Government Response to the Third Report from the Committee: Deaths in Custody

Eleventh Report of Session 2004–05
House of Lords
House of Commons
Joint Committee on Human Rights

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Report, together with formal minutes and appendix

Ordered by The House of Lords to be printed 2 March 2005
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Joint Committee on Human Rights

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

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

Current Membership

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Powers

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

Publications

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

Current Staff

The current staff of the Committee are: Nick Walker (Commons Clerk), Ed Lock (Lords Clerk), Murray Hunt (Legal Adviser), Róisín Pillay (Committee Specialist), Duma Langton (Committee Assistant), Pam Morris (Committee Secretary) and Tes Stranger (Senior Office Clerk).

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Eleventh Report

The Joint Committee on Human Rights published its Third Report of Session 2004–05 on Deaths in Custody as HL Paper 15-I/HC 137-I on 14 December 2004. The Government’s response to this report was received on 24 February 2005. It is printed as an Appendix to this Report.

Appendix: Government Response

Letter from Paul Goggins MP, Parliamentary Under Secretary of State, Home Office

I am responding on behalf of the Government to the Joint Committee’s Report on its Inquiry into deaths in custody. We welcome this report which is very thorough and wide reaching and thank the Committee for the constructive way in which it has addressed this complex issue.

Human rights come sharply into focus in the institutional setting where those detained are entirely dependent on their custodians not only to keep them safe but also to provide them with a humane, decent and caring environment. The Committee acknowledges the high priority the Government is giving to this important area and the work being carried out daily by many dedicated staff intent on keeping safe and providing a good quality of life for those in their care.

The Government agrees with the Committee that strategies for preventing deaths must go beyond the walls of our institutions and the report underscores the value of joint working across departments, an approach the Government promotes. The existing links between all of the agencies within the Criminal Justice System will become stronger with the development of the National Offender Management Service, with its closer links to the Department of Health and wider Home Office, which is putting detainees and their care centre stage.

The Government has demonstrated its commitment in this area, for example, by undertaking fundamental reform of the coroner system; by reviewing the role of the CPS in death in custody cases, by means of the Attorney General’s review; and by ensuring that investigations into deaths in police and prison custody are independently investigated by the new Independent Police Complaints Commission or the Prisons and Probation Ombudsman. Much work is in hand. Steps are being taken to introduce credible alternatives to custody and better inform sentencers. Legislation is being introduced to give the Prisons and Probation Ombudsman a statutory base and the Inquiries Bill will facilitate statutory inquiries when required.

Next month I shall be making a further statement to Parliament about the Government’s suicide prevention strategy in relation to prisons. I am also inviting Alison Liebling of Cambridge University to present the findings of her evaluation of the initial strategy to Joint Committee members. This event will take place on Tuesday 22 March at 17.45 to 18.45 in Committee Room 16.

24 February 2005
The Government Reply

Introduction

The Government welcomes this very thorough and constructive report into deaths in custody and is grateful to the Joint Committee for its recognition of the complex issues that surround this subject. There is no simple formula for keeping safe those held in State institutions and the Committee acknowledges the efforts of many dedicated staff across all our custodial institutions who strive to keep safe a vulnerable and troubled population, whose characteristics render them particularly at risk of self-injury or suicide. Deaths in state custodial settings remain rare events, but each one is a terrible tragedy affecting families, staff and other detainees deeply.

Tackling deaths in custody is a key priority for the Government and we are determined to do everything possible to improve safety and reduce the number of deaths in our institutions. The Government welcomes the Joint Committee’s endorsement of its proactive approach and the support for many initiatives presented as evidence to the Inquiry. Much work has been done before and since the Committee began its Inquiry, as the Government’s response illustrates. Indeed, despite the number of deaths, the paradox is that more than ever before is being done to make our institutions safer for all who live and work in them.

Human rights come sharply into focus in institutional settings where detainees are deprived of their liberty and dependent on state custodians not only to preserve their lives but also to provide a decent, humane and caring environment. The Government agrees that its strategies ought not to operate in isolation. They must be embedded in the culture of our institutions at every level and within every discipline. Policy across the board is already developing in these ways in all the custodial services. The Prison Service’s strategy, for example, can be summarised as “Reducing distress and promoting the well-being of all who live and work in prisons”. It encompasses a wide spectrum of the work of the Prison Service through integration with other agendas that have overlapping aims—such as resettlement, detoxification, health, purposeful activity, staff outlooks, leadership and training.

Strategies for reducing deaths must also go beyond the walls of the institutions so that all agencies that come into contact with detainees work together to keep them safe. Joint working ensures consistency of practices and standards across the board and provides mechanisms for sharing good practice and learning lessons when things go wrong. The Government promotes cross-department working and welcomes the Committee’s endorsement of this approach in this challenging area. There is already much joint working in respect of police, courts, escort services, prisons, probation, mental and physical health, prison health and drugs programmes. These links are becoming stronger with the development of the National Offender Management Service, which, with its closer links to the Department of Health and other parts of the Home Office is bringing all these interests together while simultaneously putting detainees and their care centre stage. The Government will consider carefully the Committee’s final recommendation that it should establish a cross-departmental expert task force on deaths in custody and in its response to this recommendation, promises the Committee a further response in six months.
The Government supports the Committee’s stance that the deaths in custody debate must be widened to encompass the whole criminal justice system. We have already demonstrated our commitment in this area, for example, by reviewing and promising reform of the coroner system and reviewing the role of the CPS in death in custody cases, by means of the Attorney General’s review, which the Committee acknowledges has led to significant reforms. Beyond that, steps are being taken to introduce credible alternatives to custody and better inform sentencers. Legislation is being introduced to give the Prisons and Probation Ombudsman a statutory base and the Inquiries Bill will facilitate statutory inquiries when required.

The Government’s detailed responses to the Committee’s recommendations follow, numbered as they appear in the Report. The recommendations themselves are shown in bold type.

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.**

We agree the Committee’s suggestion that data about previous mental health and substance misuse treatment in respect of prisoners who take their own lives or harm themselves would be a helpful addition to the data currently collected. It is clear from research that imported vulnerabilities in the prison population in general, and in particular, mental health and substance misuse issues, are important factors. Information about current and historical treatment for mental health problems or substance misuse is, however, difficult to collect reliably and may rely on self-reporting. Some attempts at capturing relevant information retrospectively are being made, using data sourced from investigation and incident reports following incidents. It has recently become possible to link routine information on how many acts of deliberate self-harm involve prisoners on approved medication, which is issued for a range of mental health reasons and drug detoxification. This will not, however, allow for the routine identification of medication type. Future emphases on offender management and information exchange between agencies should increase sharing of relevant mental health and drug information.

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 Government notes the Committee’s endorsement of the three-year safer custody programme that ran from April 2001, some parts of which overlap with its successor programme, an outline of which was announced in March 2004. The Government will make a further statement about the new programme next month when it will also publish an evaluation of the earlier programme by Dr Alison Liebling of the Cambridge Institute of Criminology.
The Committee heard evidence about the three-year programme. Some of the key achievements are repeated here—

- 2,656 new Listeners were recruited with further recruitment and training continuing
- Suicide Prevention Coordinators (or equivalents) now operate in all prisons across the estate
- Introduction of the Insiders peer support scheme. (Insiders are peer supporters, selected and trained by officers, to offer information and support to new prisoners during Reception and first night in custody)
- A new, improved and simplified system for escort staff to identify prisoners who may be at-risk of suicide or self-harm (now also being considered for use by the police)
- An investment of over £21million is allowing physical improvements to be made at six ‘Safer Local’ pilot sites
- Piloting of improved arrangements for prisoners held in court cells
- Development of a new reception screening process so as to better identify those prisoners with mental health needs
- Considerable awareness-raising of suicide prevention issues and dissemination of good practice
- Development of safer prison design, including ‘safer cells,’ which have been found effective in preventing impulsive suicide attempts
- The introduction of a revised system to record incidents of self-harm, thereby improving the consistency, detail and quality of the information collected
- Approximately 300 mental health professionals have been recruited to do in-reach work in establishments. It is anticipated that a total of 600 will be in place by end of 2006.

As the Committee notes, a separate but related programme specifically for women prisoners is being developed. This builds on a number of interventions such as crisis counselling for women identified as being at elevated risk of suicide or self-injury at both Holloway and Bullwood Hall and other psychological programmes specifically targeted at women in prison such as short duration group work and longer-term, intensive interventions. Short duration group programmes and crisis counselling provide emotional support to vulnerable women and help to manage short-term risks. More intensive interventions assist women in addressing the complex and reciprocal relationships between the practical, emotional and interpersonal difficulties that underlie suicidal and self-injurious behaviours.

A large amount of research on suicidal and self-injuring behaviour among women and women prisoners has been drawn upon to inform the developing suicide prevention
strategy for women prisoners. This has consistently shown that women are more likely than men to injure themselves, both in prisons and the broader community. The Prison Service Safer Custody Group’s data relating to incidents of attempted suicide and self-injury in prisons shows that women account for almost half of all incidents, whilst they comprise only 6% of the total prison population. Similarly, there is evidence that women in the community are more likely than men to self-injure (although men are more likely than women to take their own lives). Some of the published research into suicidal and self-injurious behaviours examines possible gender-specific precipitating factors and identifies histories of sexual abuse, homelessness, violence during childhood, expulsion from school, mental health problems and substance misuse as relevant to women’s motivations for attempting suicide or otherwise injuring themselves (Snow, 2002; Singleton et al., 1998).

The Prison Service is committed to learning more about these very complex issues to assist prisoners who injure themselves, both in terms of understanding the factors that underlie self-injury, and also in terms of equipping prisoners with alternative ways of dealing with the issues that lead to self-injurious behaviours.

75. **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.**

The Government agrees the Committee’s view that deaths in custody of juveniles and young people are especially distressing and welcomes the Committee’s support for the measures it is taking to minimise the risk of self-injury and suicide amongst this vulnerable age group. The tragic death of Joseph Scholes at Stoke Heath Young Offender Institution on 24 March 2002 was fully investigated by the Prison Service (assisted by an advisory panel made up of independent experts from the Prisons and Probation Ombudsman’s office, Social Services and the Youth Justice Board). Additionally Trafford Youth Offending Team undertook a local management review, which fed into a Serious Incident Review conducted by the Youth Justice Board. Trafford Area Child Protection Committee carried out a “Part 8” review under Part 8 of the Department of Health’s document “Working Together to Safeguard Children” and Joseph’s death was subject to a thorough 10-day inquest before a jury.

The Government carefully considered the subsequent recommendation made by Mr J P Ellery, the Coroner of Shropshire (Mid and North Division) that there should be a public inquiry but concluded that this was unlikely to bring to light any additional factors not already uncovered in the earlier investigations. The Government, however, agreed that the coroner’s concerns should be addressed. These fell into three broad categories. These were: the appropriateness of the sentence itself; operational matters such as the effectiveness of pre-sentence and placement procedures; and whether the juvenile secure estate as currently configured is able to provide fully for vulnerable young people.

The Government decided, after seeking comments from Mrs Yvonne Scholes, Joseph’s mother, that three different types of response were needed, and took the following action—
We referred the circumstances in which Joseph received a custodial sentence on three counts of attempted robbery to the Sentencing Guidelines Council, requesting it to take his case into account in its current work to draw up guidelines on sentencing for robbery;

We appointed David Lambert, a former Assistant Chief Inspector of the Social Services Inspectorate, to examine the operational issues raised by this case, including through the coroner’s inquest; and

We asked the Youth Justice Board, which was preparing a draft strategy for the future juvenile custodial estate, to take full account of the points made by the coroner on the adequacy of custodial provision for vulnerable young offenders.

The Government firmly believes that these measures are the most appropriate response to the coroner’s concerns, and are more precisely focused on each type of issue than a public inquiry would have been.

The Government agrees the Committee’s view that local authority secure accommodation should be used wherever possible for children, with the use of Prison Service custody reduced to an absolute minimum. The Government uses only local authority secure accommodation and comparable places in secure training centres for children under the age of 15, and for the more vulnerable 15 and 16 year olds. The Government believes that any sort of custody for young people should be a last resort, and that approach is enshrined in legislation (the Powers of Criminal Courts (Sentencing) Act 2000). For those young people whom the courts do send to custody, the Youth Justice Board seeks to make the best possible use of available accommodation, taking full account of age and other factors that contribute to vulnerability. Local authority secure children’s homes and secure training centres provide for the youngest trainees. It would not be appropriate for these young people to mix with older juveniles, who are generally placed in a juvenile young offender institution. The most vulnerable 15 and 16 year olds are also held outside young offender institutions. The Youth Justice Board considers that more provision is needed for vulnerable 15 and 16-year-old boys, and its recent consultation paper *Strategy for the Secure Estate for Juveniles* proposes a new form of ‘intermediate’ accommodation, with smaller-scale units and more intensive staff support for trainees, which would address this need. (See also the response at paragraph 128).

The juvenile secure estate has evolved considerably since it was set up in 2000 and continues to develop. The Government believes the proposals in *Strategy for the Secure Estate for Juveniles*—the consultation period ends on 28 February—set a clear direction for the future of the estate.

86. 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.

We agree that it is important to provide information in this area. The Confidential Inquiry into Homicides and Suicides has now been extended to cover all sudden, unexplained deaths in psychiatric units. It also collects information on recent use of restraint. In
addition to five-yearly full reports a table will be published each year showing deaths by ethnicity and gender. The first report has been submitted to the Department and will be summarised on the Confidential Inquiry website at www.national-confidential-inquiry.ac.uk.

The National Patient Safety Agency (NPSA) has established a system (the National Reporting and Learning System (NRLS)) for the notification of all patient safety incidents. This system includes reporting for deaths and self-injury. Reports sent to the NPSA will be subject to statistical and critical analysis, together with other safety data, to identify trends and emerging patterns or themes of incidents as part of the NPSA’s Patient Safety Observatory. The NPSA will then identify priorities for action.

The Mental Health Act Commission records information on all deaths of detained patients, including natural deaths.

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.

The Committee recognises the intense vulnerability of a high proportion of those in prison, and the significant challenges involved in caring for such a risk-laden population. The Government’s response at paragraph 114 below addresses these issues more fully.

The Prison Service strives to provide the best possible care for those with mental health problems in its custody. Further detail is included in the Government’s responses at paragraphs 198, 206 and 210 below, but significantly: a total of £10 million of dedicated funding has been made available from the NHS budget to support the introduction into prisons of multi-disciplinary in-reach teams; this investment is expected to double so that it reaches £20 million a year by 2005/06; and 300 staff have already been recruited to carry out this work and a total of 600 will be in place by the end of 2006. The Prison Service is now providing staff with much more training in mental health issues and awareness. Further detail is provided in the Government’s response at paragraph 142 below. But there is no doubt that an effective approach to caring for mentally ill offenders goes beyond the prison walls. The Government is therefore seeking to divert those with mental health problems away from prison custody where possible (see also the response at paragraph 197); and ensuring that those who are too ill to remain in prison are moved to secure hospitals as swiftly as possible (see also the responses at paragraphs 197 and 206).

Beyond that, and as reported in detail in the National Director for Mental Health’s report published in December 2004 (The National Service Framework—Five Years On (NSF)), mainstream mental health services in England have been seeing significant improvements in recent years. In line with the implementation of the national service framework for mental health and the commitments outlined in the NHS Plan and the Priorities and Planning Frameworks, services have taken great strides to improve access to effective treatment and care, reduce unfair variation, raise standards, and provide quicker and more convenient services.
In the financial year in which the NSF for mental health was published (1999/2000) reported Hospital and Community Health Services mental health spending on people of all ages was £3.87 billion. By 2002/03, this had risen to £4.60 billion (2002/03 prices in both cases). The increase in spending over this period was therefore £728 million (or 19% in real terms).

The benefits of additional investment are best seen in the growth in the provision of community based mental health services. For example, the caseload for community mental health teams increased to 310,000 last year from 252,000 in 2001. In addition, around 14,000 people are now being seen by assertive outreach teams every year and it is expected that around 70,000 people will benefit from crisis resolution services in total in 2004–05.

The progress is not limited to community teams. Since 1997, the number of consultants in the psychiatry group has increased by over 40%. We now have a quarter more psychiatric nurses working in the community and at least 60% more clinical psychologists than there were in 1997.

The national rate of death from suicide has been steadily falling for the past five years. The overall death rate from suicide in the most recent period (2001–03) has fallen to 8.6 deaths per 100,000 population. This marks a reduction of 6% from the baseline rate in 1995–97 of 9.2 deaths per 100,000.

With the publication of *Personality Disorder: No Longer a Diagnosis of Exclusion* in January 2003, the services for people with personality disorders have also benefited from a more inclusive approach to the treatment and support of people with such disorders by mainstream mental health services and partner agencies in the NHS, local authorities, the police and the probation service. *No Longer a Diagnosis of Exclusion* is gradually helping people with personality disorders to get appropriate clinical care and management from specialist mental health services.

Further development of the whole range of mental health services in accordance with the NSF and the NHS Plan is expected to lead to the freeing up of inpatient beds and ease the flow of patients, including prisoners requiring transfer, into and out of secure settings.

114. **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.**

The Committee acknowledges that on the basis of the evidence presented to it during its Inquiry, it is difficult to demonstrate causal links between prison numbers and deaths in custody. The Prison Service understands the detrimental effects on prisoners of greater movement around a full or near full system, but also believes that the continuing high levels of apparent self-inflicted deaths are a product of the high proportion of prisoners with key risk factors (including multiple vulnerabilities, mental health problems, drug and/or alcohol abuse, family background problems, previous abuse, history of self-harm, relationship problems); and that alleviating the causes of distress will reduce deaths. Emerging research indicates that factors such as security and order and family contact (as
well as the factors above) contribute significantly and directly to levels of distress, and that physical safety is most significant. Therefore there is considerable emphasis on the Prison Service’s Violence Reduction strategy (running parallel to and with the Suicide Prevention strategy) which is emphasising staff personal responsibility for managing incidents of violence based on an understanding of the causes, rather than allocating blame (a responsive approach, rather than a reactive approach), and, whilst leaving no doubt what behaviour is unacceptable, seeking a reasoned and sustained change in bullying behaviour rather than retribution. Nevertheless, an increasing prison population is of concern and the Government is responding in a number of ways. It is reforming the correctional services with the introduction of The National Offender Management Service (NOMS), which has responsibility for both the proper punishment of offenders and reducing re-offending. The main aim of this new organisation is to ensure the end-to-end management of offenders both in the community and in custody and will place the offender at the heart of the system. Building effectively on investment in the prison and probation services and the successes of both means breaking down the barriers and separation between the two organisations.

As NOMS is introduced, offenders will benefit from consistent, coherent challenge, support, and where necessary intensity of supervision and monitoring. The introduction of end-to-end offender management will ensure not only reparation to communities and victims but also the reduced likelihood of re-offending. In this way, NOMS, with its emphasis on reducing re-offending, will help balance demand with capacity.

The Government is also providing more effective options for sentencers including effective and demanding community penalties and is giving careful consideration to other short-term contingency measures to safely manage the population. In addition, the Sentencing Guidelines Council is working with sentencers to address regional variations in sentencing as well as seeking to reduce the use of short custodial sentences.

NOMS also continues to investigate options for providing further increases in prison capacity over the coming years and there are currently a number of projects underway to increase operational capacity. These include expanding capacity in existing prisons by building new accommodation and a programme to build new large multi-function prisons.

Funding was provided in 2002 for around 4,000 additional prison places, as part of an ongoing programme, to be built by 2006. A number of these places have been developed and are already in use, including places in existing prisons and a new prison for women providing 450 places, HMP Bronzefield, at Ashford (near Heathrow). HMP Peterborough is due to open in March 2005 and will provide 840 places. In addition, funding has now been provided for a new building programme to create additional places.

The prison population is carefully monitored to ensure that those prisons experiencing particular difficulties with population levels receive support through the movement of sentenced prisoners to other prisons with vacancies as soon as operationally possible. In doing so, the National Offender Management Service seeks to make maximum use of all available space within the prison estate to ensure full and complete use of any spare capacity.
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.

The number of certified normal accommodation (CNA), or uncrowded capacity, places in a cell, cubicle or room is the number of prisoners that it can accommodate at one time to the standard specified for uncrowded conditions. This is determined on the basis that the accommodation provides reasonable space for each prisoner and the ability to use the toilet in private. CNA represents the good, decent standard of accommodation that the Prison Service aspires to provide to all prisoners and there are no plans to change the criteria.

Operational capacity is the total number of prisoners that an establishment can hold at any one time without serious risk to good order, security and the proper running of the planned regime. It is kept constantly under review in the light of changing operational conditions and is determined and approved by Prison Service Area Managers using operational judgement and knowledge of establishment regime and infrastructure. Breaches of the operational capacity are rare, short-term and must be approved by the responsible Area Manager. There are no plans for an independent review of operational capacity.

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.

A population protocol is already in place that specifies that prisoners with severe enduring mental illness are not allocated or transferred without discussion between the Health Care Services of both prisons. Allocation or transfer is based on an assessment of risk and need, coupled with the ability of the establishment to care for the individual. Similarly, prisoners on or within 14 days of completing a detoxification programme have their symptoms stabilised prior to consideration being given to their movement. If a transfer is necessary operationally, the clinical team must be satisfied that the prisoner is fit to move and that the Healthcare department of the receiving establishment can provide continued care and case management.

Prison Health is currently producing guidance for the Prison Service on improving continuity of healthcare for prisoners that will cover health issues relating to the transfer of prisoners. All prison establishments should provide the same level of care as a normal general practice. A receiving prison should not refuse to accept a transferred prisoner unless healthcare needs go beyond the bounds of normal primary care and secondary care cannot be locally provided. Communication between the sending and receiving establishments should reflect normal communication between clinicians in the community and should attempt to resolve any potential problems before transfer takes place in order to cause minimal distress to the prisoner.

Establishments are able to remove Listeners from the allocation list so that Listeners are not routinely transferred for six months after completing their training.
120. 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.

The Government does not accept that the prison system is at breaking point or that it is unable to meet its duty of care to prisoners. The Government believes that prison is necessary for dangerous, serious and seriously persistent offenders and that sentences should be as long as necessary for punishment and public protection, but no longer. Sentences in individual cases are a matter for the courts alone, but the Government does believe that community punishments can make a major impact and supports their increased use, particularly for some non-violent offenders such as those convicted of theft and handling or fraud, who now receive short prison sentences. The Government’s reform of the probation service, with its focus on reducing re-offending, means that rigorously enforced community sentences are a real and tough alternative to imprisonment.

As part of the reform of the sentencing structure, the various kinds of community order for adults will be replaced in April 2005 by a single generic community order with a range of possible requirements. Courts will then be able to choose different elements to make up a bespoke community order, with intensive packages of requirements available for those who might otherwise receive a short prison sentence. The intention is for the court to be able to provide each offender with a sentence that best meets the need of the particular case, at any level of seriousness, and for sentences to be more effectively managed by the correctional services who will need to work together closely in delivering the new sentences. These reforms will support community punishment as a tough and credible alternative to imprisonment.

The Government believes that currently short-term prison sentences of less than 12 months, where prisoners are released at the halfway point with no support or supervision in the community afterwards, are often ineffective. Such short prison sentences do not always rehabilitate offenders. They are in prison long enough to disrupt positive ties in the community which contribute to reducing re-offending but not long enough for any significant rehabilitative programmes. This is why the structure of short prison sentences, where these are deemed appropriate by the courts, is being transformed by the Criminal Justice Act 2003 so that they will be more effective at addressing the needs of offenders.

April 2005 will also see the implementation of the Suspended Sentence Order (known as Custody Minus). This is a new suspended custodial sentence that allows the court to impose community requirements up front. The Government also plans to introduce Custody Plus during 2006/2007. This will mean that all custodial sentences of less than 12 months will consist of a short custodial period of between two weeks and three months followed by a licence period of at least six months. When the court makes a Custody Plus
order it must state the licence requirements the offender will be subject to. The range of requirements available will include programmes aimed at changing offending behaviour, such as aggression replacement training or addressing substance related offending.

The Act also introduces Intermittent Custody (IC) for lower risk offenders to reflect the Government’s determination to avoid some of the negative outcomes, such as loss of employment, accommodation and family disintegration, which can accompany even relatively short periods of full-time custody. Courts will have the option of sentencing a suitable offender either to weekend custody or weekday custody. This will enable the sentence to meet the personal circumstances of individual offenders.

In general terms, weekday IC will be an option for unemployed offenders in the lower risk category for whom community and family links can be maintained. A key objective for this group will be to get them into full-time employment as soon as possible in the sentence. Weekend IC is designed for offenders in full-time employment or education, or with full-time caring responsibilities for whom a custodial sentence is deemed unavoidable.

IC is currently being piloted at two establishments: at Kirkham, near Preston, for male offenders and at Morton Hall, near Newark, for women. The pilots are going well and the first twelve months have seen a steady growth in the number of IC orders imposed by the courts. On the first anniversary of the pilots (week ending 30 January) the running total of IC orders stood at 158 (44 imposed on females and 114 on males). We are currently looking at options to extend the existing Morton Hall catchment area in order to extend the availability of the sentence to courts with a reasonable travelling time of Morton Hall. This will help to increase the take-up of IC places for women offenders. The then Home Secretary responded to the success of the pilots by announcing the extension of Intermittent Custody beyond the two pilot sites and planning for that expansion is now underway. In the short term, this will involve an increase in the number of participating courts for the two existing pilot sites. The longer-term expansion of IC will take place within the context of the current review of the prison estate. See the response at paragraph 114 above for information about the vulnerable nature of the prison population.

125. **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.**

The Government agrees the Committee’s view that sentencers must be well informed about the range of non-custodial sentences at their disposal and accepts that since Probation Liaison Committees were abolished in 2000 there has been no statutory mechanism to ensure effective dialogue between sentencers and those who deliver sentences. Communication is reliant on local commitment and liaison takes place between local probation services and sentencers. To ensure such communication is consistently delivered we intend to introduce consultative fora involving sentencers, court staff and offender managers. We are consulting on arrangements at both magistrates court and criminal justice area level. One function of the fora will be to provide feedback to sentencers on the effectiveness of sentences, as well as to enhance understanding of sentencing options available locally. We are working on establishing shadow fora in a few areas as soon as possible to develop best practice. Sentencers in the Intermittent Custody
catchment areas were fully briefed by means of material distributed via the Judicial Studies Board and briefing and training events.

126. **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.

We agree that magistrates and judges should receive feedback on sentencing decisions including information when someone they have sentenced to custody self-harms, or commits or attempts suicide. Many sentencers welcome this feedback and the local fora referred to in the preceding response will be used for this purpose. The Committee’s recommendation that the Sentencing Guidelines Council should issue guidance to courts to consider the risk of self-harm when sentencing to custody has been drawn to the attention of the Council for consideration. One option open to the Council might be to build this subject into a “General Sentencing Issues” paper planned for 2005 but this is a matter for the Council, which is independent of Government. Sentencers are already empowered to consider mitigating sentences when there is risk of self-injury. See also the response at paragraph 129 below.

128. **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.

The Government agrees that provision of a wide range of accommodation is necessary to meet the varying circumstances of offenders below the age of 18, particularly those unsuited to the prison environment. The Youth Justice Board already has wide power to allocate trainees serving Detention and Training Orders (DTOs) to a wide range of accommodation. Section 107 of the Powers of Criminal Courts (Sentencing) Act 2000 provides that a DTO trainee may be accommodated in a secure training centre; a Prison Service young offender institution (separate ones are provided for juveniles); accommodation provided by a local authority for the purpose of restricting the liberty of children and young persons; accommodation provided for that purpose under subsection (5) of section 82 of the Children Act 1989 (financial support by the Secretary of State); or such other accommodation provided for the purpose of restricting liberty as the Secretary of State may direct.

The draft Youth Justice Bill seeks to extend this power by enabling DTO trainees to be accommodated, additionally and where appropriate, in open local authority accommodation. Trainees serving periods of detention under sections 90 or 91 of the Powers of Criminal Courts (Sentencing) Act 2000 may already be placed in any form of accommodation the Secretary of State may direct. The draft Bill seeks to extend a similar degree of flexibility to DTO trainees.

Decisions on young people on remand are primarily a matter for the courts, which may allow them to be released on bail, remand them to the care of a local authority (with or
without a request that they be held in secure accommodation) or remand them to the Secretary of State’s custody—in practice nearly always a juvenile young offender institution. Age and gender determine which kind of custody, except that a 15 or 16-year-old boy will go to a young offender institution unless he is vulnerable and a place is available in local authority secure remand. Young people subject to a local authority secure remand may, with the Secretary of State’s consent, be accommodated in a secure training centre.

Additionally, the Youth Justice Board’s consultation document *Strategy for the Secure Estate for Juveniles* (November 2004) makes proposals for the development of the estate up to 2007–08, including the provision of “intermediate units” in juvenile young offender institutions for the minority of older juvenile offenders with needs that require more intensive staff support. The Board plans to explore the development of these units within available resources.

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.**

Sentencing is a matter for the courts but the Government agrees that sentencers should be adequately informed about the vulnerability of individual offenders. Sentencers should balance the seriousness of the offence and the risk of harm offenders pose to others with the risk of harm to themselves. Courts receive such information by means of the Probation Service’s Pre-Sentence Report, which includes a risk of harm assessment. If there is a high or medium risk of self-injury the Probation Officer will consider whether to ask to adjourn to complete a further assessment. Additionally, when asked the Probation Service will make assessments and a sentencing proposal, taking into consideration all factors covered in the assessment, the nature of the offence and any indication the sentencer has given as to sentencing options. The report will propose suitable and available sentencing options, including community penalties, even where the sentencer may have indicated that a custodial sentence is likely.

Section 166 of the Criminal Justice Act 2003 gives sentencers the discretion to mitigate sentences by taking into account such information and allows sentencers to impose a community sentence, providing there are relevant mitigating factors, even where the offence would normally have justified a custodial sentence.

The Criminal Justice Act 2003 also states that a court must not pass a custodial sentence on an offender unless it is of the opinion that the offence, or combination of offences are serious enough to warrant such a sentence. When assessing the seriousness of the offence the court may take into account any mitigating factors including a risk of self-harm, which may not in itself be sufficient to prevent a custodial sentence depending upon the facts of the case.

As mentioned in the response at paragraph 120 above, the Criminal Justice Act 2003 introduces a new community sentence. This new sentencing framework will allow courts much greater flexibility when passing sentence and will support community punishment as a tough and credible alternative to custody. See response at paragraph 197 for information about court diversion schemes.
130. **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.**

The Government’s position on the use of prisons to hold immigration detainees, which remains unchanged, is that prison accommodation will not be used routinely but that there remains a need to hold individual detainees in prisons for reasons of security and control. However, we are keen to ensure that the number of immigration detainees held in prisons is kept to the minimum and that, where detention in prison is appropriate in individual cases, the period of such detention lasts for no longer than is necessary.

The Immigration and Nationality Directorate (IND) and the Prison Service have recently agreed a revised protocol on the management of immigration detainees. It sets out the limited criteria under which individual detainees may be transferred to prison or, in the case of convicted prisoners, remain in prison on completion of sentence. In doing so, the protocol makes clear that immigration detainees should be held in prisons only when they present specific risk factors that indicate that they are unsuitable to be held in immigration removal centres, for example, convictions for serious offences involving violence or serious sexual offences.

The protocol also establishes arrangements for dealing with foreign national prisoners who are approaching release from sentence and who need to be detained under Immigration Act powers pending deportation or removal from the UK. These arrangements are aimed at ensuring that IND is notified of such individuals by the Prison Service prior to release and thus allow for timely decisions on appropriate places of detention to be taken. They are in addition to the existing notification arrangements at the start of a prisoner’s sentence. The cases of individuals who have been transferred to prison or held there on completion of sentence will be kept under regular review and, where there is a change in risk factors, consideration will be given to transfer to an Immigration Service removal centre.

133. **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.**

We agree that the Committee is right to highlight the importance of obtaining prisoners’ previous medical records. The proposed guidance on improving continuity of healthcare for prisoners (see response at paragraph 116 above) will reinforce the need for establishments to make efforts to obtain any information required from the prisoner’s GP or other relevant service with which the prisoner has recently been in contact. The prisoner’s explicit consent should be obtained before doing this, although in exceptional circumstances information may be requested and disclosed without consent. The guidance will stress that, where clinically indicated, there is a wide range of sources that can be checked for information. Audit of compliance with this requirement falls within the local NHS Primary Care Trust’s clinical governance procedures.
134. **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.**

We agree that early identification of those at risk of self-harm or suicide is crucial and it is a fundamental element of the Prison Service’s suicide prevention strategy. The Prison Service has introduced a new procedure for screening prisoners’ health needs on first reception, which involves using a new, and more effective, three-stage process. This focuses on identifying prisoners with immediate and/or significant health needs, including mental health needs. Prisoners identified as having such needs are further assessed and plans drawn up for their clinical management. These new arrangements were piloted in 10 establishments and the results showed improved detection rates for serious and immediate health problems. Importantly, there was a markedly increased likelihood of people with severe mental illness or at risk of suicide being identified. The new reception health screening system has already been introduced at the majority of prison establishments that receive prisoners direct from the courts. Work is underway to ensure that it will be in operation at the remainder by April 2005.

Prison Health commissioned a comprehensive training course to ensure staff are fully trained in the use of this reception screen. Training commenced in April 2003 and arrangements are being made for future courses to sustain the number of trained staff.

Prison receptions also utilise risk information received from sources outside the prison. For example, the implementation of OASys (Offender Assessment System) in all Prison Service Areas was completed at the end of 2004. OASys classifies offending related needs and provides risk assessments that inform the construction of sentence plans. OASys highlights a prisoner’s ‘risk of harm’ (to themselves or others), which better informs staff in deciding whether a prisoner requires extra care and support.

Additionally a new, improved and simplified system for escort staff to identify prisoners who may be at-risk of suicide or self-harm (now also being considered for use by the Police—see response to 165) was introduced in January 2004. This Suicide/Self-Harm Warning Form works in conjunction with the Prisoner Escort Record—the main tool for transferring prisoner information between police, escorts and prison—and as well as alerting prison reception staff to risk of self-harm, and providing supporting information, this system steers escort staff to providing the care at-risk prisoners require.

136. **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.**

We agree with the Committee that whenever possible prisoners should arrive at prison at a reasonable hour so that proper assessments (as outlined in the response to paragraph 134
above) can be carried out. New contracts for the escort of prisoners, which started on 29 August 2004, were planned to bring improvements in the escort service including the return of prisoners to prison following their appearances in court. The bedding-in period for the new contracts has been more difficult than anyone anticipated and we accept that performance has so far fallen short of that required. NOMS are managing these contracts robustly and contractors’ performance is being monitored and managed. As a result of these measures, performance is improving. There will, however, always be some prisoners who are late from court or for whom the journey to prison is more than usually long.

Women’s prisons and establishments for juveniles are particularly affected as they have such large catchment areas. The Prisoner Escort and Custody Services is encouraging courts to deal with cases of female and juvenile prisoners first so that they can be returned to prison earlier in the day but this cannot always be guaranteed. Work is on going to identify appropriate police accommodation in which prisoners may be held if they have particularly long journeys especially if they are mid trial. This may in some cases be a better option for the prisoner than a long journey.

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.

The Prison Service’s suicide prevention strategy continues to focus attention on the first hours and days in prison, when research indicates that many prisoners are most at risk of suicide. Offering reassurance to prisoners, particularly new receptions, by explaining procedures and answering immediate concerns may help prisoners overcome some of the fears that can lead to self-harm. To help those newly arrived in prison feel safe staff are encouraged to reassure and give support to prisoners who may be feeling worried and anxious, and—in line with the Prison Service’s violence reduction strategy (referred to in response at paragraph 202)—to be alert to any signs of bullying. Additionally, information about Samaritans and peer support schemes are provided orally and in writing to all new receptions, transfers and those prisoners with a change of status, and prisoners are given free and private telephone access to Samaritans.

The Prison Service, working with courts and escort contractors (and in consultation with DCA) is also seeking to engage with prisoners before they even reach prison and, through the use of video and written publicity material, explain to worried prisoners what care they will receive and what the available sources of help are. This development is intimately linked to the support prisoners receive on first night and beyond. Furthermore, almost £5 million of the £21 million invested in physical improvements at the six ‘Safer Locals’ pilot sites was used for First Night Centres.

We endorse the Committee’s commendation of the First Night in Custody project at Holloway prison, which is providing a valuable service to many women spending their first night there.
Prison Service establishments decide locally how they will tailor their induction processes—in terms of length, content and delivery—to the particular needs of those in their care. All prisoners new to an establishment must receive an induction process appropriate to their needs, with priority being given to the safety and well being of new receptions, particularly during their first night. Induction begins a full range of assessments required for the prisoner’s time in custody and prepares them for transition to normal location.

It is recommended that where possible a discrete unit should be used for induction but the location of the induction unit is a matter for local management, provided that the accommodation used is suitable. An interactive induction staff support toolkit has recently been launched giving advice and guidance on best practice.

142. **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.**

In recognition of the high levels of mental ill health in the prison population, the Prison Service is now providing staff with much more training in mental health issues and awareness. The Prison Officer Entry Level Training (POELT) for all new Prison Officers covers mental health as a separate subject and also has mental health awareness embedded throughout to integrate theory and practice. There are also sessions on suicide prevention, bullying, drug strategy and health services for prisoners. The introduction of a new risk assessment and care-planning system to support prisoners at-risk of self-harm or suicide is accompanied by extensive training that is backed up by mental health awareness and risk management training. NIMHE (National Institute Mental Health England) is working with the Prison Service on a regional basis to support the introduction of this new care-planning system and is able to offer specialist support to healthcare and mental health in-reach.

Running concurrently to and integrating with the introduction of this new care-planning system, NIMHE is delivering a three-day mental health awareness training package specifically for Prison Service staff, developed by the University of Bournemouth. A comprehensive support pack, comprising of training manual, course participant manual, evaluation report, and CD ROM, have been produced and circulated to all NIMHE regional prison mental health leads. This material covers warning signs and advises staff when and how to refer those needing further care. The implementation of this programme is determined by region. A mental health awareness training video also developed for Prison Service staff has been produced and circulated to all establishments. These videos will be used by the mental health awareness trainers to raise key issues and prompt discussion and exploration of mental health themes.

A total of £10 million of dedicated funding has been made available from the NHS budget to support the introduction into prisons of multi-disciplinary teams, which are designed to provide mental health services for prisoners along the lines of mental health teams in the community. £1 million has been allocated to women’s prisons. NHS mental health in-reach investment should reach £20 million a year by 2005/6 to ensure there will be in-reach type services available to every prison in England and Wales by 2006. The investment is also helping many existing teams to expand the services they offer.
143. **We recommend that provision should be made for exchange of information on suicide risk from prisons to the police in appropriate cases.**

Both the Prison Service and ACPO have recognised that there is a significant gap in the intelligence chain in respect of the police knowing that a detainee self-harmed during an earlier period of prison custody. Proposed solutions centre on the Police National Computer (PNC), which provides a fast and efficient way of exchanging information. Already, 42 prisons have PNC access via stand alone terminals for the purpose of extracting previous convictions information. We are exploring whether those 42 prisons could be enabled to place suicide/self-harm warning markers for themselves and on behalf of a cluster of prisons in their area. An application was approved in principle by the PNC Access Application Panel (PAAP) on 29 September 2004 but the Panel raised concerns about information security and data protection. A project board is to be set up to look at all the aspects of the enhanced access and decide how the Prison Service can take forward and manage PAAP’s concerns.

An interim option using faxes or emails has been explored with the Metropolitan Police based on an initiative that operated between September 2000 and April 2001 by Leicestershire Constabulary with HMP Leicester and HMYOI Glen Parva. The evaluation of this initiative reported that having risk warnings on 34 persons re-arrested during this period allowed the police custody staff to take action appropriate to each case to lessen the likelihood of the prisoner harming themselves. However, the PNC Access Panel was unable to agree this system because of issues of data verification and validation. Depending on progress on direct PNC inputting access, the Prison Service is to re-visit implementation of this interim solution.

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

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

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

146. **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.**
Although the levels of suicide in immigration detention remain extremely low, we are concerned to ensure that individuals who may present a risk of suicide are not detained unless necessary and that, when such individuals are detained or such a risk arises during the course of detention, they are cared for appropriately.

There remains a presumption in favour of granting temporary admission or release in all cases. Decisions to detain are taken on the basis of the individual circumstances of the person concerned, including their fitness to be detained. It remains the case that individuals who suffer from serious medical conditions or who are mentally ill are not normally considered suitable for detention.

All individuals entering immigration detention are subject to a risk assessment that includes the risks of suicide and self-harm. It must be remembered that, initially at least, little may be known about individuals who are detained. However, an individual who has been identified at any point as presenting a risk of suicide or self-harm will be managed appropriately in line with the removal centre’s suicide and self-harm procedures, which are supported by IND’s Operating Standard on the Prevention of Suicide and Self-harm. Aside from the formal risk assessment process, concerns about an individual detainee may be raised by any member of the removal centre staff or Immigration Service staff and will trigger the relevant procedures.

We note the Committee’s concern about the possibility that issues of medical confidentiality might have impeded the exchange of information about the effect of detention on a detainee’s health or the presence of a suicide risk. We welcome the Committee’s remarks about the need to balance the interests of potentially competing ECHR rights. IND and the Department of Health have agreed to discuss this issue with removal centre healthcare staff with a view to clarifying the IND Operating Standard on Healthcare and, if appropriate, issuing further guidance to relevant staff.

147. **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.**

We agree that sub-standard or unsafe conditions of detention are unacceptable for all detainees not just those at risk of self-harm or suicide. In order to ensure that all specialist mental health services reach appropriate standards a significant proportion of recent investment is being targeted at improving them. There are many examples of good physical environments and new investment will enable those facilities that fall short of the ideal to attain a similar standard. An extra £30 million capital money for mental health services has been awarded for 2005/06. In addition to this the national investment in, and development of, services to reduce reliance on inpatient admission such as assertive outreach, early intervention and crisis resolution services will help to reduce pressure on inpatient facilities. (See also the response at paragraph 98 above.)

In relation to the high secure hospitals, the strategic case for development at Broadmoor has been considered by a wide variety of stakeholders and has been given commissioner support to proceed to the next phase, the development of an outline business case. The improved infrastructure planned will meet all the concerns about physical infrastructure and will ensure that a safer environment is developed.
The National Patient Safety Agency has established the Safer Wards for Acute Psychiatry Initiative. This aims to better understand the factors that underpin safety on acute psychiatric wards and how they interact with each other. The initiative has gathered information from literature review, site visits and interviews with staff and service users. Potential safety solutions that address issues identified will now be piloted.

The responses at paragraphs 114 and 115 above provide information about funding for prison builds and the management of operational capacity to ensure a safe environment is maintained. For the Prison Service decent conditions go beyond the provision of decent accommodation. Its Decency Agenda is one of the key priorities in the Service’s Five Year Strategy for public sector prisons. ‘Decency’ for the Prison Service means the development of positive staff-prisoner relationships within a caring and secure environment; and that all staff, prisoners and those visiting prisons or having dealings with the Prison Service are treated fairly and lawfully irrespective of their race, colour, religion, gender or sexual orientation.

The Home Office provides guidance to all police forces on the specifications required in police cells to ensure they are warm, safe and sanitary, although it is up to chief officers to ensure that these minimum standards are met. However, the police do not detain anyone in cells that are sub-standard or unsafe, whether or not they are at risk of self-harm. All police forces are currently ensuring that cells have no ligature points and that they are compliant with Article 3 and Article 8 of the ECHR. See also the response at paragraph 152 that refers to court cells.

149. **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.**

The Government agrees with the Committee that safer cells should be more widely available in prisons but that safer cells cannot alone be an adequate response to the problem of self-inflicted deaths in prison. Design solutions to minimise impulsive acts is a key element in a wider holistic suicide prevention strategy. The other four main elements are: regime, activities and care planning for all prisoners; improved knowledge and outlooks of all staff at all levels; meeting the special needs of the most vulnerable; and training and support for staff. These elements encompass mental health care, good staff-prisoner relationships, risk assessments and peer support.

Most of the approximate 3,500 safer cells are in contracted prisons because of the relative newness of their accommodation. Current policy for public prisons is that all new accommodation in category A, B and local prison establishments will be fitted with 100% safer cells and new category C accommodation will be fitted with 25% safer cells. Ready-to-use Units and Modular Units are not generally be fitted with safer cells, where risks are managed operationally. Refurbished accommodation schemes in local establishments will always consider safer cell inclusion, which is mandatory in high-risk areas. We know that that safer cells do save lives but accommodation can never be completely safe.
150. If 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). 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; and

151. 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.

The Government gives the highest priority to keeping safe those in its custody. But it agrees that it should not aim to impose absolute safety by draconian means. Indeed recourse to such means can in fact contribute to an individual’s feelings of distress and despair. Such approaches do not address the underlying causes of suicidal behaviour, but serve to draw attention to the individual, may make them feel degraded and punished and may discourage others from disclosing suicidal feelings.

The Prison Service rejects approaches such as those adopted in some countries where at-risk prisoners can be held in empty cells with gratings on the floor, where clothes and possessions are routinely removed, and the use of physical preventative means such as leg irons, head restraints and handcuffs is endorsed. This approach is alien to that in the UK and would not be compatible with the Prison Service’s desire to treat all prisoners with dignity and respect.

In some exceptional circumstances, the removal of items (including clothing) may be necessary, but the Prison Service endorses such an approach only as necessary for the immediate safety of the prisoner, and then for the shortest time possible. Prisoners identified as at-risk of suicide or self-harm are not held in unfurnished conditions unless they are additionally violent or refractory. Prison Service guidance encourages the use of alternative means of keeping an individual safe and a long-term approach to their care and well-being. (See also responses at paragraphs 201/202.)

The Prison Service approach differs in some respects to that of the Police, which, unlike the Prison Service, holds people for relatively short periods. The Police often remove items such as shoelaces and belts—items that can most easily be used for self-harm—where there are grounds for believing that someone may be a suicide risk. It is the responsibility of local Police forces to ensure an appropriate balance between dignity and safety is reached. Nationally, the powers and procedures for searches and the seizure of articles are governed by the Police and Criminal Evidence Act (PACE) 1984. These are balanced against the rights of the individual, and PACE Code C sets out safeguards and protections for the members of the public to ensure compliance with human rights legislation.
The Association of Chief Police Officers (ACPO) and the National Centre for Policing Excellence (NCPE) have set up a Project Group, which includes the Home Office, to develop and disseminate policy, guidance and best practice on the safer handling of detainees in order to contribute to the prevention of deaths in custody. The Project Group will publish this guidance in 2005.

The Department of Health published guidance in 2000, Safety, Privacy and Dignity in Mental Health Units, underscoring the Government’s commitment to ensuring patients’ safety, privacy and dignity in inpatient settings by indicating what practical steps staff should take to ensure a high standard of humane treatment and care in a safe and therapeutic environment.

152. **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.**

The Government is committed to the provision of a safe environment in all areas of detention. Removal of ligature points alone is an insufficient response as the Committee recognised in respect of provision of safer cells, but must form part of a wider more holistic suicide prevention strategy. Nonetheless, work is in hand to remove ligature points wherever possible.

Following the Chief Medical Officer’s report An Organisation with a Memory, a directive was issued requiring all local mental health services to reduce to zero the number of suicides on acute psychiatric wards by ensuring that immediate action was taken to remove all non-collapsible structures such as bed, shower and curtain rails in all psychiatric in-patient settings. All trusts have since reported compliance. In addition, the National Institute for Mental Health in England (NIMHE) has developed a toolkit for local services to measure progress in implementing the recommendations of the report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Safer Services. The kit includes specific guidance on covering or removing likely ligature points. NIMHE continues to support local services to implement these and other recommendations relating to the prevention of suicide.

Some prison establishments have a window replacement programme where safer windows without bars are being installed. Some prisons are introducing reduced risk furniture (consisting of a bed, locker and table), sometimes in parallel with an installation of safer cells programme. Ultimately, safer furniture will replace standard furniture with its multiple ligature points. An improved safer cell light that makes it more difficult to burn through the diffuser and attach a ligature has also been developed.

The results of safer prison built environment developments have also contributed to the design criteria for the court custody suites. The Department of Constitutional Affairs (who with the relevant Magistrates Courts’ Committees are responsible for construction and subsequent works funding) is committed to providing a safe environment for all users of its buildings, and has worked closely with Prisoner Escort and Custody Services (who are responsible for and take the lead in setting the design criteria for the custody suites) on the
removal of risks such as ligature points within the cell areas. The latest Court Design Guide incorporates significant learning from the Prison Service’s Safer Custody Programme.

Although removing ligature points in court cells is given priority over other refurbishment and building works identified for action, risks in these areas are sometimes managed in other ways, the short-term removal of belts and shoelaces being an example. The Prison Service in discussion with escort contractors is discouraging this in line with the responses at paragraphs 151 and 362. See also the responses at paragraphs 147 and 149, particularly in relation to police cells.

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.

The Police Service is committed to providing levels of healthcare to those in its custody, equal to that provided in the community. The revised PACE Codes of Practice permit healthcare professionals in custody suites and a current survey of forces has indicated that at least sixteen forces are already using nurses in their custody suites, whilst a further nineteen forces are actively considering this option. One force is using paramedics and only seven forces have no plans to change. The policy intention behind the revisions to the Code is to increase the scope for widening the range of healthcare professionals involved in the treatment of detainees in custody suites. The revisions are intended to result in increased flexibility, improvements in response times and the opportunity for best value efficiencies in the way healthcare is delivered in custody suites.

Included in the revised PACE Code of Practice C is an observation list for custody officers to follow for detainees with known risks, including drug intoxication. Guidance to police forces about detainee risk assessment was issued in Home Office Circular 32/2000. This circular sets out minimum standards for risk assessment procedures to be applied to all detainees coming into police custody and covers the key risk factors including drug/alcohol and mental health issues.

An Advisory Forum on Police Surgeons was set up in April 2002, which not only provides a national oversight and monitoring of the police surgeon service, but is also tasked with facilitating the professional development of the service. Its programme of work includes developing and monitoring centres of excellence for training police surgeons and overseeing assessment, training and accreditation procedures.

First aid training is included in mandatory training for probationer police officers and national occupational standards have been developed for Custody Officers. Via the Justice and Offender Services Health Education Development group, we are considering joint training initiatives covering the police, Prison Service and probation service to raise awareness of mental health issues and substance misuse.
The National Centre for Policing Excellence (NCPE) is working to establish minimum standards of best practice for custody provision, including healthcare provision whilst retaining the forensic expertise of forensic physicians. NCPE project workers have liaised with the Prison Service to learn from its experience, particularly around the use of the Suicide/Self-Harm Warning Form. This was designed to identify at-risk prisoners from the earliest point in the custody process, keep them safe according to local protocols and standardise the recording of information between agencies. Initially used by contracted escorts and accompanying at-risk prisoners to prison reception, Merseyside Police have piloted their own use of this—commencing in police custody—during 2004. ACPO has indicated a preference for incorporating this in a revised version of the Prisoner Escort Record, but as such a review is currently not deemed necessary (the PER carries much other information as well as basic risk warnings) consideration is been given to recommending in the NCPE guidance the police use of the Suicide/Self-Harm Warning Form.

166. **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.**

There is already the power to use section 34(1) of the Criminal Justice Act 1972 to designate treatment centres and we continue to give this serious consideration as an alternative to police custody for drunk and incapable detainees. The Government is already supporting the continuing development of a range of effective routes to appropriate assessment and treatment for those with substance misuse problems in police custody who may benefit from this.

The safe management of severe intoxication in those detained in police custody is determined on the basis of medical advice, usually provided by police surgeons. Many of those intoxicated in custody do not require any specific treatment. However, in severe or emergency cases, particularly where there is concern about level of consciousness and risk of harm, appropriate transfer to a healthcare setting, usually emergency care departments, is arranged.

Alcohol arrest referral and diversion pilots have an extremely important contribution to make in improving the framework within which intoxicated detainees are handled. Currently only a minority of forces have dedicated alcohol referral schemes for those in police custody. Historically there have been examples of good practice, for example the St Ann’s Centre in Leeds; and arrest referral and diversion schemes at Holborn and Watford will offer an opportunity in the short term to evaluate innovative best practice. The Government will take the opportunity of evaluation to seek to spread good practice and to consider alternatives to police custody.

169. **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; and**

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. New**
funding arrangements must ensure that prisons have appropriate and adequate resources to ensure that this equivalence is achieved.

The Government notes the Committee’s endorsement of the transfer of responsibility for commissioning prison healthcare in publicly run prisons to NHS Primary Care Trusts. From 1 April 2004, at the beginning of a staged process, 18 PCTs assumed commissioning responsibility for health services in 34 prisons in England. PCTs will assume responsibility for commissioning health services in the great majority of the remaining publicly run prison establishments from 1 April 2005 and by April 2006 commissioning responsibility will be fully devolved to the NHS. The general principle that physical and mental healthcare in prisons must be of the same standard as that provided by the NHS in the community is fundamental to the transformation of healthcare provision in prisons. The Government is committing significant additional resources to facilitate the transfer of commissioning responsibility to the NHS. Revenue investment will have risen by over £40 million a year by 2005–06, an increase of more than a third over the 2002–03 baseline. The Prison Service is investing around £20 million a year over the same period to rebuild and refurbish prison health care facilities. Steps will be taken to ensure that the national allocation of funds to PCTs beyond 2006 takes account of prison populations.

177. 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.

The Government agrees that drug maintenance programmes should be available to prisoners who need such a programme. To improve the drug treatment services available to problematic drug users in custody, the Prison Service, the Home Office and the Department of Health have developed a collaborative treatment ‘Vision’ that aims to improve clinical treatment practices, based closely on assessed need; boost Counselling, Assessment, Referral, Advice and Through-care service (CARATs) support during the early phase of intense clinical management; enhance the links between CARAT staff, clinical services and community treatment teams; and improve overall continuity of care for problematic drug users.

Key elements of the Vision, intended to build on the quality of treatment being delivered, include more effective screening on reception; evidence-based clinical interventions (detoxification and maintenance-prescribing programmes); co-ordinated services to address associated health needs, in particular blood-borne viruses and mental health problems; intensive psychological support during the first 28 days in custody, when risks of suicide and self-harm are at their highest; structured treatment interventions to meet identified need (including intensive support during clinical treatment, a balanced programme of CARATs support, and short duration and intensive drug rehabilitation programmes); and effective implementation of the Drug Interventions Programme (formerly the Criminal Justice Interventions Programme).

Maintenance prescribing is included in the Vision. Greater use of maintenance will be made according to assessed, individual need and as resources permit. Clinical services are provided in all local and remand prisons and these will continue to be the focus for such
interventions. It is planned to make clinical services available throughout the prison estate in order that maintenance prescribing can be delivered, if required, according to need wherever a prisoner is located. The Department of Health and Home Office are discussing investment from 2007/2008 onwards to permit 78,000 prisoners to receive effective treatment services based on National Treatment Agency for Substance Misuse models of care by 2008.

178. **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.**

Short-term prisoners are not excluded from drug treatment. Such offenders have been able to access clinical services (primarily detoxification) and CARAT support. In some cases, where sentence length has allowed, they have also been able to engage with the P-ASRO (Prisons—Addressing Substance-Misuse) drug rehabilitation programme. Inevitably, short-term prisoners are unable to access longer-duration intensive drug treatment programmes. Prisons have, however, long been conscious of the need to do more to help those problematic drug users who spend only a short period of time in custody or who are on remand. Accordingly, in April 2004, the Prison Service piloted an innovative, high-intensity short duration drug treatment Programme (SDP) that is primarily aimed at those problematic drug users in custody for a short period. SDP is now being rolled-out across the prison estate. 24 SDPs are currently running.

SDP is intended to be a platform for the longer-term needs of such problematic drug users once they return to the community. To help ensure drug-misusers receive timely continuity of care on release, prisons—through their CARAT teams—are already key stakeholders in the Government’s national Drug Interventions Programme.

The Prison Alcohol Strategy was launched on 17 December 2004. This will focus on improving the consistency of alcohol treatment measures across the prison estate and build on existing good practice by providing a framework for addressing offenders’ alcohol problems. Prisoners’ alcohol misuse can already be addressed as part of poly-substance misuse and the strategy’s wider elements will be deliverable when resources permit.

179. **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.**

As mentioned in the response at paragraph 178 above, the Prison Alcohol Strategy was launched on 17 December 2004 and is being introduced as resources allow. The current focus is to consolidate the alcohol treatment work already being carried out in establishments, and to build on the good practice already evident across the estate. To help ensure consistency in delivery of alcohol interventions, the Strategy is supported by a Minimum Standards Treatment Interventions Good Practice Guide. This includes a ‘model’ treatment framework—developed in line with the Department of Health’s Models of Care. The Strategy is also underpinned by a Testing Good Practice Guide.

180. **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.

The Government agrees that many drug misusers leaving prison are particularly vulnerable. The Drug Interventions Programme is a critical part of the Government’s strategy for tackling drugs. The Programme involves the criminal justice and treatment agencies working together with other services to provide a tailored solution for adults—particularly those who misuse Class A drugs—who commit crime to fund their drug misuse. Delivery at a local level is through criminal justice integrated teams (CJITs) with a case management approach to offer access to treatment and support. This begins at an offender’s first point of contact with the criminal justice system through custody, court, sentence and beyond into resettlement. Key partners to the Home Office are the criminal justice agencies such as the police, prisons, probation officers and the courts, along with the Department of Health, the National Treatment Agency and treatment service providers and those who provide linked services such as housing and job-seeker support.

CARAT (Counselling, Assessment, Referral, Advice and Through-care) teams are the focal point for the Drug Interventions Programme in prisons. The CARATs team is responsible for ensuring that release planning is carried out in partnership with the CJIT and other relevant parties such as probation and resettlement teams. As part of pre-release planning, the CARATs team reviews the prisoner’s drug related needs and where appropriate and with the client’s consent, refers the case to CJIT to ensure that continuity of care is maintained. Release is a critical phase for DIP targets and part of release planning should include assessment of the need for immediate support on release. It is the responsibility of CARATs and the CJIT jointly to ascertain the best option for the individual. CJITs also provide support to individuals awaiting treatment.

A range of improvements to encourage drug users into treatment and other interventions before, during and after a custodial sentence have been progressed—

- A wide range of drug interventions is provided for problematic drug users in custody to address low, moderate and severe drug misuse. These include CARATs, clinical services (detoxification and maintenance-prescribing programmes) and intensive drug rehabilitation programmes. As mentioned at paragraph 178 above, currently a high-intensity short duration drug treatment programme (SDP) is also being introduced—primarily to cater for those drug misusers who spend only a short period in custody (and who previously had to rely on CARATs and clinical services).

- Drug testing on release on licence of adult prolific and other priority offenders is on track to start in April 2005.

- All offenders with drug problems who will be released on licence will have additional licence conditions considered as part of the release planning process. This may require the offender to attend an accredited programme or other cognitive based intervention.
• Specific work aimed at the risk of overdose post release includes a video specially commissioned for this purpose and a card warning of the risk of overdose is available to all prisoners on release.

• Prisons and the National Probation Directorate are actively supporting problem drug users before and on release. Short-term prisoners who are not released on licence are supported by the CJITs and, when Custody Plus is implemented they will additionally be subject to statutory probation supervision. The link between prisons and the community will be strengthened by the appointment of Regional Offender Managers and by the new regional resettlement strategies. Better supervision and support of all released prisoners will be a central purpose of the National Offender Management Service.

• The Integrated Team Minimum Data Form currently used in the Drug Intervention Programme “intensive” areas for monitoring and research purposes and to support continuity of care is currently being revised. Once the revised form is rolled out nationally—from April 2005—information will be available to indicate the number of Drug Intervention Programme clients released from prison who are going onto the CJIT caseload and re-engaging in treatment.

• The Home Office Research and Development Service is planning a new additional data collection field on cause of death of those under Probation Service supervision. In particular, cause of death for those on Detention and Training Orders is likely to be recorded.

The Prison Service is also working to improve the support for departing prisoners identified as being at-risk of suicide or self-harm by ensuring an equivalence of support mechanisms through newly developed local policies at the two prisons piloting Intermittent Custody, and through the new risk assessment and care planning process that includes specific instructions on care planning for release. For example, when a prisoner has had the support of Samaritan trained prisoner peer supporters (Listeners) it is ensured they know how to contact Samaritans outside prison.

184. 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.

There are no present plans to introduce a needle exchange scheme in prisons in England and Wales. The Prison Service continues to monitor developments in the field both at home and abroad, including existing practice in the community here, policy and practice in custodial settings abroad and the effectiveness of needle exchange schemes over other harm minimisation measures. The Prison Service acknowledges that needle exchange schemes are the primary prophylactic measure in place against the spread of blood borne viruses through injecting outside prison. However, it is concerned that introduction of a needle exchange scheme would risk undermining the anti-drugs strategy in prisons by appearing to give confusing messages to staff and prisoners about the acceptability of injecting in prisons. There are also concerns about the potential for needles to be used as offensive weapons.
Nonetheless, although its drug strategy and other measures have achieved considerable success in reducing drug misuse in prison, the Prison Service recognises that HIV and other serious communicable diseases such as hepatitis are readily spread when drug users share contaminated injecting equipment. The possession of injecting equipment is strictly prohibited in prisons. Studies of drug taking behaviour in prison show a significant reduction in injecting whilst in prison custody. The 1997 Public Health Laboratory Service Prison Survey showed 17% of prisoners reported having injected in the month prior to custody, 30% (3.5% of total) of whom reported injecting in prison. Seventy five per cent (2% of total) of those who injected in prison shared needles. Therefore evidence shows that only a small core of prisoners persist in injecting and are highly likely to share any such items that they manage to acquire.

In 1997/8 the then Public Health Laboratory Service undertook an unlinked, anonymised survey of the prevalence of HIV, hepatitis B (HBV) and hepatitis C (HCV) amongst the prisoners in eight prisons in England. The results showed that, in the total sample, prevalence of anti-HIV was 0.36%, of anti-HBV was 7.8% and of anti-HCV was 7.5%. Around 25% of the adult male prisoners surveyed had injected drugs at some time and injecting equipment was shared by three-quarters of those who injected in prison. The prevalence of HIV infection in adults who injected drugs was low (less than 1%). However, the prevalence of current hepatitis C infection (30%) and of past hepatitis B infection (20%) was sufficiently high for there to be a considerable risk of the transmission of these viruses through injecting practices within prison.

As a proportionate response to the risks associated with the sharing of needles, the Prison Service is reintroducing disinfecting tablets across the estate so that prisoners can clean any illicitly held injecting equipment before passing it on to others. The London School of Hygiene and Tropical Medicine has been contracted to design and implement a strategy for reintroduction of the tablets at all prison establishments in England and Wales.

It would be premature to introduce needle exchanges into prisons until methadone maintenance programmes become much more widely available to prisoners and such a move would require Prison Service policies on the possession of injecting equipment to be reconsidered, since it would not be possible to distinguish between illicitly held needles and those issued under an exchange scheme. This would, in turn, signal a markedly different approach to drugs in prison.

A dynamic relationship exists between the smoking and injecting of drugs. People can move from one access route to another according to circumstances. Evidence exists to demonstrate a reduction in injecting whilst in custody. Increased availability of needle exchanges might encourage greater injection of drugs in prisons as the equipment for doing so would be available to prisoners on a less risky basis. If that were to happen, there would be an increased risk of fatal overdoses and the overall number of syringes in the prison system might well increase.

185. 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.
There are no plans to commission an independent review on policy relating to the availability of condoms in prison. The facts of custody and the need to maintain good order and discipline mean that it would be difficult for prisons to take action that might be perceived to encourage overt sexual behaviour by prisoners, such as making condoms freely and easily available to them throughout their stay in prison. The Prison Service recognises that sex in prisons is a reality, which carries with it a public health dimension. Prison doctors were advised by the Prison Service’s former Director of Healthcare, in a circular letter dated 16 August 1995, that they should prescribe condoms to individual prisoners on application if, in their clinical judgement, there was a known risk of HIV infection. Compliance with this policy is, however, known to be variable across the prison estate. The Prison Service is therefore looking at ways of making the policy clearer and more uniformly applied, through revised guidance and instructions.

195. **We recommend that levels of prescription should be closely monitored by health authorities in the 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 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.**

As the Committee notes, prescribing beyond British National Formulary (BNF) limits will in some cases be clinically appropriate and clinical care could suffer if such prescribing were inappropriately discouraged. The Government believes that this stance is compliant with Articles 3 and 8 of the ECHR. It is the responsibility of individual clinicians to act in the interests of individual patients and to be aware of current guidance and best practice, including administration of medication. In instances where high doses are a clinical necessity it is important to ensure that care and prescribing are well documented, kept under close review and medication reduced as soon as no longer indicated.

Clinical guidance to the NHS is provided by the National Institute for Clinical Excellence (NICE) and to professional groups through the appropriate professional bodies. The NICE guideline on schizophrenia, for example, argues that antipsychotic drugs should be prescribed at the lowest effective dose, and that it is undesirable to use more than one antipsychotic drug at a time. The Department of Health will continue to work with the Royal College of Psychiatrists and other professional bodies on key clinical issues, such as those related to prescribing, including ethnicity issues. This was highlighted in the recently published action plan for mental health care for black and minority ethnic groups, *Delivering Race Equality*, and the Department of Health’s response to the independent inquiry into the death of David Bennett.

The Government believes that the monitoring of prescribing (including monitoring on the basis of ethnicity) is best tackled through local clinical governance arrangements, rather than through a new statutory reporting requirement. The Healthcare Commission has powers to review all aspects of health care, including treatment.
197. We urge the Government to ensure that it continues to make inroads in diverting mentally ill offenders from the courts and prisons, and efficiently transferring the seriously mentally ill from prison to hospital.

There are more than 130 court diversion schemes currently operating in England and Wales. Standardisation of these schemes, with a strong emphasis on evidence-based practice, is a priority. Ensuring that people who have a severe mental illness with acute presentation receive care appropriate to their needs is also a high priority within the prison mental health national programme described in the response to paragraph 198 below. Transfer from custodial settings to NHS secure facilities should be effective and timely. As explained in the response to paragraph 206 below, a fully funded two-year project is underway to strengthen existing arrangements and identify areas for streamlining in this process.

198. 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 also a necessary component of compliance with the positive obligation to protect Convention rights under Articles 8, 3 and 2 ECHR.

The underlying theme of the prison mental health strategy has been to ‘mainstream’ mental health services in prison so that the same level of care is available inside prison as in the wider community. In order to help further that objective, at the end of 2003 the National Institute for Mental Health in England (NIMHE) was commissioned to implement a national prison mental health programme. This programme now forms part of a wide range of innovative NIMHE projects and work-streams. Mainstreaming prison mental health within NIMHE ensures that front-line clinical staff and service users in prison are linked into a range of new developments, learning is shared and good practice disseminated. For example, a nationally developed care pathway for prison mental health has been developed for the first time. This core document, which has been published on the Department of Health website, provides detailed guidance to staff and service commissioners alike and, by following the prisoner from arrest through custody and on to release, underpins the concept of end to end offender management.

201. We recommend that the Prison Service examines ways of restricting the transfer of disruptive prisoners, many of whom are also deeply vulnerable.

The Prison Service is examining ways of restricting the movement of disruptive prisoners across the estate and is shortly to issue new instructions which it believes will improve the individual care provided to prisoners who are difficult to manage. The Director General in his oral evidence to the Committee explained that there was no overt policy supporting the practice known colloquially as “sale or return”. This describes the process of a particularly difficult or disruptive prisoner who is unable to settle in a particular prison being transferred elsewhere to see if a change in the environment or circumstances will help with the settling process, on the understanding that, if the transfer is unsuccessful the prisoner will be returned to the sending establishment.

A revised Prison Service Order (PSO) will be issued shortly setting out the principles for maintaining order in prisons. The PSO will make clear that prisoners displaying difficult or
disruptive behaviour must be individually case-managed and that the aim must be to help individuals to achieve an acceptable level of behaviour within the establishment. Some prisoners with a poor behaviour record do benefit from a fresh start in a new location. Where a transfer is appropriate the PSO will instruct that such transfers are to be permanent with no return conditions. Area population protocols, which support these processes and ensure there is a degree of consistency and oversight above establishment level, are to be made mandatory. The PSO also makes clear that individual prisoner management strategies and reasons for transfer must be formally recorded.

The Committee recognises that prison staff face considerable challenges in managing prisoners who are not only violent, disruptive or unpredictable, but who are also at intense risk of self-harm or suicide. Such prisoners may adopt disruptive behaviour to mask their underlying vulnerability, and/or have multiple diagnoses of personality disorder, substance dependence and mental illness. The Prison Service is including in its revised Prison Service Order 2700 (Suicide Prevention and Self-Harm Management) a new chapter on managing at-risk prisoners whose behaviour is particularly difficult to manage. The extensive guidance document to accompany the chapter will cover issues such as managing food refusal, removal of items, carrying out constant observation and resolving power struggles. Good practice examples offer options to manage such prisoners without resort to use of more robust measures, for example, cellular confinement or use of force, which can themselves contribute to prisoners’ levels of distress.

202. **Prisoners known to be problematic and aggressive towards other prisoners should not be placed on vulnerable prisoner units.**

At risk prisoners who present difficult or aggressive behaviour need to be managed within the available options which may include a Vulnerable Prisoner Unit (if appropriate), location in a single cell on normal location, or transfer to another wing or unit or a Health Care Centre or Segregation Unit. Other processes available to support the management of difficult or aggressive prisoners include the Incentives and Earned Privileges Scheme, which provides rewards for good behaviour and loss of privileges for poor behaviour, or, more punitively, the internal disciplinary process, which can be used to formally punish prisoners who have broken Prison Rules and may ultimately lead to additional days being added to a sentence by an Independent Adjudicator.

There are a small number of prisoners who present a significant and persistent high level of aggressive behaviour. Such prisoners can be referred for consideration for a place in a Close Supervision Centre, small units managed within the High Security Estate. Introduced in February 1998, Close Supervision Centres (CSCs) hold the most dangerous, disturbed and disruptive prisoners. The aim of CSCs is to allow seriously problematic prisoners to develop a settled and acceptable pattern of behaviour by removing them from main location prisons and locating them to small, highly supervised units. CSC prisoners often have a range of complex and diverse psychological, psychiatric and security needs. CSCs also provide long-term containment of those who continue to pose a threat. There are currently 33 CSC prisoners held at locations at Woodhill, Wakefield, Whitemoor and Long Lartin. There are comprehensive arrangements for selection and case management of prisoners sent to a CSC, overseen by a CSC Selection Committee and chaired by the
Director of High Security Prisons. See also the response at 211 below relating to the Dangerous and Severe Personality Disorder Initiative.

Another significant initiative is the introduction in 2004 of the Prison Service Violence Reduction Strategy based on human rights principles and in line with the standards of decency, safety and respect of a ‘healthy prison’. Reducing violence, in all its forms, is fundamental to the Prison Service objectives and to the re-settlement and rehabilitation agenda. The Service is committed to doing this by constructively and consistently taking action to prevent violence and promote fairness and decency.

Prison Service Order 2750 places a mandatory duty on each public sector prison to develop a violence reduction strategy tailored to address issues and problems locally, regularly identifying the prevalence and nature of violence and bullying in the establishment and the short and long term steps taken to reduce these. A Violence Reduction Strategy must aim to promote a safe and healthy prison environment and foster a culture of non-violence. Guidance has also been issued and an intranet toolkit promotes a risk management and problem-solving process in order to help establishments develop practical solutions, including environmental and physical measures as well as alternatives for behaviour management. Specific issues such as racism and drug related violence are addressed with good practice examples.

206. 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.

As the Committee notes, considerable efforts have already been made to reduce delays in transferring mentally disordered prisoners to hospital. In 2003 721 prisoners were transferred to hospital as restricted patients under sections 47 and 48 of the Mental Health Act 1983, a rise of 12% on the 2002 figure of 644. (Figures for 2004 have not yet been published but are expected to show an increase on last year’s figure.)

Nevertheless, the Government accepts that there remains a lack of clarity around the arrangements for transferring such prisoners to hospital. The Prison Service, Prison Health, the National Institute for Mental Health in England (NIHME), and the commissioners and providers of NHS hospital services have therefore agreed to work collaboratively on a two year project aimed at strengthening the existing arrangements and identifying areas where streamlining might be possible.

210. 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.

The Government recognises that there are very high levels of mental ill health in the prison population. It explained, in its evidence to the Committee, what steps are being taken to ensure that care and treatment is delivered in the setting most appropriate to an individual’s needs, namely diversion of mentally ill offenders from prison; provision of appropriate mental health care equal to that available in the community within the prison
setting for those who do not need to be in hospital; and arranging the speedy transfer of the acutely mentally ill from prison to hospital. See also the Government’s response at paragraph 197 above.

Funding decisions are taken in the light of an adequate assessment of need. The need for forensic beds will reflect shifts in the whole system of care, including the needs of those in prison who require transfer to a secure hospital bed. Over the past three years the number of patients in high secure hospitals has dropped substantially, resulting in an increase in the need for and number of medium secure beds. Regional needs assessment exercises are taking place within prisons and the community to help determine the need for high and medium secure forensic services. Regional commissioning plans reflect their findings and, in addition, a national, overarching strategy is being developed. In order to meet demand there is a growing specialisation within medium security, and new service models that can provide viable alternatives to high secure services are being developed, for example, in services for women.

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.**

The Dangerous and Severe Personality Disorder Programme, as a pilot initiative, aims to gather evidence about how best to provide assessment and treatment services, and their effectiveness, for dangerous offenders whose risk of reoffending is linked to severe forms of personality disorder. The pilots cover high and medium secure settings, and the community. The evaluation of the programme will look at, among other things, how best to shape services in the future and the balance between those services being provided in prisons or in secure hospitals, and at effective community service models to meet the health needs and manage the risk of those who could be released or be diverted away from custody.

220. **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.**

The Cross Government Group on the Management of Violence, which includes representation from the Department of Health (mental health and prison health care), the Home Office and the Police, is currently considering section 136 policy, including the issue of provision of appropriate places of safety and whether there should be a statutory obligation on healthcare trusts to provide places of safety. The Committee’s recommendation will be considered further by the Group in the context of this work.

We accept that police cells are unlikely to provide the right environment for people requiring detention under the Mental Health Act. On 1 April 2004, the Home Office issued Circular 17/2004 giving guidance to inform local protocols between the police and health services on handling potentially violent individuals. The guidance advocated that there
should be an inter-agency management steering group at a senior level to monitor the operation of local protocols and to identify and disseminate best practice lessons. A current example of good practice in this area is the Risk Data Sharing Project managed by the London Development Centre for Mental Health, which will enable the police to exchange information with health bodies on individuals with mental health problems. Shared training involving all the participating local agencies is advised. A recent pilot mental health awareness training course for police officers took place in Northumbria when key frontline officers receiving training input on all aspects of mental health from service users and experienced personnel supplied by local health bodies.

221. **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.**

We agree that transfers of detainees held under section 136 from police cells to hospital must operate effectively. The draft Mental Health Bill proposes the introduction of a new power enabling the transfer of patients between places of safety. This will help limit the amount of time an individual might be detained in a police cell. The Cross Government Group on the Management of Violence referred to in the preceding paragraph will also consider this recommendation further.

In April 2004 the Department of Health published a checklist on the management of patients with mental ill health in emergency care settings, which states that local interagency protocols should exist that cover arrangements for section 136. This policy should address, amongst other things; place of safety, who should stay with the patient and who is responsible for transport.

223. **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.

Immigration Service staff at removal centres will pass on any concerns about an individual’s physical or mental health to the IND office responsible for that individual’s continued detention. The person’s continued detention will be reviewed in the light of such concerns. Where there are concerns about an individual’s fitness for detention, or the ability to provide the level of care that may be required in a removal centre, consideration will be given to the grant of temporary admission or release. In all cases, we are concerned to ensure that a person’s detention remains human rights compliant.

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.
The Government agrees the fundamental principle that use of restraint in detention must be a last resort and this made clear in its guidance to staff in all detention areas. The challenge is to ensure safety of detainees and minimise the need for physical intervention by finding better ways to prevent and manage aggression. To this end the National Institute for Mental Health in England (NIMHE) has begun working with the National Patient Safety Agency (NPSA) on a programme of work, including new guidance for trainers and for service providers to work to on the management of aggression. It published interim guidance in February 2004—Developing Positive Practice Standards to Support the Safe and Therapeutic Management of Violence and Aggression in Mental Health Inpatient Settings, which all service providers are expected to follow. This states that staff need to be trained in how to prevent and deescalate violent situations and emphasises that any physical intervention should be a final option in a hierarchy of therapeutic interventions. Moreover, the existing Mental Health Act Code of Practice (19.12) is clear that any restraint should be used only for as long as is absolutely necessary.

The National Institute for Clinical Excellence (NICE) is also preparing new guidelines on the short-term management of violent behaviour in inpatient psychiatric settings The Short Term Management of Violence (Disturbed Behaviour) in Inpatient Psychiatric Settings, which is expected early in 2005. NIMHE will publish its definitive guidance later in the year, reflecting feedback on the interim version and the NICE guidance.

The Prison Service has recently undertaken a complete review of guidance to staff on the use of force, taking into account the consultation version of the NICE guidelines. The guidance covers the use of de-escalation techniques, the proportionate application of control and restraint holds and, most importantly, the need for staff to be aware at all times of any signs of physical distress from the individual under restraint. Similarly, ACPO guidance ACPO/Centrex Personal Safety Manual of Guidance makes clear that police officers should use all other methods available to them before resorting to the use of force, which should be reasonable, necessary and proportionate.

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 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.

The Government agrees that hospitals should ensure that their seclusion polices are compatible with their duties under the Human Rights Act; are in line with the Code of Practice; and are implemented accordingly. Action was taken by the Department of Health to reinforce this following the judgment of the Court of Appeal in the Munjaz case (June 2003). The Department issued a statement to the NHS saying that the Court of Appeal had confirmed that the Mental Health Act 1983 Code of Practice should be observed by all to whom it is addressed unless they have good reason for departing from it in relation to an individual patient. The statement was drawn to the attention of all NHS Chief Executives and Directors of Social Services in England through the NHS Chief Executive Weekly Bulletin. The Mental Health Act Commission issued a guidance note on the judgment in
January 2004. An appeal against the Munjaz judgment itself is scheduled to be heard by the House of Lords in June 2005.

245. We welcome the enhanced standards and transparency that these guidelines will bring. We remain concerned at the under-enforcement of guidance in this highly human rights-sensitive area. We were 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.

Mental health services are expected to follow the interim guidance from NIMHE—Developing Positive Practice to Support the Safe and Therapeutic Management of Violence and Aggression in Mental Health Inpatient Settings, referred to in the response at paragraph 234. This states that timely and accurate recording and reporting is central to local clinical governance arrangements and compliance with Health and Safety legislation. In addition, Trust Boards should ensure that root cause analysis systems are in place to review adverse incidents. Where the seriousness of the incident warrants it, a formal internal review should take place, which involves a Trust Board member and external independent input. The need for Trusts to record and review all episodes of physical restraint is supported by the current Mental Health Act Code of Practice.

Reporting and recording will also be addressed in the forthcoming NICE guidance, (also referred to in paragraph 234) and the definitive NIMHE guidance, which will be published later this year.

There are currently no plans for making health authorities statutorily responsible for recording all violent incidents. National reporting procedures for physical and non-physical incidents are set out in Directions issued by the Secretary of State through the Counter Fraud and Security Management Service (CFSMS) for incidents in relation to staff. The NPSA National Reporting and Learning System aims to record all patient safety incidents. These systems will help to ensure that a national picture of violent incidents can be established. For mental health services this will be further supported by the national inpatient census being carried out in 2005. This will cover all inpatients and include questions about the use of physical intervention, including seclusion. The census will be repeated in future years.

248. In our view use of the prone position, and in particular prolonged used, 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.

The Government agrees with the Committee that the use of prone restraint should be avoided if possible and, if used, be for as short a length of time as is possible. Delivering Race Equality in Mental Health Care and the Department of Health's formal response to the independent inquiry into the death of David Bennett was published on 11 January 2005. The inquiry report, while acknowledging that any fixed time limit for prone restraint
would be arbitrary, nonetheless proposed that no patient should be restrained in a prone position for longer than three minutes. The Department’s response declined to set a time limit but accepted the need to ensure that any physical intervention in mental health settings is used only as a last resort, in the safest way possible and for the shortest period of time that is necessary for patient and staff safety.

*Developing Positive Practice to Support the Safe and Therapeutic Management of Violence and Aggression in Mental Health Inpatient Settings* says that: “Wherever possible, restraining service users on the floor should be avoided. If, however, the floor is used then this should be for the shortest period of time and for the central reason of gaining control of the situation. In exceptional situations where the service user needs to be placed in the prone position (face down) this should be for the shortest possible period of time to bring the situation under control.”

The NICE guidelines expected early in 2005 and the subsequent revision of the NIMHE guidance will help consolidate guidance in this area and make reference to alternative interventions, such as rapid tranquillisation or seclusion, and emphasise the need for appropriate training, resuscitation skills and equipment. As mentioned in the response at paragraph 234 above, the Prison Service is revising its guidance in line with the developing NICE guidelines. See the response at paragraph 275 below in relation to guidance for police forces.

252. **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.**

Pain or discomfort should of course be avoided wherever possible but there may be extraordinary situations where pain or discomfort is unavoidable for both the staff and detained person (for example, when its use is deemed the only way to safely resolve an emergency when alternative interventions have been considered and proven ineffective). In such circumstances the members of staff involved must record and report such action through established reporting systems. The decision and action taken needs to be justified as being the minimum use of force, which is proportionate to the risk associated with that particular set of circumstances.

All staff using physical interventions, including the use of pain, should do so in accordance with their code of professional practice or conduct and issued guidance (for example by mental health service providers on the basis of NIMHE guidance). Where staff are not professionally bound by a code, they must always act within the expectations and policies of their employer and work in a way that meets the published professional code of conduct for their particular discipline.

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, or Article 14 ECHR read with Articles, 2, 3 and 8, and of the obligations of police forces under the Race Relations Acts. 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.

The Government accepts as a fundamental principle that in all custodial settings the use of control and restraint must never be used in a racially discriminatory way. The definitive guidance on the management of violence and aggression for mental health settings (described in the response to paragraph 234) will emphasise ethnicity and cultural issues as a core theme. The development of that theme will be supported by a group representative of a wide range of cultural and ethnic backgrounds in liaison with NIMHE Race Equality Leads. The existing Mental Health Act Code of Practice (19.12) is clear that any restraint used should be sensitive to race and gender issues.

Staff providing mental health services need the right training, supervision and leadership if they are to give all their patients culturally sensitive and safe care. This was reinforced in October 2003 with the publication of Engaging and Changing (a guide to effective policy for the care and treatment of detained BME patients) which includes guidance on the provision of culturally appropriate care and staff training. Respecting diversity is one of ten Essential Shared Capabilities (ESCs) being developed by NIMHE and the Sainsbury Centre for Mental Health (SCMH) that everyone working in mental health services should achieve during pre-qualification training. NIMHE, SCMH and the NHS Institute for Learning, Skills and Innovation will collaborate on a training programme to run alongside ESC, which will have a specific focus on race equality in mental health.

In addition to the ESC programme, Delivering Race Equality the Department of Health’s action plan for mental health services for black and minority ethnic groups sets out further action for delivering greater cultural capability in the NHS mental health workforce. Interim guidance on the management of violence and aggression—Developing Positive Practice to Support the Safe and Therapeutic Management of Violence and Aggression in Mental Health Inpatient Settings reinforces the need for cultural sensitivity and training particularly in respect of the recognition, prevention and de-escalation of aggression and violence. The inpatient census, referred to in the response at paragraph 245 above, will collect data on ethnicity and the use of physical interventions and seclusion.

The National Centre for Policing Excellence Guidance referred to in paragraph 263 below also includes training on cultural diversity issues for police officers. Additionally, The Police Race and Diversity Learning and Development Programme is a major new programme aimed at improving police performance in race and diversity through learning and development. The strategy was launched on 24 November 2004 and identifies the requirements for race and diversity training across the police service.

263. As a minimum requirement to ensure Human Rights Act compliance, we recommend that police forces should ensure that no custody office 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 offices, 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 culture awareness, in fulfilment of police forces’ obligations under the Race Relations (Amendment) Act, as well as under the Human Rights Act.

We agree that the role of custody officer is an important specialised role for which appropriate initial and refresher training is essential and which needs to be promoted by all forces as a professional role with additional responsibilities. CENTREX provides a national custody officer training programme which is reviewed and updated every six months. Many forces now use this programme or have amended their existing courses in light of the national programme. Many forces provide two or three weeks training before officers are appointed to custody duties and refresher training is becoming much more common. Input into the central framework comes from bodies such as the ACPO Medical Working Group. The key areas regarding deaths in custody are risk assessment, adequate checking on vulnerable prisoners, first aid, liaison with medical personnel, searching, hazard awareness, record keeping, and conflict resolution. A number of forces have introduced additional training for operational officers in the searching of detainees in order to identify and remove all possible ligatures or items that could be used to cause self-harm.

Forthcoming National Centre for Policing Excellence (NCPE) guidance, which will establish minimum standards of safer custody practice and set out an integrated competency framework, is expected to recommend that all custody staff be required to meet national occupational standards before they take up posts in custody suites. Refresher training is likely to be set as a minimum requirement of 2 days a year. The NCPE guidance, due to be issued in January 2006 under the Police Reform Act 2002, is not mandatory but forces will need to justify any departure from it.

Custody officers, detention officers, escort officers, custody assistants and constable gaolers must also receive training and refresher training in first aid, staff safety, self-defence and use of force. Each police force must have a Race Equality Scheme in place that shows how the police meet the requirements of the Race Relations Amendment Act 2000. In addition, CENTREX is introducing an ‘Equality Scheme’ for all ranks of the police force and ACPO is about to introduce a Race Diversity Strategy that will give guidance to forces on race equality issues. CENTREX will also be delivering the ACPO National Learning Requirement for race and diversity training. ACPO advises that training for human rights and diversity issues should be reflected in all aspects of training to ensure that the custody staff prevent any bias entering into working practices.

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.

The Prison Service abolished the principle of central prescription of training in February 2003, believing that decisions on training should not be imposed, but made locally by managers based on an assessment of local business needs, priorities and resource constraints. For example, training in open prisons would be more usefully directed at
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resettlement issues rather than a centrally prescribed programme such as use of force. The onerous nature of the previous mandatory training regime meant that establishments were unable to meet the scale of training requirements being set by the centre. Training in all the areas identified by the Committee is available.

All new prison officers undertake Prison Officer Entry-Level Training (POELT), an eight-week course that provides new staff with a foundation level of training in core skill areas. This includes sessions on self-injury and suicide prevention; mental health awareness; and diversity, which includes cultural awareness. “Heartstart” (resuscitation) training is also included in the programme. Underscoring the importance of this training, 204 resuscitations were carried out on prisoners following self-harm incidents in 2003 and a further 102 in the first nine months of 2004. In total, one week of the POELT course is devoted to control and restraint training and all new officers need to be assessed as competent prior to completing the course. Subsequently, officers are expected to receive control and restraint refresher training annually. This is a key performance target for establishments, and Area Managers agree a realistic target, taking account of operational circumstances, for the numbers of officers to be trained annually. Ongoing training is also available in respect of cultural awareness, which forms part of the diversity awareness package encouraged for delivery to all staff.

It is not practicable to provide first aid training for all prison staff but the Service aims to train and maintain an appropriate number of First Aiders in every area of the organisation in order to satisfy Health and Safety legislative obligations. Training in respect of assessing and caring for at-risk prisoners is covered in the response at paragraph 142 above.

269. 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.

The NIMHE/NPSA programme of work on the management of violence and aggression, described in the response to paragraph 234 above, includes the development of proposals for the accreditation and regulation of trainers and training programmes. Since training alone cannot deal with all the issues, accreditation will also take account of organisational systems and leadership to ensure the provision of safe environments. These proposals are due to be finalised this year and will include reference to cultural sensitivity in training.

The interim guidance Developing Positive Practice to Support the Safe and Therapeutic Management of Violence and Aggression in Mental Health Inpatient Settings referred to in the response at paragraph 234 above requires all staff who work in areas where they are likely to be exposed to aggression or violence to undertake physical intervention skills training no later than three months of moving to an area where these skills are required. Refresher training is required annually. There are no current plans to make this guidance statutory.
The NHS Security Management Service, in conjunction with NIMHE and other key stakeholders, is developing a training programme in non-physical intervention techniques for mental health service staff. It covers prevention and de-escalation, underpinned by a legal and ethical framework. The programme will be introduced early in 2005 and will form a mandatory foundation course before training in physical intervention skills.

Current guidance requires that all staff who may be involved in the restraint process must be trained in basic life support skills and attend annual updates; the physical risks associated with restraint; recognising conditions of physical and respiratory distress and signs of physical collapse; side effects of medication and how to take appropriate action; use of emergency equipment; and knowing how to summon appropriate assistance. Refresher training is required annually.

275. **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.**

We do not accept that there should be a national code of practice as there is extant national guidance, “ACPO/ CENTREX Personal Safety Manual of Guidance”, on the use of restraint in police custody. It is seen as the definitive guide as it is produced by operational practitioners and subject to ongoing review, providing an efficient way to ensure good and bad practice examples are disseminated quickly and directly. The manual advocates that the use of force is both reasonable and proportionate, and is in compliance with the Convention on Human Rights.

The NCPE Guidance on custody issues, referred to in the response at paragraph 263 above, will include a chapter on the safer use of restraints. This will emphasise the necessity for full training (and the need for regular refresher courses) in the safer use of restraints. It will illuminate the risks surrounding positional asphyxia and the problems around prone restraint.

There is no central recording of all incidents involving the use of force, as actions relating to the operational use of techniques is a matter for the chief officer of each force area. It is that officer’s responsibility to ensure that adequate training and supervisory processes are in place. Any person who considers that the level of force used has not been reasonable has recourse to the courts. Further, the person may make a complaint under the complaints system introduced in April 2004 and overseen by the Independent Police Complaints Commission.

All training on control and restraint complies with the Convention on Human Rights and is taught by accredited trainers. CENTREX and Skills for Justice are currently working with stakeholders on drawing up national standards for training on control and restraint techniques (due 2005).
The Home Office, through the Police Leadership and Powers Unit (PLPU), sits on the cross government expert group on managing potential violence and the use of restraint, referred to in the next response. This Group has an ongoing remit to work with stakeholders and practitioners, including the police, on accessing and disseminating best practice on control and restraint from shared experience. This expert group includes colleagues with knowledge and experience in managing people suffering from ill mental health.

279. **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.**

The Government is promoting cross-government working to ensure consistency of working practices and standards among all staff working in custodial settings and notes the Committee’s endorsement of this approach. The Cross Government Group on the Management of Violence includes representation from the Department of Health (mental health and prison health care), the Home Office, the Prison Service and the Police. It is currently considering a range of issues in relation to the management of violence, including restraint techniques, training, accreditation, monitoring and revising the interim standards for the NHS *Developing Positive Practice to Support the Safe and Therapeutic Management of Violence and Aggression in Mental Health Inpatient Settings* published in 2004. It reports to the Department of Health Mental Health Programme Board and the Board of the National Institute for Mental Health, England.

The working group does not have a monitoring function as each agency has its own monitoring arrangements in place. For example, NHS quality and performance is assessed and monitored through clinical governance procedures, local commissioning and by the Healthcare Commission. The Prison Service has systems of self-audit and external audit for control and restraint usage.

281. **In our view, adequate staffing is a necessary precondition to safety and Article 2 protection.**

We agree that adequate staffing is necessary in all custodial settings and note the comments of the Committee about Broadmoor. The maintenance of staff and patient safety is of utmost importance in the High Security Psychiatric Hospitals. Staffing levels of all key staff groups are regularly monitored throughout the High Security Psychiatric Hospitals by their host Strategic Health Authorities. Most recent data indicates that in Broadmoor Hospital between 10 and 12% of all nursing posts are vacant, although nurse to patient ratios are maintained at all times through use of locum staff. Such vacancy levels are not unusual for mental health services in the south of England. The patient population within the High Secure Hospitals has reduced significantly as a consequence of the Accelerated Discharge Programme in recent years, which has enabled overall improvements in staff to patient ratios.

The guidance due to be issued in January 2006 by the National Centre for Policing Excellence referred to at paragraph 263 above will require that, while staff numbers in
custody suites may be flexible, sufficient staff should always be available to manage all detainees safely.

While recruitment in some areas will always be challenging (such as south east England) and for some specialisms, there are currently no serious problems in relation to staffing levels for operational staff across the Prison Service which has been very successful in the last two years in bringing new people into the Service. Record numbers of prison officers have been recruited to the public sector Prison Service during 2003 and 2004. 2,420 officers were recruited in 2003 (an increase of 50.5% on 2002), and 2,135 officers were recruited in 2004.

Overall, operational staffing availability at 31 December 2004 was just 1.3% below the operational staffing requirement, which the Director General considers to be an acceptable operating margin.

Vacancy rates of operational staff are monitored closely, with monthly reports provided to the Prison Service Management Board and Senior Operational Managers. This enables action to be taken quickly to alleviate any particular local shortfalls that may arise.

287. **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.**

The Government agrees that it is important to provide families bereaved by a death in custody with prompt, accurate information and with sensitive support and assistance for as long as is necessary. We note that the Committee heard evidence from a number of public bodies about the work being done in this area to improve these services to families and to involve them in investigation processes. In addition to the initiatives commended by the Committee, the National Patient Safety Agency plans shortly to produce information for the NHS on open disclosure, which includes advice on communication with relatives and family. It will also produce an information pack to be published alongside the new guidance on the conduct of independent inquiries in mental health care. This will cover the need of families and relatives for information, advice and support.

The Prison Service has been working in partnership with Metropolitan Police to develop a training course specifically for prison staff in this very difficult area. The course, which is based on the Met’s own training package, has been piloted very successfully and is being further developed as it is rolled out across the prison estate during 2005. In addition, the Prison Service has prepared a guidance document, again with the help of the Metropolitan police and many other organisations that work and support bereaved families, to assist staff who take on the difficult role of liaising with a family bereaved by a death in prison custody. This includes advice on breaking the news of a death to a family with the
recommendation that this should be done by prison staff in person whenever possible. Every police force now has trained family liaison officers.

Keeping next-of-kin details up to date can be challenging in some custodial settings. The Prison Service in particular is considering ways of how this can be achieved more effectively.

295. **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.**

Guidance to coroners about information for and the needs of families as well as others in the coroner system was agreed and circulated in 2004. Home Office pilots to review other options for improvement include expanding a support service now working in the London coroners’ courts and support for a range of local initiatives (including meetings with faith groups, families and bereavement organisations) to ensure information for families is more systematic and consistent. Other coroners are also taking forward work to support families with improved websites and a range of local meetings to improve stakeholder inclusion.

300. **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.**

Narrative verdicts are proving to be a useful extension to the conclusions of inquests and a session on how this area of work is developing is now part of the Home Office training course for coroners. The implications of the Middleton judgement, other recent cases and the European Convention on Human Rights will inform the Government’s work in taking forward the recommendations made in both the Luce Report and in the Third Report from the Shipman Inquiry. Narrative verdicts are also providing a useful basis for learning lessons and preventing recurrences of custodial deaths. The Prison Service for example in particular welcomes this development.

301. **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.**

The Government intends fundamental reform of the Coroner system and a White Paper will be published next month. We set out in a Position Paper published in March 2004 in response to the Luce Report the need to ensure that reforms are affordable. Currently it is for local authorities to determine how each coroner service is funded. In many areas the police provide staff who work with the coroner. We encourage funders to make sure that changes are properly resourced, including the work that may result from cases where Article 2 is engaged. The House of Lords’ judgment referred to by the Committee also led to the setting up of Mr Justice Keith’s non-statutory public inquiry into the circumstances surrounding the death of Zahid Mubarek at Feltham Young Offenders Institution on 28
March 2000. The Inquiries Bill, introduced into the House of Lords on 24 November 2004, will facilitate giving such inquiries appropriate statutory powers in future. See also the response at paragraph 306.

302. **For disclosure to the 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.**

We agree that pre-inquest disclosure to families should be made as far in advance of the inquest as possible. Indeed, this has been the practice both of the police and Prison Service for some time in respect of deaths in custody, under voluntary protocols. It is the case that for some coroners there are significant resource and accommodation constraints which have made giving full information complex and this issue will be considered as part of the work to reform the coroner service. No fee is payable for pre-inquest documents. However, the Home Office can investigate if there is concern that charges being made are inappropriate.

303. **We recommend that Coroners should have statutory power to compel the production of documents.**

This recommendation will be considered as part of the work to reform the coroner service.

304. **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.**

The Government shares the concern expressed here about the delays in the holding of some inquests. There are often good reasons why it can take time to investigate complex cases like custody deaths and it is essential for such investigations to be thorough as well as to take into account other inquiries being made. While recognising that there can be reasons for delay it is also crucial to minimise such delays. There have been some cases where delay is unacceptable; work is underway to ensure these backlogs are tackled and reduced.

The Northern Ireland Court Service will shortly publish a response to their recent consultation exercise on Administrative Redesign of the Coroners Service in Northern Ireland. This response will set out what changes will be made to reform the coroner service. It will include the appointment of a High Court Judge as head of the service supported by three full-time coroners. It is anticipated that these changes will alleviate the current backlog of cases and provide the public with a more professional and effective coroner service.
306. **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.**

The need to make sure that the reforms are affordable is set out clearly in the Position Paper published last March. Work done since that date has highlighted the need for further resources so that the new system can tackle the whole range of tasks identified. Reforms are needed to ensure both Article 2 compliance where required and to improve the system for investigating all deaths.

309. **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 of legal assistance should be provided to the next-of-kin.**

The Government agrees with the Committee that bereaved families must be able to participate fully in death in custody inquests that engage Article 2. Currently, publicly funded Legal Help is available for those who qualify financially. Legal Help allows solicitors to provide advice or assistance on almost any point of English Law, and will help a family, for example, to prepare questions to put to the coroner. Although funding for advocacy before the coroner is excluded from the mainstream legal aid scheme, since November 2001 the Lord Chancellor has authorised the Community Legal Service to fund applications for advocacy on behalf of the immediate family of the deceased at an inquest concerning a death occurring in police or prison custody, bringing this type of case back into mainstream funding. Moreover, since December 2003 Ministers have had the power to waive the upper financial eligibility limit for publicly funded legal representation in cases in which Article 2 is engaged and it is equitable to do so. In practice therefore, legal representation and assistance is available to all those who need it in death in custody cases but who could not be expected to pay for it.

Nonetheless, funding of legal assistance for such families is under review as part of the work on the proposed White Paper on coroner and death certification reform. Following a recent case consideration is now being given as to how families who do not speak English can understand proceedings and advise their legal representatives.

319. **We are concerned that Article 2 compliant independent investigations following deaths in policy 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 Article 2 ECHR, will be undermined if the IPCC cannot employ sufficient investigators to carry out its statutory mandate appropriately.**

We are pleased with the start made by the Independent Police Complaints Commission, which has launched 22 independent investigations since it became operational on 1 April 2004. We are satisfied that its funding, which has enabled recruitment of 72 independent investigative staff, is sufficient to discharge its responsibilities under Article 2 effectively. The level of resources and funding required will be kept under regular review. There will generally be a coroner’s inquest in these cases, which will contribute to the satisfaction of the Article 2 investigative obligation.
324. 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.

We believe that the effective implementation of the protocol will benefit both organisations in supporting prosecutions in suitable cases and further reduce the scope for unnecessary delays.

327. 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.

We will work with the IPCC to identify any gaps in its jurisdiction, especially those that may cause issues for Article 2 compliance and, where appropriate, consider changes to the IPCC’s responsibilities to address these. We have, for example, introduced a new category of cases known as death and serious injury matters, which will be included in the Serious Organised Crime and Police Bill.

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.

Both the Prisons and Probation Ombudsman (PPO) and the Independent Police Complaints Commission (IPCC) are independent bodies, but the Government supports the establishment of more effective procedures for co-operation and information sharing between them and the further development of best practice in their work on deaths in custody. We understand that mechanisms have already been set up to share views on developing working practices including staff training, investigation methodology, family liaison, and the relationship between IPCC/PPO investigations and the Coroner’s inquest. The IPCC has also invited a wider group (which includes HM Inspectorate of Prisons, the Mental Health Act Commission, the Prisons and Probation Ombudsman and the Prison Service) to look at how lessons learned from deaths in custody that occur in institutions in different sectors can be shared.

332. 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 investigation under Article 2 ECHR.

The Management of Offenders and Sentencing Bill, introduced in the House of Lords on 12 January 2005 and published on 13 January contains provisions to put the Prisons and Probation Ombudsman (PPO) on a statutory footing and to equip him with the necessary powers of investigation. The PPO currently investigates, on a non-statutory basis, deaths of prisoners, residents of approved premises and removal centres. The legislation will extend his remit to include secure training centres. Whether or not the PPO is on a statutory basis, the Government believes that coroners’ inquests provide the primary means by which Article 2 obligations are met.
333. 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 Prison 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.

All deaths in prisons in Northern Ireland are independently investigated by the Police Service of Northern Ireland on behalf of the Coroner. Additionally, following such a death, the Northern Ireland Prison Service (NIPS) undertakes a review of Prison Service procedures and each case is carefully examined to determine whether changes are required to NIPS procedures. Administrative provision will exist for the Prisoner Ombudsman to undertake an inspection of Prison Service procedures in such cases, if requested to do so. There are currently no plans to make express or statutory provision for the Prisoner Ombudsman to conduct investigations into such deaths.

334. We recommend that investigations into deaths in custody should address whether non-custodial options had been available and whether the sentencing court has ascertained whether the person they sentenced was at risk of suicide.

Sentencing policy and the decisions of the courts are not matters for the Prisons and Probation Ombudsman and there are no plans formally to extend his terms of reference to include investigation of these issues. Nonetheless, there may be circumstances when it would be right for an investigation to consider what options were before the court when it decided to send someone into custody. In such cases the Ombudsman is likely to comment and the Government will consider his comments carefully. The Ombudsman’s reports will be powerful learning tools and the Government is pleased to note that he intends to share his annual and other reports as he sees fit with bodies such as the Sentencing Guidelines Council and local Criminal Justice Boards.

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; and

340. 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.

At present following the deaths of patients from unnatural causes there is an initial internal Trust investigation to establish whether there are any immediate actions that need to take place. There is normally an inquest into such deaths which, as the Committee points out, since the House of Lord’s decision in R v HM Coroner for the Western District of Somerset ex parte Middleton, 2004 and R v HM Coroner for West Yorkshire ex parte Sacker, 2004 can
provide for an article 2 compliant investigation. The coroner will be able to widen the scope of an inquest to look at the circumstances surrounding the death, including any systemic failures, and the coroner may elicit the jury’s conclusions on issues of fact, for example by inviting the jury to return a narrative verdict or by giving the jury a series of factual questions to answer.

In individual cases where Article 2 is engaged, the inquest alone or in some cases the combination of inquest and NHS independent investigation should provide for an effective investigation under Article 2 and the Government is not at present disposed to establish a new body to conduct such inquiries. Guidance on the conduct of independent inquiries in mental health services is currently being reviewed to give greater clarity about the circumstances in which they would be expected and the processes that should be employed. The findings of the Committee’s report and the implications of human rights legislation will be considered as part of this work.

We are developing a memorandum of understanding between the Department of Health, the Health and Safety Executive and ACPO to help ensure that liaison between the relevant bodies in the investigation of such deaths is as effective as possible. The National Patient Safety Agency has recently been providing training for mental health service staff in root cause analysis. This will help to ensure consistency and transparency in the process of all health service investigations and emphasises the importance of liaison with relatives and families.

355. **We welcome the measures taken in response to the Attorney General’s review, and stressing particular the importance of thorough and prompt information provision to families.**

The Government welcomes the Committee’s recognition of the measures taken by the CPS in response to the Attorney General’s Review of the role of the CPS in cases arising out of a death in custody. Of the twelve recommendations made as a result of the Review, ten have now been implemented in full and two are pending. In particular, the pool of lawyers trained to deal with cases of death in custody has been extended from six to 27. All cases are subject to proactive monitoring of progress, and case decisions are reviewed by the Director of Public Prosecutions. As the Committee noted, families of victims are offered meetings with the CPS lawyer during the course of the review process and, in the event of a decision against prosecution, will have the opportunity for a further meeting to have that decision explained. We believe that these changes will ensure efficient, high quality and fair decision-making, proper communication with families, and promote confidence in both the decisions taken and the process itself.

357. **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 death in Mental Health Act detention, to advise on evidential and procedural matters.**
The CPS statutory remit extends to criminal casework only. Once a criminal investigation is underway or is in real prospect then the CPS has a developing role in advising the police on the conduct of that criminal investigation. This role can extend to advising on managing the interface between criminal and other inquiries, as is evidenced by the CPS Protocol with the Health and Safety Executive. From the CPS perspective their concern will continue to be to assist the police in providing advice on the conduct of criminal investigations.

The Government seeks greater liaison and cooperation across its Departments and other agencies. This is a key theme throughout the Committee’s report and one that we welcome and are developing further. ACPO is currently preparing a protocol between the police, CPS and the Prison Service dealing with police investigations of deaths in prison custody. The Prisons and Probation Ombudsman (PPO) operates a local protocol with the police to ensure that his investigators do not impede the work of the police or prejudice criminal proceedings. The proposed statutory PPO will be able to notify the police if he forms the view that a criminal investigation is required and can share information for that purpose. However, the PPO’s role does not extend to evidence gathering on behalf of the CPS.

The Department of Health accepts the need for all investigations into deaths to take advice, as appropriate, from the police and the CPS. To help support this we are developing a memorandum of understanding between the Department of Health, the Health and Safety Executive and ACPO to help ensure that liaison between the relevant bodies in the investigation of such deaths is as effective as possible.

362. We recommend that consideration be given to introducing an offence of causing or allowing the death of a person in State custody.

The Government recognises that those who care for people in state custody must be personally accountable for their actions or omissions, but considers the range of existing offences sufficient to cover the likely eventualities involving staff in a death in custody. Existing provisions include the offences of murder, unlawful act, manslaughter, gross negligence, manslaughter and misfeasance in a public office.

The Health and Safety at Work Act provides a further mechanism by which individuals can be held responsible for their errors and omissions. There are also disciplinary options available within the particular public service involved.

The offence of causing or allowing the death of a child or vulnerable adult in sections 5 to 8 of the Domestic Violence, Crime and Victims Act 2004 applies only to domestic situations where a child or vulnerable adult is at serious risk. We considered carefully whether it should extend to institutional settings, such as care homes. But, as Baroness Scotland said on 21 January 2004, during passage of the Bill, “We have taken the view that very special circumstances pertain when a person is within the sanctity of what they believe to be their own home which deserve special and extraordinary measures separate from the norm. We have not at this stage sought to extend the measure to public institutional care. The Committee will know that when elderly or other vulnerable individuals are placed in the care of an institution supervisory and regulatory controls apply with regard to how that person is managed and monitored and there is a degree of accountability that one can pursue”. In passing the legislation, Parliament accepted this position. While we appreciate
the Committee’s concern in respect of deaths in custody, we consider the same arguments apply and would be very reluctant to extend such a novel offence in this way beyond the domestic circumstances for which it was specifically designed into institutional settings where other controls apply.

The Committee recognises, at paragraphs 150 and 151, that the positive obligation to protect must be balanced with avoidance of excessive control. Extending this offence into institutional settings could, because of fear of prosecution, tip that balance towards control and work against individualising care. It could also have a negative effect on staff morale and recruitment, increasing the potential to blame individuals rather than seek root causes when things go wrong so that lessons can be learnt.

366. **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.**

The Government recognises the importance of accountability where serious management failures lead to death and is committed to publishing a draft Bill on corporate manslaughter this Parliamentary Session. The details of our proposals, and the sort of circumstances in which it would apply, will be set out in the forthcoming Bill.

**Final Recommendations**

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.

The Government accepts that the State has particular responsibilities to seek to preserve the lives of those in its care and wishes to give further consideration to this recommendation, in consultation with existing bodies and their sponsoring organisations. As the Committee recognises, there is much evidence of good and developing practice in individual sectors such as prisons and police, but there is scope to share this much better and a new central, permanent body would be one way forward. Among the issues that need to be further examined are the extent to which existing and developing approaches satisfactorily address the functions suggested for a new body, whether a new body could be funded without diverting resources away from frontline efforts to prevent and reduce deaths, how a new body would sit in relation to existing bodies, and the relevance as a model of the cross governmental group on the management of violence. Whatever the Government decides about a new body, it wishes to build on the considerable work underway in this whole area and develop existing structures, with a renewed stress on analysing the lessons from deaths in custody and seeking where appropriate to make effective changes in policy and practice. The Government will respond further in six months.

Meanwhile, the rest of this response sets out the existing and developing machinery—in respect of prisons, probation, police, immigration, and secure hospitals – that might better be brought together. For prisons and probation, the development of the National Offender Management Service is bringing together some key interests – prisons, probation, mental health, prison health, drugs programmes—under one roof. The prison mental health programme is overseen by the Department of Health and NIMHE. There is a Suicide Prevention Strategy Advisory Group (membership under review) which helps provide leadership and support to partners and stakeholders working to implement the Government’s wider suicide prevention strategy led by Professor Louis Appleby.

The Ministerial Roundtable on Suicide in Prisons, chaired currently by Paul Goggins, brings together people responsible for running prisons, probation, prison health and the Youth Justice Board, with the Inspectorate of Prisons, the PPO, and a range of key prison interest groups and partners such as the Howard League, Samaritans and Inquest. Prisoners usually attend meetings too. Prisons (and early probation) safer custody strategies have been set, and progress reported on, with frequent Roundtable discussion taken into account. It does not cover police, immigration or mental hospital interests.

A recent Roundtable discussion, led by Paul Goggins, considered the Roundtable’s future against the background of the Joint Committee’s report. It expressed strong support for the Roundtable as a valuable, informal, inclusive, practically orientated and reasonably sized
group that pooled its knowledge to mutual benefit and which should be changed as little as possible. If it did change, members saw the main scope to be in respect of all deaths in prison and offender deaths in the community.

The organisational framework for issues around deaths in police custody centres on the National Custody Forum and the National Centre for Policing Excellence, and an ACPO-chaired Standing Committee on learning the lessons from adverse incidents. Membership of the National Custody Forum consists of such key stakeholders as the Home Office, the Prison Service, Forensic Physicians and others. The remit of this Group is to provide an integrated multi-agency forum to assist in the development and dissemination of policy guidance and best practice, thereby enhancing the safe and efficient provision of custody services. The NCPE Guidance on the Safer Detention and Handling of Persons in Police Custody will establish minimum standards for custodial care, and includes a chapter on learning the lessons from adverse incidents.

One of the ways in which the Government has shown its determination to address death in custody issues is through the establishment of the independent IPCC to investigate deaths in police custody and the transfer to the Prisons and Probation Ombudsman, on an administrative basis pending legislation, of responsibility for investigating deaths in prisons, probation hostel residents and removal centres. It is already seeking to build on this by establishing machinery better to learn the lessons from what goes wrong. There will be an exploratory meeting in March between representatives of the IPCC, the PPO, the Prisons Inspectorate, NOMS (Prison Service) and the Mental Health Act Commission to examine the scope for, in particular, the co-ordination and sharing of lessons learned. The outcome of this and other consultations will feed into a further memorandum to the Joint Committee by August.
Formal minutes

Wednesday 2 March 2005

Members present:

Jean Corston MP, in the Chair

Lord Campbell of Alloway  Mr Kevin McNamara MP
Baroness Falkner of Margravine  Mr Richard Shepherd MP
Lord Judd  Mr Paul Stinchcombe MP
Lord Plant of Highfield  Mr Shaun Woodward MP

The Committee deliberated.

* * * * *

Draft Report [Government Response to the Third Report from the Committee, Deaths in Custody], proposed by the Chairman, brought up, read the first and second time, and agreed to.

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

Ordered, That the Government Response to the Third Report from the Committee, Deaths in Custody, be appended to the Report.

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

* * * * *

[Adjourned till Wednesday 9 March at Four o’clock.]
Reports from the Joint Committee on Human Rights since 2001

The following reports have been produced

Session 2004–05


Fifth Report  Identity Cards Bill  HL Paper 35/HC 283

Sixth Report  Scrutiny: Second Progress Report  HL Paper 41/HC 305


Eighth Report  Scrutiny: Fourth Progress Report  HL Paper 60/HC 388


Tenth Report  Prevention of Terrorism Bill  HL Paper 68/HC 334

Session 2003–04


Fifth Report  Asylum and Immigration (Treatment of Claimants, etc.) Bill  HL Paper 35/HC 304


Seventh Report  The Meaning of Public Authority under the Human Rights Act  HL Paper 39/HC 382
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