House of Lords
House of Commons
Joint Committee on Human Rights

# Mental Health and Deaths in Prison: Interim Report

## Seventh Report of Session 2016–17

*Report, together with formal minutes relating to the report*

*Ordered by the House of Lords*
*to be printed 26 April 2017*

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## Joint Committee on Human Rights

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

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

### Current membership

HOUSE OF COMMONS

Ms Harriet Harman QC MP *(Labour, Camberwell and Peckham)* (Chair)

Fiona Bruce MP (*Conservative, Congleton*)

Ms Karen Buck MP (*Labour, Westminster North*)

Jeremy Lefroy MP (*Conservative, Stafford*)

Mark Pritchard MP (*Conservative, The Wrekin*)

Amanda Solloway MP (*Conservative, Derby North*)

HOUSE OF LORDS

Baroness Hamwee (*Liberal Democrat*)

Baroness Lawrence of Clarendon (*Labour*)

Baroness O'Cathain (*Conservative*)

Baroness Prosser (*Labour*)

Lord Trimble (*Conservative*)

Lord Woolf (*Crossbench*)

### 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.

### Publication

Committee reports are published on the Committee's website at www.parliament.uk/jchr by Order of the two Houses.

Evidence relating to this report is published on the relevant inquiry page of the Committee's website.

### Committee staff

The current staff of the Committee are Robin James (Commons Clerk), Donna Davidson (Lords Clerk), Murray Hunt (Legal Adviser), Alexander Horne (Deputy Legal Adviser), Katherine Hill (Committee Specialist), Penny McLean (Committee Specialist), Shabana Gulma (Specialist Assistant), Miguel Boo Fraga (Senior Committee Assistant) and Heather Fuller (Lords Committee Assistant).

**Contacts**

All correspondence should be addressed to the Clerk of the Joint Committee on Human Rights, Committee Office, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 2467; the Committee's email address is jchr@parliament.uk

# Contents

# 1 Purpose of this report

1. Our inquiry into mental health and deaths in prison has been interrupted by the pending Dissolution of Parliament. This short report summarises the considerable amount of work we have done on the inquiry to date and the further work we planned. It sets out some provisional conclusions arising from the evidence we have taken. In particular, we propose some specific measures which we believe should be incorporated into law. We had hoped to put these before Parliament as amendments to the Government's Prisons and Courts Bill. If similar legislation is brought forward by the Government in the next Parliament, we hope amendments along the lines we intended will be proposed, even if our successor Committee has not been appointed by then. We encourage our successors to resume work on this inquiry as soon as possible.

# 2 The scale of the problem

2. The number of self-inflicted deaths in prison has risen steadily from 58 in 2010 to 119 in 2016, the highest number since records began in 1978.[1] There has been a particularly sharp increase in the number of self-inflicted deaths in the female estate, up from five in 2015 to 12 in 2016 (the highest on record since 2003).[2] The rise in self-harm and suicide in prisons has been described by the Chief Inspector of Prisons as "shocking", with the death toll predicted to continue to rise in view of the "unacceptably violent and dangerous places" that prisons have become.[3]

3. The Government has acknowledged the gravity of the problem. On 3 November 2016 the Lord Chancellor and Secretary of State for Justice, Rt Hon Liz Truss MP, published a White Paper on prison safety and reform, and announced immediate measures intended to improve prison safety.[4] The Government announced the recruitment of 2,500 additional prison officers, and that every offender will have a dedicated prison officer offering regular one-to-one support. It also promised robust action to tackle emerging threats to safety in prison, in particular psychoactive substances, mobile phones and the use of drones to smuggle things into prisons.

1 Ministry of Justice Deaths in Prison Custody 1978–2016 Table 1.1 Deaths by cause and calendar year
2 Ministry of Justice Deaths in Prison Custody 1978–2016 Table 1.2 Deaths by gender
3 HM Chief Inspector of Prisons for England and Wales, Annual Report 2015–16, HC 471, July 2016, pp 8—9
4 HC Deb, 3 Nov 2016, col 1067

# 3 Human rights framework

4. Human rights law imposes a positive duty on the state to protect the life of those in its care, including in prisons. Article 2 of the European Convention on Human Rights (the right to life) places a positive obligation on the State to protect the lives of people who are in the care of the state, including prisoners. This entails an obligation to ensure a safe environment for prisoners, which in turn requires a number of positive steps to be taken, such as effective risk assessment, effective review of that risk assessment at regular intervals, sharing of the risk assessment with relevant agencies, access to timely and appropriate support including specialist mental health services, and regular family contact. Article 2 also imposes an obligation to investigate any such deaths. Overarching all this is the obligation under Article 14 of the Convention to ensure that there is no discrimination in relation to the enjoyment of the right to life in Article 2.

5. In addition to the ECHR, there are other relevant human rights standards which specifically address the treatment of people with mental illness and the treatment of prisoners, such as the UN Principles for the protection of persons with mental illness and the improvement of mental health care, the UN Principles for the treatment of persons under any form of detention, the UN Standard minimum rules for the treatment of prisoners (the 'Nelson Mandela Rules') and the European Prison Rules. There are also specific recommendations of the UN Treaty bodies concerning the treatment of prisoners with mental health conditions, such as the UN 'Bangkok Rules' on Women Offenders and Prisoners.

6. Our specialist adviser, Professor Philip Leach, has submitted to us a helpful overview of the human rights law framework relevant to this inquiry; this has been published on our website.[5]

5 Professor Philip Leach (MHP 0043).

# 4 Our inquiry

7. In 2016, the Committee's Rapporteur on Mental Health and Human Rights, Amanda Solloway MP, carried out a number of informal meetings with key professionals working in the field of human rights and prison reform. She visited HMP Glen Parva, HMP/YOI Parc and the Anawim Centre, and shadowed a prison inspection at HMP Eastwood Park. Her findings informed the terms of reference for the inquiry which we announced on 14 December 2016.

8. Our inquiry has sought to establish whether a human rights based approach can lead to better prevention of deaths in prison of people with mental health conditions. The inquiry has been structured around three broad themes:

- Whether prison is the right place for vulnerable offenders such as those with mental health conditions and/or learning difficulties
- The way prisoners with mental health conditions are treated in prison
- How to ensure that lessons for the future are learned, errors not repeated and that good practice becomes common practice.

9. Our inquiry has also considered cross-cutting themes such as the importance of leadership, governance, recruitment, training, development and retention of good staff, resources, and identification of good practice. We have liaised closely with the House of Commons Justice Committee which has conducted a number of inquiries that overlap with ours in some of their themes, such as prison governance and performance, prison safety and staffing, and young adults in the criminal justice system, including in custody.[6] However, our inquiry has focussed on those issues in the specific context of mental health and human rights.

10. There have been a number of detailed inquiries into the problem of deaths in custody in recent years, making a large number of recommendations. A number of reports have found that a common feature of such deaths is that they involved prisoners with mental health conditions, often as one of a number of multiple vulnerabilities, including, for example, abuse, discrimination, deprivation, poor education and lack of maturity.

11. Amongst the most significant of these reports are the following:

- The Woolf Report on Prison Disturbances (1991)
- Joint Committee on Human Rights, Third Report of Session 2004–05, Deaths in Custody (2004)
- The Corston Report of a Review of the particular vulnerabilities of women in the criminal justice system (2007)

6 The Justice Committee has published reports on prison safety (May 2016) and the treatment of young adult offenders in the criminal justice system (October 2016). It has announced an overarching inquiry into prison reform and conducted a first sub-inquiry into governor empowerment and prison performance, with a report published on 7 April 2017. Publication details of these reports are as follows: Justice Committee, Sixth Report of Session 2015–16, Prison safety, HC 625; Seventh Report of Session 2016–17, The treatment of young adults in the criminal justice system, HC 169; Twelfth Report of Session 2016–17, Prison reform: governor empowerment and prison performance, HC 1123.

- The Bradley Report of a review of people with mental health problems or learning disabilities in the criminal justice system (2009)
- Prison Reform Trust and Inquest report, Fatally flawed: Has the State learned lessons from the deaths of children and young people in prison? (2012)
- The Baroness Young Report, Improving outcomes for young black and/or Muslim men in the Criminal Justice System (2014)
- Changing Prisons, Changing Lives: the Harris Review of self-inflicted deaths in custody of 18–24 year olds (2015)
- Equality and Human Rights Commission (EHRC) Report, Preventing Deaths in Detention of Adults with Mental Health Conditions (2015)
- EHRC Progress Review (2016), reviewing the steps being taken to implement the recommendations made in the Commission's 2015 Report
- Howard League for Penal Reform and the Centre for Mental Health report, Preventing Prison Suicide (2016)

12. Our inquiry has focussed on why progress has not been made on preventing deaths in custody, despite the insightful analysis and many recommendations contained in the reports listed above. For this reason we began our oral evidence programme by hearing from the authors of some of those reports or representatives of the bodies which produced them: Baroness Corston, author of the 2007 Corston Report; Francis Crook, Chief Executive of the Howard League for Penal Reform which produced the 2016 report on Preventing Prison Suicide; Lord Harris, Chair of the Independent Advisory Panel on Deaths in Custody from 2009 until 2015 and author of the 2015 Harris Review; and Juliet Lyon CBE, Lord Harris's successor as Chair of the Independent Advisory Panel. On a later occasion we also took evidence from Lord Bradley, author of the 2009 Bradley Report. We probed with these witnesses why their reports had not had the impact they would have wished. We asked them which they regarded as their most important recommendations which had not been implemented, and why they thought they had not been implemented. The witnesses' answers are set out in the published transcript of their evidence. We urge anyone concerned about these matters to read this.[7]

13. In addition, we have taken oral evidence from a wide range of other expert witnesses and interested parties, and had planned to take further oral evidence as set out in paragraph 17 below. We also received 43 written submissions. We are grateful to all who submitted evidence.

14. We wish to single out for special mention a number of witnesses whose lives have been directly impacted by the subject of our inquiry. We took oral evidence from the families of Dean Saunders, who took his own life on 4 January 2016 while remanded in custody at HMP Chelmsford, and of Diane Waplington, who took her own life in 2014 while detained in HMP Peterborough. We are very grateful to the families for sharing with us their experiences and their conclusions about lessons to be learned from these tragic events.

7 Qq1–14 and Qq76–85

15. We also took oral evidence from two adults who had been sentenced by means of a hospital order under the Mental Health Act 1983 and are currently in a medium secure hospital, and two young people who at the time when they appeared before us were serving sentences in a Young Offender Institution. All four had personal experience of mental health issues within the prison system. They gave oral evidence in private, and an edited version of that evidence (redacted to ensure their anonymity, at their own request) has subsequently been published.[8] We wish to thank these witnesses for their courage in volunteering and for the quality of their evidence, which was frank, moving and raised many issues of real concern.

16. We finally wish to thank our specialist advisor, Professor Philip Leach, Professor of Human Rights Law and Director of the European Human Rights Advocacy Centre at Middlesex University, for his invaluable assistance.[9]

8 Qq15—33 and Qq34—56

9 Professor Leach declared the following interests relevant to the inquiry: Professor of Human Rights Law, Middlesex University; Director, European Human Rights Advocacy Centre; Solicitor (member of Law Society of England and Wales); Board member, Open Justice Initiative; Vice-Chair, European Implementation Network; Co-Investigator, Human Rights Law Implementation Project.

# 5 Some key proposals for legislation

17. In the short time that has been available to us to produce this report, since the Government's announcement of a general election on 8 June, it has not been possible for us to produce a detailed analysis of the evidence we received nor to reach final conclusions. We have not completed our planned programme of evidence and visits, and in particular we have not had the opportunity to hear from Ministers their response to the arguments of other witnesses.[10] However, we wish to put on record the details of some specific measures which we believe should be incorporated into law.

18. During the inquiry the Government introduced its Prisons and Courts Bill, which received Second Reading in the House of Commons on 20 March 2017. We thought that the Bill would provide a legislative opportunity to give effect to certain recommendations related to our inquiry which required primary legislation. We wrote to the Government on 30 March asking, amongst other things, how it proposes to make a number of specific improvements to the legal framework.[11] We asked for a response by 13 April but had not received one by the time the House of Commons agreed to the Dissolution of Parliament on 19 April. We had planned that the Chair of the Committee would table, on our behalf, a number of amendments to this effect at Commons Report Stage, which we understand had been scheduled to begin in late May.

19. These amendments would have sought to make the following specific improvements to the legal framework:

- A statutory duty on the Secretary of State to specify and maintain a minimum ratio of prison officers to prisoners at each establishment
- A prescribed legal maximum to the time a prisoner can be kept in their cell each day
- A legal obligation for the Prison Service to ensure that each young prisoner or adult prisoner with mental health problems has a key worker
- A legal obligation that the relatives of a suicidal prisoner should be informed of and invited to contribute to the Assessment, Care in Custody and Teamwork (ACCT) reviews (unless there is a reason that it should not be the case)
- To deal with the problem that young people, and prisoners with mental health conditions which place them at risk of suicide, have a particular need to be able to contact their families but, from the evidence we received, were often unable to do so, provision should be made in the Prison Rules to enable them to make free phone calls to a designated family member or friend

10 A further evidence session had been scheduled for 10 May 2017, at which we had expected to hear from Peter Clarke, Chief Inspector of Prisons; Paul Tarbuck, Head of Healthcare Inspection, HMIP; Nigel Newcomen, Prisons and Probation Ombudsman; and David Strang, Steering group member of the National Preventive Mechanism (also Chief Inspector of Prisons for Scotland). The theme of this session would have been how lessons can be better learnt following deaths in custody. Preparations were also underway for the Committee to visit HMP/YOI Isis and HMP Thameside on 4 May; and to take evidence from Ministers on 7 June.

11 Letter from Rt Hon Harriet Harman MP, Chair of the Committee, to Rt Hon Elizabeth Truss MP, Lord Chancellor and Secretary of State for Justice, regarding the Prison and Courts Bill, dated 30 March 2017

- Where a prisoner needs to be transferred to a secure hospital, a legal maximum time between the diagnosis and the transfer
- A mechanism to ensure the Secretary of State's accountability to Parliament for overcrowding
- A mechanism to ensure the Secretary of State's accountability to Parliament for maintaining the specified staffing levels

20. In addition, we intended to propose an amendment to the purpose clause in the Bill to make explicit that one of the aims of prison is to treat prisoners with humanity, fairness and respect for their dignity.

21. Tabling amendments to add these provisions to the Bill would have enabled parliamentarians to engage with the Government over how best to achieve improvements about whose desirability there is widespread agreement, either through primary legislation or by changes to the Prison Rules. If the Prisons and Courts Bill or similar legislation is reintroduced in the new Parliament, we hope that similar amendments will be tabled, even if the Committee has not yet been re-established by the time that the Bill resumes its passage, to allow progress to be made on this urgent matter.

# 6 Other issues

22. During the five oral evidence sessions held as part of the inquiry and from the written evidence received, a number of further themes emerged:

- The increased provision of Liaison and Diversion services[12] is positive but questions remain about whether these are being rolled out quickly enough and whether community mental health provision is adequate to support individuals with mental health conditions.
- Too often people who are acutely mentally unwell, such as Dean Saunders, are inappropriately being sent to prison as a 'place of safety'; there is an urgent need to resource and make better use of community alternatives to prison for offenders with mental health conditions, particularly those who are currently given short sentences (in this category women receive shorter average sentences than men for the same offences).
- Prisoners serving IPP (imprisonment for public protection) sentences are at particularly high risk of mental ill health.
- Training for prison officers has been reduced and leaves many ill-equipped to identify and address mental health problems among prisoners. This is a serious issue which needs to be tackled.
- The Government has made proposals for greater autonomy for prison governors and measures to hold them more accountable for prisoner safety. We believe that strong leadership is vital to recognising mental health issues and reducing the number of self-inflicted deaths in prison custody.
- Equivalence of care: there is huge variation in the availability of mental health services in prisons, which do not reflect those expected in community settings, with some prisons having little or no provision of vital services such as clinical psychology.
- The proliferation of New Psychoactive Substances has had a marked effect on prison safety and the mental health of prisoners.
- Prisoners with mental health problems need continuity of care and access to safe housing on release from prison: the prospect that these will not be available increases the risk of self-harm and self-inflicted death at the end of their sentence as well as reoffending.
- Finally, the lack of an independent oversight mechanism to oversee the implementation of recommendations made following a self-inflicted death in prison means that currently lessons are not learnt and opportunities to save lives in the future are not taken.

12 The establishment of Liaison and Diversion (L&D) services was a key recommendation of the Bradley Report. These services identify, assess and refer people who have mental health problems and learning disabilities when they come into contact with the police and courts. They assess the person's needs, advise on their case management and ensure that those in need receive the treatment and support they require.

# 7 Looking forward

23. We urge our successor Committee when established in the next Parliament to take forward our scrutiny of the issues raised in this inquiry. The evidence we have taken, written and oral, has been reported to the two Houses and published on our website. We commend our provisional conclusions and recommendations as set out in this short report to our successors. There is a moral obligation on the Government to take effective action to reverse the alarming rise in the number of people with mental health conditions who lose their lives while in prison. We hope that our successors will put further pressure on the Government to do this.

# Declaration of Lords' interests

## Lady Hamwee

Trustee for Safer London.

## Lord Woolf

President or Chairman of numerous voluntary bodies working in the areas of prisons and justice.

Author, The Woolf Report (1991).

A full list of members' interests can be found in the Register of Lords' Interests.

# Formal Minutes

## Wednesday 26 April 2017

Members present:

Ms Harriet Harman MP, in the Chair

| | |
|---|---|
| Baroness Hamwee | Fiona Bruce MP |
| Baroness Lawrence of Clarendon | Ms Karen Buck MP |
| Baroness O' Cathain | Jeremy Lefroy MP |
| Lord Trimble | Amanda Solloway MP |
| Lord Woolf | |

Draft Report (*Mental Health and Deaths in Prison: Interim Report*), proposed by the Chair, brought up and read.

*Ordered*, That the Chair's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 23 read and agreed to.

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

*Ordered*, That the Chair make the Report to the House of Commons and that the Report be made to the House of Lords.

[The Committee adjourned.

# Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

| Wednesday 22 February 2017 | *Question number* |
|---|---|
| **Juliet Lyon,** Chair, Independent Advisory Panel on Deaths in Custody, **Lord Harris of Haringey, Frances Crook,** Chief Executive, the Howard League for Penal Reform, **Rt Hon the Baroness Corston** | Q1–14 |

| Wednesday 1 March 2017 | |
|---|---|
| **Ms A**, **Mr L**, **Dr Janet Parrott**, Forensic Psychiatrist, **Nurse Stacey Washington** | Q15–33 |
| **"Harry", "James", Dr Heidi Hales,** Forensic Psychiatrist, **Dr Celia Sadie,** Clinical Psychologist | Q34–56 |

| Wednesday 8 March 2017 | |
|---|---|
| **Ms Donna Saunders, Mr Mark Saunders, Ms Clare Hobday Saunders, Ms Deborah Coles,** Director, INQUEST | Q57–67 |
| **Ms Sheila Waplington, Ms Marlene Danter, Ms Deborah Coles,** Director, INQUEST, **Selen Cavcav,** Caseworker, INQUEST | Q68–75 |

| Wednesday 15 March 2017 | |
|---|---|
| **Deborah Coles,** Director, INQUEST, **Dr Andrew Forrester,** Consultant and Honorary Senior Lecturer in Forensic Psychiatry, South London and Maudsley NHS Foundation Trust and Institute of Psychiatry, **Rt Hon Lord Bradley PC** | Q76–85 |
| **Mike Rolfe,** National Chair, the Professional Trades Union for Prison, Correctional & Secure Psychiatric Workers (the POA), **Andrea Albutt,** President, Prison Governors Association, **Mike Trace,** Chief Executive, Rehabilitation for Addicted Prisoners Trust (RAPt), **Mark Johnson,** Founder, User Voice | Q86–94 |

| Wednesday 29 March 2017 | |
|---|---|
| **Lord Farmer, Dr Éamonn O'Moore,** Director, Health and Justice, Public Health England, and Director, UK Collaborating Centre, World Health Organization, **Catherine May,** Head of External Affairs in Wales, Equality and Human Rights Commission, **Dr Kate Paradine,** Chief Executive, Women in Prison | Q95–107 |

# Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

MHP numbers are generated by the evidence processing system and so may not be complete.

1 British Medical Association (BMA) (MHP0012)

2 Catch22 (MHP0023)

3 Centre for Mental Health (MHP0010)

4 Dorset Police & Crime Commissioner (MHP0038)

5 Dr David Scott (MHP0004)

6 Dr Kulvinder Singh (MHP0002)

7 Equality and Human Rights Commission (MHP0015)

8 Farah Damji (MHP0041)

9 Hammersmith and Fulham Mind (MHP0039)

10 Helen Carter (MHP0042)

11 HM Inspectorate of Prisons (MHP0032)

12 Human Rights Implementation Centre, University of Bristol (MHP0019)

13 Independent Advisory Panel on Deaths in Custody (MHP0029)

14 INQUEST (MHP0033)

15 JUSTICE (MHP0025)

16 Liberty (MHP0028)

17 Medical Justice (MHP0014)

18 Mental Health Foundation (MHP0021)

19 Ministry of Justice (MHP0027)

20 Mr Markus Findlay (MHP0005)

21 PAPYRUS Prevention of Young Suicide (MHP0016)

22 Prison Governors' Association (MHP0030)

23 Prison Reform Trust (MHP0011)

24 Prisoners' Advice Service (MHP0008)

25 Prisoners' Education Trust (MHP0018)

26 Prisons and Probation Ombudsman (MHP0009)

27 Professional Trades Union for Prison, Correctional & Secure Psychiatric Workers (MHP0035)

28 Professor Charlie Brooker and Russell Webster (MHP0003)

29 Professor Phillip Leach (MHP0043)

30 Public Health England (MHP0036)

31 Rethink Mental Illness (MHP0020)

32 Royal College of Psychiatrists (MHP0026)

33 Substance Use and Addictive Behaviours (SUAB) Research Group (MHP0024)

34 The British Association for Counselling and Psychotherapy (MHP0007)
35 The Howard League (MHP0013)
36 The Royal British Legion (MHP0006)
37 UK National Preventive Mechanism (MHP0031)
38 University of Warwick (MHP0022)
39 Unlocked Graduates (MHP0034)
40 Women in Prison (MHP0037)
41 Women in Prison (MHP0040)

# List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

### Session 2015–16

| | | |
|---|---|---|
| First Report | Legislative Scrutiny: Trade Union Bill | HL Paper 92/HC 630 |
| Second Report | The Government's policy on the use of drones for targeted killing | HL Paper 141/HC 574 |
| Third Report | Appointment of the Chair of the Equality and Human Rights Commission | HL Paper 145/HC 648 |

### Session 2016–17

| | | |
|---|---|---|
| First Report | Legislative Scrutiny: Investigatory Powers Bill | HL Paper 6/HC 104 |
| Second Report | Counter-Extremism | HL Paper 39/HC 105 |
| Third Report | Legislative Scrutiny: (1) Children and Social Work Bill; (2) Policing and Crime Bill; (3) Cultural Property (Armed Conflict) Bill | HL Paper 48/HC 739 |
| Fourth Report | The Government's policy on the use of drones for targeted killing: Government Response to the Committee's Second Report of Session 2015–16 | HL Paper 49/HC 747 |
| Fifth Report | The human rights implications of Brexit | HL Paper 88/HC 695 |
| Sixth Report | Human Rights and Business 2017: Promoting responsibility and ensuring accountability | HL Paper 153/HC 443 |
| First Special Report | Counter-Extremism: Government Response to the Committee's Second Report of Session 2016–17 | HC 756 |