House of Lords
House of Commons

Joint Committee on Human Rights

Deaths in Custody: Further Developments

Seventh Report of Session 2006–07

Report, together with formal minutes and appendices

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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 LORDS	HOUSE OF COMMONS
Lord Fraser of Carmyllie	Mr Douglas Carswell MP (Conservative, *Harwich*)
Lord Judd	Mr Andrew Dismore MP (Labour, *Hendon*) (Chairman)
Lord Lester of Herne Hill	Nia Griffith MP (Labour, *Llanelli*)
The Earl of Onslow	Dr Evan Harris MP (Liberal Democrat, *Oxford West & Abingdon*)
Lord Plant of Highfield	Mr Richard Shepherd MP (Conservative, *Aldridge-Brownhills*)
Baroness Stern	Mark Tami MP (Labour, *Alyn and Deeside*)

Powers

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

Publications

The Reports and evidence of the Joint Committee are published by The Stationery Office by Order of the two Houses. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/commons/selcom/hrhome.htm.

Current Staff

The current staff of the Committee are: Nick Walker (Commons Clerk), Bill Sinton (Lords Clerk), Murray Hunt (Legal Adviser), Judy Wilson (Inquiry Manager), Angela Patrick and Joanne Sawyer (Committee Specialists), Jackie Recardo (Committee Assistant), Suzanne Moezzi (Committee Secretary) and James Clarke (Senior Office Clerk).

Contacts

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Report

1 Report

We wrote to the Home Secretary, Rt Hon Dr John Reid MP, on 6 December 2006 asking the Government to supply us with a written memorandum updating the Committee on overall developments in relation to the strategy of the Government and the other authorities concerned in preventing deaths in custody since the Government's two responses to the previous Committee's report on deaths in custody.[1] We asked for the memorandum to address progress in dealing with the Committee's recommendations which were accepted by the Government, and in particular the question of whether the IPCC forum on deaths in custody is achieving concrete results. Under cover of a letter dated 9 February 2007 from Rt Hon Baroness Scotland of Asthal QC we have received a memorandum in response to this request. We publish this memorandum as an Appendix to this Report. We will comment as appropriate on the memorandum in future Reports which we publish on related matters.

[1] Third Report of Session 2004-05, *Deaths in Custody*, HL Paper 15-I/HC 137-I. The Government's two previous responses to this Report were published as the Eleventh Report of Session 2004-05, *Government Response to the Third Report from the Committee: Deaths in Custody*, HL Paper 69/HC 416, and the Second Report of Session 2005-06, *Deaths in Custody: Further Government Response to the Third Report from the Committee, Session 2004-05*, HL Paper 60/HC 651.

Formal Minutes

Wednesday 28 February 2007

Members present:

Mr Andrew Dismore MP, in the Chair

Lord Judd	Nia Griffith MP
Lord Lester of Herne Hill	Dr Evan Harris MP
Lord Plant of Highfield	
Baroness Stern	

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Draft Report [Deaths in Custody: Further Developments], proposed by the Chairman, brought up, read the first and second time, and agreed to.

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

Several Papers were ordered to be appended to the Report.

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

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[Adjourned till Monday 5 March at 4.00pm.

Appendices

Appendix 1: Letter dated 6 December 2006 from the Chairman to the Rt Hon John Reid MP, Secretary of State, Home Office

My Committee continues to take a close interest in Government policy to address the urgent question of reducing deaths in custody, following the previous JCHR's inquiry and report into the subject. As you are probably aware, Baroness Stern, a member of the JCHR, attends meetings of the IPCC forum for preventing deaths in custody, and keeps us informed of the principal developments there.

My Committee would nevertheless be grateful if you could supply it with a written memorandum updating the Committee on overall developments in relation to the strategy of the Government and the other authorities concerned in preventing deaths in custody since the Government's two responses to the previous Committee's report, which were published in the Committee's 11th Report of Session 2004-05 and its 2nd Report of Session 2005-06. It would be helpful if this memorandum could address progress in dealing with the Committee's recommendations which were accepted by the Government, and in particular the question of whether the IPCC forum is achieving concrete results.

As you will know, we are considering separately, in our scrutiny of the Corporate Manslaughter and Corporate Homicide Bill, the question of whether the scope and applicability of the new offence of corporate manslaughter in relation to public bodies is such as to satisfy the requirements of Article 2 ECHR in the context of deaths in custody and other contexts. At report stage in the Commons on 4 December, of course, this matter was debated on an amendment which I had tabled, and we would expect the Lords to return to the subject. We are also considering in our legislative scrutiny work the extent to which the provisions of the draft Coroners Bill would meet the procedural requirements of Article 2 for effective investigation of certain deaths, including deaths in custody. If you wished to offer any further observations on these two issues in your memorandum that would be welcome.

I would be grateful if you could send us the requested updating information by the end of January 2007.

Appendix 2: Letter dated 9 February 2007 and memorandum from the Rt Hon Baroness Scotland of Asthal QC, Minister of State, Home Office

In response to your letter of 6 December to John Reid, the Government is able to report substantial progress during the last two years since the Government's initial response to the Committee's recommendations. The new multi-agency group known as the Forum for Preventing Deaths in Custody is still in its early stages but making good progress. The group continues to be grateful to Baroness Stern for her involvement in its development.

In its response, the Government provides some comment on the other issues on which you invited comment, specifically those we feel are most relevant to further work to prevent deaths in custody.

You will recall that Harriet Harman wrote to you separately on 22 January, regarding the modernisation of the coroner system. Since the, on 30 January, the Government announced further changes to the draft Coroners Bill aimed at strengthening the power of Coroners' recommendations and improving the role of inquests in death prevention. The new proposals will apply to any organisation where a person has died and the inquest raises public health and safety issues, including prisons, hospitals and nursing homes. Under the changes, organisations will be required to respond to recommendations made by coroners and to say what preventative actions they will take. These responses will be monitored by the Chief Coroner and reported annually to Parliament.

Gerry Sutcliffe wrote separately to the Committee on 25 October 2006 regarding the Corporate Homicide and Corporate Manslaughter Bill: while the attached memorandum explores the Government's commitment to improving the care of detainees, it does not endorse the application of the offence to deaths in custody as an appropriate means of doing this.

The memorandum reports on key developments in the Government's strategies to reduce deaths in State custody, including developments connected with article 2 ECHR, and on the progress made on each of the Committee's recommendations previously accepted by the Government. The Government's original responses to the Committee's recommendations have not been included but can of course be of accessed in their entirely at the following link:

http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/69/69.pdf

Introduction

The Government is grateful for the opportunity to provide a comprehensive update on the continuing work being undertaken to reduce the number of deaths in custody, and we are pleased to be able to report substantial progress in a number of key areas.

The Government promotes the joint working approach that the Committee has endorsed. In the two years since the Government's initial response to the Committee's recommendations there has been a welcome sustained reduction in self-inflicted deaths in prisons. The new multi-agency group, the Forum for Preventing Deaths in Custody, is in the early stages of its work and development but is providing an invaluable mechanism for sharing and analysing information about policy and practice across organisations including those responsible for police, prisons, probation, mental and physical health, investigative and inspectorate bodies. The Forum and its constituent organisations are committed to sharing good practice and learning lessons. Its Secretariat is Home Office funded. Its independent chair, currently John Wadham of the Independent Police Complaints Commission (IPCC), has recently reviewed progress to date and a note from him is included within this memorandum.

The draft Coroners Bill (published on 12 June 2006) proposes national leadership and national standards for Coroners - in particular the services which bereaved people can expect to receive, including access to a new appeal system. The draft Bill aims to do three things: firstly, improve the way that the system serves the public interest and meet bereaved families' concerns; secondly, strengthen Coroners' work and thirdly, create a national structure for Coroners' work. The Government has already accepted the need to give Coroners power to make a report on lessons learned from a particular death or a particular incident more prominent, by removing provisions from the current Coroners Rules to the face of the Bill. Additionally, we are considering the possibility of making it a requirement for the Chief Coroner to include - in his annual report to Parliament - a summary of the reports made by Coroners, and for him to have a duty to check what action has been taken by authorities to whom a report has been made. We will also consider whether a statutory obligation should be put on authorities to respond formally to Coroners' reports. More details on procedures to support these new processes will be dealt with in secondary legislation. These matters are ones in which the Forum has taken an interest (described later in this memorandum) and on which dialogue will continue.

The Committee has invited the Government's comments on the Corporate Manslaughter and Corporate Homicide Bill, specifically regarding the scope of the offence in relation to deaths in custody. Parliamentary Under Secretary, Gerry Sutcliffe wrote to the Committee about the compatibility of the Bill with the European Convention on Human Rights (ECHR) on 25 October 2006. In this memorandum, we set out in more detail the reasons why we do not believe the offence should extend to deaths connected with the exercise of custodial functions. The Government reiterates its commitment to further improving the way the prison, police, immigration services, and others look after detainees in their care, but it does not believe that applying the offence to deaths in custody is appropriate. In summary, the Government considers that because of the complex risk factors which contribute to safety in custody, combined with the intrinsically Governmental nature of

decisions about how these risks are managed and the other forms of accountability, the Bill should not be extended to deaths in custody.

The remainder of this memorandum reports on key developments in the Government's strategy, including developments connected with Article 2 ECHR, and on the progress that has been made on the Committee's recommendations previously accepted by the Government. The main developments are recorded in the text to paragraph 2.8.15, other developments are detailed in the tabular form that follows. There is repetition between the text and the table so that the latter is accessible as a largely self-contained document; but to avoid undue repetition, the Government's original responses to the Committee's recommendations have not been included. These can be accessed in their entirety at the following link:
http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/69/69.pdf

1. Key Developments

1.1 Article 2 of ECHR

1.1.1 Since the Government's previous response to the JCHR in October 2005, there have been a number of developments concerning the Government's responsibility under Article 2 of the ECHR. The key development is the judgement handed down by Mr Justice Munby, and upheld by the Court of Appeal, concerning the requirement to investigate a "near death" of a prisoner in custody who was deemed to be at a "real and immediate risk" of harming himself at the time of his attempted suicide. This judgement and other cases are contributing in particular to the investigations strand of the National Offender Management Service (NOMS)/ Prison Service wider suicide prevention strategy.

1.1.2 The Home Secretary has commissioned the Prisons and Probation Ombudsman (PPO) to conduct investigations into two near death cases. We will be looking closely at the findings from these investigations to inform policy on suicide prevention. The first follows a Judicial Review brought by the Official Solicitor acting on behalf of a prisoner known as "D" who, following a suicide attempt was left with permanent brain damage. In the "D case" (D v SSHD) the prisoner's representatives put forward the case that under Article 2 there was a requirement to investigate the circumstances of D's "near death". Mr Justice Munby ruled that a public inquiry should be held in this case. The Court of Appeal upheld Mr Justice Munby's judgment that an investigation must be undertaken but narrowed some of the procedural requirements set out in the original judgment.

1.1.3 Policy and practice on investigating other incidents of serious self-harm or "near deaths" will be developed taking into account the emerging case law and the experience gained from the PPO's investigations. Meanwhile, prison Governors are advised to consider commissioning investigations into this type of incident, involving the prisoner's family and an independent element. Additionally, NOMS' Safer Custody Group are working with Oxford University's Centre for Suicide Research, who will be undertaking two case control studies of prisoners who attempt suicide, one of male prisoners and one of female prisoners. We hope this study will result in significant new information which will inform future suicide prevention policy.

1.2. Corporate Manslaughter

1.2.1 The Government does not believe that the new offence of corporate manslaughter should apply to deaths connected with the exercise of custodial functions. Custodial institutions such as prisons face a uniquely difficult environment. In seeking to reduce risks, prisons must do so within the constraints of the resources available and balancing the needs of all prisoners in making those decisions. Often prisoners bring a number of risk factors, such as substance misuse or mental health problems, into custody. The very fact of being in prison can make their risk of suicide significantly higher. This means that prisons are not in control of all the factors: in particular, the number of people sent there by the courts and whether those people are at risk of suicide.

1.2.2 The decisions of courts in individual cases are crucial, as they should be. The

prison system cannot simply decide to stop accepting new prisoners, or otherwise refuse to accept certain high risk individuals, because of the additional strain that they may place on the limited resources available to monitor such persons to a level required to prevent all suicides or other tragedies. Having to respond to these external pressures can mean that the balance of resources in a prison can shift quickly from one where adequate provision is available to one where it is not.

1.2.3 The Government does not consider that the offence of corporate manslaughter should apply to deaths in custody because the factors which contribute to the safe running of prisons, and other custodial institutions, involve many matters of core Government decision making and issues of public interest which render questions about the management of such factors inappropriate for judicial, as opposed to Parliamentary, scrutiny. The Government agrees with the Committee that this justification cannot be used as a blanket exemption for all decisions made by public authorities, and in the prison context the offence does apply in relation to duties owed as employers and occupiers. We believe that in these contexts any element of public policy decisions in the management of health and safety is not great enough to justify their exemption. But we believe that how custody itself is managed is inextricably linked with Government decision making and therefore these circumstances should be excluded.

1.2.4 This Corporate Manslaughter Bill is intended to address a failing in the current law of corporate manslaughter. It is not, and it has never been, our intention that it should be a vehicle for introducing judicial scrutiny of core Government decisions. These decisions include issues such as allocation of public funds across Government, balancing protecting the public against the need to imprison offenders, and Government policies about the management, treatment and rehabilitation of people in custody who may be both vulnerable and dangerous. The criminal courts are not the appropriate place for decisions about these issues to be scrutinised. We believe that the Parliamentary process is the right form of accountability for such decisions.

1.2.5 Furthermore, the process of Parliamentary scrutiny is supported by other forms of investigation and monitoring. Deaths in prison or police custody are subject to rigorous independent investigation through public inquests before juries and independent reports by the PPO or IPCC respectively. These investigations are capable of ranging widely over management issues and are publishable once an inquest has been held. Additional forms of accountability, such as public inquiries, can be authorised if the circumstances are sufficiently serious.

1.2.6 The Government wishes to see further improvements in the way the prison, police and immigration services look after detainees in their care and to see fewer deaths in custody, but it does not believe that applying the offence to deaths in custody is the right way to try and achieve that end.

1.3. The Forum for Preventing Deaths in Custody

1.3.1 The Forum for Preventing Deaths in Custody has now agreed its membership and terms of reference and held three full meetings during 2006. The group is independently chaired with its membership made up of fifteen organisations, all with in depth knowledge

of issues relating to deaths in custody[2]. Its terms of reference are: "The forum exists to learn lessons and effect change to prevent deaths in custody."

1.3.2 During these early stages of the Forum's existence, members have explored a number of key issues related to deaths in custody. Member organisations have been asked to explain how they learn lessons from deaths in custody and how they share this learning both internally and with other relevant sectors. The Forum is challenging weaknesses where it finds them. Echoing the Joint Committee's position that recommendations from coroners should be reviewed and consideration given to taking them forward, the Forum has expressed concern about the ability and willingness to learn from inquests into custody deaths. The group is actively proposing changes to the rules governing coroners' powers in this respect. As a result of the Forum's discussions, the Coroners Society for England and Wales, a member of the Forum, have begun work to improve systems for the collation and dissemination of the Rule 43 reports that may be generated following an inquest.

1.3.3 As the Forum brings together senior representatives from organisations that provide custody and those organisations who inspect, investigate and oversee them, the group's meetings have inevitably highlighted issues where a multi-agency approach is beneficial. One example of this is the formation of a working group looking specifically at the importance of physical custody environments. This sharing of expertise relating to the impact of environment on the welfare of detainees is an invaluable part of learning from when deaths have occurred. It is also crucial to sharing good practice between the agencies involved.

1.3.4 The Government has provided funding for secretariat support for the Forum and this full time resource has, for example, enabled the Forum to develop a website www.preventingcustodydeaths.org.uk, where all papers and minutes are published. The Forum's work is clearly of public interest and there is strong support for its pooled learning to be shared openly and transparently.

1.3.5 A note from the Chair of the Forum for Preventing Deaths in Custody completes this part of the memorandum.

[2] The following organisations are represented on the Forum: Association of Chief Police Officers; Prison Service; Immigration and Nationality Directorate; Department of Health; Coroners Society of England and Wales; INQUEST; Mental Health Act Commission; Independent Police Complaints Commission; Prisons & Probation Ombudsman; HM Chief Inspectorate of Prisons; HM Inspectorate of Constabulary; Home Office; Private sector prisons; National Probation Directorate and the Youth Justice Board.

A note from the Chair of the Forum for Preventing Deaths in Custody:

Subsequent to the initial meetings to set up the Forum, the group held three full meetings in 2006 and has had a full time secretary since July. During its early meetings the Forum has explored some of the key issues pertinent to preventing deaths in custody and our programme of work for the coming year will build upon this valuable work.

Member organisations have discussed how each of the organisations share and learn lessons about deaths in custody both internally and with other relevant sectors. We found weaknesses in some of the systems: concern about the ability and willingness to learn from inquests into custody deaths led us to seek changes to the powers available to coroners in preventing future deaths. The Minister for the Department of Constitutional Affairs invited us to submit a proposal for how the Coroners Reform Bill might be used to enhance the provisions available to coroners in this respect. The Forum believes that the Coroners Reform Bill is a step towards much needed improvement to the coronial system. In the absence of the passing of the bill, we will continue to recommend improvements to the system and are seeking to achieve this through amendments to the Coroners Rules.

The Forum has brought together the knowledge and expertise of different organisations: our meetings have highlighted some 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 pertinent information about detainees and can often be the only way of transferring information about a person's risk of self-harm or vulnerability from one agency to another. The Forum is currently pressing for a more joined-up approach between the Prison Service and police. This crucial tool needs to be developed to reflect the needs of both agencies so that it can offer the best possible protection for detainees.

The Forum's work is also prompting further consultation between the police and Prison Service on how best to work towards the Police National Computer (PNC) being available for prison staff. Access to the PNC by prison staff might be a key tool in helping them make better risk assessments. By allowing them to enter data the police service would also be more aware of safety issues when the person concerned is next dealt with by police officers. From our work it seems that the two bodies have had different expectations about how and when this can be progressed and without our continuing intervention it is likely progress would be difficult.

In its report, the Joint Committee rightly emphasised the need for the individual sectors who care for people in custody to share the learning and good practice that they have developed. The Forum has established a working group to explore how the design, maintenance and location of physical custody environments may reduce deaths. The group brings together the expertise of representatives from Special Hospitals, Prison Service, ACPO, the Mental Health Act Commission and the private sector prisons and provides the opportunity for a practical working group to share learning and to develop advice on best practice.

During our first year we have dealt with some difficult issues which provide significant challenges for all the organisations involved in the Forum. We have explored the

management of detainees who can be disruptive, violent and damaging (as well as damaged). The agencies who have an oversight or investigative function have been able to discuss 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 of these types of events has been invaluable.

The Forum's high level membership has been crucial in achieving the commitment of the organisations involved. However, in order to prevent custody deaths we need not only to be open and transparent but also accessible to those who might need advice or be able to offer it. The appointment of a full time secretary has enabled the Forum to develop a website[3] where all papers and minutes are published. The website will include an interactive advice point where practitioners can access information about preventing deaths and can also contribute their knowledge and experience. It has also been possible to build links with agencies outside the Forum's membership who are involved in protecting and caring for those in custody. Organisations in Scotland and Northern Ireland have been keen to engage with the learning and sharing the Forum is developing. The depth and breadth of experience within the Forum results in its members being able to offer information and support to organisations who want to benefit from the knowledge base we are building.

We have also formed links with other key committees which are 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.

The Forum's membership provides a strong foundation of expertise and experience. However, it is acknowledged that we must ensure that the Forum has the power and resources to act when it feels it necessary. In its original report on deaths in State custody, the Joint Committee described the need for a cross-departmental expert task-force on deaths in custody. The Forum is succeeding in bringing together members with expertise in the preventing custody deaths but our ability to influence member organisations to improve practice (and to respond to bad practice) may be enhanced if the Forum were, in the future, to be chaired by someone entirely independent.

The Forum's members are committed to its work. We have very much welcomed the involvement of Baroness Stern during these very early stages of the group's development. We are, inevitably, still making progress in identifying and challenging the problems related to custody deaths: and these still exist in all the different custodial settings. We are keen to build upon our achievements and to strengthen our ability to affect change in whatever way we can. We hope to continue to have the benefit of Baroness Stern's involvement and would very much welcome the input of the Joint Committee regarding the Forum's developing structure, remit and powers.

John Wadham

Chair

[3] The website can be accessed at www.preventingcustodydeaths.org.uk.

Forum for Preventing Deaths in Custody

2. Update on Government Strategy

2.1 Learning from Deaths in Custody and from investigations

2.1.1 The willingness to learn lessons and share good practice is central to the Government's approach to preventing deaths in custody. Each of the Government bodies involved in caring for prisoners has a part to play, as do the organisations that oversee, investigate or inspect custodial environments. The same is true for Coroners, who are often in the unique position of being aware of important areas of learning across each of the custodial settings. The work being undertaken by the Coroners Society for England and Wales to collate and disseminate Rule 43 reports is key to multi-agency learning. This, in conjunction with developments such as the Forum for Preventing Deaths in Custody, has much to contribute to cross-sector learning.

2.1.2 The PPO has investigated all deaths in prisons (public and private) and detention centres and all deaths of probation hostel residents since 1 April 2004. The PPO's remit has also been extended to include deaths of young persons in secure training centres (STCs) and a discretionary power to investigate deaths occurring following release from immigration detention. It remains the Government's intention to seek to provide a clear statutory basis for the PPO at the next appropriate opportunity. The introduction of the PPO meant that there would be a real opportunity to learn from independent investigations which would be more consistent, better quality and involve families more. The Ombudsman is bringing independence, greater scrutiny, improved family involvement and greater public confidence into reports into deaths in custody. The reports, and the investigations upon which they are based, are of a very high quality and they are increasingly being analysed at a local and central level, themes extracted, good practice disseminated across the estate and 'lessons learned' reflected in policy and practice.

2.1.3 To date, the PPO has opened over 550 independent investigations into deaths in prison custody, or amongst the residents of Approved Premises or those held in immigration detention (these figures include a small number of discretionary investigations into deaths of people following release from prison but who were not resident in Approved Premises). Over 100 anonymised reports (regarding investigations of deaths which have been to inquest) have already been published on the Ombudsman's website (www.ppo.gov.uk).

2.1.4 The Ombudsman's terms of reference expressly require him to provide "explanations and insight" for the bereaved family, and as a matter of practice the Ombudsman employs a team of family liaison officers to ensure that the family is engaged with the investigation. A meeting or meetings are also set up between the family and the Ombudsman's investigator to ensure that all the family's concerns are reflected in the investigation methodology. Moreover, the Ombudsman's presumption is that disclosure of information during the course of the investigation and at its completion should occur as fully and as early as his powers and the law allows. Together, these approaches have done much to ensure that the family of a person who has died can participate fully both in the Ombudsman's investigation itself and in the Coroner's inquest.

2.1.5 A measure to put the PPO on a statutory footing was included in the Management of Offenders and Sentencing Bill, introduced in the House of Lords on 13 January 2005. However, the Bill did not progress due to the calling of the general election. It remains the Government's intention to seek to provide a clear statutory basis for the PPO at the next appropriate opportunity. In the meantime the PPO will continue to provide, on a non-statutory basis, rigorous and independent investigation of deaths of prisoners and residents of approved premises and immigration removal centres. The PPO's remit has also been extended to include deaths of young persons in STCs and a discretionary power to investigate deaths occurring following release from immigration detention. Whether or not the PPO is on a statutory basis, Coroners' inquests provide the primary means by which Article 2 obligations are met.

2.2 Prisons

2.2.1 Overall developments to make prisons safer

2.2.1.1 Recent figures have shown that there were 67 apparent self-inflicted deaths among prisoners in England and Wales in 2006 - the lowest figure since 1996. This represents a fall of 14% percent, compared with 78 such deaths in 2005. The three year average figure is on course to show a further reduction in the three years to April 2007.

2.2.1.2 The Government recognises that it is crucial to build on the progress made. Specifically, work is underway to support public and contracted prison sectors in continuing to give safer custody work the high profile it needs at establishment, area and national levels. There is a continuing need to support the staff who engage in ongoing risk management of prisoners and who deliver key care interventions such as Assessment, Care in Custody and Teamwork (ACCT). It is also vital that work continues to keep senior managers fully informed and aware of what works to make prisons safer in terms of risks of suicide, self-harm and violence. Safer Custody Group continues to move this agenda forward by communicating it effectively in a number of ways, including through Safer Custody News.

2.2.1.3 In the coming financial year, Safer Custody Group is embarking on sizeable pieces of work to consolidate the experience and learning of recent years in respect of safer custody (which incorporates suicide prevention, self-harm, and violence reduction). In addition to sustaining key interventions such as ACCT, developing the learning agenda is crucial with work taking place to distil information from operational experience, PPO and Inspectorate reports and inquest outcomes to inform practice for providers and commissioners.

2.2.1.4 The good practice in sharing information and learning lessons is an increasingly important part of preventing custody deaths. For example, reducing prisoner self-inflicted deaths and managing self-harm is a key priority for Ministers, the NOMS and the Prison Service. The NOMS/Prison Service suicide prevention strategy (which aims to reduce distress and promote the wellbeing of all who live and work in prisons) places strong emphasis on learning including, through reports into deaths in custody by the PPO and the new multi agency Forum. Other important sources of learning include inquest verdicts and reports made by Coroners under Coroners Rule 43, HMCIP (HM Chief Inspector of

Prisons) and IMB (Independent Monitoring Board) reports. As indicated previously, learning from serious incidents of self-harm or near deaths is also key.

2.2.1.5 In response to concerns raised by HMCIP in her Thematic Report on Recalled Prisoners, the Prison Service has issued specific new instructions on the reception of former prisoners recalled to custody from licence, to address the risks and uncertainty created by their unexpected return to custody.

2.2.2 Healthcare in prisons

2.2.2.1 There has been impressive investment in prison healthcare with nearly £176 million available in 2005-06, and £200 million available for 2006-07. The target date for Primary Care Trusts (PCTs) to commission prison health services within their areas was April 2006: all appropriate PCTs met this target.

2.2.2.2 The Government introduced a new prison reception screening tool for those first received into custody in 2004. This now helps staff to identify quickly all those who have health concerns - including mental health problems - so that their needs can be assessed. There are now 360 (whole time equivalent) more staff employed on mental health in-reach provision; which exceeds the NHS Plan commitment of 300 in post by the end of 2004. In addition, since 2006, all prisons have access to these mental health in-reach services.

2.2.3 Drug and alcohol misuse

2.2.3.1 Drug misuse amongst offenders being received into custody remains a significant challenge. On average, 55% of those received into custody report a serious drug problem; in some prisons that figure is much higher – up to 80% testing positive for Class A drugs on reception in some local prisons.

2.2.3.2 The custodial elements of the NOMS Drug Strategy and, in particular, drug interventions play a key role in the wider resettlement agenda of reducing re-offending. Effective delivery of drug interventions is key – until drug misusing prisoners' dependence can be stabilised or overcome, less scope exists to introduce peer support, build on supportive family ties, or offer education and skills that will help offenders lead law-abiding lives on release.

2.2.3.3 A comprehensive treatment framework for drug misusers in prison is in place, which is compatible with the National Treatment Agency's (NTA) revised Models of Care. The interventions available are designed to meet the needs of low, moderate and severe drug misusers – irrespective of age, gender or ethnicity.

2.2.3.4 The interventions comprise: Clinical services, encompassing detoxification and maintenance-prescribing programmes in all local and remand prisons. Detoxification services provide clinical support and intervention for drug misusers to help them achieve withdrawal from drug dependency. CARATs – Counselling, Assessment, Referral, Advice and Through-care) services, a low threshold tier 2/3 drug service that, following assessment, delivers treatment and support providing problematic drug users with access to a range of wider drug and non-drug services both in custody and on release. CARATs

create a Care Plan based on the specific needs of an individual prisoner. If assessed as necessary, prisoners will be referred to more intensive treatment programmes.

2.2.3.5 Available in all prisons in England and Wales, CARATs represent the key through-care connection, linking with the community through the Drug Interventions Programme (DIP). DIP's principal focus is to reduce drug-related crime by engaging with problematic drug users and, using a case management approach, moving them into appropriate treatment, retaining them in treatment and supporting them through and after treatment, whether in a custodial or community setting.

2.2.3.6 Intensive drug rehabilitation programmes in prison can be split into three main categories; cognitive behavioural therapy, the 12-step approach and therapeutic communities. For those prisoners serving short sentences, the short duration drug treatment programme (SDP) is available. Currently there are 115 programmes running in 103 establishments, including SDP in 40 establishments.

2.2.3.7 The drug treatment framework is backed up by the Mandatory Drug Testing (MDT) programme. MDT has three main objectives – to deter prisoners from misusing drugs through fear of being caught and punished, to supply better information on patterns of drug misuse and to identify individuals in need of treatment.

2.2.3.8 Drug treatment in prisons is underpinned by a range of quality standards, appropriate to the type of treatment and linked closely to the NTA's Models of Care. The highest quality drug treatment in prison more than matches the highest quality provided in the community.

2.2.3.9 To improve the drug treatment services available to problematic drug users in custody, the Home Office and the Department of Health have developed an Integrated Drug Treatment System (IDTS). IDTS in prisons will make a real difference to drug treatment – with enhanced clinical services and psychosocial support available for drug misusers during the first 28 days in custody.

2.2.3.10 IDTS is seeing £17 million invested in enhanced clinical services and psychosocial support during 2006/07 – with 17 prisons benefiting from full IDTS and an additional 28 receiving enhanced clinical services.

2.2.3.11 Alcohol is a problem for a significant number of those entering prison – with 63% of sentenced males and 39% of sentenced females reporting a hazardous drinking pattern in the year before coming into prison. To help meet this need, prisons have in place a comprehensive Alcohol Strategy for Prisoners. The strategy complements the existing NOMS Drug Strategy, the NPD Alcohol Strategy – Working with Alcohol Misusing Offenders – a Strategy for Delivery and the wider programme of resettlement activity. The Strategy provides a framework for addressing prisoners' alcohol problems, balancing treatment and support with supply reduction measures.

2.2.3.12 The focus is to improve consistency and build on good practice in the delivery of treatment from within existing resources and provide a robust framework to test prisoners for alcohol. Currently there is no central funding available for alcohol treatment. As a result, where local funding allows, prisons deliver alcohol interventions from within existing resources.

2.2.3.13 Given the growing pressure to expand alcohol treatment services for those in prison, it might at first appear helpful to divert drug treatment resources to help balance alcohol treatment needs, nevertheless, Government priority remains to reduce re-offending linked to illicit drug misuse – with drug treatment effectively remaining ring-fenced. The prisons' approach is in line with wider Government policy. When more resources become available, prisons will look to expand alcohol treatment services.

2.2.3.14 Future work will see the development of two alcohol programmes, one based on the cognitive behavioural therapy approach and the second based on the 12-step approach - both programmes will be piloted during 2007 and then evaluated.

2.2.4 Throughcare and aftercare of offenders moving through prison (and the community)

2.2.4.1 **Overview of the Drug Interventions Programme (DIP):**

The principal focus of the DIP is to reduce drug related crime by engaging with problematic drug users and, using a case management approach, moving them into appropriate treatment, helping to retain them in treatment and supporting them through and after treatment, whether in a custodial or community setting.

2.2.4.2 It aims to break the cycle of drug misuse, offending behaviour and custody by intervening at every stage of the Criminal Justice System (CJS) to engage offenders in drug treatment. In order to do so, it has built on existing interventions, such as arrest referral, and introduced some new elements (drug testing in relation to selected, mainly acquisitive crime, offences, required assessment for those testing positive, Restriction on Bail, Conditional Cautioning etc). These individual interventions have been brought together to create an integrated approach which enables appropriate and continuing engagement with an individual at arrest, on charge, in court, during and on completion of community and custodial sentences or statutory supervision in the community and on leaving treatment.

2.2.4.3 DIP is designed to engage with a broad range of drug misusing offenders, who are at different stages in their drug misuse and offending careers. It aims to prevent crime through early interventions as well as reduce crime levels by engaging the most problematic and prolific offenders. Special measures for young offenders are also being implemented. Its main focus, however, given the need to target resources most effectively and given the evidence base around links between certain types of drug use and offending behaviour, is on those who use Class A drugs, in particular, Heroin / Opiates, Cocaine and Crack Cocaine.

2.2.4.4 **24/7 Client Phone Line:**

As part of the development of the DIP all 149 Drug Action Teams (DAT) partnerships in England and Community Safety Partnerships in Wales have been tasked with developing and implementing a phone line service for existing or potential CJIT clients, particularly targeting those who have left prison and/or treatment. The phone line should be delivered in line with minimum standards and guidance provided 24 hours, 7 days a week. 88% (133) (NB correct figures as of January 2007) of DATs in England and partnerships in Wales now provide a 24/7 client phone line which meets minimum standards and these

arrangements are promoted nationally, regionally and locally. CARAT workers can now access information to include as part of pre-release planning.

2.2.4.5 **Preventing Homelessness:**

Building on existing practice and informed by examples delivered through the Street Crime Initiative and National Rent Deposit Forum, the DIP worked with the Department for Communities and Local Government, NTA, NOMS and other Home Office partners to identify key components for a comprehensive rent deposit model which would support drug misusing offenders particularly those leaving prison and residential settings in selected DAT areas. Practice and emerging findings from this work have been proactively shared across England and Wales to assist areas in delivering their plans to prevent homelessness.

2.2.5 Juveniles

2.2.5.1 The Offender Management Bill seeks to extend the power afforded by the Youth Justice Bill by enabling Detention and Training Order (DTO) trainees to be placed, additionally and where appropriate, in accommodation provided on behalf of a local authority for the purpose of restricting the liberty of children and young persons and by enabling the Secretary of State, by order, to specify other permissible types of accommodation. Trainees serving periods of detention under sections 90 or 91 of the Powers of Criminal Courts (Sentencing) Act 2000 may already be placed in any form of accommodation the Secretary of State may direct. The Bill would enable a similar degree of flexibility to be extended to DTO trainees.

2.2.5.2 The Youth Justice Board's Strategy for the Secure Estate for Children and Young People (November 2005) includes plans, which are currently being taken forward, for the development of the estate up to 2007-08, including the provision of "intermediate units" in juvenile young offender institutions for the minority of older juvenile offenders with needs that require more intensive staff support. It is hoped that these units can be developed within available resources.

2.2.6 Women

2.2.6.1 As a result of calls for a public inquiry following the tragic series of six deaths at Styal prison between August 2002 August and 2003, Baroness Scotland announced in early 2006 that there would be a review to identify gaps in provision for particularly vulnerable women on each occasion they come into contact with the CJS. Baroness Jean Corston agreed to undertake the independent review, and her report is now with Home Office Ministers. It will be published by the Government soon.

2.3 Immigration

2.3.1 Removal Centres

2.3.1.1The Immigration and Nationality Directorate (IND) has traditionally followed the Prison Service model of a self-harm reduction strategy in using a system known as F2052SH and is in the process of adopting the procedures under the Prison Service's new

ACCT system. The system will be entitled Assessment, Care in Detention and Teamwork (ACDT) and it is planned that the ACDT will have been fully implemented across the Immigration Detention Estate by July 2007.

2.3.1.2 Steps have to been taken to ensure that issues of medical confidentiality do not impede the exchange of information about the effect of detention on a detainee's health or the presence of a suicide risk. An operating standard on Health Care advises health care staff that, in exceptional circumstances, they are able to override an individual's wish for medical confidentiality.

2.3.2 Foreign National Prisoners

2.3.2.1 Since April 2006 IND's first priority has been to maximise public protection by ensuring that no foreign national prisoners (FNPs) are released without being considered for deportation. The Criminal Casework Directorate, which has responsibility for FNPs pending deportation has recruited large numbers of additional staff to increase the number of cases considered and removed at the end of sentence, and to deal more effectively with the cases of those detained post-sentence.

2.3.2.2 By spring 2007 we hope to reach a position whereby the consideration of deportation for all FNPs will begin six months before the end of their sentence. We are making steady progress in this regard and deportation is now considered around two months before release in many cases. As we make progress we will be able to complete the consideration and make arrangements for deportation in appropriate cases without the need to detain. A new system of case ownership has been introduced to ensure that all deportation cases are managed and tracked by individual caseworkers as they pass through the system. This will help improve communication between IND and the Prison Service as queries relating to specific cases will be routed more easily to the appropriate caseworker.

2.4 Police

2.4.1 Overall developments

2.4.1.1 A key development is the publication of the Guidance on the Safer Detention and Handling of Persons in Police Custody (which was published by CENTREX on behalf of Home Office and ACPO on 8 February 2006). The guidance encapsulates all aspects of the custodial process. CENTREX are currently developing a national training programme for custody officers around the integrated competency framework and minimum standards of safer custody set out in the guidance; it is hoped that this will be available in Summer 2007. In developing the training package, the Government is also looking at the appointment and placing of police officers and police staff in the custody area and the scope for putting in place a designation or accreditation process. The importance of appropriate information sharing about individual risk and vulnerability is well documented. Crucially, the guidance makes specific reference to the PER form and associated guidance, setting out detailed and specific checklists on what a custody officer must do and what information he or she must obtain – including any earlier periods in custodial care – in order to complete a full risk assessment of the individual.

2.4.1.2 In the wider context, the Government is committed to working with the IPCC to identify any gaps in its jurisdiction, especially those that may cause issues for Article 2 compliance. Where appropriate, consideration will be given to making changes to the IPCC's responsibilities to address these. Schedule 12 of the Serious Organised Crime and Police Act 2005 now provides for cases involving death or serious injury, following contact with the police, to be a referred by chief officers to the IPCC on a mandatory basis.

2.5 Probation

2.5.1 Overall developments

2.5.1.1 Drawing mainly on lessons learnt from PPO reports into deaths in Approved Premises, Probation Circular 35/2006 (*Preventing Deaths of Approved Premises Residents* – issued on 22 September 2006) offers substantial further guidance to Probation Areas and other Approved Premises providers on issues related to the care and management of residents. Specific themes addressed include: access to OASys (Offender Assessment System) and other risk assessments, the use of shared rooms, induction processes, recording practices, liaison with offender managers and partner agencies, information sharing protocols, enforcement, first aid, the use of CCTV, the monitoring of residents, staff access to personal alarms and a raft of issues concerning residents' medication. The circular also highlights examples of existing good practice in relation to family liaison, attendance at funerals, memorials, access to healthcare and support for residents and staff in the wake of a sudden death. The circular required Approved Premises to review and revise their local strategies for reducing sudden death and self-harm, in light of the advice contained in the Circular, and to submit revised strategies to the centre by 31 December 2006.

2.5.1.2 As from April 2007 the reporting of deaths in Approved Premises will be by business year. This will bring data in line with all other National Probation Service (NPS) reporting streams and with Prison Service practice in reporting on deaths in custody. In 2006, the number of deaths of residents of Approved Premises was 10. This shows a marked reduction from the average for the past decade (18) and the previous year (17).

2.5.1.3 ACT (Assessment, Care and Teamwork) has now been rolled out across all 16 Approved Premises (APs) in the North West Probation Region and a further 5 APs in the North East and South West Regions. The programme is for a 'probation-friendly' version of ACCT to be rolled out across the remaining 8 APs in the South West by the summer. In the North East Region, four of their six APs have received ACT training and have submitted a revised strategy for the prevention of deaths of approved premises residents, as required by PC 35/2006.

2.5.1.4 The Government is introducing a new Offender Management approach through NOMS, aiming to manage offenders "through the prison gate". The current schedule of implementation sees this approach being introduced in phases over the next 18 months. Drug misusers, as well as other offenders, will usually have the same Offender Manager from the start of, and throughout, their sentence who will plan the custodial and community parts of the sentence together. In addition, an Offender Supervisor will work directly with the offender during the custodial part of the sentence, to implement the sentence plan and prepare the offender for release.

2.5.1.5 Work is underway to tackle alcohol misuse by those recently released from custody. In May 2006, the National Probation Directorate (NPD) published 'Working with Alcohol Misusing Offenders – a Strategy for Delivery'. The strategy, which complements the 'Prison Service Alcohol Strategy', contains a number of actions for NPD and recommendations for probation areas to improve provision, many of which are being taken forward in 2006-07.

2.6 Mental Health Issues

2.6.1 Getting mentally ill people out of custody and into hospital

2.6.1.1 In November 2005, the Government issued a protocol which set out what must be done when a prisoner, awaiting transfer under the Mental Health Act 1983, has been waiting for a hospital place for more than three months following acceptance by the NHS. There has been a significant decrease in the number of people waiting over 12 weeks for a transfer – in the quarter ending June 2006 – 44 prisoners were waiting, down from 62 in the same quarter in 2005. Work is now underway to establish a national waiting time standard for transfers under the Mental Health Act between custodial settings and hospitals. A waiting time of two weeks is currently (until July 2007) being piloted by a number of mental health trusts. It is of note that in 2005 24% more prisoners with mental illness too severe for prison were transferred to hospital than in 2002 – up to 896 from 722.

2.6.1.2 The Government is looking at the practicalities of putting into place a system whereby a court would be informed when an offender sentenced there commits suicide or causes themselves serious self-harm within the first month of being received into custody or being sentenced. Sentencers are already empowered to consider mitigating sentences when there is risk of self-injury, which is part of the pre sentence report. Other priorities have meant that it was not possible to include the topic on the Sentencing Guidelines Council's work programme for 2006/2007. While sentencing policy and the decisions of the courts are not matters for the Prisons and Probation Ombudsman, within proper limits of his terms of reference, he has commented on the use of custody in a number of his investigation reports. The Government believes that this approach has been helpful.

2.6.1.3 Accurate quantitative and qualitative information about Court Diversion and Criminal Justice Liaison (CD & CSL) schemes is an essential first step to improving services. Together with information from the NACRO national database, and from Revolving Doors' 2006 report, this will inform guidance for a publication in 2007. The aim is to build on preliminary work to support delivery of good quality CD & CSL schemes by the regional centres of the Care Services Improvement Partnership. This includes work to develop a draft Service Level Agreement between Courts and the NHS to improve the quality and timeliness of psychiatric reports. It will also take account of NACRO's findings with King's College and the Institute for Criminal Policy Research due in 2007: this research examines the effectiveness of CD & CSL to meet the needs of women and offenders with a mental health problem from black and minority ethnic (BME) communities.

2.6.1.4 In January 2005 the Offender Mental Health Care Pathway was published. This care pathway document lays down valuable best practice templates to guide providers and commissioners on mental health services for those involved in the CJS. It is based on the

best evidence currently available, sourced from both literature and innovative clinical practice, and is intended to guide the practice of people who directly deliver services and support decision making for those who commission them. Also in 2005, the Department of Health announced a £130 million capital investment in mental health services. In 2006/07 and 2007/08 £100 million of this money has been targeted on developing health-based place of safety for assessment of people detained under the Mental Health Act by the police and in improving Psychiatric Intensive Care Units (PICUs). This was in recognition of the fact that many people picked up by the police who need a mental health assessment are taken to police stations as the "dedicated place of safety", as required by the Mental Health Act. In part, this money will go towards developing more appropriate facilities to reduce the reliance on police stations.

2.6.1.5 The Government made £130 million available to the NHS from April 2006 for the improvement of the mental health estate, in particular the development of hospital-based places of safety. £42 million of this money has been allocated in 2006/7. Up to £58 million will additionally be made available in 2007/8. This money will facilitate an increase in hospital-based place of safety facilities and will reduce the reliance in some areas on police stations. The Government is working with the Department of Health, ACPO and the Directorate of Health and Offender Partnerships to examine the wider issue of commissioning of mental (and physical) healthcare for those that come into police custody and contact. This will look to baseline current activity in each force areas and working arrangements with local trusts.

2.6.1.6 The Committee will be aware that a report published in December 2006 *Avoidable Deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness* contains all the information on suicides between April 2000 and December 2004, and homicides which occurred between April 1999 and December 2003. Attention has been given to train staff within prisons and raise levels of knowledge and competence about the management of suicide risk. The report found that in-patient suicides in mental health units, as a proportion of all patient suicides, fell from 17% in 1997 to 11% in 2004 – this translates to 67 fewer deaths in 2004. The full report is available on the new Confidential Inquiry website at www.medicine.manchester.ac.uk/suicideprevention/nci/

2.6.2 Protocols between health and custodians

2.6.2.1 In recognition of the importance of appropriate information exchange, the NHS Security Management Service agreed a Memorandum of Understanding with ACPO in 2006 which provides a framework for the exchange of information in order to achieve clear lines of communication at a local level between health and police bodies. The whole document can be found on: http://nww.cfs.nhs.uk/pub/doc/sms.agreements/mou.sms.acpo.pdf.

2.6.2.2 In December 2006 Professor Louis Appleby (National Clinical Director Mental Health) agreed a joint one year project between the ACPO and the National Institute for Mental Health in England (NIMHE) which aims to produce national guidance on work between police forces and local mental health services.

2.6.3 Secure Hospitals

2.6.3.1 The NHS now has regional Commissioning Plans in place to ensure strategic planning for secure services, taking into account the needs of the whole of the population, including the needs of offenders. These local Commissioning Plans will be under constant review and will be updated to take account of changing local circumstances.

2.6.3.2 In addition, a modernisation plan is in place for each of the three high secure hospitals and each hospital has a dedicated group in place chaired by the relevant Strategic Health Authority (SHA), to ensure that there is coherent planning across high and medium security. The Outline Business Case for development at Broadmoor is currently being developed. As part of this process new building standards for high security are being developed against which all new builds in high security can be benchmarked.

2.6.3.3 Every death in high security is subject to an internal inquiry by the Trust and following this, if further investigation is required, the relevant SHA will take responsibility for this. Consideration is being given to ensuring that every death in high security is subject to objective external review. This is being discussed via the Cross Government Forum for Preventing Deaths in Custody. All other deaths of detained patients are reviewed in accordance with the healthcare providers' clinical governance procedures.

2.6.3.4 The NHS, ACPO and Health and Safety Executive (HSE) signed a Memorandum of Understanding entitled *'Investigating patient safety incidents involving unexpected death or serious untoward harm. A protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health and Safety Executive*' in February 2006. This mentions that all deaths must be investigated using existing NHS procedures, including those developed by the Department of Health and the National Patient Safety Agency (NPSA). This can be accessed at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4129918&chk=P5hkFZ

2.6.3.5 The NPSA receives thousands of incidents into the National Reporting and Learning System (NRLS) each week and has developed a systematic approach to reviewing NRLS data. Cuts of data (samples of 150 incident reports) in specific care settings (e.g. mental health) or by incident type (e.g. medication incidents) are analysed on a monthly basis. In addition to this, all reports of death are reviewed and analysed. It is also worthy of note that the NPSA launched '*Being open when patients are harmed*' information for the NHS on open disclosure in September 2005, which includes advice on communication with relatives and family. The NPSA has also produced an information pack to be launched in March 2007 alongside the new guidance on the conduct of independent inquiries in mental health care.

2.7 Restraint in health settings

2.7.1 In October 2005, the NHS SMS (Security Management Service) launched the first ever national training syllabus to tackle violence against staff in mental health and learning disability services. *Promoting Safer and Therapeutic Services* was developed by an NHS SMS-led expert group including NIMHE. The syllabus is designed to provide training in

recognising, de-escalating and managing potentially violent incidents, whilst improving staff and service-user safety. It constitutes the foundation training that has to be provided to staff ahead of any training in physical intervention techniques.

2.7.2 The accompanying implementation guidance indicates the actions required by health bodies to ensure compliance with Secretary of State Directions (2003/2004). The syllabus does not set out to alter current good practice but aims to establish a minimum standard. Seminars were designed to enable training providers to understand the work that is taking place nationally to tackle violence. Attendance at a familiarisation seminar provided trainers with an overview of the strategy adopted by the NHS SMS in relation to tackling violence in mental health and learning disability services in order to bring about a significant and sustainable reduction in aggression and violence, taking into account other security related matters in these services. The National Institute for Clinical Excellence (NICE) published new guidelines on the short-term management of violent behaviour in inpatient psychiatric settings in February 2005 – *The Short Term Management of Violence (Disturbed Behaviour) in Inpatient Psychiatric Settings* (this is available on the NICE website at http://www.nice.org.uk/pdf/cg025niceguideline.pdf.) These guidelines made specific reference to the above syllabus as the standard of training in non-physical intervention that staff in mental health and learning disability services must achieve. NIMHE will publish its definitive guidance early in 2007, reflecting feedback on the interim version and the NICE guidance and incorporating additional guidance on the sexual safety of patients on in-patient units.

2.7.3 In May 2006 the Cross-Government Group on the Management of Violence stood down as it had a time limited function linked to the NIMHE/NPSA two year project of the same name. However, detailed proposals were put forward to the Department of Health on the introduction of a national system for the Accreditation and Regulation of trainers and programmes of education and training in the prevention and management of violence in mental health services. These proposals included the establishment of an advisory committee to oversee and advise on these developments which were based around the membership of the previous cross government group, with a governance board involving:

- HSE
- HCC
- NPSA
- BILD
- NIMHE
- SMS
- Representatives from health and social care
- Service user representatives

The information gathered by the key organisations could then be compared and areas with identifiable trends targeted for prompt inspection.

2.8 Coroners

2.8.1 The Coroner reform programme was established in response to a report of the fundamental review of death certification and coroner services, published in 2003; and to recommendations made in the third report of the Shipman Inquiry. In May 2005, the Department for Constitutional Affairs took over responsibility for Coroners and the Coroner reform programme. On 6 February 2006, further plans were announced in an oral ministerial statement and a briefing note was published. These were developed into a draft Coroners Bill which was published on 12 June 2006.

2.8.2 As mentioned in the introduction, the three main aims of the bill are:

- The Bill will give families involved in the inquest process a clear legal standing in the system. For the first time, families will have rights through the introduction of a charter for bereaved people, laying out the level of service in relation to information and consultation that families can expect, and through a new appeals system, enabling then to challenge a Coroner's decision.

- The Bill will establish a proper appointments system for Coroners, who will have to be legally qualified and will have to work solely as Coroners, instead of having another job and working part time as Coroners.

- For the first time there will be a Chief Coroner who will provide national leadership for Coroners, as the Lord Chief Justice does for judges. This will be supported by national standards, a coronial advisory council, an inspection system and national training for coroners and their officers.

2.8.3 The Bill introduces national leadership and national standards - in particular the services which bereaved people can expect to receive, including access to a new appeal system. It will also make transparent the system for appointing Coroners and increase their powers when conducting their investigations.

2.8.4 Public consultation ran until late last year and a report of the outcome will be published shortly. The fact that the Coroners Bill is not part of the main programme for this session gives us additional time for consultation with stakeholders so that the legislation can be further improved. We will also explore, in consultation with those who deliver and fund the service and those who represent people with experience of it, whether there are other changes that can be made to improve the system in advance of and to complement legislation. The Coroners Bill will be brought before Parliament as soon as time allows.

2.8.5 The Government's aim is to have the best features of a national structure, headed by a Chief Coroner, with the best features of local service delivery. A partnership between the police, local authorities, their local coroners and the Chief Coroner should ensure that the service is embedded as an adequately funded local service, with national leadership and standards on key matters. As with the police force, the education system, and many other services which come within the remit of local authorities, this structure will ensure responsiveness to local circumstances and help to build strong local partnerships with other services, while at the same time providing national leadership and national standards.

2.8.6 Clause 10(2) of the draft Coroners' Bill requires for the scope of the investigation to be widened to include an investigation of the circumstances of the death where this wider investigation is necessary to ensure compliance with the European Convention on Human Rights, in particular the "right to life" Article 2. It is not intended to define the precise circumstances where a coroner should conduct an Article 2 investigation, but guidance will be issued before the Bill is implemented to ensure a broad consistency of approach.

2.8.7 It is not the Government's intention to cut across established statutory arrangements for the conduct of inquiries into particular types of death, for example in relation to Local Safeguarding Children Boards. There will however be further consideration of the issues raised about disclosure (both to coroners and by coroners) – and whether there needs to be more on the face of the Bill – and further discussions with the relevant parties about access to intercept material.

2.8.8 A key part of the Chief Coroner's role will be to establish service level and resource benchmarks and models against which local authorities can measure the service at a local level. The Government strongly believes that these benchmarks and models will help identify resource gaps and guide local authorities in their responsibility to adequately fund the service.

2.8.9 The Government is providing additional funds under the Bill proposals. This amounts to £6 million per annum and £15 million in set-up costs to aid the transition to the reformed service. The additional £6 million will include funds for the Chief Coroner's office, an appeals system, inspection, additional medical input at both central and local level, and a number of other new components all of which will help build a stronger service in the future.

2.8.10 The Government previously indicated its concern regarding the delays affecting some inquests, which occur for a number of reasons. It may take time to gather together the evidence the Coroner requires and for investigations to be completed and there can be difficulties in finding court accommodation, especially if the courtroom needs to be suitable for prisoner witnesses or to allow spaces for a number of legal or other representatives. There are sometimes issues for families in arranging and funding legal support, and delays in summoning a jury. Coroners investigating more contentious or complex cases may also decide to wait for the outcome of the PPO's separate investigation, which itself can be delayed waiting for toxicology/histology reports and/or Clinical Reviews.

2.8.11 Work continues to reduce delays and backlogs. The provisions in the draft Bill will tackle some of the problems in the current system in England and Wales, like limited jurisdiction flexibility. The new leadership structure and flexibility will allow resources to be directed where needed, including the reallocation of cases to a different coroner area if the need arises. Negotiations are underway to ensure that Coroners can make use of Her Majesty's Court Service estate to hold inquests wherever possible so that improved accommodation is available. The reforms proposed in the draft Coroners' Bill will remove the existing restrictions on where coroners are able to hold inquests and to move bodies for the purposes of post mortems in order to provide a flexible response based on the needs of each case.

2.8.12 The Northern Ireland Court Service has introduced a number of important reforms to the coroners' service and officially launched the new Coroners Service for Northern Ireland in June 2006. These include the creation of a single coroners jurisdiction headed by a High Court Judge and supported by three full-time coroners, the appointment of Coroners Liaison Officers and the development of a Coroners Service Charter for bereaved families. These changes will alleviate the current backlog of cases and provide the public with a more professional and effective coroner service.

2.8.13 A draft Charter for bereaved families was published for consultation alongside the Draft Coroners' Bill on 12 June 2006. The draft Charter is not part of the Bill and it will therefore be subject to later consultation and discussion. But it contains clear standards about information provision, including the disclosure of documents, and also the opportunity for family involvement in coroners' investigations and their new rights of appeal against Coroners' decisions.

2.8.14 The Government received representations about funding for advocacy at inquests during the consultation on the draft Coroners Bill. Some families feel they face difficulties at inquests when other interested persons are legally represented and they are not. Further consideration is being given as to how this might be tackled without adding to the legal aid budget. This is one of the issues which is likely to be fully debated when the Bill is brought before Parliament, as soon as time allows.

2.8.15 Where the family of the deceased do not speak English, Article 2 requires that an interpreter will need to be provided to enable them to be able to fully engage in the process. This will need to be for the entire length of the proceedings, not merely for any period during which the family may be giving evidence. In general, it will be for the coroner to fund this expense. Legally-aided families may be entitled to obtain expenses from the Legal Services Commission in order to communicate with their lawyers, but in general costs relating to inquests must be met by the Coroner concerned.

2.8.16 The Government has already accepted the need to give coroners power to make a report on lessons learned from a particular death or a particular incident more prominent by removing it from the current Coroners Rules to the face of the Bill. On 30 January, the Government announced further changes to strengthen this provision: a statutory obligation will be put on authorities to formally respond to reports, and the Chief Coroner will include - in his or her annual report to Parliament - a summary of the reports made and the responses to them. More details on the associated detailed procedures will be dealt with in secondary legislation.

3. Progress Update on Accepted Recommendations

No.	Recommendation	Government Response
72	**We welcome the introduction of this scheme on a trial basis. If it is proven to be effective we strongly urge the Government to extend it nationwide as quickly as possible. In particular we welcome the individual crisis counselling for women and programmes specifically targeted at women. We recommend further analysis of the experiences of women and in particular reasons why they have a far greater tendency to self-harm than men.**	The Government through the Ministerial Round Table on Suicide has endorsed the continuing Safer Custody programme, and is determined to build upon the evaluation of the Safer Locals Programme by Dr Alison Liebling of the Cambridge Institute of Criminology. Some further key achievements to date of the Safer Custody Programme are: • The new assessment and care planning system (ACCT) based around the individual and dedicated case management, has been introduced at 115 establishments (as at 4/1/07), with completion of the ACCT implementation programme on target for the end of 2006-07. • Training all staff in contract with prisoners to ACCT Foundation level (suicide prevention and self-harm management), with many more receiving ACCT specialist training and/or mental health awareness training, has run as a part of the ACCT implementation programme. • Over 3,000 new Listeners were recruited with further recruitment and training continuing • Suicide Prevention Coordinators (or equivalents) operate in all prisons across the estate. Good practice continues to develop, such as quarterly meetings of Co-ordinators from the women's estate with an emphasis on learning lessons from custody deaths in addition to attendance at annual gatherings of Co-ordinators across the entire estate. • An investment of over £26 million has resulted in physical improvements being made to the six 'Safer Local' pilot sites. • Development and introduction of a new health reception screening process: In 2004, the Government introduced a new prison reception screening tool for those first received into custody. This now helps staff to identify quickly all those who have health concerns - including mental health problems - so that their needs can be assessed. Now 360 more (whole time equivalent) staff are employed on mental health in-reach provision; exceeding the NHS Plan commitment for 300 in post by end 2004. Since 2006, all prisons have access to these mental health in-reach services. • Therapeutic Intervention schemes continue to across the women's estate and are being expanded to male establishments. • The introduction of improved systems for cross-CJS sharing of risk of self-harm and related care planning information. As a result of calls for a public inquiry following the tragic series of six deaths at Styal prison between August 2002 August and 2003, Baroness Scotland announced in early 2006 that there would be a review to identify gaps in provision for particularly vulnerable women on each occasion they come into contact with the CJS. Baroness Jean

		Corston agreed to undertake the independent review, and her report is now with Home Office Ministers. It will be published by the Government soon.
75	**There has never been a public inquiry into the death of a child in custody. We recommend that the Home Secretary order a public inquiry into the death of Joseph Scholes in order that lessons can be fully learnt from the circumstances that led up to his tragic death. We also recommend that local authority secure accommodation should be used wherever possible for children, with use of prison service custody reduced to an absolute minimum.**	Following the Government's action after the death of Joseph Scholes, the below changes were made to the sentencing on robbery: • The Sentencing Guidance Council (SGC) published a draft guideline under the statutory consultation procedure in November 2005 and its definitive guideline in July 2006; • David Lambert presented his report to the Home Office in October 2005. We published it, together with the Government's response, which set out in detail the action we are taking, in September 2006 at http://press.homeoffice.gov.uk/Speeches/st-lambert-report-180906?version=1; and • The draft strategy was published for consultation in November 2004 and the final document, *Strategy for the Secure Estate for Children and Young People,* in November 2005. The Government firmly believes that these measures were the most appropriate response to the Coroner's concerns, and were more precisely focused on each type of issue than a public inquiry would have been. The Youth Justice Board considers that more provision is needed for vulnerable 15 and 16-year-old boys, and its *Strategy for the Secure Estate for Children and Young People* includes plans to provide a new form of 'intermediate' accommodation, with smaller-scale units and more intensive staff support for trainees, which would address this need. The Government believes the plans in *Strategy for the Secure Estate for Children and Young People* set a clear direction for the future of the estate.
86	**We recommend that annual statistics should be published by the Department of Health, recording the numbers of natural and self-inflicted deaths, homicides and deaths which are restraint-related, as well as attempted suicides, and detailing the age, gender and ethnicity of those who died or attempted suicide.**	*Avoidable Deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness*, was published in December 2006. This contains all the information on suicides between April 2000 and December 2004, and homicides which occurred between April 1999 and December 2003. It is available on the new Confidential Inquiry website at http://www.medicine.manchester.ac.uk/suicideprevention/nci The National Patient Safety Agency (NPSA) receives thousands of incidents into the National Reporting and Learning System (NRLS) each week and has developed a systematic approach to reviewing NRLS data. Cuts of data (samples of 150 incident reports) in specific care settings (e.g. mental health) or by incident type (e.g. medication incidents) are analysed on a monthly basis. In addition to this, all reports of death are reviewed and analysed.
116	**We further recommend that a protocol should be introduced in all prisons stating that prisoners with specific**	The Prison Service Order *Continuity of Healthcare for Prisoners* was issued in February 2006. For those prisons receiving the new Integrated Drug Treatment System (IDTS), *Clinical Management of Drug*

	health or psychiatric needs should not be selected for transfer unless the receiving establishment's medical officer has agreed the transfer. Listeners should not be transferred on overcrowding drafts.	*Dependence in the Adult Prison Setting* describes how clinical services for the management of substance misusers in prison should develop during the next two years as increasing resources permit. The aim is to address the current challenges facing the care and treatment of substance misusers in prisons. This includes guidance on stabilisation and detoxification periods. In November 2005, the Government issued a protocol which set out what must be done when a prisoner, awaiting transfer under the Mental Health Act 1983, has been waiting for a hospital place for more than three months following acceptance by the NHS. Work is now underway to establish a national waiting time standard for transfers under the Mental Health Act between custodial settings and hospitals. A waiting time of two weeks is currently (until July 2007) being piloted by a number of mental health trusts.
126	**We recommend that the Sentencing Guidelines Council should issue guidance to courts to consider the risk of defendants harming themselves if they were to receive a custodial sentence. Magistrates and judges should receive feedback on their sentencing decisions, including information on when someone they have sentenced to custody self-harms, or commits or attempts suicide.**	We are looking at the practicalities of putting into place a system whereby a court would be informed when an offender sentenced there commits suicide or causes themselves serious self-harm within the first month of being received into custody or being sentenced. Sentencers are already empowered to consider mitigating sentences when there is risk of self-injury, which is part of the pre-sentence report. The Committee's recommendation that the Sentencing Guidelines Council should issue guidance to courts to consider the risk of self-harm when sentencing to custody has been drawn to the attention of the Council for consideration. Other priorities have meant that it was not possible to include the topic on the Council's work programme for 2006/2007. It is possible that issues relevant to the recommendation may be considered in the context of the proposed paper on sentencing young offenders; the timing of this paper is likely to depend on the progress of any new legislative provisions. The issues may also be considered in a general sentencing issues paper, although such a paper does not currently feature on the work programme as a number of 'general issues' already have been, or will be, considered in the context of other papers.
128	**We recommend that the government should take the opportunity afforded by the Youth Justice Bill to empower the Youth Justice Board to direct the form of custody of a sentenced child who has been assessed as particularly vulnerable. Such powers must be accompanied by adequate funding for suitable forms of accommodation for vulnerable children, both on remand and following sentence.**	The Offender Management Bill seeks to extend this power by enabling Detention Training Order (DTO) trainees to be placed, additionally and where appropriate, in accommodation provided *on behalf of* a local authority for the purpose of restricting the liberty of children and young persons and by enabling the Secretary of State, by order, to specify other permissible types of accommodation. Trainees serving periods of detention under sections 90 or 91 of the Powers of Criminal Courts (Sentencing) Act 2000 may already be placed in any form of accommodation the Secretary of State may direct. The Bill would enable a similar degree of flexibility to be extended to DTO trainees. Additionally, the Youth Justice Board's *Strategy for the Secure Estate for Children and Young People* (November 2005) includes plans, which are currently being taken forward for the development of the estate up to 2007-08, including the provision of "intermediate units" in juvenile young offender institutions for the minority of older juvenile offenders with needs that require more intensive staff support. The Board plans in seeking to develop these units within available resources.

130	**We recommend that detention of immigration detainees in prisons should be urgently reviewed with a view to reducing the numbers of such detainees held in prison, with particular reference to those who may be at risk of suicide or self-harm.**	A new system of case ownership has been introduced to ensure that all deportation cases are managed and tracked by individual caseworkers as they pass through the system. This will help improve communication between the Immigration and Nationality Directorate (IND) and the Prison Service as queries relating to specific cases will be routed to the appropriate caseworker.
141	**We commend the work done by first night in custody schemes and recommend that all prisons introduce similar schemes to support prisoners received into custody for the first time. We also recommend that new prisoner receptions should receive a minimum of a week of close observation and assessment in a dedicated area. This would provide prisoners with time to acclimatise to their new environment and would allow staff to carry out proper risk and health assessments.**	In response to concerns raised by HM Chief Inspector of Prisons (HMCIP) in her Thematic Report on Recalled Prisoners, the Prison Service has issued specific new instructions on the reception of former prisoners recalled to custody from licence, to address the risks and uncertainty created by their unexpected return to custody.
143	**We recommend that provision should be made for exchange of information on suicide risk from prisons to the police in appropriate cases.**	An interim option using faxes or emails was piloted with the Metropolitan Police based on an initiative that operated between September 2000 and April 2001 by Leicestershire Constabulary with HMP Leicester and HMYOI Glen Parva. An explanation of how establishments could implement this good practice was contained in a 2005 Prison Service Instruction (18/2005), and ACPO and the Prison Service are in the final stages of agreeing a protocol to make this arrangement mandatory. The PER (Prisoner Escort Record) is now being reviewed, taking account of operational experience and policy advances, to see what improvements can be made. Guidance on the Safer Detention and Handling of Persons in Police Custody published by CENTREX on behalf of Home Office and ACPO on 8 February 2006 makes specific reference to the PER form and associated guidance. Importantly, the 2006 guidance sets out detailed and specific checklists on what a custody officer must do and what information he or she must obtain – including any earlier periods in custodial care – in order to complete a full risk assessment of the individual.

147	**Sub-standard or unsafe conditions of detention may violate Article 3 ECHR, as well as Article 8. We recommend that funding should be made available to ensure that people at risk of self-harm or suicide are held in decent conditions of detention.**	The Outline Business Case for development at Broadmoor is currently being developed. As part of this process, standards for high security are being developed against which all new builds in high security can be benchmarked. The Safer Detention Guidance (see paragraph 143) sets out expected standards in relation to buildings and facilities.
151	**We recommend that strategies for suicide prevention in all forms of detention should take into account the need to respect the privacy and physical integrity of people in detention. Excessive focus on control, at the expense of detainees' well-being, will not prevent deaths in the long term, and will not assure compatibility with the Convention rights.**	The Immigration and Nationality Directorate (IND) has traditionally followed the Prison Service model of a self-harm reduction strategy and is in the process of adopting the system recently introduced by the Prison Service to replace the earlier procedures under F2052SH. The Prison Service system is now called the Assessment, Care in Custody and Teamwork (ACCT). Although IND will follow that same system it will be called the Assessment, Care in Detention and Teamwork (ACDT). We expect to have the ACDT fully implemented across the Immigration Service Detention Estate by July 2007. Attention has been given to train staff within prisons and raise levels of knowledge and competence about the management of suicide risk. Avoidable Deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness, published in December 2006, found that in-patient suicides in mental health units, as a proportion of all patient suicides, fell from 17% in 1997 to 11% in 2004 – this translates to 67 fewer deaths in 2004 . As outlined in the response to recommendation 143, guidance for handling persons in police custody was published in February 2006. The guidance contains a grid for 'levels of observation' which take account of the level of risk and level of privacy then afforded to provide the right level of care in the specific and individual circumstances of the person.
152	**It is a particular concern in relation to deaths in custody that detainees at known risk of suicide may be held in an environment which includes ligature points. We recommend that efforts should continue to provide safe accommodation in all forms of detention.**	Her Majesty's Court Service (HMCS) is now responsible for the construction and subsequent works funding for court custody suites and is committed to providing a safe environment for all users of its buildings. HMCS has and continues to work closely with Prisoner Escort and Custody Services (PECS) (who are responsible for and take the lead in setting the design criteria for the custody suites). The use of safer cells cannot alone be an adequate response to the problem of self-inflicted deaths in prison. Design solutions to minimise impulsive acts is a key element in a wider holistic suicide prevention strategy. In December 2003 the Prison Service Management Board (PSMB) agreed with the Jill Dando recommendations to continue the safer cells programme but confirmed that safer cells investment policy was for PSIB to agree. The sources of funding would need to be explored; any significant expansion would be dependent on additional SR2004 funding.

		The PSMB considered the merits of enforcing the use of Safer Cells in all refurbishment exercises in Local Prisons. It was considered that there could be a risk in creating an inflexible policy not supported by the available funding. Therefore, all refurbishment cases should be reviewed on an individual basis. It was decided to confirm the existing policy that, for new accommodation in existing prison establishments: • All Cat A, B and local prison establishments would be fitted with 100% safer cells to the full Property Services Group (PSG) specification. • Cat C prison establishments would be fitted with 25% safer cells to the full PSG specification. • RTUs and MTUs would not generally be fitted with safer cells to full PSG specification and risks would be managed operationally. It was further agreed that, for refurbished accommodation in local prison establishments: Consideration should always be given to include safer cell provision in all business cases commissioned by the EPC. Such provision should be mandatory in high risk areas. The PSIB would delegate responsibility to the EPC to decide the final option and therefore the number of safer cells to be provided, on advice from SCG, balanced by risk, other priorities and resource availability. Safer cells would be to full PSG specification.
170	**We recommend that as a general principle physical and mental healthcare in prisons must be of the same standard as provided by the NHS in the community. New funding arrangements must ensure that prisons have appropriate and adequate resources to ensure that this equivalence is achieved.**	All Primary Care Trusts (PCTs) with a prison in its area had taken over commissioning prison health services by the target date of April 2006. Some £118 million was transferred for 2002-03: the figure spent on prison healthcare in 2005-06 was nearly £176 million, and for 2006-07 nearly £200m is available.
177	**In order to reduce deaths in custody and adequately care for those imprisoned we fully endorse the expansion of drug maintenance programmes in prison for addicts to help relieve the distress of getting off drugs and the risk of overdose on**	To improve the drug treatment services available to problematic drug users in custody, the Home Office and the Department of Health (DH) have developed an Integrated Drug Treatment System (IDTS) the key elements are to provide:- • improved clinical treatment management with greater use of maintenance prescriptions and the number of treatment/stabilisation programmes; • intensive CARATs support during the first 28-days of intense clinical management for all patients;

	release. We recommend that high quality drug maintenance programmes are readily available in all prisons in England and Wales to all those prisoners who require such a programme.	• greater integration of treatment generally but a particular emphasis on clinical and CARAT services, with the objective of creating multi-disciplinary systems; • better targeting of interventions to match individual need; • raising of standards to NTA Models of Care levels to ensure that following triage and comprehensive assessment , a range of fully co-ordinated and structured services are available; and • Strengthening links to Community Services including Primary Care Trusts, Criminal Justice Integrated Teams (CJITs), Drug Treatment providers etc. Clinical services are provided in all local and remand prisons and these will continue to be the focus for such interventions. However, severe and unpredicted reductions in DH funding plans have restricted the full roll out of IDTS and final decisions on the level of NOMS funding are yet to be taken. Therefore in 2006/07 full IDTS (Clinical and CARATs) will be implemented in 17 prisons with a further 28 receiving funding for enhanced clinical services only. At this stage it is not envisaged that funding for full roll out will be made available from the current spending round.
178	**We recommend that if people are sent to prison on short sentences or on remand, drug and alcohol treatment must be made readily available for them.**	The Short Duration Programme (SDP), deliverable in around four weeks, has been further rolled-out across the prison estate – and is now running at 40 establishments. Short-term offenders are also still able to benefit from engagement with clinical services – the delivery of which is being boosted during the first 28 days in custody, under the Integrated Drug Treatment System (IDTS); CARATs (Counselling, Assessment, Referral, Advice & Through-care services); and, in some cases, from engagement with the P-ASRO (Prisons – Addressing Substance-Related Offending) drug rehabilitation programme (deliverable in around six weeks). In those 17 prisons involved in the first stage roll-out of IDTS and where enhanced clinical and psychosocial support will be available – IDTS will be available to all new receptions which will include both those on remand and short sentences; the 2006 Department of Health document *Clinical Management of Drug Dependence in the Adult Prison Setting* clearly states that maintenance prescribing for this group should be offered where appropriate. The 28-day psychosocial support will also provide intensive CARAT intervention for this group of prisoners. Additionally, more has been done to help alcohol-misusers – in May 2006, the National Probation Directorate (NPD) published *Working with Alcohol Misusing Offenders – a Strategy for Delivery*. The strategy, which complements the *Prison Service Alcohol Strategy* in creating a coherent NOMS Alcohol Strategy, contains a number of actions for NPD and recommendations for probation areas to improve provision; many of which are being taken forward in 2006-07.
179	**We recommend that there should be an expansion of alcohol misuse treatment with ring-fenced funding, and that standards should be set for the**	In addition, we are developing two alcohol programmes. One is based on cognitive behavioural therapy (CBT) and the second on the 12-step approach; both programmes will be piloted during 2007. The pilots will be evaluated and if successful, we would then seek accreditation.

	provision of alcohol detoxification and treatment in custodial settings.	Additional funding to expand drug treatment in prison has been drawn from successive spending rounds. Alongside, no additional funding was made available for alcohol. Currently there is no central funding available for alcohol treatment. As a result, where local funding allows, prisons deliver alcohol interventions from within existing resources. Given the growing pressure to expand alcohol treatment services for those in prison, it might at first appear helpful to divert drug treatment resources to help balance alcohol treatment needs, nevertheless, the top government priority remains to reduce re-offending linked to illicit drug misuse – with drug treatment effectively remaining ring-fenced. The prisons' approach is, therefore, in line with wider Government policy. When more resources become available, Prisons will look to expand alcohol treatment services,
180	**Although this inquiry deals with deaths in custody, rather than following release, the Convention human rights obligations of detaining authorities do not end on release. The positive obligation to protect life under Article 2 ECHR requires that reasonable steps should be taken to protect those whose lives are known to be at risk. Newly-released prisoners with known vulnerabilities should therefore be afforded appropriate support. We also recommend that the Prison Service should collect statistics on whether prisoners who undergo detoxification while in prison go on to commence and complete drug treatment.**	The principal focus of the Drug Interventions Programme (DIP) is to reduce drug related crime by engaging with problematic drug users and, using a case management approach, moving them into appropriate treatment, helping to retain them in treatment and supporting them through and after treatment, whether in a custodial or community setting. It aims to break the cycle of drug misuse, offending behaviour and custody by intervening at every stage of the Criminal Justice System (CJS) to engage offenders in drug treatment. In order to do so, it has built on existing interventions, such as arrest referral, and introduced some new elements (drug testing in relation to selected, mainly acquisitive crime, offences, required assessment for those testing positive, Restriction on Bail, Conditional Cautioning etc). These individual interventions have been brought together to create an integrated approach which enables appropriate and continuing engagement with an individual at arrest, on charge, in court, during and on completion of community and custodial sentences or statutory supervision in the community and on leaving treatment. Key partners include the police, courts, NOMS (prisons and probation /offender managers) drug treatment providers and those who provide 'wraparound support' to address practical issues relating to housing, education, finance, employment. These partnerships have been supported through joint working with Government Departments such as the Department for Communities and Local Government, Department of Health and Department of Work and Pensions and are working to identify and promote joined up solutions. DIP is designed to engage with a broad range of drug misusing offenders, who are at different stages in their drug misuse and offending careers. It aims to prevent crime through early interventions as well as reduce crime levels by engaging the most problematic and prolific offenders. Special measures for young offenders are also being implemented. Its main focus, however, given the need to target resources most effectively and given the evidence base around links between certain types of drug use and offending behaviour, is on those who use Class A drugs, in particular, Heroin / Opiates, Cocaine and Crack Cocaine.

		To initiate and support continuity of care, drug misusing offenders may be referred to CARAT teams by Criminal Justice Integrated Teams (CJITs) in the community using the agreed Drug Interventions Record (DIR). Other individuals - not previously known to the CJIT - may be newly identified by the CARAT teams as needing CARAT services. The CARAT team will take responsibility for managing treatment whilst the offender is in prison through further assessment and work as required. Offenders aged 18 and over who require drug services and who are seen by the CARAT team are given information about DIP and encouraged to agree to the sharing of information with the CJIT for continuity of care purposes. Their details are (with their informed consent) shared with the CJIT team in the area to which they will be released and the CJIT will be informed of further assessments and significant treatment events, again using the agreed DIR processes. They are also encouraged to share information with the Offender Manager for the purpose of effective sentence planning and/or to inform the pre-sentence report (PSR). The CARAT team will liaise with the CJIT in the offender's area of residence when preparing release plans as well as liaising with sentence planning and resettlement teams in prison and OMs (in the community). Drug misusing offenders in prison who are assessed as requiring ongoing access to drug treatment services in the community will be referred to the Single Point of Contact (SPOC) in the relevant CJIT, as long as the individual has given their consent for information to be passed to the CJIT. The CJIT will consider whether the individual is to be taken onto its caseload. This decision is based on the drug-related needs of the individual and the capacity of the CJIT. Where the individual is taken onto the caseload, the CJIT will provide or broker access to treatment and wraparound services as appropriate. When it is not appropriate for the individual to be taken onto the CJIT caseload e.g. where there are more appropriate services for the individual than those which the CJIT would provide, the CJIT might, more appropriately, "signpost" and refer the individual to other services in the community. 24/7 Client Phone Line : As part of the development of the DIP, all 149 Drug Action Teams (DAT) partnerships in England and Community Safety Partnerships in Wales have been tasked with developing and implementing a phone line service for existing or potential CJIT clients, particularly targeting those who have left prison and/or treatment. The phone line should be delivered in line with minimum standards and guidance provided 24 hours, 7 days a week. 88% (133) (NB correct figures as of Jan 07) of DATs in England and partnerships in Wales now provide a 24/7 client phone line which meets minimum standards and these arrangements are promoted nationally regionally and locally. CARAT workers can now access information to include as part of pre-release planning. Preventing Homelessness - Building on existing practice and informed by examples delivered through the Street Crime Initiative and National Rent Deposit Forum, the DIP worked with the Department for Communities and Local Government, NTA, NOMS and other Home Office partners to identify key components for a comprehensive rent

		deposit model which would support drug misusing offenders particularly those leaving prison and residential settings in selected DAT areas. Practice and emerging findings from this work has been proactively shared across England and Wales to assist areas in delivering their plans to prevent homelessness.
184	**We recommend that the Prison Service and the Department of Health should give further consideration to whether needle exchanges could be effective in reducing the spread of communicable diseases in prisons.**	The position remains as before – disinfecting tablets are currently being piloted in a number of prisons with plans full introduction during 2007 – but there are no plans to introduce needle-exchange schemes in prisons in England and Wales.
197	**We urge the Government to ensure that it continues to make inroads in diverting mentally ill offenders from the courts and prisons, and efficiently transferring the seriously mentally ill from prison to hospital.**	Accurate quantitative and qualitative information about Court Diversion and Criminal Justice Liaison (CD & CSL) schemes is an essential first step to improving services. The Centre for Public Innovation (CPI) report commissioned by HOPS in 2006 to review current practice summarises features of the most effective schemes. Together with information from the NACRO national database, and from Revolving Doors' 2006 report this will inform guidance for a publication in 2007. The aim is to build on preliminary work to support delivery of a good quality of CD & CSL schemes by the regional centres of the Care Services Improvement Partnership. This includes work to develop a draft Service Level Agreement (SLA) between Courts and the NHS to improve the quality and timeliness of psychiatric reports. It will also take account of NACRO's findings with King's College and the Institute for Criminal Policy Research due in 2007 (on the effectiveness of CD & CSL to meet the needs of women and offenders with a mental health problem from black and minority ethnic (BME) communities) In November 2005, the Government issued a protocol which set out what must be done when a prisoner, awaiting transfer under the Mental Health Act 1983, has been waiting for a hospital place for more than three months following acceptance by the NHS. In 2005, 24% more prisoners, with mental illness too severe for prison, were transferred to hospital than in 2002 – up to 896 from 722. There has been a significant decrease in the number of people waiting over 12 weeks for a transfer – in the quarter ending June 2006, 44 prisoners were waiting, down from 62 in the same quarter in 2005.
201	**We recommend that the Prison Service examines ways of restricting the transfer of disruptive prisoners, many of whom are also deeply vulnerable.**	A Prison Service Order (PSO) has been issued that sets out the principles for maintaining order in prisons. It makes clear that prisoners displaying difficult or disruptive behaviour must be individually case-managed and that the aim must be to help individuals to achieve an acceptable level of behaviour within the establishment. Some prisoners with a poor behaviour record do benefit from a fresh start in a new location. Where a transfer is appropriate the PSO states that such transfers are to be permanent with no return conditions. Area population protocols, which support these processes and ensure there is a degree of consistency and oversight above establishment level, are

		now mandatory. The PSO also makes clear that individual prisoner management strategies and reasons for transfer must be formally recorded. Whilst the PSO requires these processes to be in place it has been found that it covers too many areas. The elements mentioned above will stay in place but will be covered differently in new instructions that will follow later this year.
202	**Prisoners known to be problematic and aggressive towards other prisoners should not be placed on vulnerable prisoner units.**	Numbers in Close Supervision Centres (CSC) remain low, presently under 30 (down from 33 at the time of the initial response). HMCIP completed a thematic inspection of CSCs and high security segregation entitled 'Extreme Custody', which reported in June 2006 (published in November 2006). The report endorses the developments in CSCs since the previous thematic inspection in 2000, stating that 'there is no doubt that the system has evolved positively', but also highlights areas requiring further attention. The Government response to this is presently being prepared and will be produced by the end of February 2007.
206	**We welcome ongoing efforts to speed up arrangements for the transfer of mentally ill people from prisons to hospitals. Prison, despite improved psychiatric provision, is not an appropriate place for people with serious mental health problems and transferring these vulnerable people to NHS settings must be given high priority.**	See response to paragraph 116 and 197
210	**In the meantime, we are in no doubt that too many vulnerable people with mental health problems are wrongly being held in prisons. Funding decisions for NHS high and medium secure hospitals must invariably take into account the imperative to address this.**	The NHS now has regional Commissioning Plans in place to ensure strategic planning for secure services, taking into account the needs of the whole of the population, including the needs of offenders. These local Commissioning Plans will be under constant review and will be updated to take account of changing local circumstances. A modernisation plan is in place for each of the three high secure hospitals and each hospital has a dedicated group in place chaired by the relevant SHA to ensure that there is coherent planning across high and medium security.
211	**If the Dangerous and Severe Personality Disorder Initiative jointly run by the Department of Health and Home Office is shown to be successful, consideration should be given to**	It is too early for us to come to a view about the success or otherwise of the Dangerous and Severe Personality Disorder Programme (DSPD).

	extending this as an alternative to prison for offenders with severe personality disorders.	
220	**People requiring detention under the Mental Health Act should not be held in police cells. Police custody suites, however well resourced and staffed they may be, will not be suitable or safe for this purpose, and their use for this purpose may lead to breaches of Convention rights. In our view, there should be a statutory obligation on healthcare trusts to provide places of safety, accompanied by provision of sufficient resources for this by the Government.**	In October 2005 the Department of Health (DH) announced a £130 million capital investment in mental health services. In 2006/07and 2007/08 £100 million of this money has been targetted on developing health-based place of safety for assessment of people detained under the Mental Health Act by the police and in improving Psychiatric Intensive Care Units (PICUs). This was in recognition of the fact that many people picked up by the police who need a mental health assessment are taken to police stations as the 'dedicated place of safety', as required by the Mental Health Act. In part, this money will go towards developing more appropriate facilities to reduce the reliance on police stations. During 2006 individual mental health trusts prepared their proposals for the development of facilities in line with the above guidance. These were submitted to their respective Strategic Health Authorities for approval and subsequent submission to the Department of Health. A panel of experts at the Department considered the applications in line with the guidance and allocated the funding late in 2006. It is anticipated the new facilities will start to become available during 2007/08. In some cases, where s136 facilities are associated with the building of new PICUs, they will become available later. We recognise that there may be exceptional circumstances (extreme violence, public safety) in which a police cell may be used for this purpose, but, we accept that police cells do not provide the right environment for people requiring detention under the Mental Health Act. The Home Office is working with DH, ACPO (Association of Chief Police Officers) and the Directorate of Health and Offender Partnerships to examine the wider issue of commissioning of mental (and physical) healthcare for those that come into police custody and contact. This will look to baseline current activity in each force areas and working arrangements with local trusts.
221	**Transfers from police cells to hospital must operate more effectively. We recommend that a statutory duty be placed on healthcare trusts to take responsibility for people detained under section 136 of the Mental Health Act.**	The Government is making £130 million available to the NHS from April 2006 for the improvement of the mental health estate, in particular the development of hospital-based places of safety. £42m of this money has been allocated in 2006/7. Up to £58m will additionally be made available in 2007/8. This money will facilitate an increase in hospital-based place of safety facilities and will reduce the reliance in some areas on police stations. On 1 April 2004, the Home Office issued Circular 17/2004 giving guidance to inform local protocols between the police and health services on handling potentially violent individuals. The NHS Security Management Service agreed a Memorandum of Understanding with the Association of Chief Police Officers in 2006 which provides a framework for the exchange of information in order to achieve clear lines of communication at a local level between health and police bodies. The whole document can be found on:

		http://nww.cfs.nhs.uk/pub/doc/sms.agreements/mou.sms.acpo.pdf In January 2005 the offender mental health care pathway was published. This care pathway document lays down valuable best practice templates to guide providers and commissioners on mental health services for those involved in the criminal justice system. It is based on the best evidence currently available, sourced from both literature and innovative clinical practice. Foreword by John Boyington (Director Health and Offender Partnerships) and Professor Louis Appleby (National Clinical Director Mental Health). The offender mental health care pathway is intended to guide the practice of people who directly deliver services, and support decision making for those who commission them. The first section deals with best practice in police custody. In December 2006 Professor Louis Appleby (National Clinical Director Mental Health) agreed a joint one year project between the ACPO and the National Institute for Mental Health in England (NIMHE) which aims to produce national guidance on work between police forces and local mental health services.
242	**Failure to justify a departure from the Code of Practice as a necessary and proportionate response to the exceptional circumstances of a specific case is likely to lead to the responsible health authority being found in breach of the Human Rights Act. We recommend that the Department of Health should take further steps to ensure that health authorities are aware of their responsibilities under the Human Rights Act following the Munjaz case, and that health authorities should implement the necessary changes to seclusion policies and apply them in practice.**	On 13 October 2005, the House of Lords upheld the appeal by Mersey Care NHS Trust. In doing so, they said that the Code of Practice is guidance to which great weight must be given and from which hospitals should depart only where they have cogent reasons for so doing. That judgement was again drawn to the attention of NHS Chief Executives.
263	**As a minimum requirement to ensure Human Rights Act compliance, we recommend that police forces should ensure that no custody office should**	The Safer Detention Guidance (see paragraph 143 above) encapsulates all aspects of the custodial process. CENTREX are currently developing a national training programme for custody officers around the integrated competency framework and minimum standards of safer custody set out in the guidance. The guidance should be available in Summer 2007. In developing the training package, we are also looking at the appointment and placing

	start work without training for this specialised role. Reliable human rights protection and the safety of detainees requires a standardised training programme for custody offices, consistently applied across all police forces, and including regular follow-up training. This could be facilitated by a national accreditation scheme for custody officers. Training should cover first aid and control and restraint, identifying and responding to drug and alcohol intake, and identifying and responding to mental disorder, risk of suicide and self-harm. It should also include training on culture awareness, in fulfilment of police forces' obligations under the Race Relations (Amendment) Act, as well as under the Human Rights Act.	of police officers and police staff in the custody area and the scope for putting in place a designation or accreditation process.
266	**We recommend that both initial and ongoing training in suicide prevention, including first aid, resuscitation, and mental health awareness should be made mandatory for all prison staff, along with regularly updated training on the use of control and restraint and on cultural awareness.**	In total, one week of the POELT course is devoted to control and restraint training and all new officers must be assessed as competent prior to completing the course. Subsequently, officers are expected to receive control and restraint refresher training annually. This is a key performance target for establishments, and Area Managers agree a realistic target, taking account of operational circumstances, for the numbers of officers to be trained annually. The existing diversity module for POELT, which covers all aspects of cultural awareness, is currently being reviewed. As part of the review, consultation is taking place with external stakeholders including the National Body of Black Prisoner Support Groups and ex-offenders and the results will be used to inform the content of the revised training material.
287	**All institutions of detention should develop and implement procedures to inform family members of a death promptly and sensitively, to provide them with appropriate support, advise them on how the post-mortem investigation will proceed, and to**	The National Patient Safety Agency (NPSA) launched '*Being open when patients are harmed*'' information for the NHS on open disclosure on 15 September 2005, which includes advice on communication with relatives and family. It has also produced an information pack to be launched in March 2007 alongside the new guidance on the conduct of independent inquiries in mental health care. The NHS, ACPO and Health and Safety Executive (HSE) signed a Memorandum of Understanding entitled *'Investigating patient safety incidents involving unexpected death or serious untoward harm. A protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health*

	provide them, promptly, with information on the circumstances of the death and seek agreement with the family on procedures to be used for the return or disposal of the possessions and personal effects of the deceased. Staff members should be trained in effective liaison with families in these circumstances. Contact details of the next-of-kin of detainees should be kept as comprehensively as possible to ensure that they can be informed in as sensitive a way as possible. Wherever possible, staff should visit the family to inform them in person of the death.	*and Safety Executive'* in Feb 2006. This mentions that all deaths must be investigated using existing NHS procedures, including those developed by DH and the NPSA (page 4). Link to doc: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4129918&chk=P5hkFZ
295	**We welcome the Home Office commitment to implement the Luce Report, in particular the establishment of a Family Charter for the coroners' court. We hope that the commitment to family involvement will be made a reality through full provision of information and documentation.**	A draft Charter for bereaved families was published for consultation alongside the Draft Coroners' Bill on 12 June 2006. The draft Charter is not part of the Bill and it will therefore be subject to later consultation and discussion. But it contains clear standards about information provision, including the disclosure of documents, and also the opportunity for family involvement in coroners' investigations and their new rights of appeal against coroners' decisions.
300	**We welcome the introduction of narrative verdicts in inquest proceedings, as enabling a fuller explanation of the causes of deaths in custody. We emphasise the need for coroners in the exercise of their discretion to make full use of narrative verdicts in deaths in custody cases, in order to provide a full explanation of the case as required by Article 2.**	Narrative verdicts are providing a useful basis for learning lessons and preventing recurrences of custodial deaths. See later (response at 376) for developments on reporting lessons learned in the draft Coroners Bill. The House of Lords judgment in Amin in October 2003 set out the purpose of an Article 2 investigation: "The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light … that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others". Reducing prisoner self-inflicted deaths and managing self-harm is a key priority for Ministers, the National Offender Management Service (NOMS) and the Prison Service. Learning from all deaths in custody is an important strand of the NOMS/Prison Service suicide prevention strategy, from sources including Prisons and Probation Ombudsman (PPO) investigation reports and inquest verdicts and reports made by Coroners under Coroners Rule 43.

301	**We recommend that the resource implications of the House of Lords' ruling that fuller inquiry and a narrative verdict is required in some inquests where Article 2 is engaged, must be taken into consideration in the Government's response to the Luce report.**	The coroner reform programme was established in response to a report of the fundamental review of death certification and coroner services, published in 2003; and to recommendations made in the third report of the Shipman Inquiry. In May 2005, the Department for Constitutional Affairs (DCA) took over responsibility for coroners and the coroner reform programme. On 6 February 2006, further plans were announced in an oral ministerial statement and a briefing note was published. These were developed into a draft Coroners Bill which was published on 12 June 2006. The Bill will introduce national leadership and national standards - in particular the services which bereaved people can expect to receive, including access to a new appeal system. It will also make transparent the system for appointing coroners and increase their powers when conducting their investigations. Public consultation ran until late last year and a report of the outcome will be published shortly. The fact that the Coroners Bill is not part of the main programme for this session gives us additional time for consultation with stakeholders so that the legislation can be further improved. We will also explore, in consultation with those who deliver and fund the service and those who represent people with experience of it, whether there are other changes that can be made to improve the system in advance of and to complement legislation. The Government's aim is to have the best features of a national structure, headed by a Chief Coroner, with the best features of local service delivery. A partnership between the police, local authorities, their local coroners and the Chief Coroner should ensure that the service is embedded as an adequately funded local service, with national leadership and standards on key matters. As with the police force, the education system, and many other services which come within the remit of local authorities, we believe this structure will ensure responsiveness to local circumstances and help to build strong local partnerships with other services, while at the same time providing national leadership and national standards. Clause 10(2) of the draft Coroners' Bill requires for the scope of the investigation to be widened to include an investigation of the circumstances of the death where this wider investigation is necessary to ensure compliance with the European Convention on Human Rights, in particular Article 2 the "right to life". It is not intended to define the precise circumstances where a coroner should conduct an Article 2 investigation, but guidance will be issued before the Bill is implemented to ensure a broad consistency of approach. As now, resources for a reformed service will be provided by local authorities and the police. These will however be supplemented by additional funds provided by the DCA to cover the new elements resulting from the Bill. The DCA will provide for additional annual running costs and for significant one-off implementation costs. It is expected that these additional annual running costs of the service will be in the region of £6 million. The significant one-off implementation costs will be in the region of £15 million.
302	**For disclosure to the family to support real and effective participation in the inquiry, as required by Article 2, it must**	The DCA is now responsible for Coroners and agree that pre-inquest disclosure to families should be made as far in advance of the inquest as possible. DCA can investigate if there is concern that charges being made are inappropriate.

	be thorough, prompt and affordable. We recommend that the fullest possible disclosure should be made to the family well in advance of the inquest. We recommend the Court Service review its arrangements for levying disclosure charges with a view to providing a free or at least an affordable alternative for bereaved families.	The transfer of responsibility for investigating deaths in prison custody to the Prisons and Probation Ombudsman (PPO) that took effect in April 2004 has introduced much greater openness and transparency into the procedure, an approach very much supported by the Prison Service. The Ombudsman's terms of reference expressly require him to provide "explanations and insight" for the bereaved family, and as a matter of practice the Ombudsman employs a team of family liaison officers to ensure that the family is engaged with the investigation. A meeting or meetings are also set up between the family and the Ombudsman's investigator to ensure that all the family's concerns are reflected in the investigation methodology. Moreover, the Ombudsman's presumption is that disclosure of information during the course of the investigation and at its completion should occur as fully and as early as his powers and the law allows. Together, these approaches have done much to ensure that the family of a person who has died can participate fully both in the Ombudsman's investigation itself and in the Coroner's inquest into their death.
303	**We recommend that Coroners should have statutory power to compel the production of documents.**	Clause 50 and 51 of the draft Coroners' Bill include powers for the coroner to seize , inspect and take copies of documents if he or she has reason to believe that doing so might assist their investigation and they have reason to believe that seizure is necessary to prevent the items being hidden, lost, damaged, changed or destroyed. The powers of entry, search and seizure – which are intended to equally apply to coroner's officers - will only be exercised with the permission of the Chief Coroner, if the coroner reasonably suspects that there might be something on the premises directly relevant to the investigation into a death. The coroner must have been unable to contact the person from whom they could get permission to enter and search the premises, have already had permission refused or have reason to believe that permission would be refused. It is likely that we will add a further provision to cover the circumstance where a coroner could seek permission to exercise this power if he or she has reasonable cause to suspect that evidence would be removed, altered or destroyed if they forewarned the owner of their intentions. It is not the Government's intention to cut across established statutory arrangements for the conduct of inquiries into particular types of death, for example in relation to Local Safeguarding Children Boards. There will however, be further consideration of the issues raised about disclosure (both to coroners and by coroners) – and whether there needs to be more on the face of the Bill – and further discussions with the relevant parties about access to intercept material.
304	**Where the inquest is the means by which the Article 2 duty of investigation is satisfied following a death in custody, then significant delays may breach Article 2, which requires that an investigation into a**	Every death custody is a tragedy affecting families and staff deeply. Families are clearly further distressed by delays in the inquest proceedings and staff too can be badly affected by long delays before they give evidence at an inquest. The Government previously indicated its concern regarding the delays affecting some inquests, which occur for a number of reasons. It may take time to gather together the evidence the Coroner requires and for investigations

	death be prompt. We are concerned that current delays may in some instances lead to breaches of Article 2. We emphasise the need for the reviews of the coronial system, both in England and Wales and in particular in Northern Ireland, to address delays in the system.	to be completed; and there can be difficulties in finding court accommodation, especially if the courtroom needs to be suitable for prisoner witnesses or to allow spaces for a number of legal or other representatives. There are sometimes issues for families in arranging and funding legal support, and delays in summoning a jury. Coroners investigating more contentious or complex cases may also decide to wait for the outcome of the PPO's separate investigation, which itself can be delayed waiting for toxicology/histology reports and /or Clinical Reviews. Work continues to reduce delays and backlogs. The provisions in the draft Bill will tackle some of the problems in the current system in England and Wales, like limited jurisdiction flexibility. The new leadership structure and flexibility will allow resources to be directed where needed, including the reallocation of cases to a different coroner area if the need arises. Negotiations are underway to ensure that coroners can make use of the HMCS estate to hold inquests wherever possible so that improved accommodation is available. The reforms proposed in the draft Coroners' Bill will remove the existing restrictions on where coroners are able to hold inquests and to move bodies for the purposes of post mortems in order to provide a flexible response based on the needs of each case. The Northern Ireland Court Service has introduced a number of important reforms to the coroners' service and officially launched the new Coroners Service for Northern Ireland in June 2006. These include the creation of a single coroners jurisdiction headed by a High Court Judge and supported by three full-time coroners, the appointment of Coroners Liaison Officers and the development of a Coroners Service Charter for bereaved families. These changes will alleviate the current backlog of cases and provide the public with a more professional and effective coroner service.
306	**We emphasise the need for the government response to the Luce report to address the adequate resourcing of coroners' offices in order to ensure Article 2 compliance**	A key part of the Chief Coroner's role will be to establish service level and resource benchmarks and models against which local authorities can measure the service at a local level. The Government strongly believes that these benchmarks and models will help identify resource gaps and guide local authorities in the responsibility to adequately fund the service. The Government is providing additional funds under the Bill proposals. This amounts to £6 million per annum and £15 million in set up costs to aid the transition to the reformed service. The additional £6 million will include funds for the Chief Coroner's office, an appeals system, inspection, additional medical input at both central and local level, and a number of other new components all of which will help build a stronger service, better equipped to provide the necessary resources for increasingly lengthy and complex inquests.
309	**Participation of the next-of-kin in the investigation into a death in custody is an essential ingredient of Article 2 compliance. We recommend that, in all cases of deaths in custody, funding of**	Since November 2001 the Lord Chancellor has authorised the Community Legal Service (CLS) to fund applications for advocacy on behalf of the immediate family of the deceased at an inquest concerning a death occurring in police or prison custody, bringing this type of case back into mainstream funding. In October 2006 the Lord Chancellor extended this to cover inquests into deaths which occur while detained under the Mental Health Act 1983.

	legal assistance should be provided to the next-of-kin.	The Government received representations about funding for advocacy at inquests during the consultation on the draft Coroners Bill. Some families feel they face difficulties at inquests when other interested persons are legally represented and they are not. Further consideration is being given as to how this might be tackled without adding to the legal aid budget. This is one of the issues which is likely to be fully debated when the Bill is brought before Parliament, as soon as time allows. Where the family of the deceased do not speak English, Article 2 requires that an interpreter will need to be provided to enable them to be able to fully engage in the process. This will need to be for the entire length of the proceedings, not merely for any period during which the family may be giving evidence. In general, it will be for the coroner to fund this expense. Legally-aided families may be entitled to obtain expenses from the Legal Services Commission in order to communicate with their lawyers, but in general costs relating to inquests must be met by the coroner concerned.
327	**We recommend that the Home Office should work with the IPCC to identify any gaps in its jurisdiction, in particular where such gaps may cause problems for Article 2 compliance, and that amendment of the IPCC mandate should be considered to close these gaps.**	We have now legislated for cases involving death or serious injury following contact with the police to be a mandatory referral by chief officers to the Independent Police Complaints Commission (IPCC). This new statutory provision is contained in Schedule 12 of the Serious Organised Crime and Police Act 2005.
328	**The IPCC and the Prisons and Probation Ombudsman should establish procedures for co-operation and information sharing so as to develop best practice in their work on deaths in custody.**	The Government welcomes the close cooperation that is developing between the PPO and the IPCC. The principal means for information sharing between these two organisations and others is the Forum for Preventing Deaths in Custody (see response to recommendation 376) in which the PPO and IPCC have been the primary movers, with financial support for the Forum's secretariat from the Home Office.
332	**As a matter of priority parliamentary time should be set aside to bring in legislation giving a statutory basis to the Prisons and Probation Ombudsman, and providing him with investigatory powers equivalent to those of the Independent Police Complaints Commission. Until such a statutory**	A measure to put the PPO on a statutory footing was included in the Management of Offenders and Sentencing Bill introduced in the House of Lords on 13 January 2005. However, the Bill did not progress due to the calling of the general election. It remains our intention to seek to provide a clear statutory basis for the PPO at the next appropriate opportunity. In the meantime the PPO will continue to provide, on a non-statutory basis, rigorous and independent investigation of deaths of prisoners and residents of approved premises and immigration removal centres. The PPO's remit has also been extended to include deaths of young persons in secure training centres and a

	basis is provided, investigations by the Ombudsman are unlikely to meet the obligation to investigation under Article 2 ECHR.	discretionary power to investigate deaths occurring following release from immigration detention. It remains our view that, whether or not the PPO is on a statutory basis, coroners' inquests provide the primary means by which Article 2 obligations are met.
334	**We recommend that investigations into deaths in custody should address whether non-custodial options had been available and whether the sentencing court has ascertained whether the person they sentenced was at risk of suicide.**	Within the proper limits of his terms of reference, and having due regard for the independence of the judiciary, the PPO has commented in a number of his reports on matters relating to the use of custody. The Government believes that the Ombudsman's approach to this matter has been helpful.
339 340	**We are not assured that Article 2 standards are met in relation to all deaths of detained patients, in particular where the inquest is not sufficiently thorough to itself satisfy Article 2; and** **In our view there is a case for a permanent investigatory body, with some level of overview of all cases, rather than ad hoc investigations in a few cases, in order to support Article 2 compliance. Since the case for such a body has been accepted in relation to police detention (with the establishment of the IPCC) and prison and immigration detention (with powers of inquiry, albeit for the moment on a non-statutory basis, allocated to the Prisons Ombudsman) we can see no reason why deaths amongst this particularly vulnerable group of detained people should not be subject to a similar safeguard.**	Every death in high security is subject to an internal enquiry by the Trust and following this if further investigation is required, the relevant SHA will take responsibility for this. Consideration is being given to ensuring that every death in high security is subject to objective external review. This is being discussed via the Cross Government Forum for Preventing Deaths in Custody. All other deaths of detained patients are reviewed in accordance with the healthcare providers' clinical governance procedures.

357	**The difficulties in obtaining evidence to support prosecutions following deaths in custody need to be addressed by strong evidence gathering-powers and close co-operation between the CPS and the police or other investigating authorities. We recommend that CPS lawyers should work closely with investigators from the office of the Prisons and Probation Ombudsman, and from any independent or internal inquiry into death in Mental Health Act detention, to advise on evidential and procedural matters.**	See paragraph 287
376	**We recommend that the Home Office and the Department of Health, as the main responsible departments, should establish a cross-departmental expert task-force on deaths in custody. This should be an active, interventionist body, not a talking-shop, with its membership drawn from people with practical working experience of the problems associated with deaths in custody. The task-force should also have at its disposal human rights expertise. Broadly, the functions and powers of such a body should be— To share information on good practice in preventing deaths in custody between each form of detention; To develop guidelines on matters relating to prevention of deaths in custody; To review systems for the investigation of deaths in custody and to seek to establish consistency in such**	Provisions in the draft Coroners Bill will assist the cross government task force to review coroners' recommendations to organisations or public authorities. Clause 12(2) of the draft Bill gives the coroner power to report his findings to authorities or organisations with a view to preventing similar deaths in the future. On 30 January, the Government announced further changes to the draft Coroners Bill aimed at strengthening the power of Coroners' recommendations and improving the role of inquests in death prevention. The new proposals will apply to any organisation where a person has died and the inquest raises public health and safety issues, including prisons, hospitals and nursing homes. Under the changes, organisations will be required to respond to recommendations made by coroners and to say what preventative actions they will take. These responses will be monitored by the Chief Coroner and reported annually to Parliament. The Government has already accepted the need to give coroners power to make a report on lessons learned from a particular death or a particular incident more prominent by removing it from the current Coroners Rules to the face of the Bill. Additionally, a statutory obligation will be put on authorities to formally respond to reports, and the Chief Coroner will include - in his or her annual report to Parliament - a summary of the reports made and the responses to them. More details on the associated detailed procedures will be dealt with in secondary legislation. From 1 April 2004 all deaths in police custody are investigated by the IPCC and all deaths in prisons, those of residents of approved premises, deaths in immigration detention centres and secure training centres, are investigated by the PPO. It is the intention to give the PPO role a statutory footing at the next appropriate opportunity. The new "multi-agency group" is known as the Forum for Preventing Deaths in Custody. The membership of the group has now been agreed, as have the terms of reference. The membership of the group is drawn from high

	investigations; **To develop consistent good practice standards on training in issues relating to deaths in custody;** **To review recommendations from coroners, public inquiries and research studies, to consider how they can be taken forward, and to monitor progress in their implementation;** **To collect and publish information on deaths in custody;** **To commission research and to make recommendations to Government. Where such recommendations involve expenditure we would expect the Government to meet the needs where funding was clearly necessary to ensure observance of ECHR rights.**	level representatives of fifteen organisations, all with in depth knowledge of issues relating to deaths in custody. The following organisations are represented on the Forum: ACPO; Prison Service; IND; DH; Coroners Society of England and Wales; INQUEST; Mental Health Act Commission; IPCC; PPO; HMCIP; HM Inspectorate of Constabulary; Home Office; Private sector prisons; National Probation Directorate (NPD) and the Youth Justice Board (YJB). The groups' terms of reference are: "The forum exists to learn lessons and effect change to prevent deaths in custody." The Government has provided funding for secretariat support for the Forum and this full time resource has enabled the Forum to develop a website where all papers and minutes are published. The groups' work is clearly of public interest and there is strong support for all the Forum's learning to be shared openly and transparently. Although the Forum is in the early stages of its development, the group has already addressed some key issues relating to custody deaths. Member organisations have explained how their institutions share crucial information about those in their care and how they publicise and follow up on the learning that results from deaths. Member organisations also recently discussed how they deal with detainees, prisoners and patients to avoid conflict and reduce violence. The Forum has not been afraid to challenge weaknesses in policies or practice where they have been evident. In keeping with the Joint Committee's position that recommendations from coroners should be reviewed and consideration given to taking them forward, the Forum has expressed concern about the ability and willingness to learn from inquests into custody deaths. The group is actively seeking changes to the rules governing coroners' powers in this respect. As a result of the Forum's discussions, the Coroners Society for England and Wales, a member of the Forum, have begun work, in advance of legislation, to improve systems for the collation and dissemination of the Rule 43 reports that may be generated following an inquest. As the Forum brings together senior representatives from organisations that provide custody and those organisations who inspect, investigate and oversee them, the groups' meetings have inevitably highlighted issues where a multi-agency approach is beneficial. One example of this is the formation of a working group looking specifically at the importance of physical custody environments. This sharing of expertise relating to the impact of environment on the welfare of detainees is an invaluable part of learning from instances when deaths have occurred. It is also crucial to sharing good practice between the agencies involved. The Forum has brought together the knowledge and expertise of different organisations and the groups' meetings have raised some important 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 pertinent information about detainees and can often be the only way of transferring information about a person's risk of self-harm or vulnerability from one agency to another. The Forum's discussions have resulted in the development of a more joined-up approach between the Prison Service and police. This crucial tool needs to be developed to reflect the needs of both agencies so that it can offer the best possible protection for detainees. The Forum has been instrumental in developing consultation between the police and Prison Service regarding how

		to best work towards the Police National Computer (PNC) being available for prison staff. Access to the PNC by prison staff might be a key tool in helping them make better risk assessments. Secondly by allowing prison staff to enter data, the police service would also be more aware of safety issues when the person concerned is next dealt with by police officers. As an independent and well respected group, the Forum has been able to progress this crucial area of work. The Forum for Preventing Deaths in Custody successfully brings together the interests and expertise of all groups that care for individuals in the custody of the state. Work is underway to increase collaborative work between the Forum and other committees and groups working in this area (such as the Ministerial Roundtable on Suicide) and the Government recognises the merit of an increasingly integrated approaches.

JCHR suggestions:

114	It is an unavoidable conclusion that until overcrowding is significantly reduced, prisons, despite their best efforts, will find it extremely difficult to make any real inroads in reducing deaths in custody. This is a matter of the most serious concern and one which requires the utmost effort on the part of everyone involved in the criminal justice system to address.	**Prison building programme** We are dealing with pressures on the prison estate by building more capacity. Since 1997 we have increased prison capacity by around 19,700 places. In the last two years there has been an increase of around 2,900 places which includes building additional places at existing prisons and the opening of a new prison. 8,000 places were announced in the CJS review in July 2006, to be delivered by 2012 through a mixture of expansions at existing prisons and building a number of new prisons. The National Offender Management Service (NOMS) is closely monitoring the prison population, which fluctuates on a daily basis and continues to investigate options for providing further increases in capacity.
125	We consider it to be essential that sentencers are well informed about the range of non-custodial sentences that they have at their disposal, because current sentencing trends are placing great strain on the ability of the Prison Service to meet its Article 2 and other human rights obligations.	Liaison meetings between sentencers and probation are now in place. They take place at Crown Court, magistrates' courts bench level and in each of the 42 criminal justice areas. We are also discussing with the Senior Presiding Judge how best to organise liaison between sentencers and the Regional Offender Managers, who now commission prison and probation services. These meetings provide an opportunity for sentencers to be informed, for example, about the availability of interventions in their area which could form part of a community order and to point out any gaps in provision.
136	We consider it completely unacceptable, in the context of preventing deaths in custody, that new prisoners should arrive at prison reception too late to allow full assessment at a reasonable hour. It is essential that all new arrivals to a prison are properly assessed by fully trained staff for mental and physical health problems and for any risk of self-harm or suicide. Prisoners should arrive at prison accompanied by essential information on their state of physical and mental health and on their outside circumstances, and should arrive in good	It is accepted that all reasonable steps should be taken to ensure prisoners arrive at prison by agreed reception closure times so that proper reception assessments can be completed. Current data indicates that 95% of prisoners are delivered to prisons within the agreed reception hours. Further improvements are planned through: • A review of reception times to enable prisons to discharge prisoners to court earlier so that they can be dealt with by the courts earlier in the day • The introduction of a partnership agreement with HM Court Services intended to prioritise custody cases so that they can be completed earlier in the day • A review of the incentives applied to the escort contractors to encourage the early return of prisoners from court.

	time for a full health check to be made at a reasonable hour on the first evening in custody.	It is likely that some prisoners will continue to arrive at prison from court later than is desirable. This can be due to a number of factors including the time that courts complete their business and in particular the redirection of prisoners to other establishments outside the normal catchment area due to the high prison population. Women's prisons and establishments for juvenile prisoners are particularly affected as they have very large geographical catchment areas due to the limited number of establishments for these categories of prisoners.
146	Information on the risk of suicide or self-harm should be used to inform decisions on whether an individual is detained in immigration detention, and how he or she is cared for in detention. We are concerned that, despite guidelines, this may not be happening effectively in practice.	The Health Care standard reflects that there are exceptional circumstances which can override an individual's wish for medical confidentiality and so the concern of the JCHR has been addressed. The standard was issued on May 2003 and particular attention was brought to the aspect of medical confidentiality in a covering letter.
234	Human rights standards and the principle of proportionality require that any form of physical restraint should be a last resort. Staff should therefore be equipped with a range of skills to deal with and de-escalate potentially violent situations, as well as a range of restraint techniques that will allow for use of the minimum level of force possible. Restraint in detention should be a rare event, and should never be used as a matter of routine.	The National Institute for Clinical Excellence (NICE) published new guidelines on the short-term management of violent behaviour in inpatient psychiatric settings in February 2005 - *the Short Term Management of Violence (Disturbed Behaviour) in Inpatient Psychiatric Settings* and is available on the NICE website at http://www.nice.org.uk/pdf/cg025niceguideline.pdf.) In October 2005, the NHS SMS launched the first ever national training syllabus to tackle violence against staff in mental health and learning disability services. Promoting Safer and Therapeutic Services was developed by an NHS SMS-led expert group including the National Institute of Mental Health in England (NIMHE). The syllabus is designed to provide training in recognising, de-escalating and managing potentially violent incidents, whilst improving staff and service-user safety. It constitutes the foundation training that has to be provided to staff ahead of any training in physical intervention techniques. The accompanying implementation guidance indicates the actions required by health bodies to ensure compliance with Secretary of State Directions (2003/2004). The programme identifies ten key learning aims and provides trainers with the resources necessary to ensure the aims are achieved. The resources include a tutors' manual, course slides and a participants' work book. The syllabus does not set out to alter current good practice but aims to establish a minimum standard. In order to ensure that training providers have the opportunity to meet the standards set, familiarisation seminars took place nationally. The seminars were designed to enable training providers to understand the work that is taking place nationally to tackle violence. Attendance at a familiarisation seminar provided trainers with an overview of the strategy adopted by the NHS SMS in relation to tackling violence in mental health and learning disability services in order to bring about a significant and sustainable reduction in aggression and

		violence, taking into account other security related matters in these services. The NICE guidelines made specific reference to the syllabus as the standard of training in non-physical intervention that staff in mental health and learning disability services must achieve. NIMHE will publish its definitive guidance early in 2007, reflecting feedback on the interim version and the NICE guidance and incorporating additional guidance on the sexual safety of patients on in-patient units.
245	We welcome the enhanced standards and transparency that these guidelines will bring. We remain concerned at the under-enforcement of guidance in this highly human rights-sensitive area. We were not confident that Convention compliance can be effectively and comprehensively ensured without some statutory obligations in this area. This should include statutory obligations on all health authorities to keep comprehensive records of all violent incidents.	Reporting and recording is also addressed in the NICE guidance, (also referred to in paragraph 234) which states that: "Any incident requiring rapid tranquillisation, physical intervention or seclusion should be recorded contemporaneously, using a local template." "Incidents of physical assault should be reported to the NHS Security Management Service (SMS) as per Secretary of State directives November 2003 (www.cfsms.nhs.uk/files/VAS%20directions%20250204.pdf)." "A post-incident review should take place as soon after the incident as possible, but in any event within 72 hours of the incident ending." The NIMHE guidance, which will be published early in 2007 will reinforce this guidance. The systematic reviews of NRLS data (referred to in paragraph 86) will provide general themes and trend of violent incidents at a national level.
248	In our view use of the prone position, and in particular prolonged used, needs to be very closely justified against the circumstances of the case, and this should be reflected in guidance. There is a case for guidance prescribing time-limits for prone restraint, departure from which would have to be justified by individual circumstances. Equally importantly, those restraining a detainee should be capable of minimising the risks to him or her, through techniques to ensure, amongst other things, that airways are not blocked. They should be appropriately trained to do so.	The NICE guidance was published in February 2005 and is available on the NICE website at http://www.nice.org.uk/pdf/cg025niceguideline.pdf

252	In the most exceptional circumstances where the use of pain is considered necessary to avoid a threat to the life of or threat of serious injury to the person being restrained, or others, it would need to be very carefully justified, and be used to the minimum degree necessary. Training should emphasise these points, and should draw attention to the human rights aspects of this technique.	The decision and action taken to use force must be justified as being no more force than is necessary and is proportionate and reasonable to the risk associated with that particular set of circumstances. This position will be further reinforced in the forthcoming NIMHE definitive standards guidelines scheduled for publication early in 2007.
281	In our view, adequate staffing is a necessary precondition to safety and Article 2 protection.	Since 2004 Broadmoor Hospital has continued to implement its agreed modernisation programme. The programme encompasses a wide range of service changes including clinical and non-clinical service areas and has required considerable reallocation of resources within the hospital to ensure a focus on active therapeutic treatment programmes and improved ratios of clinical staff working with patients. The key elements of change over the past 2 years have been the following: • All wards within the hospital have reduced in size and are now a maximum of 20 beds, improving the use of the space we have available and improving the safety on wards • The mix of wards has changed to better reflect the needs of the patient population we service with an enhanced number of beds available for those patients who are more acutely ill. • We have reduced the size of clinical team caseloads so each clinical team now manages a maximum of 20 patients which has reduced the ratio of patients to key medical, psychology, social work and occupational therapy staff. • Ward staffing numbers have been enhanced with no reduction in basic establishments when ward size has reduced and with programmed ongoing investment to be completed by March 2008 to further increase nursing establishments on all wards. To date establishments have increased in the admissions wards, Intensive Care and the larger Assertive Rehab wards, with the remaining Assertive Rehab wards and High Dependency ward establishments being increased throughout 2007/08. These changes have meant that staffing ratios have improved, case loads have reduced and therefore patients have better access to a wide range of clinical staff. The shortfall of unified staff across the Public Sector Prison Service has been consistently below 2% since June 2004, which the Director General considers to be an acceptable operating margin. The shortfall at 30 September 2006 was just 0.7%.

		Vacancy rates of operational staff are monitored closely, with monthly reports provided to the Prison Service Management Board and Senior Operational Managers. This enables action to be taken quickly to alleviate any particular local shortfalls that may arise. In contracted prisons, staffing levels within individual establishments are determined by the contractor from within an overall budget allocated to them by the Authority for the operation of the establishment. In setting staffing levels contractors pay due heed to the safe and orderly operation and control of the prison and the safety and security of staff, prisoners and everyone who visits the prison. A Home Office Controller is embedded in all contracted establishments and is line managed by the Regional Offender Manager (ROM) for the area where the prison is located. Part of the Controller's duties is to monitor staffing levels to ensure the safe and proper running of the prison. Any concerns they may have would be raised with the contractor and also brought to the attention of the ROM.
333	We welcome the decision to appoint a Prisoner Ombudsman for Northern Ireland, but we note that no express provision has been made for the Ombudsman to investigate deaths in prison custody. We recommend that the Prison Ombudsman for Northern Ireland should have statutory powers to conduct independent investigations into deaths in prison custody in Northern Ireland, in line with the powers of the IPCC and with the powers exercised on a non-statutory basis by the Prisons Ombudsman of England and Wales.	With effect from 1 September 2006 the Prisoner Ombudsman in Northern Ireland has responsibility under a Memorandum of Understanding, agreed with the Northern Ireland Prison Service, to investigate any death in custody or death following discharge for a period of up to 14 days after release. Such investigations are outlined in the Terms of Reference, broadly similar to that in place for the Ombudsman for England & Wales. Additionally, deaths in custody continue to be investigated as previously by the Northern Ireland Police Service (NIPS) on behalf of the Coroner. NIPS no longer carry out a detailed examination as outlined in the previous response.

Glossary:

ACT Assessment, Care and Teamwork

ACCT Assessment, Care in Custody and Teamwork

ACDT	Assessment, Care in Detention and Teamwork
ACPO	Association of Chief Police Officers
BILD	British Institute of Learning Disabilities
CARATs	Counselling, Assessment, Referral, Advice & Through-care services
CBT	Cognitive Behavioural Therapy
CD & CSL	Court Diversion and Criminal Justice Liaison schemes
CJIT	Criminal Justice Integrated Teams
CJS	Criminal Justice System
DAT	Drug Action Teams
DIP	Drug Interventions Programme
DTO	Detention and Training Order
ECHR	European Convention on Human Rights
FNP	Foreign National Prisoners
HCC	Healthcare Commission
HMCIP	HM Chief Inspector of Prisons
HSE	Health and Safety Executive
HMCS	HM Court Service

IDTS	Integrated Drug Treatment System
IMB	Independent Monitoring Board
IND	Immigration and Nationality Directorate
IPCC	Independent Police Complaints Commission
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NIMHE	National Institute for Mental Health in England
NOMS	National Offender Management Service
NPS	National Probation Service
NPSA	National Patient Safety Agency
NPD	National Probation Directorate
NRLS	National Reporting and Learning System
NTA	National Treatment Agency for Substance Misuse
OASys	Offender Assessment System
P-ASRO	Prisons – Addressing Substance-Related Offending
PCTs	Primary Care Trusts
PICUs	Psychiatric Intensive Care Units

PER	Prisoner Escort Record
PNC	Police National Computer
PPO	Prisons and Probations Ombudsman
SDP	Short Duration Programme
SHA	Strategic Health Authority
SMS	Security Management Service (NHS)
STC	Secure Training Centre

Reports from the Joint Committee on Human Rights in this Parliament

The following reports have been produced

Session 2006–07

First Report	The Council of Europe Convention on the Prevention of Terrorism	HL Paper 26/HC 247
Second Report	Legislative Scrutiny: First Progress Report	HL Paper 34/HC 263
Third Report	Legislative Scrutiny: Second Progress Report	HL Paper 39/HC 287
Fourth Report	Legislative Scrutiny: Mental Health Bill	HL Paper 40/HC 288
Fifth Report	Legislative Scrutiny: Third Progress Report	HL Paper 46/HC 303
Sixth Report	Legislative Scrutiny: Sexual Orientation Regulations	HL Paper 58/HC 350
Seventh Report	Deaths in Custody: Further Developments	HL Paper 59/HC 364

Session 2005–06

First Report	Legislative Scrutiny: First Progress Report	HL Paper 48/HC 560
Second Report	Deaths in Custody: Further Government Response to the Third Report from the Committee, Session 2004–05	HL Paper 60/HC 651
Third Report	Counter-Terrorism Policy and Human Rights: Terrorism Bill and related matters Volume I Report and Formal Minutes	HL Paper 75-I/HC 561-I
Third Report	Counter-Terrorism Policy and Human Rights: Terrorism Bill and related matters Volume II Oral and Written Evidence	HL Paper 75-II/ HC 561-II
Fourth Report	Legislative Scrutiny: Equality Bill	HL Paper 89/HC 766
Fifth Report	Legislative Scrutiny: Second Progress Report	HL Paper 90/HC 767
Sixth Report	Legislative Scrutiny: Third Progress Report	HL Paper 96/HC 787
Seventh Report	Legislative Scrutiny: Fourth Progress Report	HL Paper 98/HC 829
Eighth Report	Government Responses to Reports from the	HL Paper 104/HC 850

	Committee in the last Parliament	
Ninth Report	Schools White Paper	HL Paper 113/HC 887
Tenth Report	Government Response to the Committee's Third Report of this Session: Counter-Terrorism Policy and Human Rights: Terrorism Bill and related matters	HL Paper 114/HC 888
Eleventh Report	Legislative Scrutiny: Fifth Progress Report	HL Paper 115/HC 899
Twelfth Report	Counter-Terrorism Policy and Human Rights: Draft Prevention of Terrorism Act 2005 (Continuance in force of sections 1 to 9) Order 2006	HL Paper 122/HC 915
Thirteenth Report	Implementation of Strasbourg Judgments: First Progress Report	HL Paper 133/HC 954
Fourteenth Report	Legislative Scrutiny: Sixth Progress Report	HL Paper 134/HC 955
Fifteenth Report	Legislative Scrutiny: Seventh Progress Report	HL Paper 144/HC 989
Sixteenth Report	Proposal for a Draft Marriage Act 1949 (Remedial) Order 2006	HL Paper 154/HC 1022
Seventeenth Report	Legislative Scrutiny: Eighth Progress Report	HL Paper 164/HC 1062
Eighteenth Report	Legislative Scrutiny: Ninth Progress Report	HL Paper 177/ HC 1098
Nineteenth Report	The UN Convention Against Torture (UNCAT) Volume I Report and Formal Minutes	HL Paper 185-I/ HC 701-I
Twentieth Report	Legislative Scrutiny: Tenth Progress Report	HL Paper 186/HC 1138
Twenty-first Report	Legislative Scrutiny: Eleventh Progress Report	HL Paper 201/HC 1216
Twenty-second Report	Legislative Scrutiny: Twelfth Progress Report	HL Paper 233/HC 1547
Twenty-third Report	The Committee's Future Working Practices	HL Paper 239/HC1575
Twenty-fourth Report	Counter-Terrorism Policy and Human Rights: Prosecution and Pre-Charge Detention	HL Paper 240/HC 1576
Twenty-fifth Report	Legislative Scrutiny: Thirteenth Progress Report	HL Paper 241/HC 1577
Twenty-sixth Report	Human trafficking	HL Paper 245-I/HC 1127-I

Twenty-seventh Report	Legislative Scrutiny: Corporate Manslaughter and Corporate Homicide Bill	HL Paper 246/HC 1625
Twenty-eighth Report	Legislative Scrutiny: Fourteenth Progress Report	HL Paper 247/HC 1626
Twenty-ninth Report	Draft Marriage Act 1949 (Remedial) Order 2006	HL Paper 248/HC 1627
Thirtieth Report	Government Response to the Committee's Nineteenth Report of this Session: The UN Convention Against Torture (UNCAT)	HL Paper 276/HC 1714
Thirty-first Report	Legislative Scrutiny: Final Progress Report	HL Paper 277/HC 1715
Thirty-second Report	The Human Rights Act: the DCA and Home Office Reviews	HL Paper 278/HC 1716