Ministry of JUSTICE

REVIEW OF THE FORUM FOR PREVENTING DEATHS IN CUSTODY

Report of The Independent Reviewer

Robert Fulton

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1. The Safer Custody Group of the Prison Service, on behalf of the Parliamentary Under Secretary of State at the Ministry of Justice, Maria Eagle, appointed me to carry out the independent element of the government review of the Forum for Preventing Deaths in Custody (terms of reference at annex 1). This report sets out my findings.

2. The terms of reference require me to consider the Forum's interaction with ministers through the Ministerial Roundtable on Suicide and otherwise. In practice I have found it necessary to look at the Forum and the Roundtable together in considering how a more effective set of machinery for preventing deaths in custody might work in the future.

3. In conducting the review I have interviewed a range of participants in the Forum and Roundtable, attended meetings of both groups as an observer, and considered various ways in which the current arrangements might be improved. I am grateful for the cooperation I have received from everyone concerned, and particularly to Kate Eves, the secretary of the Forum, and to staff in the Safer Custody Group, Prison Service, for their assistance and constructive suggestions.

Summary of recommendations

4.1 The Ministerial Roundtable on Suicide in Prisons should be replaced by a Ministerial Board on Deaths in Custody, with senior representation from all the organisations which hold people in custody or which are otherwise concerned with the issue (paragraph 17).

4.2 The Forum on Preventing Deaths in Custody should be replaced by an Independent Advisory Panel on Deaths in Custody. This should be a small group, selected for relevant expertise, and whose members would not be representatives of government departments or operational services (paragraph 17).

4.3 The Independent Advisory Panel should be supported by a Stakeholder and Practitioner Group, whose membership would include many of the members of the existing Forum (paragraph 17).

4.4 The Panel and the Stakeholder and Practitioner Group should be serviced by a secretariat which would also act (jointly with the Ministry of Justice) as secretariat to the Ministerial Board (paragraph 28).

4.5 The secretariat should have a staff and budget which will enable it to act as an effective central point for learning and communication about means of preventing deaths in custody (paragraphs 29-33).

4.6 The cost of these arrangements should be shared between the Ministry of Justice, Department of Health and Home Office (paragraph 38).

4.7 Links should be established with other jurisdictions (Scotland and Northern Ireland in particular) through the secretariat (paragraph 37).

4.8 New statutory powers are not required (paragraph 35).

4.9 There should be a further review in three years time, after which the continuation of the arrangements would depend on how far they had in practice been instrumental in reducing the number and rate of deaths in custody (paragraph 14).

The Forum for Preventing Deaths in Custody and the Ministerial Roundtable on Suicide

5. The membership of the two groups is set out in annex 2. There is some overlap in membership, but there are important differences in the remits and ways of working of the two groups:

   - as its name indicates, the Roundtable is chaired by a minister, and it therefore gives participants direct access to ministers
   - service representation at the Roundtable is at the top level (Director General of the Prison Service), but more variable at the Forum
   - the Roundtable is concerned only with suicide and self-harm in (or connected with) prisons, Secure Training Centres, immigration detention facilities and approved probation premises. The Forum looks at deaths in custody from all causes, and in all settings, including police detention and secure psychiatric hospitals
   - the Roundtable receives detailed information and statistics on suicides in prison, including mortality rates as a proportion of the prison population and trends over time, and is able to base its conclusions on this information
   - the Forum is a much larger body, comprising not only the relevant operational services (police, prisons, Youth Justice Board, Borders and Immigration Agency, mental health services etc.) and their respective oversight and investigative bodies, but also the Coroners' Society and an NGO (INQUEST). Membership is open-ended and growing
   - although the Forum is sponsored by ministers, there is no direct formal link between it and ministers, through the Roundtable or otherwise.

Human rights background

6. The establishment of the Forum was prompted, at least in part, by the call from the Parliamentary Joint Committee on Human rights (in its Third Report, 2004-05 Session[1]) for a 'central forum to address the significant national problem of deaths in custody'. The Committee recommended that this should be 'a cross-departmental expert task-force' and an 'active, interventionist body, not a talking shop'; that the membership should be drawn from people with 'practical working experience of the problems associated with deaths in custody'; and that the body should have at its disposal human rights expertise.

7. The JCHR have, however, stated that, whilst the Forum is regularly cited in government sources as a response to the Committee's recommendations, the Committee is 'not persuaded that a body of this type, with no formal powers and few resources, could effectively provide the type of active and interventionist role envisaged by' the Committee.[2] Meanwhile INQUEST has been developing proposals for a standing commission which, as I understand it, would be a more independent and authoritative body, with powers to enforce standards of care complying with ECHR obligations.

8. There has nevertheless been a strong human rights component to the work of the Forum. At the most recent meeting, for example, there was an extensive discussion of the implications of recent judgements concerning Article 2 of the ECHR in cases where unsuccessful suicide attempts had resulted in permanent harm to the prisoners concerned (near-death cases).

[1] http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1502.htm

[2] Letter of 12th November 2007 to Rt.Hon. David Hanson M.P. (Minister of State, Ministry of Justice) from the chairman of the JCHR, Andrew Dismore M.P.

Strengths and weaknesses of the current arrangements

9. The following are what I see as the strengths which need to be preserved in any new arrangements:

- ministerial involvement, currently through the chairmanship of the Roundtable
- top-level operational service involvement, again at the Roundtable
- the accountability, and the authority to commit to action, which stem from the foregoing
- the inclusion of the relevant operational services and of those whose job it is to investigate deaths in custody (including coroners)
- the openness to external influence and scrutiny demonstrated by the inclusion of interested NGOs
- genuine commitment by everyone concerned to do all they can prevent deaths in custody
- some access to detailed, good-quality data, in relation at least to suicides in prison
- some sharing of information and good practice
- a broad and inclusive membership which enables everyone concerned with deaths in custody to come together to exchange views and information.

10. Against this must be counted a number of significant weaknesses:

- the Forum is too large and diverse to be effective as a decision-making and executive body, even if it were desirable that it should be
- it lacks authority: it has no inherent powers; its membership is of varying seniority; and it has no direct formal relationship with ministers or any other source of authority
- service members attend as representatives of their organisations, and are not therefore in a position to endorse conclusions which run counter to existing policy or have difficult cost or operational consequences
- the Forum is regarded by some of its members as the talking shop which the JCHR said it did not want. Some members do not see it as very relevant to their concerns
- outside the area of prison suicides, basic statistical data are often lacking. For example, there is a lack of population data for numbers held in police custody or mental hospitals of the sort which would enable mortality rates in those services to be compared with those in prison custody
- sharing of information and good practice is unsystematic
- the amount of attention given to different custodial settings and circumstances is uneven and not determined by an assessment of comparative risk. Deaths in prisons (particularly from suicide) and in Secure Training Centres (associated with the use of restraint) have received much more attention than other deaths, for example those of detained patients, which account for more than half of all deaths in custody
- there is uncertainty about how far it is appropriate or useful for the Forum to be used as a way of holding to account those responsible for operational services
- this gets in the way of openness about things that have gone wrong and the learning of lessons.

11. The Forum can take credit for some useful achievements, e.g. influencing ministers to secure improvements in the handling of coroners' Rule 43 letters, and a start on sub-group working which has produced a valuable report on the physical environment. Nevertheless, I do not believe that the weaknesses discussed above can be fixed by simply bolting powers and resources onto the Forum as presently constituted.

Why have special co-ordinating machinery for dealing with deaths in custody?

12. Before going on to consider possible replacement machinery for the Forum and Roundtable, we should consider why, if at all, special arrangements are needed in this area. The presumption must be that public bodies should not be created or perpetuated unless there is a clear justification for their existence. The fact that people die in distressing circumstances in our custodial institutions does not automatically mean that special machinery is needed to deal with the problem: it could be that what is needed is simply to improve the systems for preventing, investigating and handling the consequences of deaths in custody within the services concerned through the management processes of those services.

13. It is generally accepted, however, that more than this is needed (as was clearly the view of the Joint Committee on Human rights) on the grounds that:

- a death in custody is a uniquely serious and irremediable event
- there is a special duty of care towards those in custody
- the factors involved are many, complex and difficult
- many of these cut across the boundaries of individual services
- action within individual services, while essential, is therefore not sufficient
- deaths could be prevented (and the human rights of those concerned better protected) if there were more effective ways of learning lessons across sectors, and if decision makers at all levels were more effectively engaged.

14. These are strong arguments, but not necessarily conclusive ones. The acid test is whether whatever arrangements are put in place have any real effect in reducing the number and rate of deaths in custody. The Prison Service's work on reducing suicide in prison shows that progress can be made, and suggests that a more systematic approach across custodial settings could have the desired effect. I believe that the proposals presented in this report are practical and capable of leading to a reduction in the number and rate of deaths in custody, but recommend that there should be a further review in three years' time to see how they are working in practice. There should be no presumption that the proposed arrangements should continue if they are found not to be effective. The timing of such a further review would also tie in with the planned timescale for applying the provisions of the Corporate Manslaughter Act to deaths in custody.

A proposed new structure

15. New arrangements to build on the work of the Forum and Roundtable, and overcome the shortcomings identified above, should (taken as a whole) be:

- authoritative: the key decision-makers (i.e. ministers and service heads) should be engaged
- effective: real action should result which reduces the incidence of death in custody
- expert: decisions at all levels should be informed by the best available expert advice, based on reliable evidence
- independent: there should be a capacity for recommendations to be made which would involve changes to existing government policy or which might have difficult financial or operational consequences, if considered desirable in the interests of preventing deaths in custody
- representative: everyone with an interest in preventing deaths in custody should have the opportunity to contribute.

16. Given the number and variety of the people who need to be involved, and their very different roles, a structure with more than one tier is likely to be needed. I have sought however to keep this as simple as is consistent with ensuring that everyone concerned has the opportunity to contribute effectively in a suitable forum. One important feature of these proposals is that the responsibilities of the ministerial group will be fully aligned with those of the rest of the system, so that there is consistent coverage at all levels of all aspects of deaths in custody, and a clear chain of accountability.

17. The principal features of this new structure are set out in the organogram at Annex 3, and are as follows:

- *A Ministerial Board on Deaths in Custody.* This would replace the Roundtable, with terms of reference extended to include all types of death in custody. Its membership would be enlarged to include the police minister in the Home Office, and representation of the police and special hospitals at equivalent level to that of the services currently represented. It would be a fairly large body (about 20 members), but still I believe manageable for the functions it was expected to perform (see Annex 4). It would have on it all the top people with the authority to make things happen, and would be the key means of ensuring that the issue of deaths in custody was kept prominently in the minds of ministers and service leaders
- The Board would be chaired by the lead minister at the Ministry of Justice, with Home Office (police) and Department of Health (secure services) ministers as co-chairs.
- *An Independent Advisory Panel on Deaths in Custody.* This would be the principal source of advice to the Ministerial Board, and its independent chair would be a member of the Board. The membership would have some similarities with that of the Forum, but it would be organised differently to enable the Panel to form independent judgements whilst at the same time being able to draw on the knowledge and experience of members of the operational services and others
- The Panel itself would consist of a small number of independent individuals selected for their expertise in matters connected with deaths in custody (i.e. not as representatives of government departments or operational services)
- The Panel would be supported by a broadly-based *Practitioner and Stakeholder Group*. This would be an open-ended and potentially large group, comparable to the existing Forum (which currently has some 30 members and is still bringing more organisations on board). However, most of its work would be done in standing or ad-hoc working groups, co-ordinated by the secretariat under the direction of the Chair of the Panel. Plenary meetings might best be held in the context of an annual deaths in custody conference, to which members of the Ministerial Board and other interested parties (e.g. bereaved families and staff with first-hand experience of deaths in custody) could also be invited.

18. The Panel would be expected to take account of the views of the Practitioner and Stakeholder Group, and to ensure, through the participation of the members of the Group, that its deliberations were grounded in practical reality. But the ultimate responsibility for recommendations and guidance would rest with the Panel, who would be free to report as they saw fit even if this did not have the unanimous support of the Group.

19. The Chair and members of the Panel should be appointed through open competition in conformity with the Code of Practice of the Commissioner for Public Appointments. The Chair will need to be someone of sufficient stature and authority to lead a group of senior experts, and to exercise influence over ministers and other senior figures. The Chair's terms of appointment should ensure that he or she can devote sufficient time to the job – likely to be about one day a week.

20. Outline terms of reference for the Board, Panel and Practitioner and Stakeholder Group are attached at Annex 4.

Working methods

21. It would be for the Chair of the Panel to determine the work programme of the Panel and of the Practitioner and Stakeholder Group, taking into account any views expressed by ministers or the Ministerial Board about priorities.

22. A first priority in the work programme should be to improve the database on deaths in custody and related incidents, so that subsequent work can be based on an evidence-led assessment of where action is most needed and would be most effective.

23. The Panel's programme of work would be taken forward through a combination of:

- studies carried out by working groups consisting of Panel members, members of the Practitioner and Stakeholder Group and others. These are likely to include standing groups on topics such as human rights or suicide, and ad-hoc groups for particular tasks
- cross-cutting reviews conducted in co-operation with inspectorates, investigative bodies and others
- a research and statistics programme commissioned both directly by the Panel and through the influencing of priorities within Departmental programmes. I have proposed a small research budget for the Panel, but this is only enough for seedcorn funding: the bulk of the research effort will still need to come from Departments and other organisations represented on the Ministerial Board and the Practitioner and Stakeholder Group
- monitoring the implementation and effectiveness of guidance and recommendations issued by the Panel.

24. The Panel would not be responsible for investigating individual deaths in custody, since there already exist adequate independent arrangements for this in most instances. But where patterns seemed to be emerging of problems or unsatisfactory practice, the Panel could carry out a review to ensure that the right lessons were learned and applied.

25. The output of the Panel's work would take the form of guidance on policy and best practice, including examining the scope for recommending common standards for measures to prevent deaths in custody. Depending on the circumstances, the panel could either issue guidance on its own account, seek the endorsement of ministers through the Ministerial Board, or put recommendations to ministers or service heads for action to be taken by them.

26. Under this proposal, the Panel would have no powers of its own to enforce compliance with its guidance and recommendations. This would require legislation (discussed further in paragraphs 34-35 below). Insofar as Panel recommendations and guidance were accepted by them, it would be for ministers and service heads to ensure their implementation, and to be accountable for the consequences of any failure to follow best practice as recommended by the Panel.

27. The Panel would submit an annual report to the co-chairs of the Ministerial Board. This would be published and presented to Parliament. Panel guidance and recommendations would also be made public, together with the response to such recommendations.

Secretariat

28. In order to ensure good co-ordination, a single secretariat should service the Board, the Panel and the Practitioner and Stakeholder Group. In the case of the Board, this would be as part of a joint secretariat with the sponsoring unit in the Ministry of Justice (the latter being responsible for briefing the co-chairs on Departmental positions). For administrative purposes it might be convenient to attach the secretariat to the sponsoring unit in the Ministry of Justice, but the secretary would need to be clearly independent and report to the Chair of the Independent Advisory Panel.

29. The secretariat would need the capacity to service the meetings of the Board, of the Panel, and of working groups under the panel. If the Board were to meet twice a year and the Panel quarterly, this would be six major meetings a year, plus the working groups. Organising an annual conference, as suggested in paragraph 17, would be another significant commitment for the secretariat.

30. The secretariat would be responsible for drafting the Panel's annual report and papers for consideration by the Board, Panel and working groups.

31. But the secretariat would need to do more than this: it should (under the direction of the independent Chair) be an active body with the capacity to drive action, think and influence. It should in particular be the central clearing house for information and learning about deaths in custody, commissioning and directing research, collecting information about deaths and their circumstances, and disseminating findings. It should also have the capacity to monitor progress on implementing agreed standards and practices on behalf of the Board and the Panel.

32. The secretariat should also have access to the expertise needed to maintain an up to date and informative website for practitioners and other interested parties, and issue e-bulletins to update them on new developments and lessons learned. The website is an essential tool for communicating about the work of the Panel, and should be seen to be independent of those of other organisations. The secretariat will also need access to general communications support for preparing publications, answering media enquiries etc. on behalf of the Panel.

33. I propose a secretariat of three people:

- a grade 7 head of secretariat, to be secretary of the Independent Advisory Panel and the Practitioner and Stakeholder Group, and joint secretary of the Ministerial Board. The secretary would report directly to the Chair of the Independent Advisory Panel.
- a deputy head at SEO or equivalent level. The holder of this post would take the lead on research, statistics and communications. The role would involve the commissioning of research and data collection, liaison with departmental and external research organisations, maintaining the Panel's website and disseminating information through electronic bulletins and paper publications. The postholder should have relevant skills to undertake these tasks, and a research or statistics background would be an advantage
- an administrator at around EO level.

Powers and statutory basis

34. The foregoing proposals do not depend on legislation to give the Board and Panel express powers, but rely on the authority of ministers and heads of the relevant services to ensure implementation (if accepted) of the Panel's recommendations and guidance. There is however a body of opinion which holds that an independent panel or commission should have statutory authority. This is on the grounds that:

- the body concerned would be more effective if it possessed powers of its own to ensure compliance with its rules and standards, through formal investigation and enforcement procedures (by analogy for example with the Human rights and Equality Commission or the Health and Safety Executive)
- a statutory basis would signal the importance of the task, and protect the body from future political change which might diminish its standing.

35. Whilst these arguments have force, I do not at this stage recommend putting the proposed arrangements on a statutory basis or giving the Panel statutory powers, for the following main reasons:

- where recommendations involve changes of policy or affect resource or operational priorities, I believe that it is better for authority to remain with ministers who are accountable for these matters (and who would have to defend publicly any decision not to implement a Panel recommendation)

- there may not be an early opportunity for legislation, and it would therefore be better to have a scheme which works without it, at least to start with
- legislation would introduce a degree of inflexibility which could be troublesome if experience suggested the arrangements needed to be changed. The further review after three years which I have recommended (see paragraph 14) might result in such changes
- when the Corporate Manslaughter Act comes into force in relation to deaths in custody, compliance or otherwise with the Panel's guidance or recommendations would no doubt be a relevant consideration in any prosecution. The recommended three-year review will provide an opportunity to check whether the proposed arrangements are proving fit for purpose in this respect.

Other jurisdictions

36. Concern has been expressed about the lack of co-ordination with other jurisdictions in the UK (Scotland and Northern Ireland) and beyond. I am sure that there would be benefit in exchanging information and lessons with other jurisdictions, but it would overload the arrangements I have proposed, which already include a very wide range of interests in England and Wales, to directly include representatives of other jurisdictions. In any case the legal framework elsewhere for dealing with deaths in custody can be very different – notably in Scotland.

37. Instead, I propose that it should be a responsibility of the Panel secretariat to establish effective links with those responsible for these matters in Scotland, Northern Ireland, the Channel Islands, Isle of Man and other jurisdictions. Correspondents in those jurisdictions would receive bulletins on lessons learned, and be invited to contribute to them where that would be useful. They could also be invited to participate in working groups of the Panel and the Practitioner and Stakeholder Group if they had something to contribute, and be invited to the annual conference proposed in paragraph 17.

Cost

38. I have provided Safer Custody Group, Prison Service, with a breakdown of the likely costs of the proposed new arrangements. I estimate that these will be in the region of £270,000 per year, including £154,000 for the cost of the secretariat and a research budget of £50,000. The equivalent current cost of the Forum is around £60,000, so the additional cost will be around £210,000. I recommend that the cost of the new arrangements should be shared between the three Departments concerned – Ministry of Justice, Home Office and Department of Health.

39. The foregoing figures do not include the cost of the time spent by participants in meetings of the Forum, Roundtable and proposed successor bodies. Although there will be some additional senior participants at the Ministerial Group (representing policing and the secure hospitals), I expect there will be fewer large meetings, and that the net cost (around £30,000) should be about the same or slightly less.

Robert Fulton 21st December 2007

ANNEX 1

GOVERNMENT REVIEW OF THE FORUM FOR PREVENTING DEATHS IN CUSTODY

Terms of Reference

To review the role and functions of the Forum for Preventing Deaths in Custody and to recommend how these might be strengthened. The review will include a fresh look at the Forum by a suitable person not connected with it, and report to Maria Eagle by 31 December with conclusions and costed proposals.

The review will take account of:

- other relevant organisational models;
- the Forum's independence from government, its interaction with Ministers through the Ministerial Roundtable on Suicide and otherwise;
- its membership, powers, resources and capacity;
- the Forum's collective and individual accountabilities, and its need effectively to employ the levers that influence delivery in its member organisations.

ANNEX 2

MEMBERSHIP OF THE FORUM FOR PREVENTING DEATHS IN CUSTODY AND THE MINISTERIAL ROUNDTABLE

Organisation	Forum member	Roundtable member
Association of Chief Police Officers	Deputy Chief Constable, Thames Valley Police	No
Border and Immigration Agency	Head of Detention Services	Deputy Director General
Coroners' Society	Representative	No
Department of Health	Head of Policy, Mental Health High and Medium Secure Services Director of Offender Health Senior Public Health Consultant, Offender Health	Senior Public Health Consultant, Offender Health
HM Inspectorate of Constabulary	Inspector	No
HM Inspectorate of Prisons	Inspector	Chief Inspector
Prison Service	Head of Women and Young People Group	Director General
Safer Custody Group, Prison Service	Head	Head
Home Office, Policing Powers and Protection Unit	Representative	No
Independent Police Complaints Commission	Deputy Chair* (Chair of Forum) Commissioner	No
INQUEST	Co-Director	Co-Director
Mental Health Act Commission	Head of Information, Advice and Second Opinion Service	No
National Offender Management Service and National Probation Directorate	Head of Offender Management	Head of Offender Management
Prisons and Probation Ombudsman	Ombudsman	Ombudsman
Youth Justice Board	Representatives	Representatives
Parliamentary Joint Committee on Human rights	Observer	No
Private sector custodial establishments	Representative (Managing Director level)	No
Howard League for Penal Reform	No	Director
Prison Reform Trust	No	Director
Samaritans	No	Representative
Independent Monitoring Boards	No	Chair of National Council
	**currently Group Legal Director, Equality and Human rights Commission, who remains as Chair of the Forum in a personal capacity*	

ANNEX 3

PROPOSED WORKING STRUCTURE ON DEATHS IN CUSTODY

Ministerial Board on Deaths in Custody

- Chair: prisons minister (MoJ); co-chairs: police minister (HO), secure psychiatric services minister (DH)
- Chair of Independent Advisory Panel on Deaths in Custody
- DG Prison Service, President ACPO, Chair YJB, Chief Executive BIA, DH director(s) responsible for offender health and special hospitals
- PPO, IPCC, HMCIP, HMCIC, Coroner's Society
- Directors: Howard League, Prison Reform Trust, INQUEST, Samaritans
- Senior representatives of Independent Monitoring Boards, National Association for Lay Visiting
- JCHR observer

Independent Advisory Panel on Deaths in Custody, and Practicioner and Stakeholder Group

- Independent Chair
- Experts of factors associated with deaths in custody (suicide and self-harm, restraint, substance misuse, psychiatric disorder, other medical conditions, etc.)
- Human rights expert
- Senior representatives of bodies responsible for investigating deaths in custody (PPO, IPCC, coroners)
- Operational experts in detention and custody (but not serving staff)

Practicioner and Stakehoder Group

- Open-ended, but to include representatives of police, prisons, YJB, BIA, private sector custody, HMRC, DH/NHS secure services, inspectorates, investigative bodies, NGOs, National Patient Safety Agency, etc.

Working Groups, composed of members of the Panel and of the Practitioner and Stakeholder Group

- Standing: e.g. operational, human rights, suicide/self–harm
- Ad-hoc: for particular reviews or tasks

ANNEX 4

MINISTERIAL BOARD ON DEATHS IN CUSTODY
INDEPENDENT ADVISORY PANEL ON DEATHS IN CUSTODY

Outline terms of reference

The shared purpose of the Board and the Panel is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of custody in England and Wales.

In pursuit of this objective -

The Ministerial Board will:

- ensure that ministers and service leaders continue to give the subject priority attention
- consider recommendations from the Independent Advisory Panel for changes in practice, and endorse them for implementation where appropriate
- use their authority to ensure that good practice (particularly that flowing from Panel guidance and recommendations) is consistently followed within the services responsible
- ensure that adequate arrangements are in place for deaths and related incidents to be properly investigated, and lessons learned and applied
- receive reports on trends and incidents, and commission action where the evidence indicates that this is necessary.

The Independent Advisory Panel will:

- act as the primary source of independent advice to ministers and service leaders (both through the Ministerial Board and where appropriate directly) on measures to reduce the number and rate of deaths in custody
- collect, analyse and disseminate relevant information about deaths in custody and the lessons that can be learned from them
- commission relevant research
- carry out thematic enquiries into areas of concern, in co-operation as appropriate with the relevant oversight and investigative bodies
- issue formal guidance (and where appropriate set common standards) on best practice for reducing deaths in custody, both on its own authority and where appropriate under the authority of the Ministerial Board
- monitor compliance with such guidance and standards
- where appropriate, make recommendations to ministers for changes in policy or operational practice which would help to reduce the incidence of death in custody.

The Practitioner and Stakeholder Group will:

- support the Independent Advisory Panel in the discharge of its functions
- contribute to Panel studies and reviews through standing and ad-hoc working groups
- ensure that information and learning is shared among the full range of organisations concerned with deaths in custody.

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