# Will a death in custody always be subject to independent investigation?

## Contents

## 5. Findings: Mental Health Services



## 6. Conclusion

## 1. Introduction and summary findings

### Introduction

1.1 Objectives of this research

Giving the leading Judgment in the well-known Article 2 case of *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51, Lord Bingham observed that '…*while any deliberate killing by state agents is bound to arouse very grave disquiet, such an event is likely to be rare and the state's main task is to establish the facts and prosecute the culprits; a systemic failure to protect the lives of persons detained may well call for even more anxious consideration and raise even more intractable problems*.' If, for whatever reason, the investigation of a custody death is not sufficiently effective or independent, there may well be consequences in terms of public confidence. However, and more importantly for Forum purposes, there is also a second (interlinked) reason why Article-2 compliance matters: an insufficiently independent investigation could also mean that valuable learning opportunities which could prevent future deaths – the identification of which is part of the rationale for requiring an independent investigation in the first place – might be missed.

This paper will first identify the scenarios in which an Article 2 death could 'slip through the net' in terms of investigation by an independent body, then consider the process(es) which would take place, and the consequences in terms of Article 2-compliance. Where it appears that no Art.2-compliant process currently exists, the paper goes on to consider how this might be remedied. It should be noted from the outset that, in the context of this paper, the term 'investigation' means the evidence-gathering process started by an official body shortly after the death. The term is not intended to refer to the coroner's inquest or any other court proceedings.

### Summary findings

1.2 Forum concerns over Operation Safeguard

It should be noted that this work was prompted by Forum concerns relating to the jurisdiction to investigate deaths of Operation Safeguard detainees, yet this research suggests that a common and lawful understanding of the responsibility to investigate a Safeguard death exists between the Prisons and Probation Ombudsman (PPO) and the Independent Police Complaints Commission (IPCC), and that it is unlikely that a Safeguard death could 'fall between the cracks' in terms of Article 2-compliant investigation: in other words, that the situation as specifically regards Operation Safeguard is relatively satisfactory (notwithstanding the Forum's wider concerns about the risks associated with the policy from the outset). This is explored more fully in Section 3 below.

## 1.3 Current practice: the criminal justice system, revenue and customs and immigration

The two bodies charged with investigating deaths which occur within the criminal justice system, immigration or revenue and customs detention are the IPCC and the PPO. There is no seamless continuum of jurisdiction between these two bodies: there are 'gaps' at various stages of both the adult and youth criminal justice processes. If somebody was to die at one of those stages in the process, the death may not be investigated by the IPCC or the PPO but potentially by the local police on behalf of the Coroner. Depending on the circumstances, it might also prompt other review processes.

## 1.4 Current practice: Psychiatric care

In terms of detention under the Mental Health Act, there is recently-published guidance on the independent investigation of deaths and near-deaths in secure units (and indeed other serious patient safety incidents), but there is no single body which would automatically be responsible for the investigation of such incidents: independent investigators are commissioned by the relevant Strategic Health Authority as and when deaths take place, following an internal investigation, and depending on the outcome of that investigation.

## 1.5 Near-Deaths

Early on in the preparation of this paper, it became clear that any discussion of Article-2 compliance and investigative jurisdiction would be incomplete without also setting out the position in relation to near-deaths. As Forum members are aware, this is a vexed question: while the duties imposed by Article 2 obviously apply equally to all public bodies and custodial settings, there has historically been little common understanding between custody providers as to what constitutes a near-death, and little commonality in terms of the procedure which would be followed in the event of a near-death[1].

In November 2008, the House of Lords gave judgment in a test case on the question of when a near-death triggers the Article 2 investigative obligation (R (JL) v Secretary of State for Justice [2008] UKHL 68). This judgment confirms that, where an apparent suicide attempt '...comes close to success, and leaves the prisoner with the possibility of serious long-term injury', the same investigative duty under Article 2 initially arises as in cases where the victim loses their life: there should be a prompt, independent initial enquiry to secure evidence while still fresh and to establish the facts. Whether the investigation then needs to take on further-reaching attributes more akin to a public enquiry will depend on the results of the initial inquiry. Where the course of events appears to be clear and reveals no issues of concern, the initial enquiry may in itself be sufficient to satisfy article 2. Where there are issues of concern, a greater degree of public scrutiny and participation of next-of-kin (or, if appropriate, the injured person themselves) may be called for, which might more closely resemble the Prisons and Probation Ombudsman's investigation in the now well-known case of 'D', following the judgment in *R (D) v Secretary of State for the Home Department.*

[1] See, for example, www.preventingcustodydeaths.org.uk/form_02-08_03_art_2_investigations_of_near-deaths_.doc

In terms of which independent person or body would be responsible for conducting the initial independent investigation, the position in terms of near-deaths is the same as for actual deaths, and 'gaps' in jurisdiction are problematic for the same reasons. Now that the Lords have clarified the position, it is essential that government departments and the relevant investigation bodies move to develop timely, effective and human rights-compatible procedures for investigating such cases.

## 1.6 Article 2-compliance

Where any death engages Article 2, an independent investigation is required: it appears that, in some of the circumstances identified here, the investigation or review processes following a death would not be Article 2-compliant, either in terms of adequacy or in terms of independence.

For the most part, this paper assumes that a PPO investigation conducted independently in practical terms, followed by an Art.2-compliant inquest, is sufficient to satisfy Article 2, but the position of the PPO, as a non-statutory office within the Ministry of Justice, means that the institutional (if not practical) independence of his office could be challenged, though this has not happened to date. This point is explored further in Section 2.3 below. For now, any conclusion on this point must therefore be tentative. Ultimately, legislation guaranteeing the PPO's independence is required in order for Article 2-compliance to be assured. The tabling of such legislation as soon as possible forms one of the central recommendations of this research.

Recent developments in Article 2 case law also cast doubt on whether or not the investigation regime for deaths in mental health services is compliant. These doubts chiefly relate to the stage when the independent investigation would be commissioned. It should also be noted that the National Patient Safety Agency (NPSA) Guidance requiring an independent investigation is just that – guidance – and not legally binding, a distinction to which the European Court of Human Rights (ECtHR) has, in the past, had regard[2].

## 1.7 Acknowledgements

In conducting this work, I posed a series of questions to the Prisons and Probation Ombudsman, Stephen Shaw, IPCC Commissioner John Crawley, and Youth Justice Board Head of Practice Framework and Innovation David Monk. Jane Webb, the PPO's Head of Fatal Incidents Investigation and Deputy Ombudsman and her colleague, Fatal Incidents Investigator Karen Jewiss also contributed, as did IPCC Director of Legal Services John Tate and Sarah Poolman, staff officer to ACPO Custody lead DCC Alex Marshall. Phil Schoenenberger of UKBA Detention Services, Dan Allison of Her Majesty's Revenue and Customs and Colin Phillips of the Department of Health assisted me on the issues of immigration detention, revenue and customs detention, and deaths in mental health services (respectively). Assistant Deputy Coroner Selena

[2] See e.g. *Khan v UK* [2000] ECHR 195, in which the Strasbourg Court concluded that, at the time of the events giving rise to the case, there was no statutory regulation of the use of covert listening devices and the applicant's Article 8 rights were not therefore protected by law. The existence of Home Office guidance on the subject made no difference since the guidance was not legally binding.

Lynch supplied helpful guidance on the role of the coroner. Above all, the Forum Chair was an invaluable source of advice and guidance. I am grateful to all of them for their assistance.

# 2. The Legal Background

## 2.1 'Independence'

Before going on to assess in greater detail whether or not the investigation of a death under various different circumstances is likely to satisfy Article 2, it may be useful to set out exactly what the case law requires.

At least initially, any death which occurs in state detention triggers the obligation to hold an effective investigation (*R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51).

The key case which sets out what is an effective investigation is *Jordan v UK*, (2003) 37 EHRR. A number of criteria for Article 2-compliance are laid down. One of these is that the investigation must be independent. *Jordan* defines independence as the absence of any 'hierarchical or institutional connection…[between the investigators and those implicated in events]'. The investigators' independence must also be a practical reality (*Ergi v Turkey* (2001) 32 EHRR 18).

For the purpose of this work, it is assumed that there is no issue that an investigation carried out by the PPO or IPCC satisfies this requirement, as already noted. That said, in the case of the IPCC, the matter would need to be the subject of either an IPCC independent investigation or an IPCC-managed investigation using a different police force to be compliant, and in the PPO's, questions could be asked of his institutional independence *per se.* This point is developed in the section 2.3 below.

In terms of mental health services, guidance from the National Patient Safety Agency notes that it is the responsibility of the relevant Strategic Health Authority (SHA) to commission an independent investigation in certain circumstances. One such set of circumstances is described as follows:

> *…when it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a state agent is, or may be, responsible for a death or where the victim sustains life-threatening injuries, there is an obligation on the state to carry out an independent investigation. This means that the investigation should be reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.*

Further guidance is given on the responsibilities of commissioning SHAs where an independent investigation is required, including the need to ensure that those who conduct it are independent of the care-providers under investigation. Aside from this, there is no specific guidance on the composition of the investigation team: this will depend on the circumstances of each case.

As well as independence, *Jordan* lays down a number of other conditions for Art.2-compliance. This research has not concerned itself with these because they are, at least in theory, capable of being satisfied by an internal investigation (provided it satisfied the other requirements such as the degree of public scrutiny and participation of next-of-kin, where required). The requirement of independence is therefore likely to be the biggest stumbling block where a death takes place which does not fall within IPCC or PPO jurisdiction, or (in the case of mental health services) is not one for which the relevant Strategic Health Authority commissions an independent investigation.

## 2.2 Jurisdiction: IPCC

The IPCC's jurisdiction is governed by the Police Reform Act 2002, Part 2 and Schedule 3, which also guarantees its independence from government and requires that IPCC Commissioners must never have served with the police service. Subject to limited exceptions relating to the definition of a complaint and the eligibility of the complainant, police forces are under a duty to refer specified categories of complaint or incident to the IPCC. There is an additional discretion to refer incidents outside the specified categories on the grounds of gravity or exceptional circumstances. Para 12, Sch.12, Serious Organised Crime and Police Act 2005 amends the 2002 Act so as to create a duty on police forces to refer to the IPCC *any* matter in which death or serious injury may have been sustained or contributed to by police contact (i.e. regardless of whether the incident is the subject of a complaint or may evidence misconduct).

On 1st April 2006, the Revenue and Customs (Complaints and Misconduct) Regulations 2005 brought complaints of referable levels of seriousness relating to officers of Her Majesty's Revenue and Customs (HMRC) within IPCC jurisdiction. The criteria for referral of such incidents are the same as exist in respect of the police service.

On 1st April 2007, the UK Border Agency (formerly Border and Immigration Agency) also fell under the IPCC's remit. The IPCC will only have jurisdiction over serious complaints and incidents arising from UKBA officers' exercise of police-like powers (these are listed in the Police and Justice Act 2006, s.41). The Independent Police Complaints Commission (Immigration and Asylum Enforcement Functions) Regulations 2008 are mandated by that section, and set out what constitutes a serious complaint or incident. The regulations do not yet extend to private contractors employed by UKBA, although this is expected to change. Incidents in immigration detention centres and short-term holding centres are specifically *excluded* from the IPCC's remit. Deaths in (and complaints arising from) removal and reception centres and short-term holding centres fall within the remit of the PPO.

When an incident is referred to it, the IPCC must decide on what level of investigation is appropriate. As already discussed, any apparent Article 2 case must be the subject of an independent IPCC investigation or one managed by the IPCC using the resources of a different police force (although see Recommendation 58 of the Stephen Lawrence Enquiry in this regard, which relates to the consequences in terms of public perceptions/ confidence where one police force investigates another). Since one of the IPCC's statutory purposes is to increase public confidence in police oversight, there is an organisational preference for IPCC independent investigations rather than IPCC-managed investigations using an outside force.

## 2.3 Jurisdiction: PPO

Unlike the IPCC, the PPO's ambit is not laid out in any statute. This was recently expected to change but the relevant provisions of the Criminal Justice and Immigration Bill, which would have set out his ambit and guaranteed the independence of his function, were dropped. (The Bill, without the relevant provisions, received Royal Assent in May 2008).

To date, in the absence of a statutory basis, the PPO has therefore worked within Terms of Reference (available at www.ppo.gov.uk) agreed between his office and what is now the Ministry of Justice. These terms include complaints relating to contracted out prisons and services and deaths which take place in Approved Premises, Immigration Reception and Removal Centres and short-term holding centres, and YOIs and Secure Training Centres. The Ombudsman has an additional discretion to investigate related matters (such as deaths of recently-released prisoners) and would investigate if asked to do so by the Secretary of State.

In terms of the definition of 'prisoner' for jurisdiction purposes, the PPO use the definition set out at s.92, Criminal Justice Act 1991, which provides that a prisoner is any one who is "…for the time being detained in legal custody as a result of a requirement imposed by a court or otherwise that he be so detained". This clearly includes those on remand, under escort, or awaiting escort. The difficulty is that it also includes people for whom it is universally accepted that the PPO is *not* responsible, such as suspects detained at police stations. Interpretation of PPO jurisdiction therefore requires the exercise of a certain amount of common sense.

That said, the Ombudsman accepts that these Terms of Reference are now out of date, and in fact the recent extension of his remit to include complaints arising from immigration detention is still not formally recognised in his Terms of Reference. It is clearly neither in the Ombudsman's nor the public interest for there to be any uncertainty over the matters for which he is and is not responsible. In his 2007/08 Annual Report, the Ombudsman says that significant work to update the Terms of Reference will be necessary if appropriate legislation is not put before Parliament relatively soon.

In terms of independence, the Ombudsman is, in practice, left to discharge his function without influence or intervention from Government, and could therefore be seen as independent in the sense of *Ergi v Turkey*. However, questions could well be raised about the hierarchical or institutional independence of his office, a non-statutory one within the Ministry of Justice. It is also worthy of note that in *Khan v UK* [2000] ECHR 195, the ECtHR held that the ability to complain to the Police Complaints Authority (PCA) did not constitute an effective remedy within the meaning of Article 13 ECHR because the legislation setting out the types of case which were required to be referred to that body did not require the referral of all cases in which it was alleged that a Convention right had been violated. The Court also drew attention to the fact that the Secretary of State appointed, remunerated and dismissed members of the PCA. Given that there is *no* legislation setting out the cases which must be remitted to the PPO for investigation, and that he is also in the same position as PCA members in these other respects, it does not seem inconceivable that a challenge could be made to the Article 2-compliance of PPO investigations.

A more fundamental change – to the Ombudsman's legal status rather than just his remit – would therefore be required before anyone could say with certainty that a PPO investigation satisfied the requirement of independence. For this reason, it is all the more unfortunate that the relevant provisions have been dropped. The current state of affairs is unsatisfactory for all concerned.

### 2.4 Jurisdiction: Strategic Health Authorities and Health Authorities

Health Authorities were created in England and Wales by the National Health Service Act 1977 (now repealed). In England, they were re-named 'Strategic Health Authorities' in 2002. By sections 1 – 8, National Health Service Act 2006 (a consolidation of earlier legislation) the Secretary of State has broad powers to give directions to Strategic Health Authorities as to the type and manner of provision of a wide variety of healthcare services. He can also create, abolish, and modify SHAs, and appoint and dismiss their members. Under certain circumstances, he can also order that any specified function of an SHA shall be exercised instead (or to a specified extent) by a Primary Care Trust, or jointly with one. SHAs have a power to direct a Primary Care Trust falling within its area to exercise any function which the SHA has been directed to perform by the Secretary of State.

In practice, the role of an SHA is usually to provide local management to NHS institutions, and provide a link between the DH and NHS. Among other things, they provide strategic planning for healthcare provision in their areas, monitor the performance of healthcare providers, manage capacity of those providers, and translate national strategies into local action. As already noted, they are responsible for commissioning independent investigations into serious patient safety incidents, including deaths and near-deaths.

## 3. Findings: Operation Safeguard

It would appear that there are no gaps in investigative jurisdiction between IPCC and PPO where a person dies during transfer or detention under Operation Safeguard.

### 3.1 Operation Safeguard and the IPCC

The IPCC are clear that anyone dying while housed in a police station (regardless of their status or whether they are there by dint of Operation Safeguard) falls within their remit. The PPO agrees.

If the death did not take place in police custody, but it was possible that an act or omission by police had caused or contributed to the death, the IPCC would be under a duty to ensure a sufficiently independent investigation into *those aspects* of the circumstances of the death, even if the death itself occurred in circumstances which would mostly be the subject of investigation by a different agency, e.g. if a person had been held under Safeguard, then left police custody and been transferred to Prison and died there.

However, responsibility for investigating the death itself and all the non police-related circumstances of it would not lie with the IPCC (in the above example, this would clearly fall to the PPO). If there was overlap in terms of what each body was investigating, the two bodies would work together, sharing information as appropriate. There is precedent for this.

### 3.2 Operation Safeguard and the PPO

Prisoners may be held in court cells under Safeguard as well as in police custody. Applying the definition of 'prisoner' set out above, any death in Court cells of a Safeguard prisoner would be investigated by the PPO.

### 3.3 Transfer of Prisoners to and from police custody under Safeguard

ACPO advise that a person in this position would never be transferred by police: the responsibility for transfer would remain a prison service responsibility, discharged by Prison Escort and Custody Service contracts (PECS) in the usual way. Anyone being transferred under PECS would be classed as a prisoner within the PPO's definition, and his remit explicitly includes contracted-out services. Responsibility for investigating the death would therefore be his.

The IPCC would therefore never be responsible for investigating the death of a safeguard prisoner which took place in transit, although (as discussed at section 3.1 above) if there was some suggestion that police had caused or contributed to the death – for example, if they failed to pass on relevant information to escort staff – then the police-related aspects of the circumstances of the death would need to be the subject of either an independent IPCC investigation or one managed by them using an outside police force to comply with Article 2.

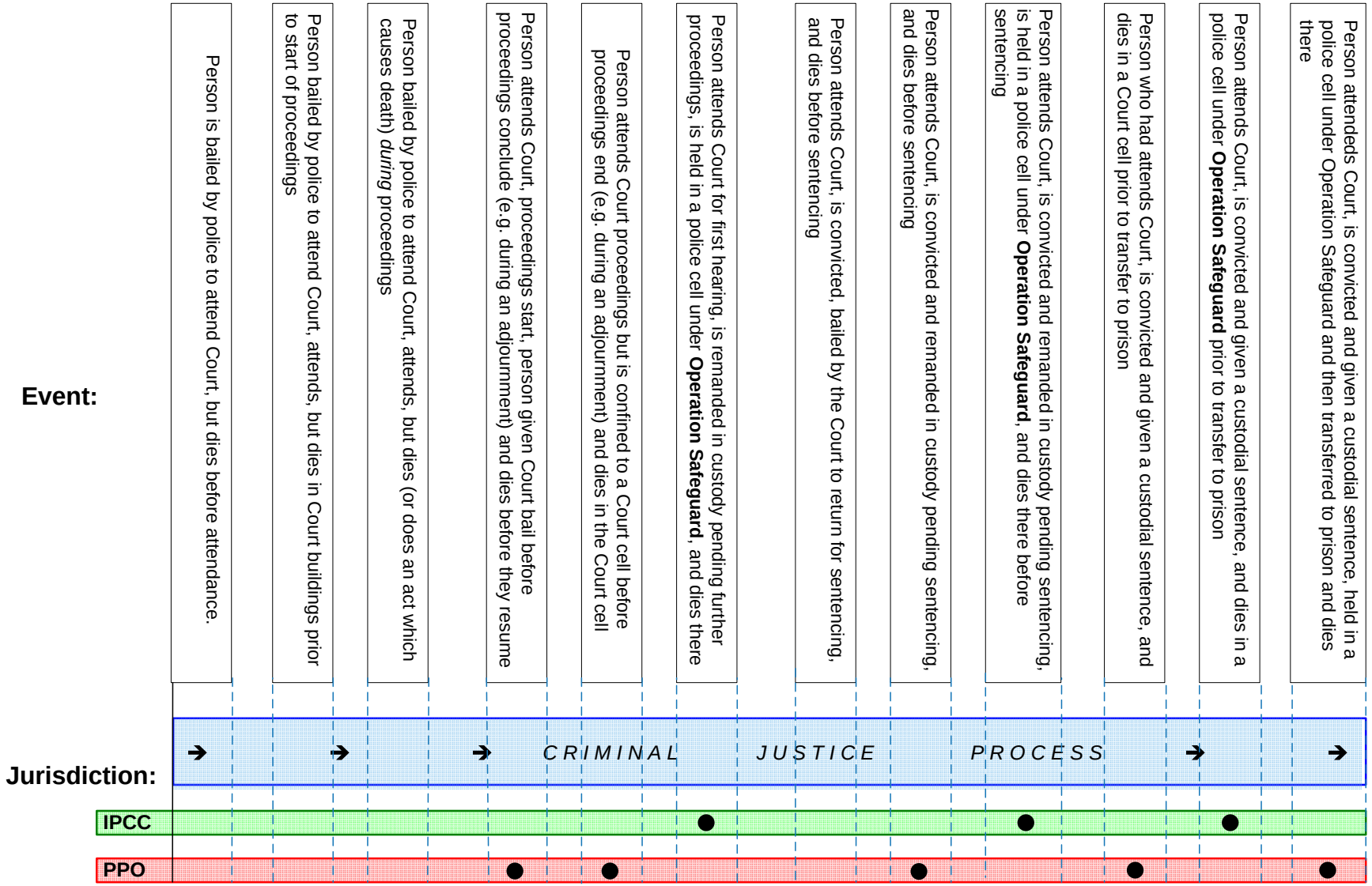
# 4. Findings: Other gaps in the criminal justice system

While it would therefore appear that there are no jurisdiction issues in terms of the deaths of Operation Safeguard prisoners, this work has revealed certain scenarios within the criminal justice system in which jurisdiction issues do arise.

## 4.1 The adult criminal justice system

Chart 1 below shows the circumstances in which neither the IPCC nor PPO believe they would automatically be required to investigate the death (though, as already noted, other specific aspects of the circumstances of a death might be the subject of investigation).

***Chart 1: Deaths on police bail, pre-trial, during trial, and post-trial***




KEY: A black marker indicates which organisation would investigate in the corresponding scenario. NOTE: Where the chart indicates that the IPCC would not investigate, the IPCC *could* nevertheless investigate if detention by or contact with police took place that may have contributed to the death. This would be an investigation of the police involvement, not the death.

.

In some cases, these gaps do not raise issues in terms of Article 2: where a person is convicted, but bailed to return for sentencing (for example) and dies prior to sentencing while still on court bail, this is not a death in custody, and therefore probably does not engage Article 2 in the absence of any factors suggestive of cause or contribution to the death by state agents.

There are, however, two sets of circumstances in which a death would engage Article 2 but an independent investigation would nevertheless be unlikely.

### 4.2 Defendants who are bailed to attend Court and die at Court either (i) before proceedings or (ii) during proceedings

Both scenarios would be rare but not impossible (or unprecedented). If the person was on police bail, the IPCC would investigate the death if the circumstances suggested that police custody/contact might have caused or contributed to it, albeit only up to the point where that possibility could be ruled out. They would also investigate if, for example, police officers had been involved with the person at the court building. They would not investigate otherwise.

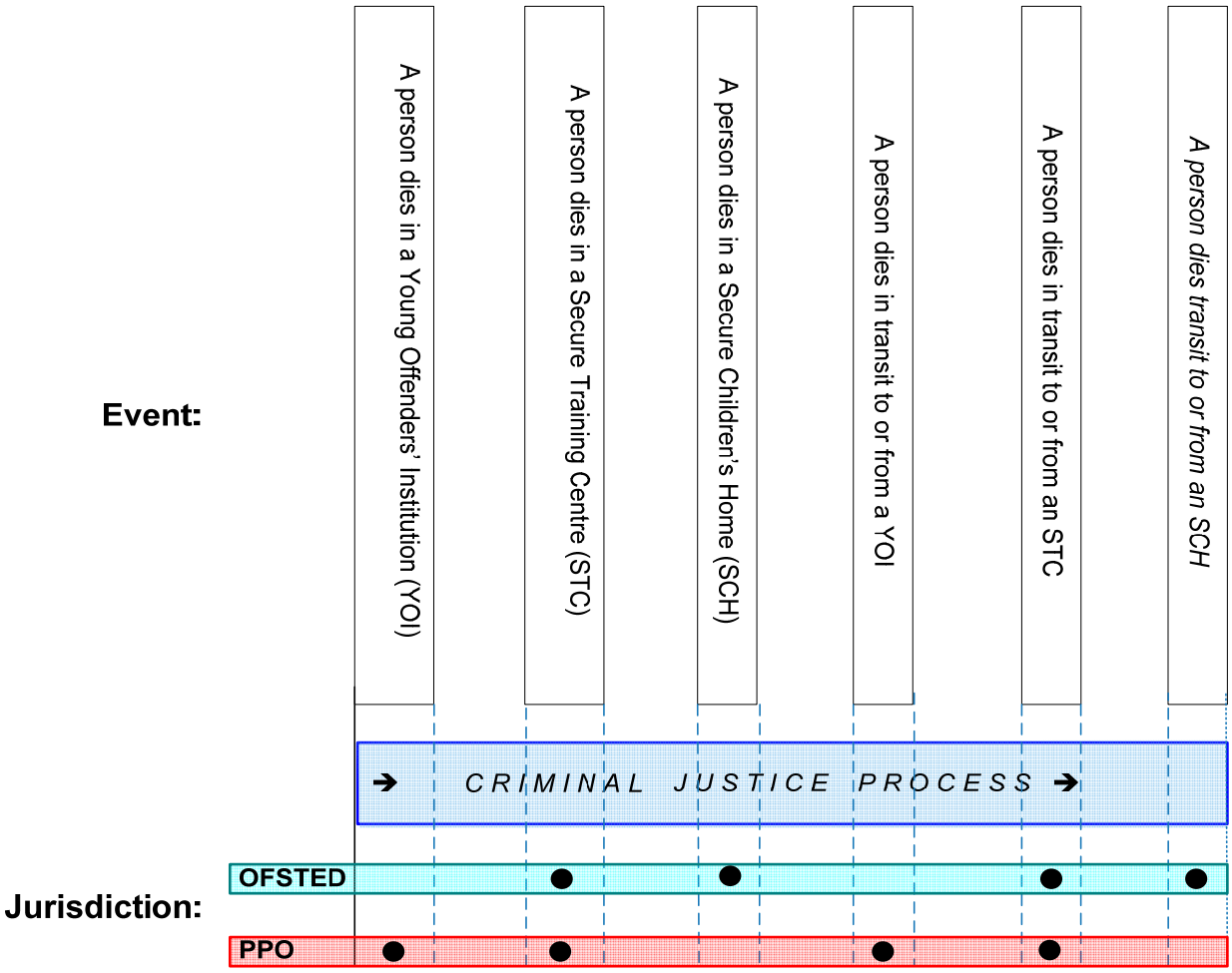
Once a person answers bail, s/he is deemed to 'surrender' to the custody of the Court: they are legally required to be there and are not permitted to leave. They are therefore in custody, at least in a technical sense. If a person is in the custody of the court, they are, by extension, in the custody of the state, so Art. 2 would almost certainly be engaged if a death was to take place. The s.92 definition of prisoner in the 1991 Act (above) could theoretically apply to a person in these circumstances, but the PPO believes it would not, in practice, investigate: the death would be investigated by the local police working on behalf of the Coroner.

Given the role of the police in gathering evidence against the defendant, arresting him or her, (possibly) detaining him or her, working with the prosecuting authorities, charging him or her and bailing him or her to return to Court, it must be open to doubt whether the investigation would be sufficiently independent in practical terms to comply with Article 2.

### 4.3 The youth justice system

Chart 2 below shows who would be responsible for investigating or reviewing deaths which take place at various stages of the youth justice process. Here, there are also two sets of circumstances in which a custody death might not be independently investigated (while these scenarios are specific to the youth justice system, it is also theoretically possible that a child or young person could also die in either of the two scenarios identified above).

***Chart 2: Deaths of detained children and young people***




KEY: A black marker indicates which organisation would become involved in the corresponding scenario.

NOTE: In the scenarios in which the chart shows that Ofsted would 'become involved', they would conduct an unannounced *establishment inspection* to ensure the safety of the establishment (or transfer procedures) for other residents, rather than an investigation of the death. This would also happen in the event of a death in a Secure Training Centre, although the PPO would also investigate the death in that event, unlike a Secure Children's Home death in which there would be no investigation as such (other than by the police in certain circumstances).

## 4.4 Children who die in (or in transfer to/from) a Secure Children's Home

While it is agreed that the PPO would investigate in all circumstances in which someone died in or in transfer to/from either a Young Offenders Institution or a Secure Training Centre, he would have no jurisdiction over a death which took place in a Secure Children's Home (or in transfer to or from one). Instead, an inspection of the establishment would be conducted by Ofsted following any death, to ensure that it is safe for other residents.

In addition, from 1st April 2008, Local Safeguarding Children Boards (LSCBs) are obliged to carry out a child death review following any unexpected child death in their area. This process involves the setting up of an LSCB sub-committee, accountable to the LSCB Chair. It will involve a nominated consultant paediatrician from the local NHS PCT, and will also work in partnership with other relevant agencies including, where appropriate, the CPS and the Coroner. Recording and monitoring must conform to the applicable NPSA standards. Where the circumstances of the case meet the criteria for a Serious Case Review to be carried out, the LSCB will commission one. Several of the criteria are relevant for Forum purposes, including whether the child apparently committed suicide and/or whether they died in a custodial setting (YOIs and STCs are cited as examples) and/or whether they were *abused* in an institutional setting (SCHs are given as an example). The criteria are silent as to the position of a child who dies, but was not apparently abused, in an SCH, although the Youth Justice Board are of the view that, in practice, it would be highly unlikely that a Serious Case Review would not take place in the event of a death in a YOI, STC or SCH.

It is clear that the Serious Case Review process is intended to work *in parallel* with investigation processes: while there is an emphasis on lessons-learning, the relevant guidance states that it is specifically *not* an investigation of the death or possible culpability (para 8.4, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children,* Department for Education and Skills, 2006). It is also a paper-based review, and indeed the DFES guidance suggests that the PPO report may often *assist* the Serious Case Review. Clearly, this could only happen if the PPO has investigated the death.

### 4.4.1 The Article 2-compliance of these arrangements

It seems highly unlikely that either an Ofsted inspection or a LSCB child death review or serious case review could comply with Article 2, or was ever intended to do so. This is for the following reasons:

1. Neither of these processes focuses on the death, except insofar as the circumstances of the death are relevant to the investigative objective of establishing the safety of the establishment and learning lessons;

2. Neither an establishment inspection nor a paper-based serious case review is likely to be deemed a sufficiently adequate investigation. *Jordan v UK* provides an illustration of what the Courts are likely to require:

   > *The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including inter alia eyewitness*

*tests, forensic evidence and, where appropriate, an autopsy, which would provide a complete and accurate record of injury and an objective analysis of clinical findings including the cause of death.*

3. LSCBs are part of the machinery of local government. It is doubtful whether a review conducted by an LSCB is sufficiently institutionally independent of any SCH which is run by the local authority, or indeed one run by private contractors on behalf of a local authority. (Admittedly, the Ofsted inspection is less likely to face this difficulty);

4. Presumably, legislators did not envisage the need for *two* Art.2-compliant investigations to be carried out: why would the guidance to Serious Case Reviews note the involvement of the PPO (and indeed encourage reference to his report) if their review was intended to replace a PPO investigation? The guidance refers explicitly to the role of the PPO in investigating deaths '…where a child dies in a custodial setting'. It seems clear that the two processes are intended to complement one another.

Clearly, if there are (or may be) suspicious circumstances, the local police would also investigate, and, unless someone was charged with a homicide offence, the matter would end up in the hands of the local coroner. However, it seems unlikely that the ambit of the police enquiry would be sufficient to satisfy Article 2: the police enquiry is unlikely to focus on how future deaths in similar circumstances might be avoided, or on identifying dangerous practices which fall short of an offence of gross negligence manslaughter (for example).

It is therefore likely that none of the processes described above following a SCH death would in themselves comply with Article 2: both conceptually and in terms of objective, there are significant differences between an establishment inspection or paper-based review and a death investigation. It is doubtful whether the Art.2 requirement of effective investigation (i.e. one not conducted in a way which undermines its ability to establish key facts) could ever be satisfied by either process. It is also doubtful whether any of these processes could satisfy the other ingredients of Article 2 such as next-of-kin participation or public scrutiny in cases where these were required. While an inquest would, of course, take place following such a death, the Coroner would not have the resources to collect forensic evidence or eyewitness first accounts (for example) and an inquest, unsupported by an independent evidence-gathering process, is unlikely to be sufficient to satisfy the Article 2 investigative obligation[3].

It therefore appears that, at present, the state would find itself unable to discharge its Article 2 investigative obligations in the event of a death in a Secure Children's Home.

### 4.4.2 PPO jurisdiction over SCH deaths

As is probably now clear, the conclusion to which this research points is that it is in some ways anomalous that the PPO investigates YOI and STC deaths but not SCH deaths, for the following reasons. In terms of the youth justice system, STCs and SCHs may under certain circumstances be used interchangeably to house children, although importantly, SCHs are also used for reasons unrelated to criminal justice. Certainly, the

[3] *Ramsahai v Netherlands* [2007] ECHR 393

child in SCH detention is in a position analogous to a prisoner in terms of the vulnerable position in which they are placed by being detained (emphasis was placed on this by the House of Lords in *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74. Where a child is placed in a secure bed and is not permitted to leave, the notion that they are not in a 'custodial setting' (in the words of the DFES guidance) seems almost inarguable. It seems strange that the Ombudsman should have responsibility in respect of two of the three types of custodial setting used for children and young people, but not the remaining one.

That said, it is clear that there is a range of views on this, and the arguments against creating two systems in one SCH must be acknowledged. Questioned on the proposed exclusion of children in SCHs from his *complaints* remit during the passage of the Criminal Justice and Immigration Bill, the Ombudsman himself argued that having two procedures in the one institution – one system for those held under criminal powers, one system for those held for other reasons – was not child-friendly. The same argument could presumably be made in respect of fatal incidents investigation. Alternatively, it could theoretically be argued that the Ombudsman should investigate the deaths of *all* SCH residents, regardless of how and why the deceased child came to be there. Leaving aside the obvious and significant resource implications that this could have for the Ombudsman, this would clearly be undesirable since, as already noted, many children in these surroundings are not there as a result of offending behaviour. From the outset, a child who is residing in an SCH as a result of the decision of a criminal court has more in common with a prisoner than one who is residing in a SCH for other reasons, so the death of such a child may be seen as a more logical subject for the Ombudsman to investigate, but even if this argument is not accepted, the Article 2 duties apply equally to all children detained by the state in a SCH, and *some* Article 2-compliant mechanism (or mechanisms) is required for the investigation of the death of any child in this position: at present, none seems to exist.

# 5. Findings: mental health services

## 5.1 The investigation process for deaths in mental health settings

As already noted, unlike the criminal justice system, there is no single person or agency which is automatically responsible for investigating the deaths of patients in mental health settings: such investigations are commissioned by the relevant Strategic Health Authority as and when required, and are expected to conform to the provisions of the NPSA's Good Practice Guidance (February 2008). (It should also be noted that such deaths are not reportable to the Coroner[4], which arguably makes Article 2-compliant investigation even more important). Whether the person commissioned to conduct the investigation is sufficiently independent for Article 2 purposes will therefore depend in each case on who is commissioned: presumably, legal advice on this question would be sought by the SHA prior to commissioning (unless that person's independence was beyond doubt).

[4] In practice, the Coroners Society of England and Wales advise that the death of any *detained* patient would, in fact, be reported. However, deaths of voluntary patients, or those who are not formally detained but *de facto* detained (which may still engage Article 2) would not.

The guidance describes the independent investigation process as having three stages. Stage 1 is an internal management review by the mental health trust, to be conducted by a person appointed by the mental health trust CEO or an executive board member. It should be carried out within 72 hours of the death, and should aim (among other things) to identify any issues requiring urgent action, secure any potential evidence, identify potential witnesses, and make contact with other relevant agencies, such as the police.

Stage 2 is an internal investigation by the mental health trust. An oversight group should be established, to identify a senior mental health trust figure to carry out the investigation, liaise with the SHA and other bodies, establish a chronology, and establish the cause(s) of the death. The investigation should be complete within 90 days. This process is expressed to be '…a necessary precursor to the independent investigation[5]' and is also intended to be a '…means of informing the scope and terms of reference for the independent investigation[6]'. It is also intended to compile an investigation report, to include any recommendations which appear appropriate based on the evidence gathered.

Stage 3 is the independent investigation. Where the necessity for one to take place is unclear, this should (according to the Guidance) be decided at the initial stakeholder meeting attended by (among others) the mental health trust. Part of its process is intended to be a review and critique of the internal investigation[7].

## 5.2 Article 2 compliance

The conclusion to which this research points is that there are a number of issues in terms of the Article 2-compliance of these arrangements[8].

### 5.2.1 Stages 1 and 2

The primary issue with the 3-stage 'independent investigation' process, as described in the Guidance, is that only Stage 3 could in fact be deemed independent in terms of the Article 2 case law. The Guidance is silent as to why the internal investigation is a necessary precursor to the independent investigation. While it is certainly conceivable that, in some circumstances, the internal investigation may help to determine the terms of reference and issues for the independent investigator, as the Guidance suggests, there does not seem to be any reason in principle why the independent investigators could not determine these for themselves, as they would in investigations in other custodial sectors.

[5] *Independent Investigation of Serious Patient Safety Incidents in Mental Health Services: Good Practice Guidance*, NPSA, February 2008, p.9

[6] *Ibid,* p.9

[7] *Ibid,* p.11

[8] It should, however, be noted that the Forum is made up of a variety of interests and views. The views expressed in this paper do not necessarily reflect the view of every Forum member or member organisation, and the Department of Health have made clear that they do not accept some of the views expressed in Section 5 of this paper, or the corresponding conclusions in Section 6.

In the model suggested by the Guidance, Stage 1 -- the process of evidence-gathering and identifying witnesses (among other investigative steps) would fall to the mental health trust in whose sphere of responsibility the death took place. It cannot be argued that there is no institutional or hierarchical connection between the mental health trust employees who are charged with taking these steps and the employees of the same trust who may be implicated in events. The House of Lords addressed exactly this point in R (JL) v Secretary of State for Justice [2008] UKHL 68, approving the view of the Forum's Chair that

> *Whenever a death or near-death occurs it is very important that a decision as to what kind of investigation is made quickly, before any evidence is disturbed or lost and before those who witnessed the events forget the details or have their accounts contaminated by the accounts of others. Obviously the more likely it is that there may be some culpability or some systemic failure associated with those that can give evidence, the more important it is that those investigating are independent of the people they are investigating.*[9].

It has been accepted both in domestic and Strasbourg jurisprudence that it is 'unavoidable' that the first steps of any investigation will be taken internally, and/or that there may be special circumstances that necessitate immediate action (such as potential loss or destruction of important evidence in the event of delay). Some investigative activity by colleagues of those implicated in events will not always therefore render the investigation non-compliant, but this will depend on the facts of each case and whether or not 'an independent element' is added to the preliminary investigation 'as soon as possible[10]'. Presumably, this will be possible in most cases in far less time than it would take for a management review to be carried out. Guidance is general in nature by definition, and unless 'special facts and circumstances' exist, which the Guidance presumably does not envisage in every case, investigative action beyond the minimum that is necessitated by time constraints by colleagues of those who may be implicated may well amount to a breach of the Article 2 investigative obligation (*Ramsahai v the Netherlands* [2007] ECHR 393 and R (JL) v Secretary of State for Justice [2008] UKHL 86).

Moreover, the Guidance does not time-limit the activities of the mental health trust to the immediate aftermath of the death: it suggests that Stage 2, the internal investigation, should be completed 'within 90 days'. Any urgent forensic opportunities (for example) are therefore unlikely ever to be available to the independent investigator by the time s/he becomes involved (admittedly, in cases in which a crime may have been committed, these opportunities would be explored by the local police, but this will not always be the case). In *Ramsahai,* a police shooting case, a delay of fifteen-and-a-half hours to the arrival of the independent investigators was held to be unacceptable where that agency could have commenced their investigation in far less time.

Admittedly, the authorities relied upon in drawing these conclusions are police or prison cases, and it could be argued that these should be distinguished from the deaths (or near-deaths) of detained patients. Undoubtedly, there are distinctions to be drawn between prisoners and detained patients, the most obvious one being that detained patients are detained to facilitate their treatment rather than as a punishment. Are these distinctions relevant for Article 2 purposes? The Strasbourg case law suggests not: the

[9] *R (JL) v Secretary of State for Justice* [2008] UKHL 68, para 94
[10] Ibid.

deprivation of liberty, and the detainee's resulting vulnerability have historically been the determining factors[11]. More recent domestic case law would seem to put this beyond doubt: in the recent test case of *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74, Lord Rodger concluded

> Plainly, patients, who have been detained because their health or safety demands that they should receive treatment in hospital, are vulnerable. They are vulnerable not only by reason of their illness which may affect their ability to look after themselves, but also because they are under the control of the hospital authorities. Like anyone else in detention, they are vulnerable to exploitation, abuse, bullying and all the other potential dangers of a closed institution*. Mutatis Mutandis,* the principles in the case law which the European Court has developed for prisoners and administrative detainees must apply to patients who are detained[12].

The elements of *detention* and consequent *vulnerability* form the fulcrum on which these authorities balance. Clearly, a detained patient is in the same position in these respects as a prisoner or any other type of detainee. The Article 2 obligations are therefore likely to apply equally.

While, as already noted, the case law suggests that pressing, practical reasons may justify a short delay to the involvement of the independent investigator, it seems equally clear that, if his or her involvement is not even considered or decided upon until an entire internal investigation has been conducted, including preparing a report and recommendations, there can be little doubt that this breaches Article 2, both in terms of independence and promptness (another ingredient of the Article 2 investigative obligation). That said, it should be noted that the Department of Health have suggested that, in some cases, an independent investigation would be decided on immediately, long before the internal investigation has reported. If that is the case, it may be appropriate to amend the Guidance to make this clearer, but even this is unlikely to be sufficient, since an independent initial investigation is automatically required in *all* cases in which Article 2 is engaged, and the independent element must be added to the investigation as soon after the death as reasonably possible.

### 5.2.2 The decision to begin an independent investigation

Notwithstanding the above, the Guidance as currently drafted suggests that an independent investigation – stage 3 in the above process – would not be automatic. It would depend on the results of stage 2 (the internal investigation) and the decision to commission an independent organisation would itself be arrived at as a result of a meeting with the internal investigators (among others). Arguably, the involvement of the body which may be implicated in events in this decision means that the decision to begin the independent investigation is not itself taken independently. It certainly cannot be seen as adding independence to the process. Moreover, the Guidance specifically suggests that the decision to begin the independent investigation should be informed by

[11] See e.g. *Slimani v France* (2004) 43 EHRR 1068, in which the Article 2 obligation was held to extend to administrative detainees as well as prisoners

[12] *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74 para 49

the findings of the internal investigation[13]. If the internal investigation was inadequate for any reason, it may not have uncovered key facts or evidence, and the decision as to whether or not to begin an independent investigation may be taken in the absence of those facts or that evidence.

### 5.2.3. The legal status of the Guidance

Leaving aside the potential shortcomings of the process recommended by the Guidance, its provisions are in any event not legally binding. This means that the investigation model it advocates does not necessarily have to be adhered to in every case, and there is no sanction in case of breach of the Guidance. In *Govell v UK*, a case which related to the use of intercept material in a criminal court, the European Commission on Human Rights held that, because no statutory system governed the use of such material under the law at the time, the material had not been obtained 'in accordance with the law' as required by the Article 8 ECHR. The Commission had been referred to the existence of Home Office Guidelines on the subject, but noted that, since these were Guidelines only, they were not legally binding. (The ECtHR went on to approve of this line of reasoning in *Khan v UK* [2000] ECHR 195 and a long line of subsequent authorities, most recently *Marper v UK* [2008] ECHR 1600). It seems likely that the NPSA's Best Practice Guidance would be construed in a similar manner. Like the PPO, independent investigators of deaths in mental health services are not on a statutory footing, and it is not inconceivable that their independence could therefore be challenged in the courts even leaving aside the difficulties identified in sections 5.2.1 and 5.2.2.

# 6. Conclusion

## 6.1 The criminal justice system

If it is assumed, for the sake of argument, that investigations by the PPO under existing arrangements are Article 2-compliant, it is possible to conclude that there is provision for independent, Art. 2-compliant investigation in most of the circumstances in which a death in custody could take place in the criminal justice system (including Operation Safeguard).

However, even working on this assumption, lacunae nevertheless exist. It seems likely that this is because the law has never been tested in a death case which fell within one of these lacunae.

Novel situations such as these potentially provide the most fertile ground for learning opportunities, yet the identification of learning may well in practice be frustrated by the lack of an independent (or possibly even effective) investigation process. This danger would be removed if Art. 2-compliant provision for these circumstances was made *now,* rather than waiting until a death takes place. This research suggests that the following measures could make a real difference:

[13] *Independent Investigation of Serious Patient Safety Incidents in Mental Health Services: Good Practice Guidance*, NPSA, February 2008, p.9

1. Tightening the provisions for investigation of deaths in (or at) court, to remove any uncertainty as to who would investigate

2. Deciding on the best way to ensure that the death of any child detained in a SCH is investigated in an Article 2-compliant way. This is likely to require discussion between Ofsted, the PPO and the Youth Justice Board

3. As an interim measure, updating the PPO's Terms of Reference to remove any ambiguity as to his jurisdiction if the hoped-for legislation relating to the PPO is not forthcoming soon

Plugging these 'gaps' would at least ensure the best chance of learning from what has gone wrong when deaths do take place. However, all three of these recommendations must be read subject to the following.

### 6.1.1 The status of the Prisons and Probation Ombudsman

Self-evidently, none of these recommendations would be sufficient to allay doubts about whether or not PPO investigations provide the required degree of independence in the first place. As already noted, this is untested, but a change to the legal status of the PPO, not just his remit, would be required in order for Article 2-compliance to be completely assured.

An inescapable conclusion of this research, and the fourth (and over-arching) recommendation, is therefore that the legislation which would guarantee the PPO's independence and provide an up-to-date definition of his function, powers and jurisdiction should be tabled before Parliament immediately. This echoes the view of the JCHR, expressed in December 2004, that '…until such a statutory basis is provided, investigations by the Ombudsman are unlikely to meet the obligation to investigate under Article 2 ECHR' (JCHR, 3rd Report, Session 2004/05, para. 332).

### 6.2 Mental Health Services

As matters currently stand, there are fundamental problems in terms of the Article 2 compliance of the investigation regime for deaths in mental health services. The following measures could overcome these problems and form recommendations 5 – 7 of this paper:

5. Tighter, legally binding provisions, which require an independent investigator to be appointed immediately in all cases, and to become involved at a far earlier stage following the death, and to determine the scope of and issues for the investigation, without external influence;

6. A restriction, within those provisions, on the involvement of employees of the mental health trust within which the death has taken place: beyond the urgent first steps of an investigation, they should play no part in it. Where special circumstances exist which necessitate a greater extent of involvement, their involvement should be the minimum necessary to deal with those circumstances;

7. The inclusion within the remit of all independent investigations of the need to make such recommendations as appear appropriate on the evidence (if any) to help prevent future deaths

**Adam Barty**
**Forum for Preventing Deaths in Custody**

**January 2009**