

Prison Reform Trust submission
**The Harris Review: Independent review into self-inflicted deaths in NOMS
custody of 18-24 year olds**

The Prison Reform Trust is an independent UK charity working to create a just, humane and effective prison system. We do this by inquiring into the workings of the system; informing prisoners, staff and the wider public; and by influencing Parliament, government and officials towards reform.

The Prison Reform Trust's main objectives are:

- Reducing unnecessary imprisonment and promoting community solutions to crime
- Improving treatment and conditions for prisoners and their families

We welcome the opportunity to submit evidence to this review. We have chosen to respond only to those questions on which we have some expertise but also submit our response to the Ministry of Justice consultation [Transforming management of young adults of custody](#) as supplementary evidence to the Review team. As a member of the Transition to Adulthood Alliance (T2A) convened by the Barrow Cadbury Trust, the Prison Reform Trust is pleased to support T2A's submission to this Review.¹

Overarching comments

Whilst we appreciate that the remit of this Review has been set externally, we wish to reiterate that the exclusion of children from its parameters presents a missed opportunity, not least because many of the young people aged 18-24 who have died in prison will spend time in custody as children. We urge the Review team to ensure that the impact of transition from youth to adult custodial estate is considered as part of its work.

We strongly recommend that the ambit of the Review is sufficiently wide to consider the journey into custody taken by children and young people who have died. A focus on prison alone will result in only a partial understanding of what happened to them and what needs to change. As [Fatally flawed](#)'s analysis of the deaths of 98 children and young people who died between 2003 and 2010 showed, they were some of the most disadvantaged in society and had had significant interaction with public services and community agencies before their entry to prison.

It is in everyone's interests to learn the lessons from the deaths of children and young people in prison and prevent such tragedies wherever possible in the future.

Identification of vulnerability

¹ www.t2a.org.uk/wp-content/uploads/2014/07/Response-by-the-Transition-to-Adulthood-Alliance-to-IAP-FINAL.pdf

1. (a) How would you define ‘vulnerability’ in terms of a young person (under 24 years) who is in NOMS custody?

In this context, vulnerability can be defined as a person in need of special supervision, support or protection because of their age, disability or possession of other characteristic known to be associated with a greater chance that they are prone to self-inflicted injury or death. As Coroners’, prisons inspectorate and prison and probation ombudsman’s reports have indicated, vulnerability can be exacerbated or reduced depending on the culture and leadership of the specific institution in which the young person is placed.

1. (b) What factors in their previous experiences are more likely to increase their vulnerability?

In 2012 the Prison Reform Trust (PRT) and INQUEST published *Fatally flawed*, a report which revealed common themes in the experience and treatment of 98 children and young people who had died in prison between 2003 and 2010.² These overlapping findings included that they:

- were some of the most disadvantaged in society and had experienced problems with mental health, self-harm, alcohol and/or drugs;
- had significant interaction with community agencies before entering prison yet in many cases there were failures in communication and information exchange between prisons and those agencies;
- despite their vulnerability, they had not been diverted out of the criminal justice system at an early stage and had ended up remanded or sentenced to custody;
- were placed in prisons with unsafe environments and cells;
- experienced poor medical care and limited access to therapeutic services in prison;
- had been exposed to bullying and treatment such as segregation and restraint; and
- were failed by the systems set up to safeguard them.

These findings highlight how key characteristics of vulnerability are shared by many young people in prison, and underline the principle of imported vulnerability put forward by Professor Liebling on the significance of young people entering prison already at risk.

As *Fatally flawed* demonstrated, vulnerability can be compounded by the institutions in which young people are placed, and their capacity to respond appropriately to the needs of young people who have experienced multiple and complex disadvantage in their lives.

Many young people are at risk of self-inflicted injury while in prison, but this risk can then be multiplied, or mitigated, by the response of the prison. Put simply prison is rarely a safe environment for young people, with specific prisons and wings being less safe than others, and thereby increasing the vulnerability of individuals. This latter finding supports the research conducted by Professor Liebling’s team at the Prison Research Centre, Cambridge, who have found that levels of distress amongst prisoners were much higher in some prisons than in others.³

² Prison Reform Trust (2012) *Fatally flawed: has the state learned lessons from the deaths of children and young people in prison?* London: PRT

³ www.crim.cam.ac.uk/research/prc/

2. (a) Are there other things that should have been done to divert vulnerable young people from the criminal justice system and from custody?

First, systems for the early identification of young people in need of help who are also in contact with the criminal justice system need to exist, universally, so there is always an opportunity to divert such young people to specialist services that have a chance of addressing their underlying needs. Liaison and Diversion services are a promising example of such an approach. We congratulate the Government on its initial investment and would recommend that full national roll-out of services be expedited.

Secondly, care needs to be taken over the decision to prosecute young people exhibiting symptoms and characteristics of vulnerability, so that such prosecutions are considered decisions. The Crown Prosecution Service's 'Code for Crown Prosecutors' should be amended expressly to allow Prosecutors to consider the specific interests and needs of young people aged 18-24 when deciding whether prosecutions will be in the public interest.

Lastly, imprisonment needs to be used as a last resort, when all other community-based sentencing options have been exhausted and only custody is justified. Where community options ought to be made available but have not immediately been identified, the judiciary should require the National Probation Service to explain such gaps in services before sentencing. A system for recording such shortfalls and raising this issue periodically with the new Regional Directors should also be put in place.

The T2A pathway developed by the Transition to Adulthood (T2A) Alliance identifies ten exit points and stages of the criminal justice process at which effective interventions for young adults can be delivered by statutory agencies and service providers.⁴ Six projects (led by ADVANCE, Remedi, Together, The Prince's Trust, Pact and Addaction) are demonstrating how multiple interventions might be commissioned and delivered across a whole 'pathway'. This model presents an opportunity for statutory agencies, including police, Police and Crime Commissioners, prisons and probation services, to work across the young adult pathway to ensure effective responses and interventions for this group.

2. (b) If yes, what?

See 2. (a)

3. At what points in their journey through custody are young people most vulnerable?

Examination of individual cases highlights that risk can change, or develop, over time. There is a danger therefore in linking vulnerability to self-injury too closely with specific points during a period of custodial remand or sentence. Thus, it is not safe to assume that a young person who has passed through most of their sentence may not remain or become vulnerable towards the end when they face the prospect of re-entry to society simply because they have not attempted, or been seen to attempt, self-injury before that point. Put simply, young people have taken their lives at all stages of a custodial remand or sentence.

However, it is obvious that for many, key moments of vulnerability will occur on or near admission, particularly for those experiencing custody for the first time. A national study by

⁴ www.t2a.org.uk/pathway/

Jenny Shaw found that a third of self-inflicted deaths in custody between 1999-2000 occurred within the first week of custody.⁵ This is supported by other research studies,⁶ including the 2007 Prison Reform Trust report *There when you need them most* which also identified individuals who had been imprisoned on multiple occasions as another high risk group. The report highlighted the value of first night services then run by PACT at HMP Exeter, HMP Holloway and HMP Wandsworth in addressing risk.⁷

Those held on custodial remand are particularly vulnerable due to the uncertainty of their situation. Setbacks around bail hearings and sentencing can also be particularly unsettling, as can news from outside of the prison, especially around the loss of close relatives. Much self-injury is associated with bullying and increases in this need to be closely monitored and robustly challenged.

4. How can systems and processes be improved in terms of identifying which young people in custody are the most vulnerable and at risk of self-inflicted death?

There is no special assessment process which is tailored to this specific age group. This is despite the growing understanding that 18-24 year olds are still maturing, and some young people within this age range will be particularly immature or experience developmental delay and may, therefore, be more vulnerable in custody.

An assessment tool, specifically designed for 18-24 year olds and concentrating on the sources of vulnerability and increased possibility of self-harm and/or bullying, would make a significant contribution to improving the safety of young people in custody. The subsidiary questions that the Review Team have established in section 5 below establish the main domains upon which such a tool should focus, although we have highlighted the particular vulnerability of care leavers and young people with an acquired brain injury. Procedures and pathways for dealing with identified vulnerabilities should then be implemented.

Armed with such a tool the single greatest step forward in current practise would then be provided by any means by which communication and information exchange between prison and outside agencies could be improved. The creation of Community Rehabilitation Companies will make an already complicated landscape, involving as it may probation services, local authorities, NHS bodies, the community and voluntary sector, and many others, more complex. However, the implementation of the Care Act in 2015 creates new opportunities, particularly around the role of Adult Safeguarding Boards for considering problems with communication.

Protocols for information exchange, and the technical means to facilitate this, can make a big difference, as can real commitment and attention from each organisation involved to the

⁵ Shaw, J, Appleby, L, Baker, D, Hunt, I, & Moloney, A. 'Suicide by prisoners: National clinical survey,' British Journal of Psychiatry (2004), 184, 263 – 267.

⁶ See for example, Harvey, J (2007) *Young men in prison: Surviving and adapting to life inside*, Cullompton: Willan Publishing and Liebling, A; with Tait, S, Durie, L, Stiles, A, and Harvey, J (2005) *Safer Locals Evaluation*, Prison Service Journal: November, 2005, Number 162

⁷ Jacobson, J, Edgar, K. & Loucks, N. (2007) *There when you need them most: pact's first night in custody services* London: PRT

sharing of information. Two initiatives from the children's estate are good examples of relatively low-cost technical solutions (with attendant agreements): *Connectivity*, introduced in 2010 to link youth offending teams (YOTs) and custodial establishments, and the national *Youth to Adult* portal developed by the Youth Justice Board (YJB) and National Offender Management Services (NOMS) in 2011 to facilitate information transfer from YOTs to adult probation services, introduced. Both would stand replication, although they will not be suitable for all agencies.

Once a young person has entered custody, all available information needs to be gathered, held in a coherent manner, and transferred with the person as they move within the prison(s). Routine examination of existing prisoner records highlight the poverty of some content and point in particular to a training need amongst prison officers of all grades.

It is important that such information is seen as being the responsibility of all officers in charge of a prisoner, and not just the health specialists. However, there is an obvious risk that overstating the responsibilities of all could give rise to a lack of ownership. To counter this we would recommend that a member of the senior management team should be given overall responsibility in this area, and with that should ensure that a named officer is available at all times. We believe that the personal officer scheme should be universally available for young adults in custody, and, if so, we would welcome personal officers being given a particular responsibility for ensuring that such information is kept up to date.

It is notoriously difficult to arrange for meetings to discuss the management of individual prisoners within the rotas of a working day, but it is clear when these do occur that they assist enormously in keeping vulnerable young adults safe by sharing information in a pro-active manner.

5. How can vulnerability be better identified in custody in terms of:

i. Age

Chronological age is a poor means of identifying vulnerability. As T2A have argued, "*the transition to adulthood is a process, not an event, and does not begin and end on a person's 18th birthday.*" Despite this, "*legislative frameworks and statutory expectations change in a binary fashion*" at a time of "*maximum risk and vulnerability*"⁸ and the transition from child to adult services, particularly for those who are in contact with criminal justice agencies, has been likened to a cliff edge.⁹

Maturity is influenced by life experience and individual characteristics, so a simple test of chronological age provides little insight into the vulnerability of the individual young person. This is especially the case for young people who have experienced childhood trauma or who have certain disabilities.

⁸ Response by the Transition to Adulthood Alliance (T2A) to the Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 year olds

⁹ www.revolving-doors.org.uk/documents/towards-a-shared-future/

However, recent studies on cognitive behaviour and development have established that the processes by which the brain develops and matures in young people typically continue until they are in their early to mid-twenties. The recent Transitions to Adulthood (T2A) report *Repairing Shattered Lives*, for example, describes ‘*peaks in development*’ which occur at different points across childhood and adolescence.¹⁰ What this means is that while young people aged over 18 are formally considered adults and are treated as such within the criminal justice system, they will still be maturing and developing the capacity to control their emotions and impulses, to plan, and behave with the objectivity that is expected of fully formed adults. They will be more open to influence, both good and bad, than older prisoners. In this sense it is useful to recognise that young adults (for these purposes 18 to 24 year olds) are likely to present a different challenge in terms of risk and vulnerability than will older prisoners.

ii. Gender

Although there has been a welcome reduction in recent years in the number of incidents of self-harm amongst women in prison, young women in custody are disproportionately likely to harm themselves compared to young men. In 2013, for example, there were 2,374 incidents of self-harm amongst 18-24 year old women, accounting for 40% of all incidents in women’s prisons. For 18-24 year old young men, the proportion was 36%.¹¹ Whilst young men remain more likely to take their lives, we note INQUEST’s analysis of the deaths of 115 women who died in prison between 1990 and 2007, which found that one in five (21%) were between 18-21 years old.¹²

18-24 year old women in prison are a minority of a minority, accounting for 16% of the female prison population at March 2014. Their small numbers, both relative to the women’s prison population and the total prison population, mean young women in prison are “*almost invisible as a group*.”¹³ For example, the [Women’s Custodial Estate Review](#), commissioned to ensure the “*custodial estate [is] organised as effectively as possible to meet gender specific requirements*” and published in 2013, makes no reference to the specific needs of this age group.

Whilst NOMS acknowledge that “*female offenders may have some different needs and risks*” the role that age plays as a factor in these needs and risks is often an afterthought, and exacerbated by the co-location of all young women in prison with adults. This contrasts with the treatment of many 18-20 year old men who are still held separately in YOIs (though see our submission to the consultation for a discussion of the increasing use of co-location for this group too). We know that certain risk factors, such as time spent in local authority care as a child, experience of sexual abuse and separation from dependents (particularly children), are greater for young women than young men¹⁴ and HM Chief Inspector of Prisons has

¹⁰ Williams, H. (2012) *Repairing shattered lives: brain injury and its implications for criminal justice* London: BCT

¹¹ Table 2.4, Ministry of Justice (2014) *Safety in custody statistics quarterly update to December 2013* London: PRT

¹² INQUEST (2013) *Preventing the deaths of women in prison: the need for an alternative approach* London: INQUEST

¹³ ‘Women in prison: Corston five years on’ HM Chief Inspector of Prisons Nick Hardwick speech to the University of Sussex, 29 February 2012 at www.justice.gov.uk/downloads/about/hmipris/women-in-prison.pdf

¹⁴ www.prisonreformtrust.org.uk/Portals/0/Documents/why%20women1312131659.pdf

highlighted that “*the emotional needs...[of] an 18 or 19 year old will usually be very different [to] the majority female prison population*”.¹⁵ As the T2A submission makes clear, “*these and other traumatic experiences are likely to still be raw in the mind of each young adult woman...it is vital that services recognise this immediate need and also take the opportunity for preventative work before such trauma becomes ‘normalised’*”.¹⁶

Given the links between self-harm in custody and anxiety caused by separation from children, it is vital that prison staff accurately identify young women who are mothers so they can be appropriately supported, and the impact of separation (including of permanent separation as a result of adoption) should be factored into assessment tools which are designed to identify those at risk of harm.

iii. Ethnicity

HM Chief Inspector of Prisons has repeatedly highlighted that young people from Black and Minority Ethnic communities feel less safe in prison than their white counterparts, and also are less likely to feel that staff respect them.

Young people from black and other minority ethnic groups are imprisoned in places where the prison workforce is much more likely to be predominantly white. While this is a complex area worthy of more detailed examination it is a long established fact that young people from minority communities are more likely to identify with staff from their own or similar groups. The absence of such models is likely to increase alienation and can lead to vulnerability.

iv. Psychosocial maturity

We commend the guide published by the University of Birmingham, the Barrow Cadbury Trust, and the Transition to Adulthood Alliance, of which we are a member, ‘Taking Account of Maturity – a Guide to Probation Practitioners’ (2013), which sets out in a practical way some of the key elements in the research literature on psychosocial maturity that apply when undertaking an assessment of a young person who has offended. Training for prison staff needs to emphasise a similar message, the danger of making assumptions around maturity (and therefore certain types of vulnerability) in respect of young people in custody.

v. Drug use

The 2012 study completed by INQUEST for PRT already described in 1. (b) found that more than a third of a sample of 98 children and young people who had died in custody had problems with drug or alcohol use.

vi. Alcohol use

See 5. (v) above.

¹⁵ ‘Women in prison: Corston five years on’ HM Chief Inspector of Prisons Nick Hardwick speech to the University of Sussex, 29 February 2012

¹⁶ www.t2a.org.uk/wp-content/uploads/2014/07/Response-by-the-Transition-to-Adulthood-Alliance-to-IAP-FINAL.pdf

vii. Location/distance from home

Closeness to home is of obvious assistance in maintaining family contact and may also assist the development of purposeful resettlement plans. In these ways distance from home can increase vulnerability. However, see also our comments in response to question 20 below concerning the importance of specialist prisons.

viii. Bereavement

There is evidence from studies of the death of children in custody that children who take their lives have often experienced the untimely death of close relatives, and that this has had a significant impact on them. It is worth noting that *Punishing Disadvantage*, a census of children imprisoned over a six month period in 2008, found that 1 in 8 had experienced the death of a parent or sibling.¹⁷

ix. Mental health needs

The 2012 study by INQUEST with PRT found that half of the sample of children and young people who had died in custody had a history of self-harm and nearly half (48%) had a history of mental health problems. Singleton et al's 2000 survey 'Morbidity among young offenders in England and Wales' reported that 16-20 year olds are more likely than other prisoners to suffer from mental health problems and are more likely to take, or try to take, their own life than any other age group, while the general increased prevalence of mental health problems amongst all adult prisoners is well known, with (for example) women prisoners being 23 times more likely to have a psychotic disorder than the general population. The figure for male prisoners is 14 times that of the general population.

x. Learning difficulties

High numbers of child and adult offenders have been shown to have low IQs (23% of children in prisons have an IQ of less than 70,¹⁸ 7% of adult prisoners have an IQ below 70 (with women in prison thought to have higher rates of learning disabilities than men),¹⁹ 25% have an IQ between 71 and 80;²⁰ and between 20 and 30% of offenders have learning disabilities or difficulties that interfere with their ability to cope within the criminal justice system.²¹ Higher proportions of prisoners than people in the general population have specific learning difficulties such as dyslexia.²² There is growing concern, although little data, about the number of offenders and prisoners on the autistic spectrum, although *Nobody made the connection*, a 2012 report published by the Office of the Children's Commissioner for England includes information on the prevalence of a range of neurodevelopmental disorders, including autism

¹⁷ Jacobson, J. et al (2010) *Punishing disadvantage: a profile of children in custody* London: PRT

¹⁸ Harrington, R. and Bailey, S. (2005) *Mental health needs and effectiveness provision for young offenders in custody and in the community* London: YJB

¹⁹ Prison Reform Trust (2014) *Brighter futures: Working together to reduce women's offending* London: PRT

²⁰ Mottram, P. G. (2007) *HMP Liverpool, Styal and Hindley study report* Liverpool: University of Liverpool

²¹ Loucks, N. (2007) *No one knows: offenders with learning difficulties and learning disabilities* London: PRT

²² Rack, J. (2005) *The incidence of hidden disabilities in the prison population* Surrey: Dyslexia Institute

spectrum disorder, traumatic brain injury and dyslexia, amongst young people in custody alongside comparative data on young people in the general population.²³

Without the necessary support, especially in new and/or distressing situations, the impact of these conditions can render an individual vulnerable. Many, for example, will experience limited language ability, comprehension and communications skills. They might have difficulties understanding certain words, understanding and responding to questions, reading body language and following social cues. They might have limited memory capacity, have difficulties recalling information, take longer to process information and have problems with ordering and sequencing. They can be acquiescent and suggestible, and under pressure, might try to appease others. They are frequently unable to read and write very well, and some may not be able to tell the time.

Research by PRT found that prisoners with learning disabilities or difficulties frequently had poorer experiences of prison than prisoners without such conditions, and that support needs were rarely recognised or met. They were almost three times as likely as prisoners without such conditions to experience clinically significant anxiety or depression – and many experienced both; they were five times as likely to have been subject to control or restraint; and three times as likely to have spent time in segregation.²⁴

xi. Communication issues

See our answer at x above. The best information is held about children, where 60% of children who offend have been found to have some communication difficulties, and of this group around a half have poor or very poor communication skills.²⁵ An inability to understand or to make oneself understood can quickly lead to frustration, anger, anxiety and depression.

xii. Educational issues

xiii. Physical limitations

xiv. Prior experience of abuse and/or trauma

Young people in custody show considerably higher rates of attachment disorders as a result of the experience of childhood trauma. Usually this will not have been diagnosed or treated in childhood with a consequence, in turn, that such young people's response to authority and instruction may be puzzling to prison officers. Some work has been done with staff in the children's estate on attachment disorders with promising results in terms of equipping staff to better understand, diagnose and manage challenging behaviour. This should be built into the training all prison officers who work with 18-24 year olds.

xv. Other

²³ Hughes, N. et al (2012) *Nobody made the connection: the prevalence of neurodisability in young people who offend* London: Office of the Children's Commissioner

²⁴ Talbot, J. (2008) *Prisoners' voices: experiences of the criminal justice system by prisoners with learning disabilities and difficulties* London: PRT

²⁵ Bryan, K. Freer, J. & Furlong, C. (2007) Language and communication difficulties in juvenile offenders, *International Journal of Language and Communication Disorders*, 42, 505-520

Care leavers

We are concerned that care leavers are over-represented amongst young people who die in custody. Analysis undertaken for *Fatally flawed* found that 8% of the children and young people who died were known to have had experience of care, though this was “likely to be a significant underestimate [as] records for young people aged 18-24 years...do not routinely capture information about historic experience of care.”²⁶ Too often, the former care status of young adults in prison is not recorded, even when they are entitled to statutory support as care leavers.²⁷

Some vulnerability will be rooted in the future plans for young adults in prisons. Many young adults enter prison with only the most uncertain of knowledge of what will happen to them on release. Lack of accommodation is a particular stressor and this situation will further deteriorate as local authorities across the country make very significant reductions in Supported People schemes, particularly Foyers and other housing schemes designed for young adults.

Acquired brain injury

There is growing evidence that children and young adults who have experienced traumatic brain injuries in their pasts are over-represented in prison populations, with reported prevalence rates for young people in custody of between 65-72%.²⁸ Such injuries are often then linked to a greater prevalence of risk-taking behaviour, and as such should be recognised as an emerging area of vulnerability. *Repairing shattered lives*, a Transition to Adulthood (T2A) Alliance report published in 2012, “draws together the important research from the UK and abroad to show that there is a high prevalence of acquired brain injuries among those in the criminal justice system, many of whom have received little or no treatment, and whose injury has not been taken into account at any stage of the process.”²⁹

General

This Review should commission an independent examination of the quality of such information available in the cases of a group of young people who recently injured themselves, attempted suicide or took their lives, in order to assess current practice in this area. The Review should publish this as a part of its findings, if need be after the main Review is completed.

6. Are there any bespoke tools that would assist in identifying particular types of vulnerability?

²⁶ Prison Reform Trust (2012) *Fatally flawed: Has the state learned lessons from the deaths of children and young people in prison?* London: PRT

²⁷ www.careleavers.com/entitlements

²⁸ Hughes, N. et al (2012) *Nobody made the connection: the prevalence of neurodisability in young people who offend* London: OCC

²⁹ www.t2a.org.uk/wp-content/uploads/2012/10/Repairing-Shattered-Lives_Report.pdf

In 2012 the Department of Health and the YJB introduced the Comprehensive Health Assessment Tool (CHAT), specifically developed for use with children, to enable consistent and comprehensive identification and assessment of health and health-related needs of children by the right professionals at the right times. Initial evaluations of CHAT have been promising, revealing, for example, high convergence rates when compared against standard assessment tools. It is likely that a similar tool would serve young adults well although CHAT was designed specifically for use with children. We are conscious that a number of organisations are actively seeking to develop such tools and there is a clear need for coordination and the emergence of an 'industry standard' approach.

We draw the Review team's attention to the 2012 report from the London Borough of Ealing and others entitled *Youth offending and speech and language therapy*, which concluded that existing screening tests for speech and language disabilities (the Broadmoor Observation of Communication and the Likert Scales) should not be used with children without considerable adaptation. We would suggest that this would also apply to their use with young adults.

7. Do attitudes and behaviour contribute to vulnerability: staff/staff, staff/prisoner and prisoner/prisoner?

Staff need a broad understanding of the nature of the vulnerabilities that will be present in a cross-section of young people in custody if they are to be able to understand, help assess and respond to this group.

For example, young people with learning disabilities or communication difficulties may have developed ways of cloaking their lack of understanding of simple instructions in a way that ultimately will increase their vulnerability. They may also be significantly more prone to risk-taking behaviour in a way that increases their vulnerability. One 18 year old with learning disabilities who took his life in custody had survived an earlier suicide attempt when in custody as a child and is reported as saying "*I'm not scared of death as I have already died once.*" This highlights the need for awareness training.

Similarly young people who experienced childhood trauma will not have learnt healthy ways of responding to instruction and conflict and staff dealing with them will need insight and skill to achieve the best results in daily contact.

Beyond this, it is our view that significant sections of the prison workforce still interpret self-harm, and the threat of self-harm, as attention seeking and manipulative. Where these attitudes occur they are dangerous and can prevent constructive engagement with young people.

A Home Office study drawing on the views of children and young people themselves revealed that self-harm and suicidal thoughts were part of day-to-day life in a young offender institution. It cited the following conversation between young men in a YOI:

"Well I can understand people hanging themselves, but when people cut their wrists that's just nasty. It was just coming out of his arm."

“When I was in one YOI about three people tried hanging themselves.”

“When you hang yourself all your problems are solved.”³⁰

This is illustrative of a culture of suicidal ideation which can exist in some institutions holding groups of vulnerable young people. Particularly in the immediate aftermath of a death or attempt, the risk of contagion is real. It is essential that staff are trained to listen to young people and respond appropriately.

Lastly the work already done by the YJB on ‘good communication’ needs to be extended across the whole young people’s estate.

Information sharing and effective communication

8. (a) What are the biggest barriers to effective information sharing and communication about potential vulnerabilities both within the criminal justice system and coming from external agencies?

The single greatest step forward in current practise would be any means by which communication and information exchange between prison and outside agencies could be improved. The creation of Community Rehabilitation Companies will make an already complicated landscape, involving as it may probation services, local authorities, NHS bodies, the community and voluntary sector, and many others, more complex.

Protocols for information exchange, and the technical means to facilitate this, can make a big difference, as can real commitment and attention from each organisation involved in the sharing of information. The Y2A portal is a good example of a relatively low-cost technical solution (with attendant agreements), that would stand replication, although it will not be suitable for all agencies.

Once a young person has entered custody, all available information needs to be gathered, held in a coherent manner, and transferred with the person as they move within and between prisons. Routine examination of such records highlights the poverty of content and points in particular to a training need amongst prison officers of all grades.

It is important that such information is seen as being the responsibility of all officers in charge of a prisoner, and not just the health specialists. We have referred previously to the role that periodic meetings to discuss the circumstances of particular young prisoners could play in keeping them safe.

(b) How might these be overcome, particularly in the context of existing resource constraints?

We do not believe the problems of information sharing that have been repeatedly highlighted in this area are principally a consequence of resource constraints. Rather this is a matter of a failure to acknowledge the importance of the issue and for all to take their share of

³⁰ Lyon, J. Dennison, C & Wilson, A. (2000) *Tell them so they listen: messages from young people in custody* Home Office Research Study 201 London: Home Office

responsibility. The Prison Service cannot be held responsible if it does not know of the previous contact that external agencies have had with young people prior to custody.

This is highlighted by the paucity of data allowing identification of young in custody who are care leavers. The most reliable data on this is found in prison inspectorate reports, though the lack of formal recording mechanisms for this information, particularly for young adults, means reports are likely to underestimate the number of care experienced children and young people in custody. The appointment by NOMS of a serving Governing Governor as Leaving Care Champion is warmly welcomed in this regard.

This Review should present the lack of information as an issue of failure of leadership both across government departments and amongst external agencies. We would welcome consideration of whether a new legal duty of cooperation with the Prison Service should be placed with a range of specified agencies to raise the profile of this issue.

9. How can information sharing and communication be improved and better utilised to identify vulnerable young people and what information should be provided from:

i. Within the criminal justice system?

See our answers to questions 4, 8 (a) and 8 (b) above.

ii. Within an institution?

See our answer to question 8 (a) above.

iii. From external agencies?

See our answer to question 8 (b) above.

11. In the context of self-inflicted deaths in custody, how can any learning and best practice from the youth secure estate be best applied to the adult secure estate?

The YJB has published its own summary of learning from the study of deaths of children in custody between 2000-2012 'Deaths of Children in Custody: Action Taken, Lessons Learnt' (2014).

In addition, we are aware that a review of the applicability of the ACCT process for 15-17 year olds in YOIs was announced in October 2013 following the publication of *Fatally flawed*. Whilst we have not seen the review findings, we would anticipate that much of the learning would be relevant to the application of ACCT for 18-24 year olds.

Elsewhere in this evidence we have referred to the following innovations:

Information sharing – 'Connectivity' and the 'Y2A portal', see our answer at 4;
Assessment tools – the 'CHAT', see our answer at 6.

Management of Assessment, care in custody and teamwork (ACCT)

13. Have the aims of Assessment, Care in Custody and Teamwork (ACCT), which is intended to reduce risk for those identified as at risk of suicide or self-harm, been achieved?

The most recent statistical report from the Ministry of Justice, published in April 2014, shows that the number of self-inflicted deaths per 1,000 prisoners fell markedly in 2008 and then remained pegged at 0.7 per 1,000 until the end of 2012 (c. 60 deaths per year). In 2013 the overall numbers rose to 74, representing a rise to 0.9 deaths per 1,000 prisoners and the highest number since 2007. Numbers of deaths of 18-24 year olds are numerically small and therefore not statistically significant, but the absolute number of self-inflicted deaths has reduced since the nineties/early 2000s, despite the rise in numbers of young adults in custody.

The absolute number of self-harm incidents for 18-24 year old men has risen steadily since 2007, despite the recent reduction in numbers of 18-20 year olds in prison. As discussed above, whilst the number of young women harming themselves has reduced since 2008, they remain significantly more likely to do so than young men.

Judged purely against these statistics ACCT cannot be said to have reduced the number of incidents of self-harm and deaths in custody.

14. Has the identification and management of individuals at risk of self harming improved since ACCT replaced F2052SH (the previous system used to manage those in custody believed to be at risk of suicide or self-harm)?

In 2011, NOMS' national safer custody managers and learning team reported that a two tier audit cycle had found weaknesses in more than half of the prisons audited in respect of:

- following the required ACTT process where it was appropriate so to do;
- completion of regular reviews and targeted reviews when circumstances change; and
- sharing of concerns between different disciplines with the prison when these indicate risk change.

In April 2014 the Prisons and Probation Ombudsman (PPO) published a thematic review of this area entitled [Self Inflicted deaths of prisoners on ACCT](#). No doubt the PPO will himself highlight his conclusions but we would concur from our own casework with his conclusion that:

“too many cases where the ACCT procedure is not followed as thoroughly as it should have been or where case reviews are not carried out within the specified timescales or information is not recorded. The ACCT should be a live plan which is reviewed and updated when a prisoner’s circumstances or risk change, again this does not always happen.”

The PPO found that ACCT processes were not correctly implemented or monitored in half of the cases of self-inflicted death that were investigated, with roughly a quarter of these being “very poorly” implemented.

In addition to concerns over ACCTs implementation, *Fatally flawed*, the joint PRT/INQUEST report into the deaths of 98 children and young people in prison, found that “in 50% of the deaths...there was a known history of self-harm and/or mental health issues yet no open ACCT or F2052SH at the time of death.”³¹ This raises considerable concerns over both the way in which risk of harm is interpreted, and the threshold for ACCT being opened.

Fatally flawed recommended “a review of the operation of the ACCT scheme as it applies to children and young people...with a view to improving the accuracy of assessments and providing better support to those identified as at risk of harm.” As mentioned earlier, a review of ACCT for 15-17 year olds was announced in 2013. In light of the PPO’s evidence of ACCT implementation, and the particular needs and vulnerabilities of young people aged 18-24 we ask the Review team to consider the case for a wider review of ACCT with particular reference to this age group.

It may transpire that it is not ACCT itself that is faulty – the framework is essentially sound – but its actual application leaves much to be desired, and attention should therefore be focused on securing improvements.

17. How can the ACCT management process be improved to better ensure that needs of those identified as at risk are more effectively met?

One step that would lead to significant improvement would be the adoption of an approach that sought to engage young people in deciding in support options. Real engagement would move practice away from a tick box approach.

For ACCT to be effective, staff need adequate training time and support to follow the process properly and better understanding of information sharing and joint working. Alongside focusing on supporting individuals at risk, prison staff must understand that caring and respectful communication and improving conditions and treatment are necessary to create a safe decent and humane environment.

Management of vulnerability in custody

20. When a young person is remanded or sentenced to custody, what issues should be taken into account in terms of initial allocation into an institution, and any subsequent transfers to minimise risk of self-harm and self-inflicted death?

In our submission to [Transforming management of young adults in custody](#) we emphasised the importance of young people aged 18-20 being accommodated separately from adult prisoners in specialist provision. This remains in our view the most important consideration here.

Beyond that proximity to home area is obviously the default option although allocation policy should also be flexible enough to take account of specific needs, for example a young person who wishes to break away from gang affiliates and therefore not be placed in a local prison.

³¹ Pg. 37, Prison Reform Trust (2012) *Fatally flawed: has the state learned lessons from the deaths of children and young people in prison?* London: PRT

As a general rule transfer should be used sparingly as it breaks up any personal relationships that may have been established between the young person and prison staff. This same point can also apply to transfers within prison. While the operation of the existing personal officer scheme has been shown to be inconsistent, we remain convinced that an effective personal officer scheme would improve many aspects of the young person's experience in prison, and in particular would help keep them safe.

Transfers between prisons also increase the risk that important information about the young person may be lost, or its transmission delayed.

21. (a) Do you think the recent changes to the Incentives and Earned Privileges scheme, which means that those sentenced to custody will have to work towards their own rehabilitation to earn privileges – they will not receive them through good behaviour alone – have an effect on vulnerable young people in custody?

Yes.

21. (b) If your answer is yes, please set out why you think this is the case, noting in your answer any evidence, case studies or research that show why this is particularly the case for this age group.

The entry level is punitive and imposed at a time of heightened vulnerability.³²

22. How do you think the processes to support young people who are transferring from the youth estate to the young adult estate can be improved to help mitigate risk of self-inflicted death?

Existing practice in this area is mixed. There are reasons to believe that performance is driven by capacity issues; where the headroom exists to plan properly for transfers these are well managed.

The key issues here are to make sure that:

- the risk of self-injury is re-assessed prior to transfer;
- this risk is communicated, together with all attendant information on the young person, to the 'receiving' prison, ideally not simply by paper transfer but by conversation between prison staff in each prison;
- the plan for the transfer is explained well in advance to the young person, and the nature of the new regime they will experience is discussed with them;
- a peer mentor ('insider') is appointed to meet the young person on transfer and meet with them over their initial period in the new prison;

³² Prison Reform Trust (2014) *Punishment without purpose: The Incentives and Earned Privileges (IEP) scheme and its impact on fairness, decency and rehabilitation behind bars* London: PRT at www.prisonreformtrust.org.uk/Portals/0/Documents/punishment%20without%20purpose%20FINAL2941007.pdf

- the transfer is organised so that the personal officer is available both as the transfer takes place and then regularly in the first few days of the transfer;
- the risk of self-injury is formally reviewed within a few days of transfer, and then again after a short period in the new prison; and
- the family of the young person are fully briefed about the transfer and provided with an early opportunity to visit and reassure their relative.

23. (a) Are 'safer cells' effective or not, and why?

Safer cells have incorporated lessons from earlier deaths and serious incidents in custody and are, therefore, more likely to reduce risk of serious harm. So they are likely to have an impact on the chances of life threatening self-harm occurring. However, improved architecture and design should never be relied upon as the whole solution. Staff need to demonstrate a supportive and caring approach to the young people in their care where safer cells are used.

23. (b) Does more need to be done to reduce the number of ligature points in cells?

There should be no ligature points in any cells.

23. (c) What could be done to improve the design of safer cells?

See 23. (b) above.

24. In the context of self-inflicted deaths, how can safety, including violence reduction and bullying, be improved in custody in terms of:

Effectiveness of systems to report violence and bullying (both by inmates and staff)

Effectiveness of systems to tackle violence and bullying (both by inmates and staff)

Use of restraint

Restraint systems and training need to emphasise de-escalation. In exceptional circumstances where restraint is used, adequate debriefing is vital after the event and should be seen as an essential component of all restraint. Far too often, use of restraint or isolation is the default setting for increasingly small numbers of staff dealing with high numbers of challenging young people.

Reducing access to dangerous items or materials

Availability of safer cells

Prescription drug sharing

Illegal drug use

Drug use amongst young people in prisons could be greatly reduced if young adult prisoners are held away from older prisoners. Imprisoning 18-20 year olds with older prisoners opens up supply routes that do not exist in the under-18 estate. Recently a mobile phone film obtained by The Mirror and the BBC showed graphically the violence stemming from mixing young people with adult prisoners and drug-dealing in custody.

Procedures following a self-inflicted death in custody

27. How can investigations into self-inflicted deaths in custody be improved, in terms of:

- i. Prison and Probation Ombudsman (PPO) processes**
- ii. Inquest procedures**
- iii. Opportunities for family input and investigations**
- iv. Ability of the Inquest and PPO to consider the context of a particular death**

The more delayed the investigation the more reduced the chances of impact of any resulting recommendations for change. With this in mind, delays in both the PPO process and, more particularly, Inquest procedures reduce the impact of the learning from both forms of enquiry. There is a case for saying that the death of someone while in the state's care should be a matter of very considerable public concern and national priority, and therefore that the PPO investigation should be completed within 6 months and the inquest within 12 months of the death of the individual concerned. Such timescales would represent a considerable improvement over existing performance. We do not believe they are unreasonable, nor do we consider that their achievement would unduly hasten the necessary investigative processes involved.

Proposing the prioritising of inquests relating to deaths in custody in this way is not to say that all inquests are not important; but it is to assert that the particular circumstances of a self-inflicted death whilst in the care of the state, and the need to ensure information is shared across agencies, lessons are learned, and further deaths are prevented, requires timely examination.

Wider lessons of course could be learned by extending the remit of the inquest, something which any coroners would support to cover the antecedents to custody and the sentencing decision made.

28. How might arrangements around Legal Aid better take into account the needs of bereaved families?

One of the recommendations put forward in Fatally Flawed, the joint INQUEST and Prison Reform Trust report on deaths of children and young people in prison, was that "*families bereaved by a death in custody should automatically qualify for non-means tested public funding to enable their legal representation at inquests.*" We repeat this recommendation here.

30. How might the learning from deaths be better disseminated?

The reactions of both institutions and individuals pass along a discernable pathway following the death of a person in custody. Once the initial shock has passed, and the resulting investigations have had a reasonable (but not overly long) period to establish the facts, it is important that a summary is then prepared by a senior named official highlighting the learning to be had from the tragedy.

Their conclusions should be published so that there is a clear record of stewardship in response to the death.

NOMS should then publish, annually, a summary of such reports and the action taken to implement the conclusions of each summary. We would repeat here the very clear conclusion of Lord Ramsbotham, former Chief Inspector of Prisons, in his foreword to *Fatally Flawed*:

*“Until and unless named individuals are made responsible and accountable for ensuring that things happen, nothing will happen”.*³³

All of this learning should be routinely covered in staff training, see our answer to question 32 below.

Staff training

32. Are staff (this includes all staff working with offenders within an establishment, whether NOMS staff or other agencies) trained and prepared for working with vulnerable young people?

There is little specialist training available for prison staff working with young adults in custody. We believe that a specialist syllabus should be designed that takes into account the characteristics of young people’s behaviour and stage of development through appropriate role modelling, promoting and maintaining positive behaviours, and clearly defining behavioural boundaries.

Training should also emphasise the destructiveness of bullying, the need to adopt a robust response to it, and the risks of prison staff becoming so exposed to a culture of bullying that they no longer recognise its pervasive threat to safety.

Staff should be familiar with an outline of the theories of attachment, of the main risk factors to which young people in custody may be prone, and of the principal lessons to be learnt from past deaths in custody.

When HMP YOI Lancaster Farms was opened the Governing Governor made a conscious effort to maximise the opportunities for staff groups to be trained together, with the aim of making the prison ‘a safe, healthy establishment’. This is clearly very difficult to do, but it does have the potential to make any training a more profound experience.

33. What specific skills do you think staff working with young people should be supported to develop so they can better identify and manage vulnerability?

See our answer to question 32 above. There is much that can be learned from applying lessons from research on parenting older teenagers.³⁴

³³ Pg. iii, www.prisonreformtrust.org.uk/Portals/0/Documents/Fatally%20Flawed.pdf

³⁴ <http://youngpeopleinfoocus.fastnet.co.uk/madetomeasure>

In addition all staff working with young people will benefit from having access to opportunities for reflective supervision from a more senior and experienced person. Young people can be very challenging and a safe opportunity in supervision to develop insights into this is generally regarded as a necessary element for staff development in other settings which involve working with young people.

34. Should volunteers be used to identify and manage individuals at risk, and if so how?

Primary responsibility for keeping young prisoners safe should rest with Prison Service and healthcare staff, and with the other professionals operating within each prison. Some volunteer schemes (see for example our answer to question 35) have been proven to support such arrangements.

As mentioned previously, our report [There when you need them most](#) demonstrated how voluntary sector services can play a vital role in meeting personal needs.

35. Are ‘listeners’ being used to best effect?

Listener schemes and facilities vary but can be excellent and are usually delivered in a most conscientious fashion. The support for the scheme within the Prison Service, and personally from the Director General of NOMS, is admirable. Our experience is that there remain some gaps in availability and such schemes are inevitably less effective with very short stay populations.

Insider schemes are similarly of great use, but likewise not consistently available.

36. How should staff be sufficiently trained so that vulnerability is effectively reported and acted upon?

See answers to questions 32 and 33 above.

37. How can procurement processes ensure that staff are trained and prepared effectively for working with vulnerable young people?

Minimum standards of staff training, management and support need to be established within all contractual arrangements.

Family, support network

38. Should arrangements around family and support network contact be improved to:

i. support vulnerable young people?

Early contact between young people and their families on arrival in prison (or following transfer to a new prison) is important in addressing one area that young prisoners regularly describe as a major source of anxiety.

The PPO's thematic review of the use of ACCT in instances where there has been a self-inflicted death of a prisoner concluded that in the majority of such cases families had not been involved in arrangements to keep prisoners safe (CAREMAP). This is a weakness in the current operational arrangements.

ii. better ensure families and friends can alert establishments to concerns?

Families need very clearly signposting to a reliable source within the prison to whom they can describe anxieties about the stress levels of their relatives. Each prison needs to recognise the importance of such a facility and ensure, on a regular basis, that it is fully operational and well publicised to families. The capacity of family members to act as a resource to troubled young people has been identified by work done by the University of Manchester and also in the HMIP thematic *Suicide is everyone's concern*.³⁵ Too often families are seen as a problem rather than as part of the solution.

Additional comments

The two main themes that emerged from [PRT's work with prisoners with learning disabilities or difficulties](#) have a wider relevance for all young adults in prisons. The prisoners concerned identified the importance of:

- having someone to talk to about their problems, preferably in private:

"You should have someone who comes to the wing to help you and then you would just have help from one person, that would be much better. If people are getting help they might laugh at you and then pick on you. There should be somewhere quiet where nobody can see you. You would find that people use it a lot more. One of the screws could do it for an hour or something."

- and more purposeful activities.³⁶

While these are very obvious points they are worthy of constant repetition.

**Prison Reform Trust
July 2014**

³⁵ HMIP (1999) *Suicide is everyone's concern – a thematic review by HM Chief Inspector of Prisons for England and Wales* London: HMIP

³⁶ Talbot, J. (2008) *Prisoners voices – experiences of the criminal justice system by prisoners with learning disabilities and difficulties* London: PRT