Forum for Preventing
Deaths in Custody

ANNUAL REPORT

2006-2007

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Commission on
behalf of the Forum
for Preventing
Deaths in Custody

The Forum's membership is comprised of representatives from the following organisations

- Association of Chief Police Officers (ACPO)
- Border and Immigration Agency (BIA)
- Coroners' Society
- Department of Health
- Her Majesty's Inspectorate of Constabulary (HMIC)
- Her Majesty's Inspectorate of Prisons (HMCIP)
- Her Majesty's Prison Service (HMPS)
- Home Office, Policing Powers and Protection Unit
- Independent Police Complaints Commission (IPCC)
- INQUEST
- Mental Health Act Commission (MHAC)
- National Offender Management Service (NOMS)
- National Probation Directorate (NPD)
- Prisons and Probation Ombudsman (PPO)
- Youth Justice Board (YJB)

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Contents

Chair's Foreword

The commitment to the Forum by those that have the responsibility for detaining and caring for those in custody, has been crucial to our work this year. The Forum's membership provides a strong foundation of expertise and experience and we have started the process of sharing information and experiences and drawing up lessons that we hope will make a difference. It is therefore only fitting that I open this annual report with a thank you to the Forum's fifteen member organisations. Their willingness to share openly information has been critical, as has their energy for our work and commitment that the Forum should make a real difference to reduce custody deaths. However, it is important to note that, while this report reflects the views of the majority of the Forum's members, there are inevitably differences of opinion over certain issues. I am grateful to each of the members for their contributions to this report, but emphasise that it is published in my name and that of the secretary.

This is the Forum's first annual report, and in practice it covers the work we have undertaken in our first eighteen months. We have now held five full meetings and have had a full time secretary for a year. We have already explored some of the key issues pertinent to preventing deaths in custody. Member organisations have considered a great deal of information about how individually they are working to reduce the number of deaths in prisons, police and mental health settings and elsewhere. We have also started to explore the need for similar work both in Scotland and in Northern Ireland although so far the Forum's resources have restricted us to primarily working in England and Wales. Interestingly the concept of a body to learn lessons and to try to prevent deaths in custody across the different institutions seems to have occurred first here and we are yet to find any parallel anywhere else in the world. Coroners in Australia though seem to be further ahead of their colleagues in the UK in trying to ensure that lessons are learnt from all deaths (not just those that occur in custody).

We have already seen much evidence of good practice in different custodial settings in England and Wales. A key area of work has been examining how each of the organisations shares and learns lessons about deaths in custody both internally and with other sectors. However, we have found weaknesses in some of the systems and we know that more could be done to prevent deaths in custody and it is this that spurs the

members of the Forum to further action. Concern about the ability and willingness to learn from inquests led us to seek changes to the powers available to coroners in preventing future deaths. We believe that the Coroner Reform Bill will be a step towards much needed improvement to the coronial system and it is very unfortunate that the legislation has not already been implemented. However until the Bill is formally introduced we recommend improvements to the system and are seeking to achieve these through amendments to the Coroners Rules.

Although we have achieved much in eighteen months, we are still in the first stages of our development. On 16 May 2007 the Government made a commitment to reviewing and strengthening the Forum's current arrangements; something which we very much welcome. Lack of resources has made our task a difficult one. We have not been able to conduct or commission research into any of the issues we believe are worthy of it, and we have no capacity to monitor or report on the recommendations that may be made as a result of investigations, inspections or inquests. However, the Home Office (and in more recent months the Ministry of Justice) through the National Offender Management Service, has provided the resources for an independent Secretary to the Forum, Kate Eves. I am particularly grateful for all her efforts to develop the Forum, despite the lack of resources to do so. Ms Eves is seconded to the Forum from the Prisons and Probation Ombudsman's Office. I am grateful to Stephen Shaw, who holds that office, for releasing an experienced member of his staff for this purpose.

In the absence of a fully-funded secretariat I have been grateful for the opportunity to form links with other groups performing similar roles to our own. The Forum has developed direct links with the Ministerial Roundtable on Suicides in Prison and the Department of Health's Suicide Prevention Strategy Group. I, and the other Forum members, have very much welcomed the involvement of Baroness Stern, who attends the Forum meetings as an observer from the Joint Committee on Human Rights. We have also been encouraged by Baroness Scotland hosting an event to bring together organisations working in this important area.

I also owe thanks to INQUEST whose committment and contribution have been particularly welcome, especially given that they are a small, non-governmental organisation with limited resources.

This report is a welcome opportunity to reflect on what we have achieved in our first eighteen months; it is also an opportunity for us to acknowledge that too many people continue to die in custody and that some of those deaths could have been prevented. That remains a real and urgent challenge. We hope that the Government's review will recognise that the Forum must have the autonomy and resources to act when it feels it necessary. The Forum is succeeding in bringing together members with expertise in preventing custody deaths but our ability to do more than this is limited at the moment.

At my suggestion, the Forum has agreed that the chair of the Forum should be completely independent of those involved in the business of detention and independent even of those whose job it is to oversee those functions.

Personally, I believe it was unfortunate that the Government resisted the extension of the Corporate Manslaughter Bill to deaths in custody and I am grateful that members of

the House of Lords persuaded the Government to change its mind. Although I expect there to be few convictions in this respect, I believe that it is likely to make a difference to how those in charge of custodial institutions understand their responsibilities. However, individual members of the Forum have different views on the inclusion of custody deaths in this legislation and the Forum has therefore not taken an official view. Despite the differing perspectives of member organisations, the Forum will continue to monitor the development of the Corporate Manslaughter Act with interest.

I believe that one of the most significant contributions this report makes is to show that approximately 600 people die in custody each year, with about a third of these apparently from other than natural causes. While it is not possible to eliminate every one of those deaths, it is clear that many lives could and should have been saved.

Many of the subjects we have examined provide significant challenges for the organisations involved in the Forum. For example, we have explored the management of detainees who are difficult to manage but still need to be protected and cared for. Throughout our exchanges, the agencies with an oversight or investigative function have been able to raise concerns about deaths which have occurred as a result of poor policy or practice. But we have equally been able to share examples of situations in which staff deal extremely well with people with very complex needs. Sharing the learning that results from both circumstances has been moving, rewarding and an impetus towards improvement. I commend this first annual report.

John Wadham
Chair
Forum for Preventing Deaths in Custody

Executive Summary

1. Almost 600[1] people die in custody each year. Many of these deaths are through natural causes but a great many others are as a result of apparent suicide attempts and other non natural causes. This report is a welcome opportunity to reflect on what the Forum has achieved in our first eighteen months but it is also an important opportunity for us to acknowledge that too many people continue to die in custody and that some of those deaths could have been prevented.

2. The concept of a body to learn lessons and to try to prevent deaths in custody across the different institutions seems to have occurred first here in England and Wales: we are yet to find any parallel to the Forum anywhere else in the world. However, some other jurisdictions are further ahead of their colleagues in the UK in trying to ensure that lessons are learnt from all deaths (not just those that occur in custody); coroners in Australia have made a great deal more progress than is the case in the UK. Concern about the ability and willingness to learn from inquests led us to seek changes to the powers available to coroners in preventing future deaths. We believe that the Coroner Reform Bill will be a step towards much needed improvement to the coronial system.

3. We have already seen much evidence of good practice in different custodial settings in England and Wales. An example of this is the fact that there has not been a restraint related death in the Prison Service for 12 years. A key area of work for the Forum is examining how each of the organisations learns lessons from previous deaths and shares this learning both internally and with other sectors.

4. The Forum is still in the first stages of its development. On 16 May 2007 the Government made a commitment to review the Forum's current arrangements with a view to strengthening them. The Forum very much welcomes this review as the current lack of resources has made the group's task a difficult one. The Forum has not been able to conduct or commission research into any of the issues we believe are worthy of it, and we have no capacity to monitor or report on the recommendations that may be made as a result of investigations, inspections or inquests. The Forum believes that its chair should be completely independent of the member organisations.

5. The Forum's work over its first eighteen months has demonstrated the need for a more robust and joined-up approach to information sharing between agencies. An example of this is the use of the Prisoner Escort Record (known as a PER form). The PER form is used to record information about people in custody, and can often be the only way of transferring information about risk of self-harm or vulnerability from one agency to another. The Forum advocates a more joined-up approach between the Prison Service and police. The PER form needs to be developed to reflect the

[1] This figure includes all recorded deaths of patients detained under the Mental Health Act 1983, all deaths of residents of approved premises and all deaths in prison, immigration and juvenile custody. It also includes all deaths in or following police custody but does not include all deaths of those who have recently been discharged from hospital, immigration detention or released from prison custody.

needs of both agencies so that it can offer the best possible protection for those in their charge.

6. The Forum's work is also prompting further consultation between the police and Prison Service on ensuring that the Police National Computer (PNC) is available to prison staff. It is the Forum's view that access to the PNC by prison staff would help them to make better risk assessments. In addition, by allowing the Prison Service to enter data, the police would also be more aware of safety issues when the person concerned is next dealt with by police officers. Discussions to date have shown that the two bodies have had different expectations about how and when this can be progressed. The Forum expects to continue its focus on this issue during the coming year.

7. The Forum has set up Working Groups to look at our areas of concern in more detail. We recently published the report of the Working Group on the Physical Environment. This report explored how the risk of suicide and self harm can be reduced by the appropriate design, management and layout of the custody environment. The group's work highlighted how much technical information, expertise and experience exists within the different sectors and recommended the establishment of a database to distil all of this valuable information.

What is the Forum?

The Forum's terms of reference

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

The scope of the Forum

The aim of the Forum is to increase learning opportunities. Initially the Forum will cover areas of work that fall within the responsibility of the Home Office, Ministry of Justice and Department of Health. In practice, this will mean work around deaths of people detained in police custody, prison, approved premises, immigration custody or those detained under the Mental Health Act. Deaths which occur after prison release may also be included in the Forum's scope, as may 'near deaths', both of which can provide important sources of learning.

The background to the Forum's development

There have been proposals to set up some kind of body to oversee and monitor deaths in custody for many years and the chief advocate for these has been the organisation INQUEST. In March 2003 Liberty published its report on *'Deaths in Custody: Redress and Remedies'* in collaboration with others, including INQUEST.

Liberty's report emphasised its support for the creation of:

> "a separate, over-arching Standing Commission on Custody Deaths. Its mandate should be to bring together the experiences from the separate investigatory bodies set up to deal with police, prison, hospital deaths and others. Such an over-arching body could identify key issues and problems, develop common programmes, research and disseminate findings where appropriate, and ensure services work together for change. Lessons learned in one institution could be promoted in other institutions, best practice could be promoted, and new policies designed to prevent deaths could be drafted and implemented across

The membership of the Forum consists of senior representatives from each of the following:

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- **Border and Immigration Agency (BIA)**
- **Coroners' Society**
- **Department of Health**
- **Her Majesty's Inspectorate of Constabulary (HMIC)**
- **Her Majesty's Inspectorate of Prisons (HMCIP)**
- **Her Majesty's Prison Service (HMPS)**
- **Home Office, Policing Powers and Protection Unit**
- **Independent Police Complaints Commission (IPCC)**
- **INQUEST**
- **Mental Health Act Commission (MHAC)**
- **National Offender Management Service (NOMS)**
- **National Probation Directorate (NPD)**
- **Prisons and Probation Ombudsman (PPO)**
- **Youth Justice Board (YJB)**

all institutions. Differing policies could be identified and changes suggested (for example with regard to restraint techniques, where it appears that every institution has different policies)."

In July 2003, the Joint Committee on Human Rights (JCHR), made up of Peers and MPs, launched an inquiry into deaths in custody and many of the Forum's members, including INQUEST, gave evidence.

In its 2003 submission to the JCHR, INQUEST advocated setting up a completely separate commission to investigate all forms of deaths in institutions. The submission said:

"Many of the issues arising from deaths in custody need to be fed into the wider agenda for social inclusion of goverment, local authorities and the voluntary sector. Many of the deaths which occur are part of a pattern which impacts on policies on combating racism, drug and alcohol use, homelessness, mental health, crime prevention and policing.

"To this end we recommend the setting up of a Standing Commission on Custodial Deaths which would bring together the experiences from the separate investigation bodies set up to deal with the police, prisons, hospital deaths and others. Such an over-arching body could identify key issues and problems arising out of the investigation and inquest process following deaths and it would monitor the outcomes and progress of any recommendations. It could also look at serious incidents of self harm and near deaths in custody where there is a need to review and identify any lessons. Arising from this it would develop policy and research, disseminate findings where appropriate and collaborate working. Lessons learnt in one institution could be promoted in other institutions, best practice could be promoted and new policies designed to prevent deaths could be drafted and implemented across all the institutions. It would play a key role in the promotion of the culture of human rights in regard to the protection of people in custody.

"It should also have the powers to hold a wider inquiry where it sees a consistent pattern of deaths. Such an inquiry could give voice to and a platform for examination of those broader thematic issues and those issues of democratic accountability, democratic control and redress over systematic management failings that fall outside the scope of the inquest. One of its functions would also be to lay the past to rest and assisting the process of effecting real and meaningful change."

The JCHR published its report on deaths in custody in December 2004. Amongst other things, the committee recommended that the Home Office and Department of Health should establish a cross Government expert task force on deaths in custody. As a consequence, in July 2004, the Independent Police Complaints Commission (IPCC) had separately suggested the idea of a Forum to capture cross sector learning following deaths in custody. The proposal met with a positive response from custodians and investigators involved in the area of work. Meetings in March and June 2005 brought together key organisations such as the Prisons and Probation Ombudsman's Office and

HM Inspectorate of Prisons. It was quickly established that much could be learned by agencies sharing information and learning across institutions.

In October 2005, the Government responded to the JCHR's report by outlining its commitment to better co-ordinate the existing processes and to work with the key agencies to consolidate a new multi-agency forum to take this forward. The Forum met for the first time in November 2005 and, following work to draft their terms of reference, met again in February 2006 to agree the programme of work for the coming year. Subsequently, the Forum has held four further meetings in June and October 2006 and February and June 2007.

More recent developments

In December 2006, the Joint Committee wrote to the Government seeking an update on the Forum's work. The Forum's chair contributed an account of the work that the group had undertaken so far. On 16 May 2007 the Government announced a commitment to strengthen the Forum and is currently conducting a review of the current arrangements. The review is due to report in November 2007.

What have we achieved this year?

Our agenda to date has been ambitious. A key task for the Forum's tri-annual meetings is establishing how sources of learning could be better shared. We were surprised how little sharing of problems and solutions there had been to date, but how interested people were in trying to find the solutions and the common threads. We have explored how the member organisations learn from deaths and share information and how recommendations from inspections, investigations and inquests are handled. Our October 2006 meeting focused on how prisoners and detainees are managed. Our discussion included, but was not limited to, the use of control and restraint, segregation/ seclusion and alternative methods of managing difficult and violent prisoners. In February 2007, we explored how staff are trained to prevent deaths in the different custody environments. Our June 2007 meeting examined the issues specific to women in custody and was informed by the recent publication of the Corston Report: A Review of Women with Particular Vulnerabilities in the Criminal Justice System. (The report can be accessed at the Home Office website: ***www.homeoffice.gov.uk/documents/corston-report/corston-pt-1?view=Binary***)

Case Study: Learning Lessons from Deaths in Prison Segregation

- *Between April 2004 and March 2007 there were 33 deaths in segregation units. Of those deaths 31 were apparently self inflicted. The vast majority of those who died in prison segregation were men (only two of the 33 were women).*

- *Overall, deaths in segregation units have accounted for 13% of all prison self- inflicted deaths between April 2004 and March 2007. The figure was 20% in 2004-2005; 8% in 2005-2006 and 11% in 2006-2007.*

- *The prisoners who are the most 'difficult' are often also the most vulnerable. Very damaged people can also be very damaging to others. Staff are undoubtedly faced with difficult decisions as to where to hold some prisoners. Prisoners may end up in segregation units when all other options have been exhausted. However, there have been examples where alternative options to segregation have not been adequately explored.*

- *The effect of segregation on an already vulnerable person's state of mind can be severe. There have been instances of failure to implement safety mechanisms particularly for prisoners at risk of self harm. For some of those prisoners who have died in segregation, the required case conferences and mental health assessments appear not to have taken place.*

- *The importance of safety algorithms and safeguarding those who are mentally ill cannot be underestimated. We have seen examples of an over-reliance on healthcare staff making decisions, and inconsistencies in the quality of the completion of safety algorithms (such as failing to consult medical notes).*

Case Study: Learning Lessons from Deaths in Prison Segregation (continued)

- *In addition to the effects of segregation itself, the impact of restricted access to stimulus and a restricted regime can also be severe. There have been examples of prisoners subject to impoverished regimes without television, radio, reading materials, in-cell hobbies or any other occupation. Giving vulnerable prisoners something to occupy their time is likely to be a crucial part of safeguarding the welfare of those in segregation.*

- *The Forum welcomes work being undertaken jointly by the Prison Service Safer Custody Group and the Department of Health to improve the safety and health of prisoners held in segregation settings. This work aims to ensure that prisoners being held in segregation have the same access to the same range of high quality health and mental health services as those living in the community and to prevent and/or reduce the number of prisoners who are physically/mentally ill or vulnerable to suicide/self-harm held in segregated settings.*

Roundtable learning from deaths

Reduction in restraint deaths in prisons

Following a number of restraint related deaths in the early 1990s, the Prison Service has worked hard to change its approach to Control and Restraint (the practice of retraining face down was identified as particularly risky). We recognise that the Prison Service has taken steps to learn from these earlier deaths, as is demonstrated by the fact that there have been no restraint related deaths in prison since 1995. The Forum wants to ensure that the lessons learned by the Prison Service are communicated to other sectors. We recognise that, on occasion, police custody death during or following restraint can be very complex as they potentially involve aggrevating factors such as drug swallowing or intoxication.

Difficulty in identifying those who are presenting an immediate risk of harming themselves

Staff who are regularly exposed to highly vulnerable and suicidal individuals often need training in when to ask probing questions. There is a risk that constant exposure to people who express the desire to harm themselves and others can result in complacency when there is a real risk of them acting out this behaviour. We have heard of many individuals who appeared “okay on the day” who have gone on to take their own lives. All too often those who have made the decision to end their lives are calmer in the time between that decision and when they actually take steps to carry this out. Investigations into deaths in custody should achieve many things - not least providing families with an insight into what has happened and fulfilling obligations under Article 2 of the European Convention on Human Rights (ECHR). However, investigations should also be instrumental in helping staff to learn from particular experiences and to gain or recover confidence in working with vulnerable patients or detainees.

Training and support for staff who deal with very violent and vulnerable detainees or patients is crucial. We have heard reports of staff dealing with very violent individuals who are in seclusion in hospital settings where there has been evidence of staff being frightened to carry out the necessary checks. Staff need to be equipped to care for vulnerable and violent patients in a way that enables them to protect themselves.

How can we make sure that individuals are placed in the most suitable environment?

We have heard numerous examples of vulnerable individuals being placed into environments which are not equipped to care for them. In some cases care that was provided in the community has ceased once the person is in custody, despite the Department of Health's responsibility to provide continuity of care for those who were receiving treatment in the community. These examples have not just related to individuals whose mental health is poor. People whose physical illnesses make custody inappropriate are also held in conditions that cannot meet their needs.

The risks associated with new types of sentencing, pressures and priorities

It is well documented that uncertainty can make prisoners particularly vulnerable. Those who have received an Indeterminate Public Protection (IPP) sentence may be particularly at risk, especially as there are signs that both prison staff and prisoners are unclear what the sentence means in practice. The Prison Service has significant difficulties in 'processing' IPP prisoners on this type of sentence through the system, with prisoners backing up in local prisons awaiting transfer to first stage lifer centres.

In addition to IPP sentences, being recalled to prison having had a licence revoked could cause particular risks, and the prisoner could find themselves 'fast-tracked' through induction, potentially increasing their vulnerability. The uncertainly of their situation, coupled with an increasing presumption towards deportation, may mean that foreign nationals are disproportionately at risk of suicide or self harm. On occasions language barriers may make it difficult to communicate.

Failures to treat alcoholism with sufficient seriousness

We are concerned that alcohol intoxication and addiction amongst detainees is not always taken sufficiently seriously. There have been instances when medication has not been appropriately dispensed. Lessons also need to be learned from deaths where front line staff appear to have become desensitised to the risks associated with extreme intoxication. It is crucial that staff are trained and refreshed to identify risk factors. They may also need to be reminded of the importance of making commonsense decisions about when it is not appropriate to care for someone in a custody environment. While there have been examples where ambulance services have refused to attend to individuals, there are also examples of good practice with ambulance trusts piloting ways to work with the local police force.

Failure to learn from near deaths

A primary barrier to learning lessons is the lack of robust structures for collating and disseminating information. This may particularly be the case for incidents that do not result in a death and are therefore not exposed to an investigation or inquest proceedings. The Forum will take a particular interest in two Article 2 compliant investigations (one into a near death, one into repeat self-harm) that are being conducted by the Prisons and Probation Ombudsman (PPO).

Systems to investigate deaths and learn lessons

The systems to investigate deaths in custody vary between the sectors represented on the Forum. If we are to learn lessons and to reduce or prevent deaths in custody, the systems for investigation must be sufficient to carry out their tasks. We welcome the

Government's commitment to put the Prisons and Probation Ombudsman on a statutory footing and to confirm that office with the powers it needs to carry out its functions (and to comply with the strictures of Article 2 of the European Convention on Human Rights).

However, the Forum is aware that the system for investigating the deaths of patients who have been detained in hospital under the Mental Health Act 1983 differs significantly from that in respect of deaths in police or prison custody. The Forum will wish to consider the effectiveness and independence of the mental health investigation system in the coming year.

Forum members have also raised concerns regarding the time taken to complete investigations and inquests into custody deaths; this is something which inhibits effectve learning.

This list is by no means exhaustive. The Forum has also discussed a number of other lessons that arise from deaths in custody including the importance of robust support mechanisms for detainees during the early days in custody and the particular vulnerabilities of detainees who are withdrawing from or being maintained on drugs.

Better access to information

The early stages of setting up the Forum have revealed that there is a great deal of information about custody deaths available. However, much of the basic statistical information is not readily accessible. The Forum is in an ideal position to collate and share such information and this report provides some key information which, to date, does not appear to be available from other sources.

How many people die in custody in England and Wales?

	2004/05	2005/06	2006/07
Police	36	28	Data not available at time of publication
Prison	199	164	162
Patients detained under the Mental Health Act 1983	328	373	351
Immigration Detention	4	3	0
Approved Premises[2]	20	17	10
Youth Custody	3	1	0
TOTAL	590	586	523[3]

NOTE: It is important to note that there are varying practices in how data are collated and analysed between each of the organisations represented at the Forum. For this reason, the data shown in the above table include deaths in custody of all classification (including apparently self inflicted, homicide and natural causes) and gives no indication of age, gender or race of the person who died. For more detailed information about the classification of deaths in each type of custody please see Annex 1.

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

[3] Excluding deaths in or following police custody during 2006/2007

Working groups

Physical custody environments

With a record prison population and the construction of larger police custody suites, the physical environment into which detained persons are received and cared for is under pressure. The Forum provides an opportunity to share expertise and knowledge across the sectors. Member organisations employ a range of approaches to reduce harm by changing the physical environment. The Forum has set up a working group to examine different approaches to the design, management and maintenance of custody environments. The group is examining all aspects of 'technical' and design-based approaches to harm prevention (including the removal of ligature points, the location or layout of cell/ ward and the use of CCTV). The working group has produced a report to summarise the approaches being taken by each of the sectors with regard to the physical custody environment. The report aims to identify gaps in knowledge, practice or policy, and also highlights good practice and how this might be shared. A summary of the report's recommendation is reproduced below:

1 Ensuring that the environment is appropriate

- In some parts of the prison estate, being placed in a Safer Cell can have a stigmatising effect. While Safer Cells are, understandably, often located in the high risk areas within prisons, consideration needs to be given to placing the cells amongst standard cells. This, coupled with the appropriate management of at risk prisoners, is conducive to reducing stigma and normalising the environment of those who may be vulnerable to self harm.

- The Working Group welcomed the joint Department of Health and Royal College of Psychiatrists' review of Core Standards of Safety. The Group recommended that, following publication of the review, the Forum should seek advice from its authors on how the standards will be implemented.

- In their 1998 report entitled *Not just Bricks and Mortar*, the Royal College of Psychiatrists recommended that clinicians should involve themselves early on in the project when mental health wards are being designed and planned. This is often now the norm in new mental health builds. Indeed, in many new mental health builds, patients' input is also a very important part of the design process. The group considered that the importance of close liaison between practitioners and designers/ architects and manufacturers cannot be over stated. As new facilities are developed it is crucial to reflect on the lessons that have been learned from past experiences and practitioners are the people best placed to provide this insight.

2 Appropriate maintenance and upkeep of the built environment

- It is crucial that Safer Cells are properly maintained. Historically, prison managers have been reluctant to afford Safer Cells the level of monitoring and maintenance that they require, viewing them as somehow separate to the rest of the prison's accommodation. Governors must take responsibility for their Safer Cells ensuring that a maintenance protocol is in place between management and 'works' staff which adheres to the specific requirements of Safer Cells.

- The Working Group acknowledged that there is a lack of commitment to timely and comprehensive maintenance of units. A lack of full maintenance agreements and

protected maintenance budgets allows maintenance budgets to be squeezed to accommodate other priorities.

- Individuals who are responsible for the repairs and upkeep are not always sufficiently in tune with the safety implications of certain actions or inactions. There is a need for greater cohesion between the criminal justice inspectors and those who have responsibility for the 'fabric' of the cells.

3 Improving learning from 'near deaths' and increasing the sharing of information on new and emerging risks from physical environments

- Anecdotally, the physical environment of custodial settings are given a lower priority as part of investigations into deaths than are the actions of staff. Organisations need to be aware of this and to ensure that the lessons are not being missed.

- The Group found that opportunities do exist for greater learning from deaths and adverse incidents in custody; however, this is currently dependent on the establishment of a robust reporting and dissemination process. The Forum could play a crucial role in sharing these lessons beyond the individual service to other custodial sectors.

- Ligature points can be found at any height. Simple lessons such as this, shared quickly and across a broad range of sectors, can save lives.

- Detainees can demonstrate ingenuity when presented with seemingly safe surroundings. The Working Group discussed a recent incident in a police cell where the metal tag from an exposed water pipe had been removed by a detainee; the tag was sharp and could easily be used for self harm or as a weapon against another person. Dissemination of this information across other forces revealed that this was not an isolated incident. The Group considered that communication and information sharing is key. The Forum should consider what contribution it should make to facilitating cross-sector information sharing specifically in this area.

4 Addressing discrepancies in the standards of safety in the built environment

- Responsibility for the procurement of building materials and equipment in police forces falls to individual Chief Officers. Suitable materials and equipment can be developed at less prohibitively expensive rates if practitioners and manufacturers are able to engage in consultation at an early stage. Not only would this approach yield financial savings, but would potentially provide products that are suitable for purpose from the outset.

- The new, larger police custody facilities currently being built will present different challenges for the staff that manage and work in them. The working group emphasised the need for practitioners to be heavily involved with the design of these facilities. Chief Officers must review staffing levels on commissioning a new or rebuilt custody facility to ensure that they are adequate. New custody facilities often require new working arrangements.

- The Working Group welcomed the Youth Justice Board's (YJB) review of its Safeguards Programmes and suggested that the Forum invite the YJB to report on the findings of its review at the end of 2007.

Family liaison

The Forum has been instrumental in bringing together representatives from several organisations with an interest in death in custody issues from a family perspective. It is envisaged that the group will be able to offer a family perspective on issues raised and proposals made by the Forum. In addition, we hope that the representatives will be able to work together to share best practice and to create a more co-ordinated approach to reduce the confusion that is often experienced by bereaved families. This group should also be able to offer an invaluable peer support mechanism for those who work closely with families.

Aside from our work with agencies who link with bereaved families, the Forum recognises the need to to engage directly with families affected by custody deaths. The perspectives and experiences of those families (and the groups that represent them) are diverse and it is essential that we find the best way of working with them. This work is a priority for the Forum and will continue to be over the coming months.

We are also setting up working groups to look specifically at the particular risks relating to the transfer and escorting of detainees and the training given to escort staff.

Coroners Reform

The members of the Forum welcomed the Coroner Reform Bill, and its publication informed our discussions about the essential role that coroners can play in preventing future deaths in custody. In August 2006 we wrote to the Rt Hon Harriet Harman QC MP, then Minister of State for Constitutional Affairs, outlining the Forum's concerns regarding the limited contribution coroners are able to make to preventing custody deaths. We believe that the current infrastructure of the coronial system and the discrepancies between the resources available to coroners contribute to the inconsistent approaches to learning from deaths. Our letter appears as Annex 2 at the end of this report.

Harriet Harman met with the Forum's Chair and Secretary and emphasised her commitment to strengthening the powers available to coroners to help prevent future deaths. The Forum was invited to provide a draft clause showing how we would wish to see the Coroners Rules strengthened, an opportunity which we welcomed.

On 30 January 2007 Harriet Harman announced that the draft Coroner Reform Bill will now include the following measures to help coroners prevent future deaths:

- Coroners will be able to require organisations to respond to their reports and to say what action they will take to prevent future deaths;
- The Coroner will be able to request a written response to his or her report within a specified timeframe and there will be a legal obligation for agencies and organisations to respond;

- The Chief Coroner, to be appointed under the bill, will monitor the reports made and responses received; and
- An annual report of these responses will be made to the Lord Chancellor and laid before the House of Commons.

We welcome these measures to strengthen the powers available to coroners and consider that the Coroner Reform Bill should be introduced at the earliest possible opportunity.

It is the Forum's aim that strengthening the provision for coroners to better contribute to learning from deaths will in turn encourage more robust approaches within the organisations who care for people in custody. If organisations are compelled to respond to coroner's recommendations we may be more likely to see evidence that investigations into deaths have in fact led to a changes in practice which are sustained and reveiwed.

Spreading knowledge about deaths

The Forum has produced a check-list for all grades of staff which is reproduced below. It should be noted that this list is based on anecdotal information from Forum members and is not intended to replace any existing policy, guidance or advice issued by individual organisations.

1 *Many deaths have occurred where information about a person's risk or vulnerability has not been communicated effectively. Always ensure that you clearly and accurately record any relevant information about a detainee. Make sure you understand what information you need to have access to and if it is not available find out why not. Think about who else might need this information (including those outside your institution), especially those who might have to care for the person in the future.*

2 *Withdrawal from drugs or alcohol often heightens mental health issues, can disguise physical illness and can also cause impulsivity and violent mood swings (especially when the withdrawal is rapid). Withdrawal can cause suicidal ideation even in people who have no history of self harm. History of drug or alcohol abuse should be clearly recorded to ensure proper risk assessment.*

3 *There are situations where it is not possible to avoid restraining a person. Be aware of the risks associated with this: restraint should be used as a last resort, use the minimum force possible, try to avoid restraining people face down or in a position which may inhibit their breathing. The person being restrained should be monitored throughout the period of restraint and afterwards to ensure no ill effects.*

4 *Policies and training on the use of restraint need to be regularly reviewed, particularly following a death involving restraint. In addition to being trained about the risks of asphyxia, staff should be provided with training on de-escalation techniques.*

5 *Individuals who act violently and aggressively will be experiencing increased levels of anxiety and potentially other physical side effects. Drug and/ or alcohol intoxication can heighten the risks to their health. If there is any sudden change in their demeanour, medical advice should be sought immediately.*

6 *Remember that people who are violent or who threaten violence can also be ill or hurt and may need urgent treatment. Sometimes the effect of alcohol or drugs can mask other problems including head injuries. Some people fake illnesses but even those that do can also get ill and need treatment.*

7 *Those who are vulnerable, mentally ill, at risk of suicide or self harm or withdrawing from alcohol or drugs are particularly at risk if placed into segregation. Ensure that a multidisciplinary team follows all necessary protocols to check that the person is safe to held in segregation.*

8 *If you are receiving someone into your care who has been treated by a medical professional, ensure that you understand if there are any risks to that person and if so how they should be monitored.*

9 *Be aware of the location of (and how to use) any cut-down equipment supplied or other equipment, for example for resuscitation, where you work. Staff responsible should also be aware of any policies and procedures for dealing with emergency situations including how to obtain emergency medical assistance.*

10 *Ensure that any notes you make in a detainee's records (including medical records) are legible and clearly annotated with your name and the date/time.*

11 *Look at the staff observation books/ custody records/nursing or medical records at the beginning of each shift to make sure that you are aware of any changes or issues to be aware of. Ensure that you document any relevant information about detainees during your shift.*

12 *Think about the impact of bad news or a change in circumstances on a detainee – have they got access to appropriate support? Ensure that staff are aware of any anniversaries of significant events that may impact on the detainees state.*

13 *Find out if there have been any custody deaths where you work. If so, were any lessons learned from the death? Find out what they were.*

14 *Find out if your organisation uses a system of codes to alert other staff in an emergency situation where someone's life is at risk.*

The Prison Service's Safer Custody News is a good example of how a regular publication can be used to communicate lessons arising from death in custody investigations. The newsletter is also a useful way of promoting good practice.

The Forum's website

The Forum's work is clearly of public interest and we are committed to ensuring that the minutes of our meetings are openly available, along with any papers and reports we

produce. Full time secretariat support has enabled us to set up a website which has the potential to be used as an interactive resource to increase knowledge about deaths in custody and improve access to information. The website is an important resource for the Forum; over the coming months the content will be updated and new features added to the site. We have been disappointed that a lack of resources has placed limitations on what we can achieve with the site, including our ability to keep it updated with news on the work we are undertaking. This is an issue which we hope will be acknowledged by the Government's review of our work so far.

The Government response to the JCHR's 2006 letter

The Joint Committee on Human Rights wrote to the Government in December 2006 requesting an update on the recommendations it accepted from the Committee's 2004 report. The Committee also asked for comment on whether the Forum was effectively achieving change.

In its response the Government was able to report significant progress in a number of areas, not least the sustained reduction in self-inflicted deaths in prisons[4]. The Government's response acknowledged that the Forum is in the early stages of its work and development but is already providing an invaluable mechanism for sharing and analysing information about policy and practice across organisations. The Forum's chair provided a note to be included in the Government's response and this was a useful opportunity to review the group's progress to date.

Collaborative working

In November 2006, Home Office Minister Baroness Scotland hosted an event to mark the progress being made in efforts to reduce deaths in custody across a number of sectors. Speakers at the event included Baroness Stern, Professor Louis Appleby of the Department of Health, John Wadham, deputy chair of the Independent Police Complaints Commission and current chair of the Forum and Stephen Shaw, Prisons and Probation Ombudsman. The speakers provided information about programmes of work across the different sectors, and the event facilitated informal discussion between all those who contribute to this important area of work.

The event encapsulated the importance of learning lessons and sharing information across sectors to reduce custody deaths. Discussion between members of the Forum and of the Ministerial Roundtable on Suicides in Prisons has helped to develop plans for the two bodies to work collaboratively and to integrate their approaches.

Links across the UK

The Forum acknowledges that those working in custodial settings in Northern Ireland and Scotland face many of the same challenges as organisations in England and Wales. We are committed to developing a system (or systems) that both deals with cross-institution learning within each jurisdiction and shares that learning between

4 The number of self inflicted deaths in prisons is higher to date this calendar year than in the same period last year. The Prison Service have advised that self inflicted deaths in prisons are subject to large random and cyclical swings and that year on year comparisions should not be used in isolation for evaluating the rate of deaths. A minimum frequency of three years is recommended.

jurisdictions. Developing links with organisations in Scotland and Northern Ireland provides a valuable opportunity for us to learn across all parts of the UK.

The Forum's secretary has begun to build links with relevant organisations to keep them up to date with development. By maintaining contact with organisations who wish to engage with the Forum, we will encourage the cross-sector information sharing we promote.

Improving inter-agency communication

Most custodial environments are highly populated, busy and stressful. It is not hard to understand how information gets lost, even when staff are well trained and supported. Our meetings have highlighted key issues that need to be addressed to improve internal and inter-agency communication. An example of this is the use of the Prisoner Escort Record (known as a PER form). The PER form is used to record information about detainees, and can often be the only way of transferring information about risk of self-harm or vulnerability from one agency to another. We want to see a more joined-up approach between the Prison Service and police. The PER form needs to be developed to reflect the needs of both agencies so that it can offer the best possible protection for detainees.

Our work is also prompting further consultation between the police and Prison Service on ensuring that the Police National Computer (PNC) is available for prison staff. Access to the PNC by prison staff might be very useful in helping them make better risk assessments. By allowing the Prison Service to enter data, the police would also be more aware of safety issues when the person concerned is next dealt with by police officers. It seems that the two bodies have had different expectations about how and when this can be progressed; the Forum expects to continue its focus on the issue.

Future goals for the Forum

Independent chair

The Forum's key strength is its standing amongst practitioners. Its independence, both from Government and from member organisations, is crucial. Our members have agreed that the Forum's Chair should be openly and transparently appointed and should not be seen to have any conflict of interest with the Forum's member organisations.

Better resources

There has been an inevitable period of 'bedding in' for the Forum in its early stages, but we have already addressed some of the key issues relating to custody deaths. We have done so despite a striking lack of resources. This has resulted in many limitations in what we are able to achieve:

- We do not currently have the resources to commission or undertake research;
- The Forum's remit only extends to England and Wales despite the fact that the same death in custody issues are replicated in other UK jurisdictions;
- The Forum itself currently has no remit to collate and analyse reports issued by coroners, and does not have sufficient resources to monitor whether and how they are implemented;
- The Forum has no formal powers and, as an independent committee, does not have any reporting line to Ministers.

The Forum has outlined some suggested improvements to the current arrangements (please see Annex 3) and it is hoped that the Government's review will take the issues we have highlighted into account.

Annex 1

How many people die in custody in England and Wales?

Table 1

Deaths in or following police[5] custody 2004/05

GENDER	Self Inflicted	Natural Causes	Substance Misuse	Unknown Given	Other*	Awaited**	No Cause	TOTAL
Male	3	14	7	0	6	1	0	31
Female	0	1	4	0	0	0	0	5
TOTAL	**3**	**15**	**11**	**0**	**6**	**1**	**0**	**36**

Deaths in or following police custody 2005/06

Male	1	7	6	0	1	5	2	22
Female	1	0	1	0	3	1	0	6
TOTAL	**2**	**7**	**7**	**0**	**4**	**6**	**2**	**28**

* It should be noted that 'Other' refers to either external or internal, for example head, injuries which were identified or aggravated while the person was in custody.

** It should be noted that 'Awaited' refers to a case for which the post mortem result is not yet available.

*** It should be noted that 'No Cause Given' includes in this category all deaths where the actual cause of death has not been ascertained at post-mortem.

Table 2

Deaths of residents of Approved Premises

YEAR	Suicide	Overdose	Natural Causes	Accident	Other	TOTAL
2004	2	8	8	1	1	**20**
2005	7	6	2	0	2	**17**
2006	2	4	4	0	0	**10**

[5] This indicates the number of deaths in or following police custody. This data was provided by the Independent Police Complaints Commission (IPCC). Under the Police Reform Act 2002 police forces must refer all deaths following police contact to the IPCC. The IPCC records deaths under four categories: fatal road traffic incidents; fatal shooting incidents; deaths in or following police custody and deaths during or following other types of police contact.

How many people die in custody in England and Wales? (Continued)

Table 3

Deaths in Juvenile Custody

YEAR	Suicide	Overdose	Natural Causes	Accident	Verdict Awaited	TOTAL
2004-05	1	0	0	1	1	**3***
2005-06	0	0	0	0	1	**1****
2006-07	0	0	0	0	0	**0**
TOTAL	1	0	0	1	2	**4**

* Of the three deaths in 2004-05, two were in Secure Training Centres and one was in a Young Offender Institute.

** The death in 2005-06 was in a Young Offender Institute.

Table 4

Deaths of women in prison custody

Type of death	2004/05	2005/06	2006/07
Self-inflicted	12	3	5
Natural Causes	5	4	1
Other non-natural	1	0	0
TOTAL	**18**	**7**	**6**

Table 5

Deaths of men in prison custody

Type of death	2004/05	2005/06	2006/07
Self-inflicted	74	71	68
Natural Causes	98	81	86
Homicide	3	2	1
Other non-natural	6	3	1
TOTAL	**181**	**157**	**156**

Table 6: Classification of Deaths of Detained Patients by Gender – 1 April 2004 – 31 March 2005

Classification of death	Male	Female	Total
Natural Causes	**151**	**111**	**262**
Self Inflicted	**17**	**18**	**35**
Substance misuse [6]	**-**	**-**	**-**
Homicide	**1**	**0**	**1**
Unknown[7]	**2**	**1**	**3**
Other	**17**	**10**	**27**
OVERALL TOTAL	**188**	**140**	**328**
Total Reviews undertaken[8]	**41**	**17**	**58**

Table 7: Breakdown of Deaths categorised as 'Other' from Table 1 – 1 April 2004 – 31 March 2005

Death categorised as Other	Male	Female	Total
Awaiting information[9]	**1**	**1**	**2**
Accidental	**2**	**2**	**4**
Iatrogenic	**1**	**0**	**1**
Drowning	**1**	**2**	**3**
Unsure accident/suicide	**8**	**1**	**9**
Fire	**0**	**3**	**3**
Method Unclear/other	**4**	**1**	**5**
TOTAL	**17**	**10**	**27**

Table 8: Classification of Deaths of Detained Patients by Gender – 1 April 2005 – 31 March 2006

Classification of death	Male	Female	Total
Natural Causes	**160**	**144**	**304**
Self Inflicted	**29**	**15**	**44**
Substance misuse	**-**	**-**	**-**
Homicide	**0**	**0**	**0**
Unknown	**0**	**0**	**0**
Other	**13**	**12**	**25**
OVERALL TOTAL	**202**	**171**	**373**
Total Reviews undertaken	**41**	**28**	**69**

[6] The Mental Health Act Commission does not have a separate category for deaths by misuse of drugs or alcohol
[7] Unknown = Where the cause of death has been established as unknown or unascertained through inquest
[8] Reviews into the circumstances surrounding the death undertaken by the Mental Health Act Commission
[9] Awaiting information on cause of death from the coroner

Table 9: Breakdown of Deaths categorised as 'Other' from Table 3 – 1 April 2005 – 31 March 2006

Deaths categorised as Other	Male	Female	Total
Awaiting information	2	3	5
Accidental	2	1	3
Iatrogenic	1	0	1
Drowning	3	3	6
Unsure accident/suicide	3	2	5
Fire	0	1	1
Method Unclear/other	2	2	4
TOTAL	**13**	**12**	**25**

Table 10: Classification of Deaths of Detained Patients by Gender – 1 April 2006 – 31 March 2007

Classification of death	Male	Female	Total
Natural Causes	154	125	279
Self Inflicted	25	16	41
Substance misuse	-	-	-
Homicide	0	0	0
Unknown	1	0	1
Other	24	6	30
OVERALL TOTAL	**204**	**147**	**351**
Total Reviews undertaken	**45**	**22**	**67**

Table 11: Breakdown of Deaths categorised as 'Other' from Table 5 – 1 April 2006 – 31 March 2007

Deaths categorised as Other	Male	Female	Total
Awaiting information	15	1	16
Accidental	3	0	3
Method Unclear/other	0	3	3
Unsure/suicide	3	1	4
Drowning	2	0	2
Fire	1	1	2
TOTAL OTHERS	**24**	**6**	**30**

Annex 2

Forum for Preventing Deaths in Custody

John Wadham, Chair
Kate Eves, Secretary

90 High Holborn
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Tel: 020 7166 3924

4 August 2006

The Rt Hon Harriet Harman MP
Minister of State for Constitutional Affairs
Selbourne House
54 Victoria Street
London SW1E 6QW

Dear Harriet

On behalf of the IPCC I chair the newly created Forum for Preventing Deaths in Custody, established in response to the Joint Committee on Human Rights (JCHR)'s report on deaths in custody.

The aim of the Forum is to increase learning from deaths in custody. Our work will initially focus upon areas that fall within the responsibility of the Home Office and Department of Health. In practice, this will mean work around deaths of people detained in police custody, prisons, approved premises, immigration custody or those detained under the Mental Health Act. The Forum brings together senior representatives of 14 organisations from Government, police, prisons, coroners, healthcare and the independent sector to learn lessons and spread best practice. Judith Bernstein from your Department was a welcome and helpful guest at our last meeting. I have enclosed some background information about the Forum which may be of interest.

At a recent meeting, the Forum focused on how organisations learn lessons and share information to prevent deaths in custody. The members of the Forum welcomed the Coroner Reform Bill, and its publication informed our discussions about the essential role that Coroners can play in preventing future deaths in custody.

It is evident that one of the key potential sources of learning following a custody death

are the reports issued by Coroners under rule 43 of the Coroners' Rules (an extract from the minutes of our recent meeting is enclosed). Their ability to report where they believe action could be taken to prevent similar deaths is a crucial mechanism in highlighting organisational failings and bringing about change. However, the Forum has identified what it considers to be a number of failings of the current provisions under rule 43.

The Forum's discussions have led it to conclude that the power provided under rule 43 is not currently robust enough. The rule is subject to individual interpretation by Coroners and we understand from the Coroners Society that some Coroners believe there is no reason to make a report as the relevant authority may already be aware of the case. Others do not feel able to write reports about matters of concern that were exposed at inquest but which did not affect the outcome in the particular case. In addition to the discrepancies over how Coroners interpret rule 43, there are real differences in how the organisations under scrutiny respond to rule 43 reports. There was particular concern that there is no requirement on organisations to respond to reports or for them to be publicly available. Equally concerning is that those bodies who receive rule 43 reports are not required to monitor or provide evidence of any changes which are instigated as a result of the Coroner's report.

I note that in their recent report the Constitutional Affairs Committee also commented on Rule 43 of the Coroners Rules (Para 205, House of Commons Constitutional Affairs Committee Reform of the coroners' system and death certification Eighth Report of Session 2005–06). The Committee acknowledged that the Coroners Rules provide no power for the coroner to compel the person to take action or to report back as to what action, if any, has been taken.

It is the Forum's view that the Coroner's inquest provides the single most important opportunity to identify how custodial deaths can be reduced. If this is the case the need to make recommendations should not be relegated to the rules but is important enough to be in the primary legislation itself. We therefore believe that the Coroner Reform Bill provides an opportunity to establish a better system to ensure that, as far as possible, we learn every lesson we can from these tragedies.

The Forum is fortunate to have the Coroners' Society for England and Wales as one of its members and has also had the opportunity to discuss its proposals with representatives from the Coroners' Unit within your department. However, I would very much welcome, as the Forum's chair, the opportunity to discuss with you whether it is possible to bring about some of the changes we propose.

I am copying this letter to Patricia Scotland who is the Minister with overall responsibility for the Forum and who chairs the Ministerial Roundtable on Suicide in Prisons.

Yours sincerely

John Wadham
Chair
Forum for Preventing Deaths in Custody

Annex 3

Strengthening the Forum for Preventing Deaths in Custody

Discussion Paper

Introduction

In the process of debating the Corporate Manslaughter Bill in the House of Commons on 16 May, the Government made a commitment to review the Forum's current arrangements, agreeing to report within six months on issues such as the Forum's autonomy from Government, increased ability to conduct research and more capacity for information sharing.

The Corporate Manslaughter Bill was debated in the House of Lords on 22 May. During this debate Baroness Ashton, Parliamentary Under Secretary of State for the Ministry of Justice, outlined that the purpose of the review is to explore how the Forum can be strengthened.
Baroness Ashton said:

"The Forum stems from the Government's response to recommendations from the Joint Committee on Human Rights for a taskforce dealing with deaths in custody. It works by comparing and contrasting approaches, identifying good practice and drawing attention to issues which need to be addressed by operational bodies or Ministers. Its terms of reference are: "The Forum exists to learn lessons and effect change to prevent deaths in custody".

I understand that its first annual report is being prepared. It has made a good start in meeting some of the criteria that the committee set for a taskforce, but we acknowledge that there is room for improvement.

For this critical area of work to be effective, a strong focus needs to remain on personally involving senior representatives from organisations that inspect, investigate and oversee custody. In the review, we will look at issues such as greater autonomy from government and improved interaction with Ministers—including the relationship with the ministerial round table on suicide, which my honourable friend Gerry Sutcliffe chairs, its powers, resources and capacity. The noble Lady, Baroness Stern, is, I understand, already in early discussion with the Forum's chairman about a seminar to explore views. That seminar would be an integral part of the review, and we will report on progress within six months."

The Forum will want to contribute to the Government's review by recommending how it should be strengthened. This paper has been prepared to prompt discussion at the Forum's June meeting and members are invited to comment on the proposals herein.

Current arrangements

The Forum came into existence independently of the Joint Committee on Human Rights' 2004 inquiry into deaths in custody. Nevertheless, it has clearly developed with an awareness of what the JCHR said in its report about the need for "a cross-departmental expert task force on deaths in custody". The Forum is making good progress towards meeting a number of the functions outlined by the JCHR. However, it is manifest that the current arrangements do have some weaknesses:

- The Forum does not have the resources to commission or undertake research;
- Current resources limit the Forum's remit to England and Wales despite the fact that the same death in custody issues are replicated in other UK jurisdictions;
- The Forum itself currently has no remit to collate and analyse reports issued by coroners, and does not have sufficient resources to monitor whether and how they are implemented;
- The Forum is a largely independent committee but has no formal powers and no clear reporting lines to Ministers.

In addition, the organisational structure of the Forum could be criticised. The Chair of the Forum is not transparently independent from its member organisations (the Chair is currently John Wadham, Deputy Chair of the IPCC). It has no academic members and no human rights expertise at its disposal (a criterion recommended by the JCHR for the task force), although some of its members, and Baroness Stern as an observer, might readily be defined as experts in human rights.

Proposals for strengthening the Forum

Strengthening the size and function of the secretariat

- The secretariat needs to fulfil three main functions: maintaining and strengthening links with Forum members across each of the sectors; commissioning, managing and/or conducting research into areas identified by the Forum members; performing all administrative and support tasks for the Chair, Forum members and related sub-committees.

- The current funding for one full time SEO post to cover each of these roles is insufficient. As with the Chair's position, the Secretary should be openly and transparently recruited.

- The Forum would greatly benefit from better information sharing about the group's remit and the work it is undertaking. Resources to enable the maintenance and development of the website would contribute to this.

Independent chair

- The Forum's Chair should be openly and transparently appointed and should not be seen to have any conflict of interest with the Forum's member organisations.

Reviewing the Forum's powers

- A commitment should be given to consideration to putting the Forum on a statutory footing at some future date.

- One of the strengths of the Forum is its independence from Government and it is important for this autonomy to be maintained. However, a commitment by Ministers to hold an annual meeting with the Forum's Chair would be a welcome signal of Ministerial commitment to the group's work. This could be connected to the Forum's commitment to produce an annual report summarising the year's work and recommendations.

- Currently, membership and attendance at the Forum is voluntary, as is the decision over whether to provide information to the group or its secretary. Consideration should be given to Ministers endorsing a statement indicating the Chair's powers to request organisations to attend meetings and to provide information when requested.

- Consideration should be given to the relationship between the Forum and the Ministerial Roundtable on Suicide and to whether other organisations (such as the Advisory Council on the Misuse of Drugs) offer a more effective organisational model. This might be best achieved by commissioning consultants.

Reviewing the Forum's remit

- Organisations in Scotland and Northern Ireland face many of the same issues as those in England and Wales. Consideration should be given to resourcing the secretariat in a way which would enable other jurisdictions to benefit from and contribute to the Forum's learning, either through setting up their own Forums or through sharing the existing Forum's secretariat. While the current Forum is supported through the Ministry of Justice and therefore has a remit limited to England and Wales, there are clear benefits to establishing mechanisms for cross jurisdictional learning and the current review of the Forum provides a logical opportunity to do this.

Alternative structures for the Forum

1 Advisory Committee on Deaths in Custody

Such a Committee could emulate the structure of a group such as the statutory Advisory Council on the Misuse of Drugs. The ACMD makes recommendations to Government on the control of dangerous or otherwise harmful drugs, including classification and scheduling under the Misuse of Drugs Act 1971 and its Regulations. It considers any substance which is being or appears to be misused and which is having or appears to be capable of having harmful effects sufficient to cause a social problem. The ACMD also carries out in-depth inquiries into aspects of drug use that are causing particular concern in the UK with the aim of producing considered reports that will be helpful to policy makers and practitioners.

Another useful example is the Police Advisory Board for England and Wales. The Board has a specific remit under section 63 of the Police Act 1996, namely to advise the Secretary of State on general questions affecting the police in England and Wales and to consider draft regulations under specific sections of the Police Act 1996, the Police Act 1997 and the Police Reform Act 2002. The Secretary of State aims to attend the Board once a year and may refer matters of serious national importance to the Board for their consideration. The

Board consists of a Chair and Deputy Chair (who are appointed by the Secretary of State) and a minimum number of members from relevant agencies, such as ACPO, the Association of Police Authorities and the Police Federation. The Board meets four times a year, may establish working parties to address specific issues and submits an annual report to the Secretary of State.

The establishment of an Advisory Committee on Deaths in Custody (whether on a statutory or non-statutory basis) could improve the profile of cross-sector work to prevent deaths in custody. It would certainly focus Ministerial and Parliamentary attention. Such a Committee would need to be supported by a secretariat with the capability of commissioning (and/ or conducting) research and producing an annual (and other) reports on preventing deaths.

One of the strengths of the Forum is its independence from Government. However, if an Advisory Committee were established in statute, its independence would be even clearer (under this model, it seems unlikely that the service providers would be directly represented).

The Forum could be the basis of an Advisory Committee, or it could adapt into a more practice-type body (see below). Under the current arrangements, the Forum's secretariat is funded by the Government, and although the role is funded by NOMS it is an independent position, reporting to the Forum chair. One of the strengths of the Forum is its independence from Government and it would be important for this autonomy to be maintained.

2 Practitioner-led working group on Deaths in Custody

The Forum has facilitated a great deal of learning and information sharing through its current membership of both custody providers and oversight bodies. Any future arrangements should not undermine this practitioner input.

A practitioner-led working group with strong links to an Advisory Committee would provide a balance between a high-level expert panel and a parallell group with a more practical, operational approach. Such a group could be comprised of a similar membership to the Forum: operational custody providers (DH; Prison Service, APCO) and oversight bodies (PPO, IPCC, Coroners Society, Inspectorates etc).

The relationship between the Advisory Committee and Working Group could work in a number of ways, such as a shared secretariat or an arrangement for a member of each group to observe the other.

Kate Eves
Secretary to Forum for Preventing Deaths in Custody
12 June 2007

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