case of leading to the identification and punishment of those responsible for a death. It does not require a prosecution in every case, in particular where a death is not deliberately inflicted, but may require prosecution in certain cases where the public policy issues are sufficiently serious, where the State is implicated in the death.³⁶⁷ It requires an efficient judicial system allowing, in appropriate cases, recourse to the criminal law³⁶⁸ and effective deterrent criminal law provisions, supported by law enforcement machinery.³⁶⁹ Thus the Article 2 duties to protect the life of vulnerable individuals, and to investigate deaths, requires a substantive criminal law that can form the basis for prosecutions where appropriate; an investigatory system that will unearth evidence to support prosecutions where appropriate; and a prosecutorial system that will allow for consistent and independent decision-making on whether prosecutions should be brought.

The Article 2 duty on the CPS as a public authority

343. The Attorney General’s Review of CPS practice in death in custody cases considered whether there should be express reference in the Code for Crown Prosecutors to Article 2

366 Norfolk, Suffolk and Cambridgeshire Health Authority, *Independent inquiry into the death of David Bennett report*, December 2003, op cit, p. 16

367 *Oneryildiz v Turkey*, App No 48939/99 18/06/02

368 *Calvelli and Ciglio v Italy*, App No 32967/96 17/01/02

369 *Kilic v Turkey*, App No 22492/93 28/03/00

ECHR, and concluded that such reference was not necessary.³⁷⁰ It was also concluded that there was no necessity to alter the Code to further emphasise the particular public interest considerations which may arise in death in custody cases.

344. A recent decision of the administrative court suggests that Article 2 does not require the DPP to consider whether the investigation at the inquest might have been inadequate.³⁷¹ We do not see how this can be considered to be compatible with the obligation on the State under Article 2 to conduct an effective investigation. However the court did go on to note “we do not exclude the possibility that even at the final stage the [DPP] may want to suggest further enquiries, the results of which may help him to reach a satisfactory conclusion.”

345. The DPP saw his office as having an important though closely defined role in discharging the State’s Article 2 obligation to investigate following a death in custody. He said—

Our duty is to give all the advice that we can to the police to ensure that they have the benefit of the best legal advice in conducting investigations. ... We do work closely with the police now in these investigations and our responsibility is to play a part in seeing that those investigations are properly serviced legally.³⁷²

346. Asked whether the CPS would intervene where it considered an investigation was being conducted inadequately to secure appropriate prosecutions in the case, Mr McDonald replied—

I cannot imagine a case of the gravity that these cases represent where if the prosecutor felt there was an omission that had some legal implications he or she would not point it out. In fact, they would be under a duty to point it out and would do so.³⁷³

347. The CPS also stressed the importance of their giving early legal advice to investigators, and of there being procedures in place which allowed them to do so.³⁷⁴ Such procedures were in place in respect of investigations under the authority of the IPCC (though we were not told of any similar procedures in relation to investigations of deaths in other forms of custody).

348. The rarity of prosecutions of police or prison officers following deaths in custody has raised concerns of bias, and diminished confidence in the CPS on the part of families of those who have died in custody. INQUEST pointed out in evidence that since 1990, of nine cases³⁷⁵ where there has been an unlawful killing verdict returned at the inquest into a death in custody, in only one case was there an (unsuccessful) prosecution following the

370 *A Review of the Role and Practices of the CPS in cases arising from a Death in Custody*, July 2003, para. 8.152

371 *R (Rowley) v DPP* [2003] EWHC 693 (Admin)

372 Q 23

373 Q 25

374 Q 28

375 First Report of Session 2003–04, op cit., Ev 89. Since this evidence was received there has been one further unlawful killing verdict, delivered on 29 October 2004 by the second inquest into the death of Mr Harry Stanley in 1999. The unlawful killing verdict in the inquest into the death of Roger Sylvester was quashed by the High Court on 26 November 2004.

verdict.³⁷⁶ Families' distrust of CPS decisions was made clear at two private meetings with members of the Committee.³⁷⁷

349. The DPP told us that—

From January 2002 to May 2004 there were 97 cases assembled by the prosecution authorities in which potential prosecutions were thought to be on the cards. Five of these were prosecuted. These were our strongest and best cases and every single one resulted in an acquittal. Since 1999 there have been four other defendants prosecuted by the prosecuting authorities following deaths in custody—three police officers and one doctor—all acquitted.³⁷⁸

350. The DPP agreed the lack of prosecutions in these cases was “a litmus public confidence issue for [the CPS] and for the State itself”³⁷⁹ He noted however that, in the experience of the prosecuting authorities, it was rare to discover evidence that a criminal offence had been committed. Even where some such evidence existed, it was often difficult to establish causation. The elements of gross negligence manslaughter, in particular, were difficult to establish. It required proof that the breach of the duty of care constituted more than a minimal cause of death, a difficult point on which there could often be expert disagreement, and that the breach of the duty of care was so serious as to amount to criminal gross negligence, which was also a high threshold to reach.³⁸⁰

351. The PCA in evidence were cautious about drawing conclusions from the dearth of prosecutions.³⁸¹ They pointed out that there had also been relatively few unlawful killing verdicts in inquests following deaths in police custody. Even in cases where there was an unlawful killing verdict, there could be evidential problems in mounting a prosecution where police officers exercised their right to silence. The Police Federation stated that they did not give any advice to police officers not to assist an inquiry, though they stressed that police officers must enjoy the same rights against self-incrimination as anyone facing prosecution.³⁸²

352. Mr McDonald emphasised the need for transparency in the CPS's procedures—

transparency is absolutely essential because unless people can see what we are doing we are not going to acquire the level of public confidence that we need in this area.³⁸³

376 Following an unlawful killing verdict, the DPP is obliged as a matter of public law to reconsider any decision not to prosecute. The positive obligation to investigate under Article 2 probably goes further, and requires the DPP to consider whether an adequate investigation has been carried out or some further investigation is needed: see para.344 above.

377 The Committee met with bereaved families on 19 May 2004, and attended a screening of the film 'Injustice' by Ken Fero on 5 February 2004

378 Q 12

379 Q 12

380 Q 12

381 Q 397

382 Q 446

383 Q 37

Attorney General's Review of the CPS

353. CPS practice in deaths in custody cases has recently been reviewed, in the Attorney General's Review of the Role and Practices of the CPS in Cases Arising from a Death in Custody. Measures decided upon as a result of the review included—

- Widening the pool of CPS lawyers taking decisions in death in custody cases, to speed up the decision-making process;
- Creating a greater role for the Director of Public Prosecutions in advising on individual death in custody cases;
- Widening the pool of outside counsel instructed to advise on death in custody cases;
- Discussions with the new IPCC regarding the relationship with the CPS, in particular in relation to early advice by the CPS immediately after a death in custody (though no undertaking is given to consider similar arrangements with the Prisons Ombudsman in relation to prisons);
- Commencement of a training programme for CPS lawyers involved in death in custody cases;
- More transparent procedures, and greater involvement of and communication with families.

354. The review also considered whether the perception of bias of the CPS justified removing deaths in custody from its remit, and allocating the decision on whether to prosecute in these cases either to an independent panel of lawyers or to a new body. It concluded that this drastic action could not be justified. In order to ensure greater oversight of the decision on prosecution, however, it was decided that the Director of Public Prosecutions should personally review all decisions on deaths in custody cases. Liberty, in written evidence, suggested that a special unit could be established within the CPS, directly responsible to the DPP.³⁸⁴

355. The DPP provided us with an account of the measures taken in response to the Attorney General's review. These include training of additional lawyers, widening of the pool of counsel to advise on deaths in custody cases; use of case management plans; briefing of the DPP on all deaths in custody cases; and regular meetings with and information to families. **We welcome the measures taken in response to the Attorney General's review, and stress in particular the importance of thorough and prompt information provision to families.**

356. There appears to be a practical difficulty in gathering sufficient evidence to support a prosecution for manslaughter in deaths in custody cases.³⁸⁵ It may be, as has been suggested to us by the PCA,³⁸⁶ that in relation to deaths in police custody, the new powers of the

384 First Report of Session 2003–04, *op cit.*, Ev 105

385 Minutes of Evidence taken before the Committee, Wednesday 19 May, *Prosecution Policy*, HL Paper 151, HC 619-I, Q 12

386 Q 398

IPCC to require the production of evidence will provide a better evidential basis for prosecutions. The recent protocol between the IPCC and the CPS should also provide a basis for effective evidence gathering that is targeted towards supporting prosecutions. As regards deaths in prison, immigration detention and Mental Health Act detention, however, these new procedures are still lacking. There appears to have been no joint working between the CPS and the Prisons Ombudsman, in relation to the investigation of deaths in prison or in immigration detention, in contrast to the procedures for close co-operation that have been developed between the CPS and the IPCC.³⁸⁷ Similarly, there are no procedures for co-operation between the CPS and the *ad hoc* or internal investigations that occur following deaths in Mental Health Act detention. These are highly significant omissions in the law enforcement machinery for investigating and prosecuting deaths in custody.

357. A reliable system which allows for prosecutions of the responsible officials where their action may amount to criminal conduct is essential to public confidence in the prosecution system and in systems of detention. It is also important to the protection of Article 2 rights in a number of respects. First, the failure of an investigation to result in prosecutions where there has been clearly criminal conduct on the part of State officials may breach the Article 2 duty of investigation in that particular case. Second, the effect of repeated failures to prosecute is to signal tolerance of conduct, whether negligent or deliberate, which causes deaths in custody. An effective system of prosecutions is an essential element of a system that prevents deaths in custody. **The difficulties in obtaining evidence to support prosecutions following deaths in custody need to be addressed by strong evidence gathering-powers and close co-operation between the CPS and the police or other investigating authorities. We recommend that CPS lawyers should work closely with investigators from the office of the Prisons and Probation Ombudsman, and from any independent or internal inquiry into a death in Mental Health Act detention, to advise on evidential and procedural matters.**

Offences relating to deaths in custody

358. One question not within the remit of the CPS review was whether there should be changes in the substantive criminal law to either create new criminal offences, or to alter the grounds for conviction of existing offences in death in custody cases.

359. The European Court of Human Rights has held that if the infringement of the right to life is not caused intentionally, the positive obligation imposed by Article 2 to set up an effective judicial system does not necessarily require the provision of a criminal law remedy in every case.³⁸⁸ The Court has also held, however, that under certain circumstances the procedural obligation to protect the right to life by setting up an efficient judicial system requires there to be recourse to the criminal law in relation to the death, even where the death has not been caused intentionally.³⁸⁹ This obligation is based on the more general

387 Q 38

388 See for example, *Calvelli and Ciglio v Italy* [GC], no 32967/96, ECHR 2002-I at para 51 (held that in the specific sphere of medical negligence the positive obligation to set up an effective judicial system may be satisfied if the legal system affords victims a remedy in the civil courts, either alone or in conjunction with a remedy in the criminal courts).

389 See *Oneryildiz v Turkey* App No 48939/99 18/06/02 para. 90

obligation under Article 13, and requires an adequate and effective domestic remedy in respect of the violation alleged allowing the appropriate national authority both to deal with the substance of an arguable complaint and to grant appropriate relief for the said violation.

360. Where the procedural obligation in Article 2 applies, the state must in certain circumstances put in place effective criminal law provisions to deter the commission of offences against the person.³⁹⁰ A number of factors have been held to be relevant to whether, in the circumstances of a particular case, Article 2 requires the setting up of a criminal law mechanism: e.g. the nature of the sector of activities in which the complaint arises, the number and status of the authorities with obligations and duties under the relevant regulations, the number of people likely to be affected by the risk in question, and the seriousness of the consequences of the carelessness in question.³⁹¹ Applying those criteria, in our view deaths in custody are likely to be seen as cases in which a domestic remedy which could merely result in an award of compensation cannot be considered to be an avenue of redress capable of discharging the state's obligation to set up a criminal law mechanism commensurate with the requirements of Article 2. Article 2 therefore requires the state to ensure that recourse to the criminal law in respect of such deaths is possible in its domestic legal system.

361. Currently the most common offence that is relevant in a death in custody case is gross negligence manslaughter. The offence requires it to be established that the defendant owed the deceased a duty of care not to expose the deceased to a risk of death that a reasonable person would have foreseen; that he or she was in breach of that duty; that the breach was more than a minimal cause of death; and that the breach of duty was serious enough to be characterised as gross negligence. As the PCA noted, it can be very difficult to clearly establish causation, even where a breach of duty has been established.

362. Consideration could be given to creating a new offence, modelled on the offence of “causing or allowing the death of a child or vulnerable adult” created by section 5 of the Domestic Violence, Crime and Victims Act 2004. Under this section, an offence is committed by an adult member of a household where a child dies at the hands of another member of the household and the first adult knew or ought to have known of the risk to the child, but did not take reasonable steps to protect the child. Based on this model, there could be an offence of “causing or allowing the death of a person in State custody”. The offence would be committed if a person died in custody, in the presence of one or more members of staff, in circumstances where the member of staff knew or ought to have known that there was a serious risk of significant physical harm to the detained person and failed to take reasonable steps to protect the detainee from that risk. This would assist in bringing a prosecution, for example, where a detainee dies following the use of control and restraint, in the presence of a number of police officers, but where there is insufficient evidence to attribute the death to one or more particular officers. **We recommend that consideration be given to introducing an offence of causing or allowing the death of a person in State custody.**

390 *ibid.*, para. 91

391 *ibid.*, para 93

363. An offence of the type considered above would be less effective in situations where a death from neglect arose from deficiencies in the system (for example in the provision of healthcare) rather than the negligence of an individual officer. In such cases, although there might be a clear breach by the State and by the relevant public authority of a prisoners' Article 2 rights, it might be both difficult and inappropriate to prosecute an individual low-level officer working within the constraints of an overcrowded or under-resourced system.

364. In these circumstances, an offence of corporate manslaughter, for which the police force, prison service or health authority could be held liable, could provide an appropriate vehicle for establishing criminal responsibility for the death. Currently, prosecutions for corporate manslaughter are difficult to bring, because of the common law requirement to identify a single person who, as the "controlling mind" of the corporation, caused the death. Corporations can be prosecuted for gross negligence manslaughter, but only if such a prosecution can be brought against an individual who can be identified with the corporation, such as a director. It is widely accepted that because of the state of the law on corporate manslaughter in the UK, it is only in the case of a small corporation that there is any realistic chance of a conviction for gross negligence manslaughter. It is therefore particularly difficult to bring successful prosecutions for corporate manslaughter against public authorities such as the police or prison service or a health authority. A Law Commission report of 1996, and a subsequent Home Office consultation paper of 2000 both accepted that the current law on corporate manslaughter was deficient for this reason and proposed the creation of a new offence of corporate killing.³⁹² A draft Bill is expected to be published shortly along the lines suggested in the consultation paper, although it is not yet clear whether this new offence will apply to public bodies.

365. The Law Commission proposed an offence of corporate killing in the following terms—

(1) A Corporation is guilty of corporate killing if—

- (a) a management failure by the Corporation causes a person's death and;
- (b) that failure constitutes conduct falling far below what can reasonably be expected of the corporation in the circumstances.

(2) For the purposes of subsection (1) above—

- (a) there is a management failure by a corporation if the way in which its activities are managed or organised fails to ensure the health and safety of persons employed in or affected by those activities; and
- (b) such a failure may be regarded as a cause of a person's death notwithstanding that the immediate cause is the act or omission of an individual.

(3) A corporation guilty of an offence under this section is liable on conviction on indictment to a fine.

³⁹² Based on a recommendation of the Law Commission, Report No. 237, *Legislating the Criminal Code: Involuntary Manslaughter* (1996)

366. We understand that a draft Bill on this topic is shortly to be published. We recommend that an offence of corporate killing be made applicable to public bodies such as police forces, the prison service and health authorities, in order to provide adequate legal protection for the right to life against careless killing by public bodies, as required by Article 2.

11 Conclusions

Concluding Remarks

367. It is clear that there are many and complex inter-related issues which lie behind deaths in custody. In large part however our analysis is chillingly simple.

- While crime levels are falling, we are holding more people in custody than ever before, and for longer, too many of whom should clearly not be there at all.
- We are holding them in conditions which are often unsatisfactory or inappropriate to their needs, many of them in prisons which are increasingly overcrowded, many miles from home.
- We are holding many people who have very special needs indeed, including those with substance abuse or mental health problems—many of whom should be held elsewhere or supervised within the community and all of whom are particularly vulnerable and at risk of taking their own lives.
- We are holding them in institutions where the officers responsible for detention are working under great pressure and are often required to deal with violent or volatile situations involving people with complex healthcare and mental healthcare needs, too often without adequate training or specialist support.
- We are attempting to deal with these problems within an institutional structure often glaringly ill-suited to meet the basic needs of detainees, let alone the full panoply of their human rights, for example by detaining mentally-ill people in prison because of a shortage of places in high- or medium-secure psychiatric units
- We are failing to provide the resources, in terms of the physical condition of many our detention facilities and the numbers of trained staff employed within them, which would create a more effective environment for the protection of detainees' human rights.
- The result is a failure properly to protect the lives of vulnerable people in the state's care through the positive measures necessary to meet the duty of care required by the state in compliance with Article 2 of the European Convention on Human Rights (ECHR) .
- And when people die in consequence of that failure, the system does not always offer an effective investigation—an essential requirement of the right to life under Article 2.
- Whilst the aim should be to avoid all deaths in custody, this is unlikely to be achieved in the present circumstances and with current resources without instituting a regime which in itself would infringe human rights.

368. Preventing deaths in custody is an immensely complex and challenging task. There is no doubt that some of the most vulnerable people in the country are to be found in our prisons, special hospitals and other places of detention. There is no doubt also, that distress caused by detention adds to these vulnerabilities.

369. Prevention of deaths in custody can best be achieved in a system which takes seriously at every level its obligation to protect the right to life under Article 2 ECHR, but which also sustains a culture which respects the dignity, privacy and autonomy of the people it detains and their rights under Article 8 and Article 3 ECHR. Emerging findings from research by the Cambridge Institute of Criminology,³⁹³ into the impact of the prison service safer custody programme, suggest that there are significant associations between the quality of prison life, levels of prisoner distress and an establishment's rates of self-inflicted death. Aspects of the quality of prison life that are associated with prisoner distress include distress on entry, perceived safety, opportunities for personal development and perceived fairness.³⁹⁴ This research shows that the positive obligation to protect people detained by the State is not only a matter of physical security, but of the culture of detaining institutions. It places a responsibility on the State's systems of detention to address the problems faced by the people they detain, whether imported or arising following detention.

370. We consider that although practical measures such as the provision of safer cells are valuable and should continue to be advanced, these measures in themselves will not resolve the problem of the continuing high rate of deaths in custody. At the level of the day to day operation of prisons and other places of detention, the culture of a prison or secure hospital, the extent to which people are treated with dignity, the quality of relationships between prisoners and staff, are all critically important. This is an aspect of suicide prevention which in the healthcare setting has been termed "relational security." It is also reflected in the standard against which the Chief Inspector of Prisons inspects, of a "healthy prison", which meets standards of decency, safety, and respect. This culture, as research appears to confirm, is fundamental to prisoner safety, and therefore to the protection of rights under Article 2.

371. These essential changes cannot be realised without commitment, both of policy and resources, at the level of central government. Adequately meeting the complex needs of many of the people held in detention is inevitably resource-intensive, requiring not only high levels of staffing, but also highly trained staff, and high and consistent levels of healthcare, mental healthcare and detoxification and drug addiction services. It is also extremely difficult to realise within an overburdened or overcrowded system, and it is incumbent on the Government to devise alternatives to custodial sentences, commanding public and judicial confidence, which can prevent the senseless incarceration of highly-vulnerable individuals, such as many of the young women we met at Holloway, imprisoned for very short periods for petty crime.

372. This misplaced over-reliance on the prison system is at the heart of the problem addressed in this report. Throughout our inquiry we have seen time and time again the links between mental illness, drug and alcohol dependencies, short sentences and potential

393 Led by Dr Alison Liebling

394 HC Deb., 10 February 2004, col. 1437W

for self-inflicted death. It must, therefore, be seen that the imprisonment of such vulnerable people is at the root of the problem itself. It is not only that this incarceration is senseless, but that it is in fact the first step on a path that can lead to the self-inflicted death of one person every four days, on average, in our custodial system. Until we change our approach to criminal justice for vulnerable people convicted of petty crime we cannot begin to meet our positive obligations under Article 2 and meet our duty of care to them.

373. A further issue which has been highlighted throughout our inquiry, and in particular in relation to police custody and Mental Health Act detention, is the lack of central co-ordination to enforce standards and train staff in areas relevant to deaths in custody. This has allowed examples of good practice to remain isolated, and essential guidelines which underpin human rights protection, to take insufficient effect in practice.

374. Neither has there been significant sharing of information and good practice between the police, prison service and NHS. The problem of deaths in custody has not been neglected by government or public bodies. Evidence to this inquiry has detailed a wealth of initiatives which have sought to research and address aspects of the problem. In this Report we have noted a number of examples of good practice which can assist in changing the culture of detention establishments to ensure better protection of detainees' rights and a reduction in the incidence of deaths in custody. However, these disparate initiatives have not been effective in tackling the scale of the problem.. They are very far from having reached the stage where they might be considered to have become firmly established in the institutional and cultural norms of our prisons, police stations, immigration removal centres and mental health units. Greater urgency in eliminating bad practice and spreading good practice throughout these institutions is badly needed. In numerous areas the issues surrounding deaths in custody are similar, regardless of whether they are being faced by our prisons, our hospitals, our police stations or our inquiry bodies. This applies to healthcare, physical and mental, risk assessment and management, dealing with violent behaviour, training staff, and devising satisfactory procedures for inquests.

Final Recommendations

375. Our principal conclusion is therefore that there is a need for a central forum to address the significant national problem of deaths in custody. One existing model for such work is the cross-government group on the management of violence, which is working towards the production of joint guidance on the use of restraint and other responses to violence, applicable across prison, police, and mental health act detention. We consider, however, that a permanent body, with a remit to address all aspects of deaths in custody, is required.

376. **We recommend that the Home Office and the Department of Health, as the main responsible departments, should establish a cross-departmental expert task-force on deaths in custody. This should be an active, interventionist body, not a talking-shop, with its membership drawn from people with practical working experience of the problems associated with deaths in custody. The task-force should also have at its disposal human rights expertise. Broadly, the functions and powers of such a body should be—**

- **To share information on good practice in preventing deaths in custody between each form of detention;**
- **To develop guidelines on matters relating to prevention of deaths in custody;**
- **To review systems for the investigation of deaths in custody and to seek to establish consistency in such investigations;**
- **To develop consistent good practice standards on training in issues relating to deaths in custody;**
- **To review recommendations from coroners, public inquiries and research studies, to consider how they can be taken forward, and to monitor progress in their implementation;**
- **To collect and publish information on deaths in custody;**
- **To commission research and to make recommendations to Government. Where such recommendations involve expenditure we would expect the Government to meet the needs where funding was clearly necessary to ensure observance of ECHR rights.**

Formal Minutes

Wednesday 8 December 2004

Members Present:

Jean Corston MP, in the Chair

Lord Bowness

Lord Campbell of Alloway

Lord Judd

Lord Plant of Highfield

Mr David Chidgey MP

Mr Kevin McNamara MP

Mr Paul Stinchcombe MP

The Committee deliberated.

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

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

Paragraphs 1 to 376 read and agreed to.

Resolved, That the Report be the Third 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 Lord Bowness do make the Report to the House of Lords.

[Adjourned till Wednesday 15 December at a quarter past Four o'clock.]

Witnesses

The oral evidence taken before the Committee and written evidence submitted to the inquiry listed against the following Ev pages are printed in Volume II of this Report

Page

Monday 12 January 2004

Ms Frances Crook, Director, Howard League for Penal Reform,
Ms Juliet Lyon, Director, **Mr Enver Solomon**, Policy Officer, Prison Reform Trust,
Ms Deborah Coles, Co-Director, **Ms Helen Shaw**, Co-Director, INQUEST
Ms Sarah Cutler, Policy and Research Officer, Bail for Immigration Detainees **Ev 1**

Monday 26 January 2004

Ms Anne Owers, HM Chief Inspector of Prisons for England and Wales **Ev 15**
Mr Stephen Shaw, Prisons and Probation Ombudsman for England and Wales **Ev 22**

Monday 9 February 2004

Ms Sophie Corlett, Policy Director, **Mr Simon Foster**, Principal Solicitor, Mind **Ev 30**
Mr Chris Heginbotham, Chief Executive, Mental Health Act Commission **Ev 35**
Dr Stephen Ladyman MP, Parliamentary Under Secretary of State, Department of Health **Ev 39**

Monday 1 March 2004

Mr Paul Goggins MP, Parliamentary Under Secretary for Correctional Services, Home Office
Mr Nigel Hancock, Head of Safer Custody Group, Prison Service,
Mr Brian Pollett, Director of Detention Services, Immigration Services,
Mr John Woodcock, Head of Police Powers and Procedures Team,
Police Leadership and Powers Unit **Ev 46**

Monday 15 March 2004

Mr Phil Wheatley, Director General, **Mr Nigel Hancock**, Head of Safer Custody Group,
HM Prison Service **Ev 60**
Mr Ian Bynoe, Deputy Chairman, **Dr David Best**, Director of Research,
Police Complaints Authority **Ev 68**

Monday 14 July 2004

Mr Steve Roberts, Deputy Assistant Commissioner, **Mr David Warcup**, Assistant Chief
Constable, Association of Chief Police Officers of England, Wales and Northern Ireland **Ev 77**
Mrs Jan Berry, Chairman, **Mr Rod Dalley**, Vice-Chairman, Police Federation of England
and Wales **Ev 82**
Mr Nick Hardwick, Chair, **Mr John Wadham**, Deputy Chair, Independent Police
Complaints Commission **Ev 87**

List of Written Evidence

Government

1	Memorandum from the Department of Health	Ev 92
2	Memorandum from the Home Office	Ev 95
3	Memorandum from the Right Honourable the Lord Falconer of Thoroton, Lord Chancellor and Secretary of State, Department for Constitutional Affairs	Ev 98
4	Memorandum from HM Prison Service	Ev 100
5	Supplementary memorandum from HM Prison Service	Ev 104

Commissions, Ombudsmen and other Public Bodies

6	Memorandum from the Independent Police Complaints Commission	Ev 106
7	Memorandum from the Right Honourable The Lord Woolf, Lord Chief Justice and the Judicial Studies Board	Ev 113
8	Memorandum from the Mental Health Act Commission	Ev 116
9	Memorandum from the Northern Ireland Human Rights Commission	Ev 121
10	Memorandum from the Prisons and Probation Ombudsman	Ev 122
11	Memorandum from the Youth Justice Board	Ev 123

Other organisations

12	Memorandum from D.C.N. Warcup, MBA, Assistant Chief Constable, on behalf of the Association of Chief Police Officers of England, Wales and Northern Ireland (ACPO)	Ev 133
13	Memorandum from the Coroners' Society of England and Wales	Ev 136
14	Supplementary memorandum from the Coroners' Society of England and Wales	Ev 138
15	Memorandum from the Dialogue Trust	Ev 139
16	Memorandum from INQUEST	Ev 141
17	Memorandum from the International Centre for Prison Studies, King's College, University of London	Ev 151
18	Memorandum from the Magistrates Association	Ev 158
19	Memorandum from Mind	Ev 159
20	Memorandum from NAPO the Trade Union and Professional Association for Family Court and Probation Staff	Ev 161
21	Memorandum from the Police Federation of England and Wales	Ev 163
22	Memorandum from Rethinking Crime and Punishment	Ev 166
23	Memorandum from Revolving Doors Agency	Ev 181
24	Memorandum from the Royal College of Psychiatrists	Ev 183
25	Memorandum from the Sainsbury Centre for Mental Health	Ev 187

Individuals

26	Memorandum from Professor Kevin Gournay CBE	Ev 189
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