INVESTIGATIONS OF DEATHS IN CUSTODY

Thank you for your letter dated 20 December 2010 concerning the Forum for Preventing Deaths in Custody research into the investigation of deaths in custody, and the State's compliance with the investigative obligations associated with the right to life (Article 2 ECHR). You have asked for confirmation of the Government's position on the recommendations made by the Forum.

As you are aware, Article 2 ECHR, in certain circumstances, imposes upon the state a positive obligation to initiate an effective investigation into how individuals have come to lose their lives or have come near to doing so. The courts have laid down general requirements for an investigation under Article 2. It must be initiated by the State of its own motion, it must be independent, effective, sufficiently open to public scrutiny to secure accountability, prompt and reasonably expeditious, and the next-of-kin (or the individual himself in a "near-suicide" case) must be involved "to the extent necessary to safeguard their legitimate interests".

The precise meaning and scope of each of these requirements however, is flexible and will vary from case to case. The decision of the House of Lords in R (JL) v Secretary of State for Justice [2008] UKHL 68 emphasises that flexibility, and confirms that there is no single, prescribed form for the investigation required under Article 2. Subject to the proposition that the investigation should meet the minimum requirements set out above, it is a matter for the relevant authorities in the exercise of their discretion to determine the nature and form of any investigation to be established. The exercise of that discretion may be impugned only on normal public law (Wednesbury) grounds.

A Coroner's inquest, which often follows an investigation by organisations including the Prisons and Probation Ombudsman (PPO) or Independent Police Complaints Commission (IPCC), is the primary means by which the state's investigative obligation under Article 2 is fulfilled in England and Wales. The coroner can widen the scope of an inquest to look at the circumstances surrounding the death, including any systemic failures, and the coroner may elicit the jury's conclusions on issues of
fact, for example by inviting the jury to return a narrative verdict or by giving the jury a series of factual questions to answer. That is not to say however, as is suggested in the report of the Forum for Preventing Deaths in Custody that this is the only means by which the investigative obligation can be complied with. Lord Bingham noted in *R (Middleton) v Coroner for the Western District of Somerset* [2004] UKHL 10 for example, that in some cases the state's procedural obligation may be discharged by criminal proceedings. Accordingly, the relevant authorities will determine the nature and form of any investigation to be established, based on the circumstances of the individual case, thereby maintaining the flexible approach to compliance with the investigative obligation under Article 2 approved by the House of Lords in *JL*.

As you have identified the Forum's research suggested that there were a number of "gaps" in the Criminal Justice System in circumstances where a death or near-death engages the Article 2 obligation. The responses to the below have been provided by the Department of Health and the Ministry of Justice.

a) **Deaths of defendants bailed to attend Court either before proceedings or during proceedings.**

It is not clear that Article 2 is engaged in such circumstances. The position of an individual bailed to the court is not analogous to that of a prisoner in custody such that the investigative obligation under Article 2 would necessarily be triggered by the death of such an individual. In the event Article 2 is engaged in the particular circumstances of a case, then the Secretary of State will determine the nature and form of the investigation needed to fully comply with the state's investigative obligation under Article 2. This could include requesting the PPO to investigate if considered appropriate by the Secretary of State.

b) **Deaths of children in, or while being transferred to/from a Secure Children's Home.**

Where a death in custody engages the investigative requirement in Article 2 of the ECHR, the requirement would normally be met by means of an inquest or a combination of the inquest, criminal proceedings and serious case review. (It is possible to imagine circumstances where some other form of public inquiry might be more appropriate, but those would be exceptional.) Investigations by the PPO fulfil an important role in relation to any death in a young offender institution or secure training centre (as well as any death in an adult establishment), but we do not see them as meeting all the criteria set out in *Jordan v UK* (2003) 37 EHRR 52 in relation to Article 2.

Although the majority of places in secure children's homes are currently filled by young people who are in custody on remand or following sentence by the courts, secure children's homes are not, principally, custodial establishments. Their primary purpose is to accommodate children in the care of a local authority, whose challenging behaviour cannot be managed in an open setting. Due to this important difference, we see the distinction between young offender institutions and secure training centres on the one hand (which are solely for the detention of young people in custody) and secure children's homes on the other (which are not) as being entirely justifiable.

The PPO's investigative remit in relation to fatalities must of necessity have some limits: however those limits were to be defined, it would be possible to point to apparent anomalies. For example, if, hypothetically, their remit were to cover secure children's homes, they would either be responsible for investigating only certain deaths that might occur in them (i.e. those of sentences or remanded young people), but not others (i.e. those of young people placed there for welfare reasons); or they would have to investigate certain deaths of young people accommodated by a local authority (those in secure children's homes), but not others (such as those in "open" children's homes). Arguments can be advanced in favour of, and against, extending
the PPO's investigative remit, but we firmly believe that the remit as currently established is based on sound principles and on practical effectiveness.

c) Deaths and near-deaths in mental health services
The Department of Health does not agree with the Forum's conclusions that there is a gap in the law relating to the investigation of deaths in a mental health context, nor that where Article 2 of the ECHR is engaged for those deaths there is not already sufficient provision for the State to meet any obligations that arise. The Forum suggested that a major point at issue is the possible lack of independence of independent investigations commissioned by strategic health authorities (SHAs) and thus the lack of an Article 2 compliant system for investigation of deaths in custody in mental health services.

But in fact the majority of deaths in custody will not be investigated through the SHA independent investigation route and the Department has never suggested that such investigations are the main mechanism by which compliance with Article 2 is to be achieved. This route primarily investigates homicides committed by those in touch with mental health services and occasionally other cases such as clusters of suicides or restraint related deaths.

Consequently, it is considered that the Forum placed insufficient emphasis on the fact that following the death of any patient from non-natural causes there is an initial internal Trust investigation to establish whether there are any immediate actions that need to take place. In the case of a non-natural death the Coroner's Society report that any detained patient death would be reported to the Coroner and an inquest will take place.

In individual cases where Article 2 is engaged, the inquest alone, or in some cases the combination of inquest and NHS independent investigation should provide for an effective investigation under Article 2. The case law that supports this includes *R (Takoushis) v HM Coroner for Inner North London* (2006) 1 WLR 461, and this case adopted the approach from an earlier decision of *Goodson v HM Coroner for Bedfordshire & Luton* (2006) 1 WLR, which held that even if the investigative obligation arises under Article 2, the range of remedies available under the judicial system will suffice to discharge the obligation. It may be concluded from the cases cited that the obligation may be discharged by a combination of various procedures: the combination of procedures could be criminal law, professional disciplinary proceedings, Trust internal investigation and the civil judicial system.

The Forum's Recommendations

The Forum has made a number of recommendations aimed at resolving the alleged gaps identified in their research:

• **Tightening the provisions for investigations of deaths in (or at) court, to remove any uncertainty as to who would investigate**

It is not agreed that the circumstances described in the research would necessarily trigger the Article 2 investigative obligation. However, we are considering whether the deaths of people at court as identified by the research, who currently may not explicitly come into the remit of an investigating body, should be investigated and if so whether that investigation should be within the remit of the PPO.

• **Identifying an appropriate means to ensure that deaths in SCHs are investigated in an Article 2 compliant way. This will require discussion between Ofsted, PPO and the Youth Justice Board**

It is not accepted that there is a gap in the law regarding investigations of deaths in SCHs (see response at point 5 above).
• Updating the PPO's terms of reference to remove any ambiguity
The PPO terms of reference were amended in June 2009 to clarify their role in relation to deaths in court premises of persons sentenced to or remanded in custody. We will also continue to work with the PPO to examine whether the deaths of the people at court as identified by the research, who currently may not come within the remit of an investigation body, should be investigated and, if so, whether that investigation should be within the remit of the PPO.

• Changing the legal status of PPO to establish its independence and ensure compliance with Article 2
We note the views on legislation in the report. We fully support the independence of the PPO and acknowledge the value of that independence in the investigation of fatal incidents. You may be aware that in our recent review of public bodies we recognised the importance of the PPO in providing independent investigation of facts and decided not to seek major changes to the PPO remit or organisation. Following on from that review, and in the light of the imminent announcement of the appointment of a new PPO, we consider this will be an opportune time to examine whether any further amendments to the PPO terms of reference are necessary and to consider the merits of a statutory basis for the PPO. However, we believe compliance with Article 2, when engaged, is primarily met by the Coroner's inquest. The PPO investigation supports that inquest where appropriate.

• Introducing tighter, legally binding provisions requiring the appointment of an independent investigator in relation to all deaths or near-deaths in mental health cases. The investigator should be involved at an earlier stage and should determine the scope and issues for the investigation without external influence
The Government does not agree that an independent investigation of the type the Forum has in mind is required for all deaths of detained patients.

Although the Department of Health do not agree with the conclusions in the research, especially as regards both the degree of independence they think necessary and its application to deaths of detained mental health patients, they acknowledge, following recent House of Lords decisions, that there may be a need for certain failed attempted suicides by detained patients to be investigated independently in a way that has not happened routinely to date. Where a detained MHA patient attempts suicide and the direct result of that suicide attempt is such that they become unable to act for themselves-usually by reason of brain damage - the SHA should commission an independent Inquiry as advised by DH Circular and NPSA guidance for Deaths in mental health settings. DH are currently discussing with the NHS how best to take this forward and especially to establish current practice in respect of such incidents.

It is the Government's declared intention, in a Bill currently before Parliament, to abolish Strategic Health Authorities. However, it is intended that both the Secretary of State for Health and the new body, the NHS Commissioning Board, will have powers equivalent to those currently used by SHAs to commission independent investigations.

• Restricting the involvement of employees of mental health institutions beyond the urgent first steps of the investigation
The decision as to whether an NHS independent investigation is commissioned, as guidance makes clear, is for the SHA to make after establishing the nature and the extent of the incident. We know of no case law that would preclude either an initial Trust service management review or an internal Trust investigation prior to the independent investigation. The SHA investigation is independent as it does not involve those employed at the Trust or those who had clinical involvement in the
incident. Guidance clearly advises that investigation team members should not have a conflict of interest or be in employment in organisation/s under investigation.

From a purely practical point of view it would be impossible for the SHA to commission an independent investigation if it could not communicate and/or obtain a report on the incident from the Trust involved. The terms of reference and scope of the independent investigation are however for the SHA to determine. Discussion with the chair of the independent investigation and families is good practice when setting terms of reference. Terms of reference will normally be agreed to involve the ability of the Inquiry to make appropriate recommendations relevant to their findings.

- Including within the remit of all independent investigators appointed for the purposes of dealing with a death in custody the requirement to make such recommendations as appear appropriate on the evidence to help prevent future deaths.

It is accepted that learning lessons and sharing good practice is central to the Government’s approach to preventing deaths in custody. The investigations carried out by the PPO into deaths in Prison custody, Approved Premises, Immigration detention centres and Secure Training Centres include the requirement to examine and make recommendations on whether any changes in policy or practice which would help prevent deaths. For NHS investigations the findings of the internal trust investigation may well help to inform the nature and scope of any independent investigation, for example by informing the terms of reference.

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