

REPORT ON THE IAP'S WORK STREAM CONSIDERING INVESTIGATIONS OF DEATHS IN CUSTODY – COMPLIANCE WITH ARTICLE 2 ECHR

Introduction

1.1 The terms of reference for the Independent Advisory Panel's (IAP's) six work streams were approved at the Ministerial Board in October 2009. This paper reports on the progress of the findings and recommendations for future work for the workstream considering investigation of deaths in custody¹ and compliance with Article 2 of the European Convention on Human Rights (ECHR) - the right to life.²

1.2 This workstream is led by Professor Philip Leach, building upon the work undertaken by the Forum for Preventing Deaths in Custody, which examined whether the current arrangements for investigating deaths in custody complied with Article 2 ECHR.

1.3 This paper sets out specific findings and recommendations about investigations of deaths in custody covering four main areas: (1) deaths of those detained under the Mental Health Act (MHA); (2) deaths in prison; (3) children who die in (or in transfer to or from) secure children's homes (SCHs); and (4) inquests. There are also general recommendations and ideas for future work.

1.4 There is considerable overlap between this work and that of the other IAP work streams, particularly those considering cross sector learning and the deaths of patients detained under the MHA. The panel members leading these groups have been working together to ensure their workstreams are complementary.

¹ This workstream has looked at detainees in all forms of state custody, in-keeping with the scope of the IAP.

² **Article 2 – Right to life**

1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:

- a. in defence of any person from unlawful violence;
- b. in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
- c. in action lawfully taken for the purpose of quelling a riot or insurrection.

The Article 2 obligations – a brief summary

1.5 Article 2 ECHR imposes a number of inter-related obligations on the state, including the positive duty to protect life and the obligation to refrain from the unlawful taking of life. Deprivation of liberty creates particular vulnerabilities for detainees in terms of Article 2, and accordingly the obligations on the state are increased in such circumstances. The European Court of Human Rights has described the obligations that arise in this way as follows:

“Persons in custody are in a vulnerable position and the authorities are under a duty to protect them. . . . The obligation on the authorities to account for the treatment of an individual in custody is particularly stringent where that individual dies.

“Where the events in issue are wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries and death occurring during that detention. Indeed, the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation”.³

1.6 Case law (from both the UK courts and the European Court of Human Rights) has established that the state can be held liable under Article 2 in a wide variety of circumstances, including, for example, arising from:

- the use of restraint;⁴
- lack of care and supervision;⁵
- inadequate medical treatment;⁶
- the failure to prevent attacks by other detainees;⁷
- disappearance from a state-run nursing home;⁸ and

³ *Salman v Turkey*, No. 21986/93, 27.6.00, paras. 99-100.

⁴ *Mojsiejew v Poland*, No. 11818/02, 24.3.09.

⁵ *Taïs v France*, No. 39922/03, 1.6.06.

⁶ *R (Wright) v Secretary of State for the Home Department* [2001] UKHRR 1399; *Tarariyeva v Russia*, No. 4353/03, 14.12.06.

⁷ *Paul and Audrey Edwards v UK*, No. 46477/99, 14.3.02; *R. (on the application of Amin (Imtiaz)) v Secretary of State for the Home Department* [2003] UKHL 51.

⁸ *Dodov v Bulgaria*, No. 59548/00, 17.1.08.

- suicides of detainees.⁹

1.7 For cases of suicide, the relevant test to be applied under Article 2 is whether the authorities knew, or ought to have known, that there was a real and immediate risk of suicide, and, if so, whether they did all that could reasonably have been expected of them to prevent that risk being realised. The European Court has also held that when people with disabilities are kept in detention, the authorities must demonstrate particular care in meeting their special needs.¹⁰

1.8 Article 2 ECHR imposes an additional duty on the state to investigate fatal incidents. The essential purpose of such an investigation is to secure the effective implementation of the domestic laws which protect the right to life, and to ensure the accountability of those responsible. Deaths in state custody will be the subject of particular scrutiny:

“...where a positive obligation to safeguard the life of persons in custody is at stake, the system required by Article 2 must provide for an independent and impartial official investigation that satisfies certain minimum standards as to effectiveness. Thereby, the competent authorities must act with exemplary diligence and promptness and must of their own motion initiate investigations which would be capable of, firstly, ascertaining the circumstances in which the incident took place and any shortcomings in the operation of the regulatory system and, secondly, identifying the State officials or authorities involved. The requirement of public scrutiny is also relevant in this context...”¹¹

1.9 Key elements of an Article 2 compliant investigation are that it is:

- Initiated by the state of its own volition
- Independent
- Effective
- Sufficiently open to public scrutiny
- Reasonably prompt
- The next of kin/family should be involved

⁹ *Keenan v UK*, No. 27229/95, 3.4.01; *R (Middleton) v Coroner for the Western District of Somerset* [2004] UKHL 10.

¹⁰ See, e.g., *Jasinskis v Latvia*, No. 45744/08, 21.12.10, para. 59.

¹¹ See, e.g., *Trubnikov v Russia*, No. 49790/99, 5.7.05, para. 88.

1.10 We should acknowledge at the outset that the Panel takes a different view to some stakeholders of the extent of the state's obligations under Article 2. For example, the duty to carry out an effective investigation arises as soon as the state is on notice of a fatal incident. Accordingly, violations of Article 2 *may* arise from errors or omissions which occur within a very short time after a death.¹² The European Court has also stipulated that:

“The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including *inter alia* eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard”.¹³

1.11 Therefore, in our view, reliance cannot *solely* be placed on the inquest system, as of course inquests usually take place some considerable time after a death. In any event, the Panel is committed to improving the investigations that are undertaken into deaths in custody in order to contribute to its main aim of bringing about a reduction in the number of such deaths, and we have made recommendations on that basis.

Following up the Report on Article 2-complaint investigation of deaths in custody by the Forum for Preventing Deaths in Custody

1.12 In January 2009, the Forum for Preventing Deaths in Custody published a report¹⁴, which examined whether the systems for investigating deaths in custody comply with the UK's human rights obligations under Article 2 of the ECHR. This report suggested that in certain circumstances, the independence requirement would not be met, particularly in relation to the investigations of deaths of detained psychiatric patients and argued that there were questions about whether the regime for investigating the deaths of detained children was fully human rights-compatible.

¹² See, e.g., *Ramsahai and others v Netherlands*, No. 52391/99, 15.5.07 (officers from the same police force as those involved in the incident took various essential steps at the beginning of the investigation, prior to the involvement of the state Criminal Investigation Department 15½ hours after the death – violation of Article 2).

¹³ *Jordan v UK* (2001) 37 EHRR 52, para. 107.

¹⁴ <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/Forum-for-Preventing-Deaths-in-Custody-Report-on-Article-2-Compliant-Investigations.pdf>

1.13 The Chair of Joint Committee on Human Rights wrote to the previous government in May 2009 requesting confirmation of whether they accepted the Forum's recommendations. The Chair of the IAP followed this up in December 2010, and the Panel received a reply from the Secretary of State in April 2011 saying that there was no single, prescribed form for an investigation, although it should meet the minimum requirements set out in Article 2. The government re-stated that the Coroner's inquest is the primary means by which the state fulfils its Article 2 obligations, although criminal proceedings may, in some cases, be the more effective way of discharging the duty.

1.14 The Panel agrees that inquests are the *primary* means by which the state discharges its duties to investigate deaths in custody, but, as noted above, we want to emphasise that the nature and extent of the investigations carried out before the inquest are also critically important.¹⁵ The positive duty to investigate promptly and effectively is undertaken in certain specified custodial sectors by the Prisons & Probation Ombudsman (PPO) and the Independent Police Complaints Commission (IPCC). There is, however, no such system in place for investigating deaths of those detained under the MHA. The Panel also has concerns that the coronial system is not sufficiently responsive or properly resourced to undertake a prompt and effective investigation into all deaths of detained patients.

Deaths of those detained under the Mental Health Act

2.1 The Secretary of State's letter in response to the Forum recommendations suggests that:

"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."

2.2 However, the two cases cited in the Secretary of State's letter relate to cases of alleged medical negligence in an NHS hospital, and *not* to individuals detained by the state. Indeed, the Court of Appeal judgment in *Takoushis* expressly referred to the 'important difference between those who are detained by the state and those who are not', noting that Mr Takoushis had not been detained.¹⁶

¹⁵ See, e.g., *R (JL) v Secretary of State for Justice* [2008] UKHL 68, at 42.

¹⁶ *Regina (Takoushis) v Inner North London Coroner and another* (2006) 1 WLR 461, at 108.

2.3 The Secretary of State also thought the Forum's report placed insufficient emphasis on the requirement for an internal Trust investigation to establish whether there are any immediate actions that need to be taken. The Panel recognises the importance of such internal activity in order to stop dangerous practices. But there remains a gap for those deaths not subject to independent investigations (currently commissioned by Strategic Health Authorities – SHAs). The internal investigation does not provide a satisfactory system for investigating the deaths of detained patients in an independent or open way, and it is possible that such a system may prevent full learning from the death. In addition, although non natural cause deaths are referred to the Coroner, those detained patients who die of perceived natural causes are not routinely referred, and there is no legal requirement to do so until the commencement of the Coroners & Justice Act 2009. Consequently, there is no state system, whatsoever, to look independently at the circumstances of natural cause deaths of detained patients. This is of significant concern given the number of such deaths¹⁷ and the learning that may be missed as a result of not investigating.

2.4 The National Patient Safety Agency (NPSA) good practice guidance on the 'Independent Investigation of Serious Patient Safety Incidents in Mental Health'¹⁸ was published in 2008. This augments Health Service Guidance 94 (27)¹⁹, issued in 2005, and describes the arrangements that Trusts should follow to undertake (i) an internal management review within 72 hours; (ii) an internal investigation usually within 90 days; and (iii) possible commissioning of independent investigations by SHAs.

2.5 Professor Philip Leach met representatives from the Department of Health to discuss the feasibility of reviewing the NPSA good practice guidance. Given existing governance arrangements, the guidance is not mandatory, although Trusts would need to have a good reason not to follow it. The upcoming changes to form the NHS Commissioning Board (NHSCB) and reduce the involvement of Department of Health in setting policy may affect the consistency of investigations even further.

2.6 The Department of Health believes that this guidance is defensible but acknowledges that it was not written in order to ensure compliance with Article 2 ECHR, and also recognises that it will need to be re-written once the governance arrangements

¹⁷ <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/03/IAP-Mid-Term-Report-February-2011.pdf>

¹⁸ <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836>

¹⁹ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4113574.pdf

for the work of NPSA have been implemented. The commissioning of independent investigations is limited to cases of homicides committed by individuals in touch with mental health services and some other cases where there have been a cluster of suicides or restraint-related deaths.²⁰ The Panel believes that this is an overly restrictive interpretation which suggests that Article 2 compliant investigations will not be carried out in all circumstances where they would be required.

2.7 In view of the weight given to SHA independent investigations (i.e. to be used for the most serious cases), the IAP considers that further research is required to review their adequacy and quality. The IAP proposes that research be undertaken into completed SHA investigations to consider issues such as scope, timeliness, quality, independence and the extent of family involvement, in order to make recommendations in due course to the NHSCB for improvements, and how this should be reflected in guidance. Accordingly, the Panel seeks endorsement from the Ministerial Board that such research should be carried out.

Recommendation 1: Research should be undertaken to review the quality of independent investigations carried out by Strategic Health Authorities.

2.8 The IAP believes that the National Patient Safety Agency (NPSA) good practice guidance on the 'Independent Investigation of Serious Patient Safety Incidents in Mental Health' is insufficient to ensure an Article 2 compliant investigation. The Panel recommends that it should be re-written when the future governance of NPSA's functions has been decided. The guidance should be applied consistently by all Trusts and independent sector hospitals, and address the following:

- clarify when an 'independent investigation' must be carried out;
- to clarify what that entails
- to clarify urgency/timings

²⁰ The arrangements in Wales are that the Welsh Assembly Government commissions Healthcare Inspectorate Wales (HIW) to provide independent reviews of homicides involving patients known to mental health services.

- the nature and scope of the investigation, adequate investigatory powers, procedures, public access, and family involvement
- to establish consistent methods of identifying learning that should be shared beyond the individual Trust.

Recommendation 2: National Patient Safety Agency (NPSA) good practice guidance on the ‘Independent Investigation of Serious Patient Safety Incidents in Mental Health’ should be re-written when the future governance of NPSA’s functions has been decided to address the shortcomings addressed by the Panel and to ensure consistent application by all Trusts.

2.9 The IAP is aware that, subject to the passing of the Public Bodies Bill, the NPSA will be abolished. Its functions are likely to be transferred to the NHSCB – and operate as a sub-group of that Board. Strategic Health Authorities (SHAs) will also cease to exist, and the NHSCB will take on responsibility for commissioning independent investigations. The IAP has explored with the Department of Health the impact this will have on existing investigation arrangements, as well as scope for improvement. Although we cannot be certain about the priority given to investigations by the NHSCB, the IAP is concerned that there is no central body with sufficient oversight of investigations of deaths of detained patients. Indeed, in 2004 the Joint Committee on Human Rights recommended the establishment of a permanent investigatory body to carry out inquiries into deaths in Mental Health Act detention.²¹

2.10 Given the current scale of changes to health governance it would be unrealistic to make specific, detailed recommendations, such as the creation of an independent investigatory body, to improve the investigation of deaths of detained patients. The IAP therefore proposes to adopt a staged approach. This will involve gathering evidence from research (as per recommendation 1) and working with those setting up new arrangements to persuade them to focus on Article 2-compliant investigations. If this is unsuccessful, the Panel will make further recommendations in future about how the new arrangements should be improved, which may include the establishment of a permanent investigatory body.

²¹ *Deaths in Custody – Third Report of Session 2004-05*, Joint Committee on Human Rights, HL Paper 15-I, HC 137-I, 8 December 2004, pp. 94-96.

Recommendation 3: Those responsible in the new NHS Commissioning Board should produce adequate guidance to clarify when independent investigations into deaths of detained patients should be triggered; to ensure the person commissioned to conduct the investigation is independent of the provider; and to ensure that all the Article 2 requirements are met.

The role of the Care Quality Commission (CQC)

2.11 The primary function of CQC is to register providers and check compliance against essential standards of quality and safety. It also monitors implementation of the Mental Health Act to protect the interests of those patients subject to powers under the Act. We understand that activity is underway to align the mental health functions with the wider regulatory function in order to strengthen the safeguards provided to detained patients.

2.12 The IAP met the CQC on 4 April 2011 to discuss its role in respect of deaths of detained patients. CQC is currently undertaking a clinical and business analysis of the death review process in the context of its wider regulatory role and in order to modernise its Mental Health Act monitoring process, and has agreed to involve the Panel in the development of, and findings from, this review. Its role in reviewing deaths is discretionary, although providers are statutorily required (under the Health and Social Care Act 2008) to report all deaths. CQC receives between 300-500 notifications each year, and reviews 70-80 of these cases. Healthcare Inspectorate Wales is notified by all hospitals across Wales of the deaths of patients detained under the Mental Health Act 1983 and is also currently reviewing its processes for the review of deaths.²²

2.13 The CQC's Notification of Death form, which should be submitted within three days of the death, is also being reviewed to identify additional information that providers should include. This will provide a more robust set of information that can be used in the regulation of services. It is also examining whether all providers are aware of their obligations to report deaths, and the process for doing so. The IAP has made

²² *Monitoring the Use of the Mental Health Act in 2009-2010*, Healthcare Inspectorate Wales, March 2011, paras. 1.22-1.24 (notification of 27 deaths in 2009-2010).

recommendations about additional information that should be included on the notification form (for example, physical health needs of the detainee), and will continue to work with CQC to ensure sufficient information is collected.

2.14 At present, CQC targets efforts on those deaths where concerns have been identified with the aim of ensuring that providers are learning lessons to prevent future occurrences. Findings from reviews that show shortcomings in an individual's care can feed into regulation of that provider. For natural cause deaths, CQC looks at the issues raised before deciding to review, and may obtain a clinical report on the death, although the triggers for commissioning such a review are not currently clear.

2.15 CQC can monitor compliance with learning points and would use their Compliance Inspectors and, where necessary, Mental Health Act Commissioners (MHACs) to check that learning is being implemented and sustained at a local level. However, there is currently no established mechanism for sharing learning between organisations. CQC can pursue this on an ad hoc basis, such as through Chief Executive Bulletins. Information about a particular provider's non-compliance is also reported by CQC in its Provider Compliance Reports.

2.16 The CQC acknowledges that there is a gap in terms of an independent investigation into the death of detained patients, as there is no equivalent of the Prisons & Probation Ombudsman (PPO) or Independent Police Complaints Commission (IPCC), although they are unlikely to be resourced to undertake a similar role in future. Nevertheless, the IAP welcomes the CQC commitment to review their role in relation to deaths of detained patients. The Panel believes that with sufficient additional resources the CQC would be an appropriate body to undertake and/or commission rigorous investigations into deaths of detained patients and disseminate learning to providers.

Recommendation 4: The Care Quality Commission should devise a specific, discrete role in relation to reviewing deaths of detained patients and consider whether it can undertake and/or commission investigations. It should report back to the Ministerial Board on progress.

Deaths in prison

3.1 The Prisons and Probation Ombudsman investigates the circumstances of the deaths of prisoners and trainees (including those in Young Offender Institutions and Secure Training Centres); residents of Approved Premises (including voluntary residents); residents of immigration reception and removal centres, short term holding centres and persons under managed escort; and people in court premises or accommodation who have been sentenced to or remanded in custody.

Clinical reviews

3.2 The Ombudsman's investigation includes examining the clinical issues relevant to each death in custody. In the case of deaths in public prisons and immigration facilities, the Ombudsman will ask the local Primary Care Trust or, in Wales, the Healthcare Inspectorate Wales (HIW), to review the clinical care provided at the prison, including whether referrals to secondary healthcare were made appropriately. The Panel has considered further whether the quality, timescales for completion and level of independence of clinical reviews into deaths in prison custody in England are adequate. Clinical reviews form a key part of the investigations undertaken by the Prisons and Probation Ombudsman (PPO), and there has been a longstanding concern about delays caused to the Ombudsman's investigation due to late delivery of clinical reviews, as well as questions about the level of independence in some circumstances where they are commissioned from within the PCT that provided healthcare to the prison.

3.3 The IAP has had a number of discussions with PPO about the problems arising from quality and delays to clinical reviews, and lack of independence. The IAP had raised the possibility of working jointly with Offender Health and PPO to conduct further research in this area to analyse the clinical quality; timeliness and independence of clinical reviews. The PPO does not wish to progress that research because they believe previous internal studies and subsequent actions have sufficiently clarified the issues. PPO undertook their own assessment of clinical reviews in 2009, to look at timeliness; suitability of the reviewer; whether the review covers points identified by PPO; and whether the recommendations were appropriate. Of 46 clinical reviews analysed, 13 had been received on time and 33 were between one and 10 months late. The PPO was satisfied that 25 of the 46 reviews had addressed relevant issues.

3.4 The Acting Ombudsman has explained that the PPO's main consideration is timeliness of reviews, rather than the quality or independence, and believes the office has made progress on driving up performance on clinical reviews in a number of ways. The problem was discussed at a joint meeting between the Secretary of State for Justice and

the Secretary of State for Health, which highlights that both departments recognise the importance of timely investigation of deaths in custody. Offender Health have also requested a meeting between PPO and the NHS Medical Director and plan to follow this up with a letter to PCTs reminding them of their responsibilities. In the longer term, the PPO hopes to gain agreement that the NHS Commissioning Board will commission reviews, and have a role in monitoring timeliness and quality.

3.5 The PPO has also amended performance targets to introduce a variable target for reports on Fatal Incident Investigations. The usual 20-26 week target for issuing draft investigation reports would not apply to those cases delayed because of clinical reviews. Outstanding investigation reports, delayed due to clinical reviews, will be measured against a separate target of issuing the report six weeks after receipt of the clinical review. This should show more clearly the effect of the delays. All the performance figures will be analysed quarterly and reported to Offender Health. This will be set out in the PPO business plan objectives for 2011/12 as follows:

“1. Work with Ministry of Justice and Department of Health to achieve a step change improvement in the timeliness and effectiveness of clinical reviews of fatal incidents.

“2. Develop and implement timeliness targets for producing fatal incidents reports which reflect joint accountability with the Department of Health/ NHS for clinical reviews. This will be linked with a number of initiatives to improve performance on clinical reviews.”

3.6 The Acting Ombudsman was satisfied that her office had taken sufficient steps to bring about an improvement in clinical reviews, although it was recognised that the commissioning route may take some years to implement.

3.7 The Panel agrees that Secretary of State for Health accountability for clinical reviews, and all the supporting activity, will help promote the importance of these investigations. However, we have residual concerns that this will be insufficient to have a measurable impact on the fundamental problem with independence of the reviews as well as timeliness and quality.

3.8 The Panel explored with the Acting Ombudsman the merits of setting up a ‘standing body’ or ‘pool’ of clinical reviewers. The Acting Ombudsman explained that,

ultimately, a system akin to HIW would be her preference. She did not think the office was sufficiently resourced to provide oversight of clinicians, and did not think such an arrangement would lead to improved timeliness or quality – and would expect the NHSCB to make the necessary arrangements without having to spend time on accrediting reviewers in future. The Panel does not think at the present time it would be realistic to recommend creation of a body for England that is akin to HIW so the pool of clinical reviewers would be a potential way forward if the new governance arrangements do not deliver sufficient improvement.

Recommendation 5: The PPO should follow up the analysis conducted in 2009 of clinical reviews, in conjunction with the IAP, to examine the effect of shared governance on quality; timeliness and independence of clinical reviews, six months after implementation, and regularly thereafter. They should share findings of these analyses with the IAP to review progress.

Statutory basis of PPO

3.9 The Justice Select Committee, in announcing its preferred candidate for the role of Ombudsman, stated that the post should be seen to have the same status and independence as the Chief Inspector of Prisons²³. They hoped that the government would put the Ombudsman's office on a statutory basis at the earliest opportunity. The Forum report suggested that independence of the PPO, by placing it on a statutory footing, would be the best way of demonstrating Article 2 compliance of investigations of deaths in prison custody. The Panel agrees with these conclusions, and believes that independence of the PPO is key to public confidence as well as adherence to Article 2, particularly in separating the Ombudsman hierarchically and institutionally from the Ministry of Justice.

3.10 The Secretary of State has explained that the PPO was reviewed as part of the Public Bodies review, and it was recognised as important for providing independent investigation of the facts in relation to deaths in custody. A decision was taken not to change its remit or organisation. However, in view of the imminent announcement of the appointment of the Ombudsman, the Ministry of Justice will be considering whether any further amendments to the PPO terms of reference are necessary, as well as the merits of a statutory basis for the PPO.

²³ <http://www.publications.parliament.uk/pa/cm201012/cmselect/cmjust/1022/102204.htm#a1>

3.11 The IAP welcomes this commitment and will discuss with the MoJ and PPO any suggestions for establishing independence to ensure it provides for Article 2 compliant investigations of deaths in prisons.

Recommendation 6: The PPO should be placed on a statutory footing to ensure independence from the Ministry of Justice.

Children who die in (or in transfer to or from) a Secure Children's Home (SCH)

4.1 The Panel agree with the Forum's conclusions that there is a gap in terms of Article 2 compliance of investigations into the death of a child who was in (or was in transfer to or from) a secure children's home (SCH).²⁴ Such deaths would be subject to a child death review by the Local Safeguarding Children Board (LSCB), which may result in referral for a Serious Case Review (SCR); and it would also be examined as part of the Ofsted inspection.

4.2 Guidance on conducting a Serious Case Review (SCR) is contained in the government's guidance, "Working Together to Safeguard Children"²⁵, which was updated in 2009. SCRs are designed to establish lessons to be learnt from the case about the way local professionals and organisations work together to safeguard and promote the welfare of children but they are not inquiries into the reasons for the child's death – and the guidance states that inquests are the way in which such duties are fulfilled. However, the deaths of children held in other custodial settings (secure training centres or young offender institutions) are subject to independent investigation by the PPO (sometimes in conjunction with the Local Authority if it meets the criteria for a Part 8 Case Review), as well as the Coroner's inquest. The IAP thinks there should be parity in terms of scope, quality and independence of investigations across the custodial settings.

²⁴ Concerns have recently been expressed by international monitoring bodies about the question of the adequacy of investigations into deaths of children in the UK: 'It is a matter of serious concern that there is no legal obligation to undertake an independent *public* inquiry into the death of a child in custody, contrary to Article 2 of the ECHR and other international standards' - MEMORANDUM by Thomas Hammarberg, Commissioner for Human Rights of the Council of Europe - Issue reviewed: Rights of the child with focus on juvenile justice, CommDH(2008)27, 17 October 2008, para. 49; 'The Committee recommends that the State party use all available resources to protect children's rights to life, including by reviewing the effectiveness of preventive measures. The State party should also introduce automatic, independent and public reviews of any unexpected death or serious injury involving children – whether in care or in custody' - Committee on the Rights of the Child, concluding observations on the UK's third and fourth periodic report, 3 October 2008, CRC/C/GBR/CO/4, para. 29.

²⁵ http://www.workingtogetheronline.co.uk/wt_2010.PDF

4.3 The IAP does not think the current arrangements for SCHs provide sufficiently independent investigation because LSCBs are formed by organisations that report to the local authority but the local authority also provides secure children's home accommodation. The Ofsted inspection may consider whether learning has been implemented but would not constitute an investigation of the individual death.

4.4 The Secretary of State's recent response to the Forum recommendations on investigations of deaths in SCHs, notes that children in SCHs are distinct from those in STCs and YOIs because of their wider role – they are not solely for the detention of young people in custody. He proposes that no changes be made to the PPO's remit to cover such cases. The Panel has discussed the potential to extend the PPO terms of reference to cover investigation of deaths of children in SCHs with the Acting Ombudsman. Her view is that although it would be feasible for the PPO to investigate deaths in SCHs, there would be issues to resolve in terms of governance, as well as the needs for additional resources to make this work viable. The Panel recognises the problems arising from separate systems to investigate deaths of children held under civil and criminal powers. However, like the Acting Ombudsman, the IAP believes such problems are not insurmountable, and given the very low frequency of such deaths in recent years (no deaths since 1998), the resource implications are limited.

4.5 The Panel also met with the Youth Justice Board (YJB) to discuss how this gap may be filled. The YJB has not taken a view as to whether the current arrangements are sufficient to meet the requirements of Article 2. However, they agreed that it would be beneficial for PPO to carry out investigations into fatal incidents in order to achieve parity across the youth justice estate. YJB recently met the MoJ and Department for Education (DfE) to seek clarification of the arrangements that should be in place to ensure a prompt, independent, investigation of any future death in SCHs. The IAP welcomes this development and we will arrange a further meeting with DfE, YJB and MoJ to explain why we believe the PPO would be the most appropriate investigatory body.

Recommendation 7: All deaths in Secure Children's Homes should be investigated by the PPO.

Inquests

5.1 There are a number of difficulties with the current coronial system, which frustrate adherence to Article 2. Much of the Panel's work in relation to inquests is being taken forward by the cross-sector learning workstream. Initial findings and recommendations from that workstream were presented to the Ministerial Board in March 2010. The Board accepted the following recommendations:

- That a specific reference to learning from deaths in state custody is included within the remit of the new Chief Coroner.
- That the new Chief Coroner is invited to sit on the Ministerial Board on Deaths in Custody.
- That guidance is developed specifically for Coroners to assist them with the production of Rule 43 Reports.

5.2 However, since those recommendations were accepted, the government has introduced the Public Bodies Bill which proposes abolition of the role and function of the Chief Coroner. The Coroners and Justice Act 2009 would have ensured that learning from deaths in state custody is given a higher priority. The focus on learning is important in order to prevent repetition of poor practice or mistakes in the future. It is the Panel's belief that the Chief Coroner post would also provide a much needed national oversight for Coroners, and be an effective mechanism for provision of guidance and standards to Coroners to embed the importance of learning during investigations and inquests. The Panel wrote to the Ministry of Justice ²⁶ expressing concerns about the potential abolition of this role and to seek assurances that the recommendations can still be taken forward. The Ministry of Justice reply ²⁷ states that Ministers are currently discussing with interested parties how alternative models might provide standard setting, guidance and oversight to Coroners, and think this may be achieved by a Ministerial Board which would decide on priorities. The Panel looks forward to receiving more details of the proposed arrangements in due course.

²⁶ <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/IAP-Letter-on-CJA-and-Chief-Coroner.pdf>

²⁷ <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/05/MoJ-Response-to-IAP-Letter-on-Chief-Coroner.pdf>

5.3 The Panel also raised the crucial importance of the post to address some of our wider concerns about the lack of effective powers available to Coroners to follow up recommendations made in Rule 43 Reports and delays to deaths in custody inquests, which have an enormous impact upon the family and staff involved. These delays can also impede compliance with Article 2 of the European Convention on Human Rights, specifically around the timely completion of investigations. The Ministry of Justice will be developing further guidance for Coroners on when to issue Rule 43 reports, and how to make these effective. The Panel welcomes the opportunity to offer suggestions for improvements to the guidance.

5.4 The IAP recognises that delays to inquests also diminish the relevance of any learning, and arguably prevent compliance with Article 2 due to the lack of prompt investigation. The cross-sector learning workstream is also looking at the impact of delays to inquests of deaths in custody and the IAP Secretariat is currently analysing returns from Coroners about the reasons for delays in order to make recommendations to the Ministerial Board to bring about an improvement in timeliness. Initial analysis shows that approximately 24% of cases were still outstanding two years or more after the death had occurred. 6% of cases were over three years old and 6% were over four years. Delays tend to be concentrated in areas with high caseloads, and Coroners cite a range of reasons for delay – most notably waiting for other investigation reports; delays exacerbated by backlog and a number of complex cases; difficulties with scheduling counsel and witnesses; and lack of resources (such as availability of courts and staff).

5.5 The Panel would have made an additional recommendation about the role of Chief Coroner in relation to monitoring or guiding Coroners on Article 2 compliance. However, the Panel will now await the outcome of the Public Bodies Bill before pursuing this recommendation. In the meantime, the IAP will work with the Coroners and Burials Unit in the Ministry of Justice to feed into development of improved guidance to Coroners on writing Rule 43 Reports. In light of the difficulties with progressing the responsibilities of the Chief Coroner role, the Panel recommends that whatever arrangements are put in place to improve oversight and guidance to Coroners, there should be a focus on deaths in custody and the following areas should be subject to particular scrutiny:

- Delays
- Disclosure/access to documents
- Family participation
- Public funding for family legal representation

- Resources for Coroners – the IAP recognise the difficulties with providing extra resources to Coroners, as they are funded by local authorities who have been required to make significant savings and reduction to some services but this should remain on the agenda.

5.6 All of these difficulties may impact on compliance with Article 2 obligations. There should be provision in the arrangements to make recommendations to Coroners in order to improve practice in relation to inquests of deaths in custody.

Recommendation 8: The model for providing standard-setting, guidance and oversight for Coroners should focus on deaths in custody to consider, monitor and ensure improvement in relation to the following:

- Delays
- Disclosure/access to documents
- Family participation
- Public funding for family legal representation
- Resources for Coroners

5.7 The Panel notes that the Ministry of Justice has issued a draft Charter for public consultation²⁸. The Charter is for those who use Coronial Services, to set out what they can expect and how to complain about the service.

Cross sector guidance

6.1 The Panel considers that the custodial sectors would benefit from clear, practical guidance as to what an Article 2-compliant investigation entails and when such an investigation is required. The guidance should summarise the arrangements for investigating deaths in custody in each of the sectors, provide examples of best practice and provide links to further information in respect of each sector. The Panel will undertake further scoping to evaluate existing guidance and consult the custodial sectors about how to make any guidance useful to practitioners and operational staff.

Conclusions and Future work

²⁸ <http://www.justice.gov.uk/consultations/cp52011.htm>

7.1 The Panel is committed to developing its contribution to Article 2 compliance of investigations of deaths in custody, and have a number of suggestions for future work, including, for example, investigations into 'near deaths' and reviewing the application of the Corporate Manslaughter Act.

Professor Philip Leach

May 2011