Independent Advisory Panel on Deaths in Custody
Response to the Prisons Strategy White Paper consultation – February 2022

Introduction

1. The role of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to advise Ministers and officials on how they can meet their human rights obligations to take active steps to protect lives, prevent deaths and keep those under the care of the state safe.[1] This response to the Prisons Strategy White Paper therefore provides input relevant to our single purpose of preventing all deaths, natural and self-inflicted, in custody.

2. Government must make the prevention of avoidable deaths in custody its top priority and prioritise the areas of prison policy and operations which would have the greatest impact in reducing them. In the 12 months to December 2021 there were a total of 371 deaths of people in prison – more than one death each day and the highest annual number of deaths ever recorded since current recording methods were introduced in 1978.[2] There were 86 self-inflicted deaths, an increase of 28% from the previous 12 months. Prisoners who were on remand had the highest rate of self-inflicted deaths at 37%, an increase on the previous year from 28%. There were 250 deaths classed as 'natural causes', a 13% increase from the previous 12 months. These numbers are only partly attributable to COVID-19.

3. The causes of deaths in custody are complex but well evidenced. To protect lives it is essential to get the basics right: ensuring adequate staffing levels and proper support and supervision; eradicating ligature points and observing health and safety requirements; delivering meaningful regimes and contact with families; and facilitating research and consultation with people with lived experience; and adequate response to expert scrutiny and implementing recommendations on how to prevent future deaths. Priority focus – and funding – should be on these issues before any further proposals are explored and delivered.

4. This response contains a summary of the IAPDC's contribution to this consultation then provides further detail on relevant questions. In keeping with its independent role to advise government on the prevention of deaths, the panel would welcome further discussion with relevant ministers and officials as this strategy is developed and delivered.

Summary

5. **The sole aim of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to prevent deaths in custody. Self-inflicted deaths and the number of avoidable deaths from 'natural causes' remain tragically high. The prevention of deaths must be at the heart of all proposals set out by Government and should form the heart of any strategy for the future of prisons.** *(paras 1-4)*

6. **Prisons are not safe places, and the planned expansion of the estate set out in this strategy presents a very real risk that the number and rate of deaths of people held under the care of the state will increase. Government should instead be investing in healthcare and community alternatives to imprisonment and, where absolutely necessary, be prioritising evidence-based design of new establishments which prioritises the prevention of deaths, replaces existing unsafe buildings, and meets the demands of the prison population's shifting demographics. Addressing fire safety risks in existing establishments must be a priority.** *(paras 17-18; 21-23)*

7. **The strategy should be used to introduce a statutory Safety Impact Assessment (SIA) for all major decisions concerning prison policy and practice. The panel agrees with the suggestion**

[1] Independent Advisory Panel on Deaths in Custody, About the IAPDC. Available at: https://www.iapondeathsincustody.org/about-us-1 [Accessed: 19/05//2021]
[2] Ministry of Justice. Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2021, Assaults and Self-Harm to September 2021. January 2022. https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2021/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-december-2021-assaults-and-self-harm-to-september-2021

made by the Prison Reform Trust, the measures in this strategy should be subject to an SIA.[3] *(paras 19-20)*

8. **The panel welcomes the commitment to increase the number of ligature-free cells in prison, though this approach must apply retrospectively to all cells where possible, not just new safer cells. Prisons must be actively instructed to review and remove avoidable ligature points and be provided with appropriate funding to do so. Learning from the secure hospital estate demonstrates that such an approach has a marked impact on the number of self-inflicted deaths.** *(paras 33-35)*

9. **All initiatives set out in the strategy, including those to enhance safety, must be underpinned by clear evidence, and research must be facilitated and incentivised in order to inform interventions. Interventions must be tailored to meet the diverse demographics of people in prison. The lack of attention to black and minority ethnic groups is a glaring omission from the strategy and must be rectified.** *(paras 27-32 and throughout)*

10. **The department should follow clear evidence on how lives lost from substance misuse can be avoided. Focus should fall on addressing the effects of alcohol misuse, not just on drugs. The strategy makes important proposals around strengthening the link between prison and health and community services. Prisoners should expect that they will receive continuity of treatment on release into the community.** *(paras 40-47)*

11. **Appropriate interventions to keep women in prison safe are well-established and evidenced. These should be delivered, including the outstanding commitments from the Ministry of Justice's own Female Offenders Strategy which incorporates recommendations made by the IAPDC to prevent suicide and self-harm amongst women in prison.** *(paras 50-55)*

12. **The strategy's focus on staff training is important, though greater focus is required on providing robust and prolonged support and supervision for staff. For example, there is currently very little in place to support staff and prisoners after the death of a person in custody and through the investigation and inquest process.** *(paras 56-59)*

13. **The importance of the continuity and consistency of prison leadership must not be underestimated when it comes to building a mutually supportive culture where all individuals feel valued and feel safe. It also contributes to more collaborative working with key partners, such as healthcare, and the sharing of best practice across establishments.** *(paras 60-61)*

14. **This strategy should be more closely aligned and integrated into the work of other government initiatives, agencies and departments to maximise the potential work ongoing elsewhere, and to support wider initiatives such as the Levelling Up agenda. Resolving issues caused by disjointed and ineffective commissioning of mental health services, for example, requires close collaboration with both local and national health partners and would help address some of the issues correctly identified as priorities in this strategy. Joint KPIs, and potentially budgets, would help strengthen partnerships and encourage more consistency in commissioning.** *(paras 65-67 and throughout)*

15. **Clear, measurable targets can sometimes drive progress. Any new set of KPIs should prioritise data about deaths in custody, especially suicides. A clear target should be established to reduce avoidable deaths. This could be based around targets set for the reduction of community suicides. Measurable targets should reference deaths related to substance misuse – correctly**

[3] Prison Reform Trust. Prison Reform Trust written response to the Prisons Strategy White Paper. February 2022. http://www.prisonreformtrust.org.uk/Portals/0/Documents/Consultation%20responses/Prisons%20Strategy%20White%20Paper%20PRT%20response.pdf

identified by the strategy as a key priority – as well as clusters of self-inflicted deaths. *(paras 65-67)*

16. **The intelligence provided by independent groups – meaning scrutiny bodies, and also charities, people in prison and bereaved families – is still underused, especially to inform the prevention of avoidable deaths. Scrutiny bodies must be encouraged to work together to share insights and provide evidence-based conclusions. The MoJ and HHMPPS must ensure greater accountability and assurance in implementing recommendations. The new prison performance dashboard should also contain data on the take-up of recommendations and matters of concern raised by investigators and inquests.** *(paras 68-71)*

Chapter One – A Roadmap to Building the Future Prison Estate

Q1. Do you agree that these are the right long-term ambitions for the prison estate?

Expansion of the estate

17. Prisons are not safe places, and any expansion of an already outsized estate will lead to an increase in deaths in custody. The reasons for building new prisons should only be in order to replace old, unsafe establishments which are no longer fit for purpose and to ease catastrophic overcrowding which continues to subject people in prison to extensive lock-up. These issues long pre-date the COVID-19 pandemic.

18. Ministry of Justice ministers must seek alternatives to building additional prison places by making the robust case to their counterparts for the greater availability of community sentences for less serious crimes, including treatment requirements to support those in need of additional substance misuse or mental health treatment, as the IAPDC, together with the Magistrates Association, set out in correspondence to the Chief Secretary to the Treasury in August 2021[4].

Safety Impact Assessment

19. The IAPDC is clear that the safety of staff and prisoners must be made an explicit factor in all major policy or operational decisions. A statutory Safety Impact Assessment, as proposed by the IAPDC in 2019[5], supported by the Prison Reform Trust in their response to this Paper[6], and explicitly proposed by the panel for inclusion in this White Paper[7], would ensure ministers, officials and staff are actively considering how proposed changes could negatively impact on staff and prisoner safety and the drivers of safety more broadly. It would prompt consideration of how these impacts can be mitigated, and whether these mitigating actions would adequately remove risks. It would strengthen accountability, reduce fluctuations in risk levels and help to prevent suicide, self-harm and violence in custody.

20. We are grateful for the considerable work already progressed by officials to integrate the SIA requirement into existing governance and decision-making processes within HMPPS, and welcome indications that this is having a positive impact on outcomes. However, a ministerial commitment to introducing safety impact assessments throughout prison decision-making as part of this White Paper would make a significant contribution to increasing the levels of safety in prisons. Indeed a review of these White Paper proposals seen and conducted through a safety impact assessment lens would be a testimony to ministerial commitment to meeting their obligations to protect lives as a first priority.

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[4] IAPDC. Juliet Lyon and Beverley Higgs to Rt Hon Steve Barclay MP Chief Secretary to the Treasury HMT. August 2021.
https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/612e2bc5e777ea499dcd78a5/1630415813940/210827+Juliet+Lyon+and+Beverley+Higgs+to+HMT+-+CSTRs.pdf

[5] IAPDC. A proposal for embedding staff and prisoner safety in all major decisions. September 2019.
https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5fabe117afc6d879073a0165/1605099800504/Safety+Assessment+%28Board+Paper%29.pdf

[6] Prison Reform Trust. Prison Reform Trust written response to the Prisons Strategy White Paper.

[7] IAPDC. Juliet Lyon to Victoria Atkins MP. October 2021.
https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/615d7a40c39a1012f5d1716d/1633516098860/211005+JL+to+VA+-+safety+impact+assessment.pdf

Design proposals

21. Research to develop effective interventions must be prioritised and facilitated across both the male and female estate. New prisons should use expert evidence of what works to ensure new designs do what is possible to create environments which are safe and, to the extent that is ever possible in prison, promote rehabilitation. Designs should address issues which cause despair, boredom, misunderstanding and sever family ties – and in the most tragic cases can ultimately lead to suicide.

22. As set out in the IAPDC's Keeping Safe[8] consultation report, prison design must facilitate education and employment, rehabilitation, healthcare and purposeful activity by providing spaces for one-to-one and group education and skills development; provide accessible facilities for older prisoners or those with specific health and neuro-diverse needs; and make the most of available in-cell technology to support family ties[9]. This should be introduced in addition to – and not in place of – in-person visits.

23. Design changes identified for new builds that are evidenced to improve safety should be applied retrospectively to the existing estate. Where this is not possible, such accommodation should be discontinued.

"The time out of cell combined with mental stimulation and active addressing of offending behaviours and attitudes can only be of benefit to inmates and I believe good practice of this philosophy would help to reduce incidents of self-harm and suicide attempts."[10]

Fire safety

24. The panel notes welcome commitments to addressing fire safety compliance in prisons, though this must go further, and faster, to reduce the very real risk of mass casualties. A recent coroner Prevention of Future Death report into the death of Christian Hinkley[11] raised concerns around the inadequacy of fire detection systems in prisons and potentially deadly delays to response times from Fire and Rescue services. Wider concerns about fire safety have also been expressed by other independent experts and independent scrutiny.[12]

25. The IAPDC welcomes plans to transform outdated data systems, which is important for information transfer between prisons and other sites about a prisoner's risks and health needs. Information sharing remains a consistent factor identified by investigations and inquests into prison deaths[13]. This is an area where family members could make an important, potentially life-saving, contribution.

Remand prisoners

26. The latest deaths in custody figures[14] show that in 2021, 37% of all self-inflicted deaths were by prisoners on remand, an increase from 28% of all self-inflicted deaths in 2020. This rise, partly due to

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[8] IAPDC. Keeping Safe: Preventing suicide and self-harm in custody. December 2017. https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ed5178d95645801a7a5e321/1591023614282/Keeping+Safe+-+FINAL+-+Dec+2017.pdf

[9]IAPDC. "Keep talking, stay safe": A rapid review of prisoners' experience under Covid-19, June 2020. https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ee115af9592717e002903f8/1591809460419/200601+IAP+rapid+review+of+prisoner+experiences+under+Covid-19+-+FINAL+CLEAN.pdf ; IAPDC: 'Just one thing' Prison safety and COVID-19, September 2020. https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5f6e11e141066201bdadec6b/1601049059093/200925+IAP+COVID-19+safety+briefing+-+final.pdf

[10] IAPDC. Keeping Safe.

[11] Scott Matthewson, Asst Coroner. PFD into death of Christian Hinkley. November 2021 https://www.judiciary.uk/wp-content/uploads/2021/11/Christian-Hinkley-Prevention-of-future-deaths-report-2021-0376_Published.pdf

[12] Home Office. Crown Premises Fire Safety Inspectorate Annual Report 2019/20. October 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1028818/2019-20_CPFSI_Annual_Report.pdf

[13]. David Donald William Reid, HM Senior Coroner. PFD into death of Saul Thomas. December 2021 https://www.judiciary.uk/wp-content/uploads/2021/12/Saul-Thomas-Prevention-of-future-deaths-report-2021-0423_Published.pdf; Lorraine Harris, Asst Coroner. April 2021. PFD into death of Darren Adams. January 2021 https://www.judiciary.uk/wp-content/uploads/2021/05/Darren-Adams-2021-0125.pdf.

[14] Ministry of Justice. Safety in Custody Statistics, England and Wales: January 2022.

the increase in the number of people being held on remand, court delays and uncertainty about hearings as a result of the pandemic, is deeply troubling and should be a key priority of ministers and leaders. Prioritisation of key work for this particularly vulnerable cohort is important to address these risks. People still serving an indeterminate sentence for public protection, the long-abolished IPP sentence, are also identified as a vulnerable group.

Chapter Two – Tackling Violence, Preventing Harm and Promoting Good Order and Discipline

Q2. Do you agree these are the guiding principles around which the future regime should be designed?

27. The panel welcomes the Strategy's stated intention to offer hope and provide safe and decent environments for people in prison. The IAPDC's consultations with prisoners[15], as well as extensive evidence from independent scrutiny, show that prisons with hope and purpose keep people safe. Leaders and policymakers must avoid narrow definitions of 'safety', instead understanding that keeping safe means engendering a sense of purpose, humanity and identity.[16]

28. Proposals in this section are broadly welcome, though 'getting the basics right' must be prioritised before further measures are considered. For example:

    a. The panel would welcome participation in the proposed innovation taskforce to consider the best interventions for prisoners at risk, though to reach accurate conclusions, expert independent research must be facilitated and incentivised in prisons. This is currently not the case.
    b. The proposal of a multi-disciplinary Enhanced Support Service for prisoners with complex needs is sensible, though government's priority should be the restoration, full rollout and consolidation of the keyworker role with low prisoner to keyworker ratios, with staff adequately resourced to provide time for one-to-one contact. People in prison need key people who they can turn to and trust.[17]

29. The panel welcomes the funding of the postvention service, delivered in collaboration with the Samaritans, and the introduction of a peer-support model for prisoners during the early days of their sentence. Other sources of support, such as chaplaincy services, should be funded appropriately.

30. We welcome proposals to ensure facilities for older prisoners are accessible and tailored to the needs of this growing demographic. Prisoners aged 70 and over are more likely to die in custody compared to any other age group, with 66.1 incidents per 1,000 prisoners in the 12 months to December 2021. Those aged over 50 accounted for 88% of all natural-cause deaths in 2021[18]. The panel anticipates that further detail on these proposals will be provided in the forthcoming older offender strategy, though encourages the department to draw from expert evidence, including the panel's report on the prevention of avoidable natural deaths in custody in collaboration with the Royal College of Nursing (RCN), in the development of solutions.[19] There is considerable scope for collaboration with bodies such as Hospice UK and Age UK.

31. The IAPDC, RCN and Royal College of GPs (RCGP) would like to see improvements to the process and use of compassionate release.

[15] IAPDC. Coronavirus Information Hub. https://www.iapondeathsincustody.org/covid-19
[16] IAPDC. 'Just one thing': Prison safety and COVID-19.
[17] IAPDC. Keep Talking, Stay Safe.
[18] Ministry of Justice. Safety in Custody Statistics, England and Wales: January 2022.
[19] IAPDC and Royal College of Nursing. Avoidable natural deaths in prison custody: Putting things right. September 2020.
https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5f736f57ef92df5643a3a461/1601400665948/200929+IAP-RCN+-+prevention+of+natural+deaths+in+custody+-+final+for+publication.pdf

32. The panel would welcome further detail, and the opportunity to feed into, the development of other proposed innovations, such as the use of new digital systems for monitoring vital signs – these need more detail.

Ligature resistant cells

'They wonder why the death rate is so high – the cells are full of things you can kill yourself with.'[20]

33. The panel is pleased to note the commitment to invest in 290 ligature-resistant cells. The use of ligatures has historically been the main method used for suicide in prison, and the percentage of deaths caused by ligature has been consistently high since 2000. Hanging remains the most common method of self-inflicted death in 2021, accounting for 83% of all incidents.[21] Increasing the number of ligature resistant cells will help address this.

34. Evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health demonstrates the removal of ligatures in secure hospitals has had a noticeable impact in the number of suicides. Between 2008 and 2014 there were approximately 20-30 deaths per year by hanging/ strangulation on the ward but since 2015 the number has fallen to between 15-20 deaths per year.[22]

35. However, the removal of ligature points must be applied retrospectively to the whole estate, not just factored into the design of new safe cells. The majority of prison suicides take place in regular cells. Prison governors must be actively incentivised to review and remove ligature points. Piping, wall fittings and light fittings would appear particularly straightforward to remove and would address this issue.[23] The NHS have done considerable work on the removal of ligature points that should be engaged with and learned from.[24]

Q4. Do you agree with our long-term priorities for making prisons safer?

36. The panel welcomes the commitment to continue offering secure family video calling and finding ways to implement long-term options in line with the recommendations of Lord Farmer's review for maintaining family ties[25], as well as lessons learnt from the roll out during the pandemic. Deprivation of liberty also means the removal of people from their families and – for many – this is often one of the hardest parts of being in custody, and can lead to ill health and death.

37. The IAPDC is conscious of the difficulties some prisoners and families have contacting and supporting each other. Some prisoners – particularly women and foreign national prisoners – are more likely to be sent to prisons a long way from their homes, making visits difficult or impossible. Both the panel's

[20] IAPDC. 'Just one thing': Prison safety and COVID-19.
[21] Ministry of Justice. Safety in Custody Statistics, England and Wales: January 2022.
[22] National Confidential Inquiry into Suicide and Safety in Mental Health. Annual report 2021: England, Northern Ireland, Scotland and Wales. May 2021. https://sites.manchester.ac.uk/ncish/reports/annual-report-2021-england-northern-ireland-scotland-and-wales/
[23] Ministry of Justice. Safety in Custody Statistics, England and Wales. January 2022.
[24] Isabelle Hunt, Kirsten Windfuhr, Jenny Shaw, Louis Appleby, Nav Kapur (National Confidential Inquiry into Suicide and Homicide). Ligature points and ligature types used by psychiatric inpatients who die by hanging: a national study. January 2012, https://pubmed.ncbi.nlm.nih.gov/22343063/; Department of Health. Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services. March 2009. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf
[25] Lord Michael Farmer. The Importance of Strengthening Prisoners' Family Ties to Prevent Reoffending and Reduce Intergenerational Crime. August 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/642244/farmer-review-report.pdf

Keeping safe report and *The Harris Review – Changing Prison, Saving Lives*[26], have recommended that, "*NOMS [now HMPPS] should invest in new technology, such as in-cell telephony and video call facilities, (for example Skype), similar to those used successfully in other jurisdictions in order to facilitate better contact with family*." The impact of measures put in place during the COVID-19 pandemic have demonstrated the effectiveness of such measures.[27]

38. The strategy states that *"there is more to do to enable prisoners to access timely healthcare treatment as missed appointments can disrupt the regime and are costly for the NHS."* Some individuals do not attend their appointments due to fear of bullying while others are not able to attend due to absence of staff escorts. This is an issue, as the PPO have found, that is particularly poor for the youngest age groups (15-34 years), with just over half receiving equivalent care compared to that received in the community. Overall, only 36% of prisoners received a proper and timely investigation of their symptoms, raising the potential for this to lead to serious illness, and in some cases, death.[28] We welcome the commitment made to addressing this issue.

39. The IAPDC welcomes the government's proposal to "*capture a thorough understanding"* of each prisoner, including their background and health issues. Central to this should be the resolving of basic issues around information sharing – between courts and prisons, and internally between prison establishments. Steps to build understanding of each individual should involve family members and close contacts throughout.

Chapter Three – The Role of Prisons and Probation in Cutting Crime and Protecting the Public

Q12. Do you agree with our long-term vision?

"…I'm stuck in hell where it's impossible to be a better man. I'm surrounded by drugs."[29]

40. The IAPDC welcomes the focus on building drug-free lives for prisoners; the scale of both drug and alcohol misuse in the criminal justice system is significant and both directly and indirectly leads to deaths in custody. The IAPDC's recent work in collaboration with the Royal College of GPs[30] demonstrates that the scale of drug and alcohol misuse in the criminal justice system is significant and both directly and indirectly leads to deaths in custody, and that opportunities to divert those with substance misuse issues are being missed, with only 6% of all community orders made with alcohol and drug treatment requirements.

41. Our report makes specific recommendations for a:

> "*streamlined approach which encourages services to be collaborative, and ideally co-located …to enable services to work in an integrated way in response to multiple social needs (including housing, employment, mental and physical health, and the effects of prior trauma). HMPPS, Ministry of Justice and the Department of Health and Social Care should consider collaborative commissioning of providers, so they become 'catch-all' services rather than providers of a collection of different parts of an individual's recovery*."[31]

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[26] IAPDC. Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds. July 2015. https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ee0f0fc53012b3f15e7a217/1591800075717/Harris-Review-Report2.pdf

[27] IAPDC. 'Just one thing': Prison safety and COVID-19.

[28] IAPDC and Royal College of Nursing. Avoidable natural deaths in prison custody: putting things right.

[29] IAPDC. Keeping Safe.

[30] IAPDC. Protecting lives: a cross-system approach to addressing alcohol and drug-related deaths within the criminal justice system. January 2022. https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/61e13ccb290c4e646791d4ee/1642151116596/IAPDC+RCGP+-+substance+misuse-related+deaths+in+the+criminal+justice+system+-+final.pdf

[31] *Ibid*.

42. Transition into the community from prison for people with complex needs can be a high-risk period, with serious risk of relapse into addiction and/or post-release. The reports calls for:

> "*the introduction of 'bridging liaison' roles, created jointly by HMPPS and NHS England and NHS Wales, would reduce the risk of professionals working in silos and ensure continuity in treatment plans. Pre-release work should involve greater outreach from prisons to community services*."[32]

43. The IAPDC report advocates the use of buprenorphine for prisoners with substance misuse issues. Prolonged-release buprenorphine injection is a new preparation which could help smooth transition to the community, reduce the use of methadone prescriptions and address issues with client engagement. Slowly released over an extended period, these injections mean reduced requirement for immediate service contact at a time when individuals have a range of pressing concerns, such as securing income and safe housing, and also help cover the relapse risk period immediately following release.

44. Additionally, the report states that there is not enough information or data about drug-related deaths in custody. We encourage the service to improve data collection in this area.

45. We welcome the government's drive to improve drug testing and deliver access to a full range of drug and mental health treatment, and the expansion of telemedicine technology should help with this. The IAPDC acknowledge that focus is needed on increasing security measures with Enhanced Gate Security, X-ray body scanners and drug trace detection equipment to stop illicit items coming in. However, funding and attention would be better spent on improving availability and access to treatment, on diverting vulnerable people away from drugs and alcohol, and providing alternatives to reduce the risk of developing addiction.

46. This strategy needs to be closely integrated into the work of other government initiatives, agencies and departments to maximise work ongoing elsewhere and support the wider Levelling Up agenda. Resolving issues caused by disjointed and ineffective commissioning of mental health services, for example, requires close collaboration with both local and national health partners and would help address some of the issues correctly identified as issues in the strategy.

47. Some plans mentioned here should be taking place already, such as prisoners receiving a health assessment within 24 hours of arriving in custody and another screening taking place within their first few weeks. This is part of getting the basics right.

Q13. Where can we go further in turning prisoners away from crime?

48. We are pleased to note planned improvements for strengthening continuity of drug treatment on release, and we call on government to develop joined-up working between departments and with other agencies in this area. As well as reducing crime, this will help prevent avoidable deaths. People leaving prison also need more support and information on how to engage with rehabilitation and resettlement services in the community rather than focussing on the sanctions for non-compliance. Clear instructions and an induction to probation services will have a more positive impact on behaviour, a better understanding of where to get help and support at this time of heightened risk.

49. We welcome the proposed objective to continue work to divert offenders away from prison into community mental health treatment, and the development of resettlement passports. Services should also engage families in this process as they will often have clear ideas about encouragement and their loved-one's motivations for engaging with relevant services.

<u>Chapter Four – A New Approach to Women's Prisons</u>

Q14. Do you agree with our long-term vision for women's prisons?

[32] *Ibid.*

50. There were no self-inflicted deaths of women in prison in 2021[33], though high-self harm rates during the pandemic and the tragic cases of two deaths of babies in women's prisons demonstrate that more action is needed. This is particularly tragic and frustrating in the context of long established and well-evidenced findings about how to keep women in prison safe. The IAPDC was disappointed to note the National Audit Office's recent justly critical review of the Ministry of Justice's progress against its own Female Offender Strategy, findings mirrored by the Prison Reform Trust and responses to the IAPDC's own report on the prevention of deaths of women in prison[34]. The Corston Report, which set out clear steps to address issues in the female estate, is now 15 years old.[35]

51. The panel's report from 2017 called for government to:
    - develop a gender-aware and trauma-informed environment in all women's prisons, including staff training on the impact of separation and loss,
    - Conduct transfers in a longer-term planned manner, with more information provided to the women being moved,
    - Improve drug and alcohol treatment in custody linked to treatment in the community,
    - Impose community sentences, with family and domestic violence support where necessary, unless the offending is so serious or dangerous that only a custodial penalty will suffice.

52. We welcome plans to deliver a longer-term ambition for the estate to introduce smaller, trauma-responsive custodial environments for women on short sentences, to introduce family units in all women's prisons and to reduce the number of women held in prison on remand. However, prison is in itself a deeply traumatic setting, and community sentencing options must be developed and funded and the use of prison as a 'place of safety' by sentencers must be eradicated. Close partnership working is required to deliver these well-evidenced interventions.

53. Governors need to ensure a higher level of emergency response training for all staff, and ensure that all cell bells are responded to – this was shown to be a pertinent issue identified in the recent Prison and Probation Ombudsman's report[36] into the death of a baby at Bronzefield prison in 2019. The PPO report also found poor staff attitudes towards the mother may have contributed to their lack of care. This must not be allowed to happen again.

54. Government must ensure that access to secure mental health accommodation is available in a timely manner to those who need it, as prisons should not be used as places of safety. A schedule with timelines to deliver commitments to improving the timeliness of transfers should be set out and published.

55. Research to develop effective interventions that prevent self-harm should be prioritised and facilitated across both the male and female estate.

<u>Chapter Five – Our People</u>

Staffing

[33] Ministry of Justice. Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2021, Assaults and Self-Harm to September 2021. January 2022.
[34] IAPDC. Preventing the Deaths of Women in Prison – initial results of a rapid information gathering exercise by the Independent Advisory Panel on Deaths in Custody. March 2017. https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5f5207216dd18341fc2848a2/1599211305040/IAP%2Brapid%2Bevidence%2Bcollection%2B-%2Bv0.3.pdf.
[35] Baroness Jean Corston. The Corston Report: A review of women with particular vulnerabilities in the criminal justice system. 2007. https://webarchive.nationalarchives.gov.uk/ukgwa/20130206102659/http:/www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf
[36] Prisons and Probation Ombudsman. Independent investigation into the death of Baby A at HMP Bronzefield on 27 September 2019. September 2021. https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/09/F4055-19-Death-of-Baby-A-Bronzefield-26-09-2019-NC-Under-18-0.pdf

"As someone who's been in prison for over 20 years I don't think there's anything that can make prison a safer place, there's too many inexperienced young staff starting in the system whereas the older more experienced staff are either moving on or leaving because they cannot cope with it anymore."[37]

56. Low staffing levels and inexperience contributes to deaths in custody. It is essential that prisons are adequately resourced and staff are adequately incentivised to stay in the service. New staff are needed not just for any new builds, but to enable the running of productive regimes in all establishments. Prisoners have been spending too long in their cells since long before the additional severe restrictions imposed under COVID-19.

57. Selecting, recruiting and retaining good, decent people who will treat prisoners with humanity, respect and common sense is vital to reducing deaths.[38] Staff and prisoners benefit from the opportunity to build positive professional relationships. Motivated staff will enable the delivery of full regimes and purposeful activity, and enable the keyworker model to be fully realised. This should be prioritised above other new initiatives and in existing prisons as well as the proposed new builds:

> "*The wellbeing of people in prison depends on the availability of staff who listen and who they can talk to and trust... Professional and considerate staff save lives*." [39]

58. The Ministry of Justice and HMPPS must work proactively with the Department of Health and Social Care and NHS England to ensure that healthcare staff in prison are also adequately resourced, and that prison healthcare professions, such as nursing, are recognised as rewarding and respected careers.[40] This would address issues which cause deaths, such as delayed emergency response and neglect of cell bells as well as gaps in healthcare teams, and would help prevent the loss of life.

59. Prisoner safety is enhanced by understanding staff who listen, prioritise acts of kindness and are supported by their employer through resourcing, support and supervision.

Leadership

60. The panel's work in other sectors, for example on deaths in police custody[41], has demonstrated the importance of clear accountability and strong leadership in the prevention of deaths. Continuity of leadership is significant in creating stable and safe environments. Governor churn has been too common at too many establishments in recent years, leading to a lack of continuity in initiatives and messaging and in some cases directly contributing to the creation of unhealthy and unsafe environments.

61. Good, strong, supportive and continued leadership is needed to build a mutually supportive culture, and a stable environment means people are calmer and more confident, services within the prison collaborate and makes for a safer environment. Such leadership at the top also prompts better partnership working with healthcare and other regimes. Sharing good leadership practice across the service will also lead to better outcomes.

Q16. Are there specific areas of training you think we should be offering prison officers which we do not already?

62. The provision of good training for staff is important, particularly in suicide prevention and emergency response. Training should be engaging, grounded in reality, and make use of material and input from

[37] IAPDC. 'Just one thing': Prison safety and COVID-19.
[38] IAPDC. Keeping Safe.
[39] IAPDC. 'Just one thing' Prison safety and COVID-19.
[40] IAPDC and Royal College of Nursing. Avoidable natural deaths in prison custody: Putting things right.
[41] IAPDC and Home Office. Preventing deaths at point of arrest, during and after police custody: a review of good practice submitted to the Independent Advisory Panel on Deaths in Custody by Police and Crime Commissioners and associated bodies. [Forthcoming]

those with lived experience to improve understanding and impact. The panel welcomes, for example, work to ensure the perspectives of bereaved families are incorporated into training for staff on the new ACCT process.

Q17. Do you agree that more bespoke recruitment training will enable prison officers to better support the needs of prisoners?

63. While robust training is important, its provision should not come at the expense of adequate support and supervision of staff. Training takes staff away from their jobs and has limited impact on responses to real-life scenarios. Mentoring by experienced staff can have long-lasting impacts. Good supervision of staff also leads to a greater understanding about information sharing, including what to pass on and to whom. This is especially important in the context of recovery from COVID-19, during which many new, inexperienced staff have been recruited who will have minimal knowledge of running full regimes.

64. Currently, for example, very little support is often in place to support staff after the death of a person in custody - through the investigation and inquest process but also reflecting on what had happened, ensuring it does not happen again and providing emotional support for, at times, very inexperienced staff.

Chapter Six - Delivering Better Outcomes in Prisons

KPIs

65. Robust Key Performance Indicators (KPIs) can, in some cases, be productive in driving progress. If KPIs are to be pursued, an explicit objective should be developed around the reduction of self-inflicted deaths in prisons. For example, ministers and officials should consider how the National Suicide Prevention Strategy's community target of an annual 20% reduction in suicides can be applied to prisons. The panel would welcome involvement supporting officials to develop such a measure.

66. Prison leadership should also be accountable for clusters of self-inflicted deaths, for which the statistics should be published. The panel encourages the use of skilled independent facilitators working with group directors to convene meetings where staff are enabled to find solutions and ways to prevent further deaths within a cluster of such deaths.

67. Joint KPIs with key partners, such as with the Department of Health and Social Care and NHS England, would help strengthen partnerships and encourage more consistency in commissioning, which repeatedly emerges as an issue causing deaths in custody. Ideally this would be accompanied by shared budgets.

Q19. How can we further strengthen independent scrutiny of prisons in future?

68. HMPPS and the MoJ must make it an absolute priority to prevent repeats of issues identified by investigations as a cause of a death. Repeat incidents can be avoided if sufficient attention is paid to embedding learning and implementing recommendations made by the PPO and by coroners in their preventing future death reports. Transparency and oversight over the implementation of recommendations must finally be improved.

69. Government should be taking clear, public steps to ensure action against and compliance with the findings of inquests and recommendations made by scrutiny bodies, many of which are repeated in subsequent reports. The proposals consulted on in 2021 will go some way to supporting this, though other steps can and should be taken, including:

    a. Taking steps to improve the quality of clinical reviewers. This will improve the accuracy of investigations and provide detailed information to inform inquests.[42]

[42] IAPDC. Protecting lives: a cross-system approach to addressing alcohol and drug-related deaths within the criminal justice system. January 2022.

b. The Prisons and Probation Ombudsman should be resourced to ensure it has capacity to develop clear understanding of wider thematic causes of custody deaths. Currently the PPO is not sufficiently resourced to investigate individual cases alongside assessing and communicating emerging themes to establishments and HMPPS HQ. PPO findings should be considered as a key evidence base in the development of policy and operational decisions.
c. Scrutiny bodies should work together systematically to corroborate and share findings with prisons and key partners. While each independent scrutiny body serves a unique purpose, their collective knowledge is currently underused.
d. The new prison performance dashboard should also contain data on take-up of scrutiny recommendations.
e. Prisons should actively learn from the scrutiny of other places of state detention, especially from investigations and inquests to increase opportunities for avoidable deaths to be reduced.

70. Where possible alternative sources of independent expertise – including from academic research, lived experience and the third sector – should be systemically incorporated into decision making to complement the findings of arm's length bodies.

71. Inquests and coroner-written Prevention of Future Deaths (PFDs) reports remain underused by operational and policy staff. The Ministry of Justice should develop, with urgency, proposals presented in response to the Justice Select Committee's inquiry on the Coroner service, including around the creation of a coroner inspectorate with an explicit function to monitor responses to matters of concern raised by PFDs.[43] HM Inspectorate of Prisons should also consider the feasibility of formally reviewing action taken in responses to matters of concern raised by PFDs. Jury narratives should be collated and published publicly, and the MoJ should work with the Chief Coroner to ensure consistency in the production of PFD reports.

Conclusion

72. This strategy should be amended to avoid missing a vital opportunity to set out a vision which prioritises prevention of the needless loss of life in custody. Short and long-term plans for the prison estate should be based on evidence, including the voices and views of current and former prisoners and their families, and prioritise the safety of those detained in the care of the estate. Brave and principled leadership is required to deliver this vision over a sensible timescale.

[43] Coroner's Society. House of Commons Justice Committee. The Coroner Service: Government Response to the Committee's First Report. September 2021. https://www.coronersociety.org.uk/_img/pics/pdf_1631266389-515.pdf

About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody (MBDC)
- Independent Advisory Panel (IAPDC)
- Practitioner and Stakeholder Group

The remit of the IAPDC (and overall of the Council) covers deaths, both natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAPDC, a non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAP's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE chairs the IAPDC.

Members of the IAPDC appointed in July 2018 are:

- Deborah Coles, Director, INQUEST
- Professor Seena Fazel, professor of Forensic Psychiatry, University of Oxford
- Professor Jenny Shaw, professor of Forensic Psychiatry, University of Manchester
- Jenny Talbot OBE, Prison Reform Trust

Further information on the IAPDC can be found on its website: www.iapondeathsincustody.org
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