Submissions from Bindmans LLP to the independent review into self-inflicted deaths in NOMS Custody of 18-24 year olds

PLEASE TREAT THE REFERENCES TO INDIVIDUAL CASES WITHIN THESE SUBMISSIONS AS CONFIDENTIAL DUE TO THE SENSITIVE NATURE OF THE ISSUES DISCUSSED AND BECAUSE SOME OF THESE CASES ARE ON-GOING.

Bindmans LLP is a civil liberties and human rights law firm established in 1974. We are a firm committed to legal aid work and representing individuals in holding the state to account. We have a specialist team of lawyers who act solely for bereaved families at inquests and our particular expertise is in representing the families of those who have died whilst in the care of the state, including in prison custody, or following close contact with state agents. We work closely with the organisation INQUEST and two of our solicitors, Charlotte Haworth Hird and Sara Lomri are members of the INQUEST Lawyers Group Steering Committee.

Sadly, we have represented, and continue to represent, a number of families of 18 to 24 year olds that have died in prison custody following self-inflicted injuries. The families of those who have died in these circumstances often feel that their loved one should not have been in custody in the first place. Sometimes this is because it is felt that a custodial sentence was unjustified or unwarranted. Invariably it is because the family feel that their loved one should have received more help and support at an early stage to help them and keep them safe (including help to break the cycle of offending or help with mental health difficulties). On occasion, families feel that their loved one should have been detained under the Mental Health Act 1983 rather than detained in prison custody. In our experience, many of the young people who die in prison custody have already been failed by one, and usually many, statutory agencies, before entering custody, many of which had a duty to protect them and keep them safe. We welcome the Harris Review and hope that it will finally truly mean that lessons will be learnt and meaningful changes will be made to ensure that further preventable deaths of young people do not occur.

We have responded to the questions posed in the call for submissions, in so far as these are within our expertise and experience. Where we feel able to make suggestions for necessary change based on that experience we have done so. As will be appreciated, these suggestions are not exhaustive of the steps that need to be taken to address the persistent and unrelenting patterns of deaths in custody.

A number of those patterns are identified in a document prepared for the 'E' case which prompted the government to establish the Review. It is appended along with the chronology and pleadings for that case. We would ask that those documents are treated as confidential to the Review.

Vulnerability

In acting for bereaved families of 18 to 24 year olds who have died in prison as well as prisoners themselves aged under 24, it is our experience that this age group is inherently vulnerable due to their age and common experiences outside custody, but that, unfortunately, their specific vulnerabilities are often undetected, on occasions masked by other problems, or not adequately responded to, particularly within the adult prison system which is not geared towards the specific needs of this age group.

In our experience many young people in custody have had extended contact with state services in their past including with the local authority as children in care or under supervision; with mental health services; or within special educational facilities. It is our view that these particular experiences make a young person particularly vulnerable, including to acts of self harm and suicide. We suggest that the link between those with extended contact with state agencies prior to arrival in custody and their vulnerability and risk of self-harm should be one of the issues explored in your review.

Example (confidential):

[REDACTED]

Events which exacerbate vulnerability

Whilst we consider that it is important that a young person's vulnerability and risk of self-harm or suicide is kept under review, our experience is that there are identifiable stages in custody when a young person appears to be particularly vulnerable to acts of self-harm. The cases in which we have acted demonstrate a repeated failure by staff across the system to recognise these points. These stages include, but are not limited to:

- When a young person first enters custody
- When a young person is approaching a court hearing, including sentencing
- After a young person has attended court, and particularly if he/she has been refused bail, has been convicted or has been sentenced
- Around significant anniversaries including birthdays, family members' birthdays, and mother's and father's day
- When a young person is transferred from one institution to another, particularly when a young person has been transferred to an institution some distance away from their family and support network
- When a young person is approaching release

Our view is that the first days in a prison, whether when first remanded or when transferred from another institution, are an extremely vulnerable time for young people. They are often unknown to staff; there is usually a lack of information available about that person (for a number of reasons including regular delays in information being transferred and failures by staff to obtain relevant information); it usually takes some time to set up access to support, including by way of telephone contact with family and friends; and it can be a particularly isolated time as individuals will not have access to work or activities and access to association and exercise may be limited. In addition, young people will often be

worried about the unknown social dynamics within a prison and (exaggerated or otherwise) rumours about regimes in a new prison, which can increase vulnerability.

Although staff often state (in interviews with the PPO and in giving evidence at inquests) that they are aware that the first days in custody are a particularly risky time our experience is that, in fact, staff do not apply this in practice. The risks present in the first few days in custody are reflected in the relevant Prison Service Instructions ('Management of prisoners at risk of harm to self, to others and from others (Safer Custody)' and 'Early Days in Custody'). In our experience, despite assertions from HM Prison Service in response to PPO recommendations and the outcome of inquests that, following deaths, staff are reminded of the content of such PSIs, the same failings continue to occur.

Example (confidential): [REDACTED]

In both of the above examples, staff have said that they did not consider either young person as requiring support under the ACCT system as both young men "appeared to be fine". This over-reliance on self-reporting, on a young person's presentation at the time of any assessment or conversation and on 'in the moment' assessments is a common feature in the cases in which we have acted and one which, in our experience, frequently leads to young people not being properly identified as at risk and therefore, not being offered appropriate support. This is a particular issue in respect of younger prisoners who are often more embarrassed or are unwilling to admit to vulnerability.

Further, we consider that the risk assessments used within the prison service are generally not sufficiently sensitive to pick up on the specific vulnerabilities and risks associated with young prisoners. [REDACTED]. We consider that the Panel would be assisted by obtaining expert advice from a psychiatric nursing expert and psychiatrist on the most appropriate risk assessment tools to be used for assessing the risk of self-harm in young people.

Necessary steps to address identification of vulnerability include:

- Detailed analysis of the link between those who have had contact with state agencies prior to entering custody and the risk of self-harm and suicide, and consideration of whether extended contact with state agencies should in itself become a risk indicator in the assessment process
- Identification and development, with expert input, of specific risk assessment tools tailored for this particular age group
- Increased and improved training of staff regarding the identification of vulnerable young people at risk of self-harm and suicide

Information sharing and effective communication

From our casework, we consider that the following are the biggest barriers to effective communication and information sharing:

- Failures by staff to contact relevant agencies and individuals to request information when assessing a prisoner
- Delays in information being provided following requests and failure to follow this up
- Failures to transfer information about a prisoner when moving between establishments
- Failure to provide basic information about a prisoner with him or her on transfer so that some information at least is provided on first reception
- Failures to transfer and communicate relevant information about a prisoner between disciplines within a prison
- Inadequate record keeping
- The number of agencies involved in a prisoner's care
- The number of different (usually incompatible) information recording systems and restrictions on different disciplines accessing those systems

Example (confidential):

[REDACTED]

Obtaining information from outside agencies

In our experience it is rare for information to be obtained for outside agencies when a young person enters prison. Whilst occasionally, an individual's GP records are requested if a particular health problem is reported, it is rare that other records, such as mental health records or social services records are requested. Whilst resources may prevent the obtaining of a complete set of records, there could be a system whereby summary information can be obtained from and shared by such external agencies. In the context of health services the practice of handing over from one clinician to another via a discharge summary is an absolute basic requirement, but there appears to be no equivalent for the commencement of care within the prison context. Although we appreciate this is a complex matter, it appears that at least some kind of summary report to the professionals based in the prison would assist. We would expect this summary to include information about an individual's diagnosis or difficulties, length of time a person has been receiving services, medication/in patient admissions (if any), assessment of need and treatment/care plan, social and family circumstances, and contact details if any immediate questions arise.

Communication with families

In our view, it is also rare for families to be used as a source of information in respect of a young person in custody. In the community when assessing a mental health patient for example, collateral information from family members is absolutely essential in the assessment process. Families are a key source of information regarding a young person's history and risk, yet they are rarely contacted for such information. We have concerns that staff will erroneously rely on the Data Protection Act as justification for not speaking with family members despite the fact that the DPA does not prevent information being obtained from families, which is to say that an officer or practitioner can telephone a family member and ask for information as the DPA relates only to disclosure of information to the family member. The DPA cannot be relied upon to prevent

information flowing into the place of detention. This kind of information flow should actively be sought as we believe it can save lives.

Further, as far as we are aware, there is no system in place which allows for important information to be provided to family members, such as if their loved one has been placed on ACCT; if he/she has been transferred to a different prison; and the availability of financial assistance in order to visit their family member in prison. This is important given that many families provide an important support network to vulnerable prisoners and can help officers to keep young people safe. Prisoners should be asked as a matter of course whether they consent to information being shared with family members and more effective systems should be put in place to ensure that this occurs.

Necessary steps to improve information sharing

- IT systems which can more easily share information
- Improved information accompanying a young person on reception (particularly in view of the risks associated with the first hours and days in a new prison)
- An improved and increased emphasis on continuity of care when entering prison custody including a requirement that GP, health and mental health records be sought and considered, and care plans formulated as required
- A requirement for prison staff to take active steps to obtain relevant information from other agencies when an individual enters prison and for agencies to provide prisons with a summary of on-going health and mental health needs of a young person
- Increased training and protocols for all disciplines in prison regarding the necessity of sharing information and the circumstances in which information regarding a prisoner's vulnerability can be shared
- A requirement to contact family members where questions regarding mental health, propensity to self-harm, or ability to cope in custody arise, or where family members have attempted to contact the place of custody to share information regarding concerns

<u>Management of ACCT</u>

We do not consider that the aim of the ACCT system to reduce risk for those identified as at risk of suicide or self harm has been fully achieved. In all of the cases in which we have act for bereaved families of 18 to 24 year olds and in which the prisoner was subject to an ACCT, there have been repeated failures to comply with PSI 64/2011, to properly implement the ACCT procedures and to ensure that monitoring and support under the ACCT procedures is effective. These failures include:

- failures to complete or update care maps
- failures to carry out a risk assessment
- failures to complete the 'triggers' section on the ACCT document
- failures to invite anyone other than discipline officers to ACCT reviews
- failures to recognise that self-harming behaviour can be as a result of mental health difficulties
- failure to open ACCTs and premature closure of ACCT documents
- inadequate entries within the daily recording sheets

- failures to carry out post-closure reviews
- failure to obtain relevant information from external agencies such as social services, GPs or community mental health teams
- failures to make and follow-up referrals to the mental health in-reach team

The list above sets out frequent issues which in our experience arise not only in relation to self-inflicted deaths of young people but across the prison and custodial estate. We have worked on countless cases across the country where either Coroners or the PPO have made recommendations in respect of the above, and Prison or YOI Governors have responded confirming that lessons have been learnt and their systems have changed. We are concerned that the professed learning is short-lived and localised.

It is with regret that we state that the frequency and extent of the failings in relation to ACCT have caused us to question the effectiveness of the system as a whole. We appreciate that self-harm and suicide prevention is a complex issue and we do not underestimate the difficulties of safeguarding young people in challenging circumstances. However, it appears that within the apparent culture of 'learning lessons', the need to properly follow the ACCT procedure is a lesson that Prisons and YOI profess to have learnt repeatedly, yet the same failings are being repeated up and down the country with tragic consequences.

Example (confidential):

[REDACTED]

A particular issue which we have come across in respect of younger prisoners is that discipline staff often consider self-harming behaviour as attention seeking or minor and therefore, low risk. In our view this misunderstanding of self-harming and suicidal behaviour could be addressed in part by the provision of basic mental health training. We understand that many prison officers regard their profession as a caring profession, and we feel that compulsory training specifically focused on analysing the impact of minimising or dismissing self-harming behaviour as attention seeking, and what positive action should be taken to assess and investigate (including speaking to family members, as suggested above) would help to address this issue.

Example (confidential):

[REDACTED]

Necessary steps to address issues arising from the Management of ACCT:

- We consider that it would assist if the Review carried out an analysis of PPO investigations and recommendations, inquest conclusions and Rule 43 (now Preventing Future Deaths) reports and responses in order to identify failings in the ACCT procedure and to make recommendations for the wholesale review and improvement of the ACCT system
- Specific training to address the perception of self harm or proposed self harm as attention seeking behaviour

- Mental health awareness training to be provided to all staff

Management of vulnerability in custody

In our view, a pervasive problem in respect of management of vulnerability amongst 18-24 year olds in prison is that young prisoners are frequently not even identified as at risk in the first place. We have set out above the examples of this, which clearly demonstrate inadequacies in identifying young prisoners at risk and in opening an ACCT document. As demonstrated by those examples, there appears to be a system wide problem of staff failing to recognise risk indicators in young people and acting upon this. There does not appear to be sufficient consideration to providing increased support to younger prisoners, including by opening an ACCT document at particularly vulnerable times, such as when a person is approaching sentencing or has just been sentenced. This is particularly the case if young prisoners do not report any problems themselves. In general, it is our view that there is an over-reliance on self-reporting to identify risk, which is particularly difficult given the frequency with which these young people present with emotional and communication problems and often use distraction and avoidance techniques to mask their true vulnerabilities.

In addition, it appears that little consideration is given to ensuring continuity and stability, in so far as this is possible, in a young prisoner's life at particularly vulnerable times. For example, we have found that young prisoners are often moved to different institutions following significant court appearances, which are often further away from family members. Therefore, at particularly vulnerable times, young prisoners are not only taken away from a familiar environment and staff who are aware of their history and needs, but also away from their support network of family and friends, sometimes to a part of the country which is unknown and alien.

Example (confidential)

[REDACTED]

Our experience shows us that the assessments that are carried out throughout a young person's time in custody are often inadequate in identifying vulnerability and how to manage that. Such assessments include those carried out on induction, those conducted through the course of sentence planning and other assessments such as cell sharing risk assessments. The inadequacies of the latter have arisen in two cases in which we have acted and specifically, the fact that cell sharing risk assessments focus on a prisoner's risk to others only, rather than also properly considering the risk a prisoner poses to himself and any measures that can be taken, in respect of cell sharing, to reduce that risk.

Example (confidential)

[REDACTED]

We have not acted in any cases in which the issue of the new IEP scheme has arisen. However, we would note as a general point that the use of the IEP scheme

as a way of punishing non-compliance with prison rules has led to increased vulnerability in some of the cases in which we have acted.

Example (confidential):

[REDACTED]

Cell design and emergency procedures

The Panel will of course be aware that the majority of self-inflicted deaths in custody are as a result of hanging and in our experience, the majority of these are by way of a sheet being threaded through cell bars. In our view, the number of deaths in custody would certainly be reduced if cell bars were removed. We would suggest that the Panel obtain expert advice on safer cell design and alternatives to cell bars without depriving prisoners of light.

In the large majority of cases in which we have acted, there have been concerns regarding the emergency procedures when a prisoner is found. This includes a lack of available emergency equipment; a lack of first aid training, which is particularly important now that some prisons, such as HMPYOI Aylesbury, do not have 24 hour healthcare and therefore, if a prisoner is found during the night, as is often the case, discipline staff have to provide life support until paramedics arrive; a lack of training and understanding by discipline staff of when a member of staff can enter a prisoner's cell without another officer being present; the inappropriate use of emergency codes leading to delays in response and in an ambulance being called; and delays in ambulance staff being allowed access to the prison.

Example (confidential):

[REDACTED]

Necessary steps for better management of vulnerability in custody:

- The Review to consider ways in which decisions regarding allocation and moves between establishments should be better informed by vulnerability and the enhanced need for support in such circumstances
- The Review to consider the impact of lack of privileges on vulnerable prisoners and how to best safeguard vulnerable prisoners during these times;
- Analysis of mechanisms of self-harm/suicide and in what practical ways these incidents can be guarded against, including considering removing bars from cells completely
- Improved emergency response systems and training of staff in first aid and responding to finding a young person with a self-inflicted injury.

Procedures following a self-inflicted death in custody

Retention and preservation of documents

Despite the existence of specific guidance regarding the retention of documents following a death in custody, our experience is that often particular documents are not retained and staff accounts are not immediately taken. In particular, we have found that often CCTV is destroyed or the only copy is given to an outside agency, which means it cannot later be located. This not only prevents the full truth of the circumstances around a death being revealed and stunts the ability to learn lessons, but it can also be extremely distressing to bereaved families and fuels concerns that some families can have about a cover-up or conspiracy which then taint the rest of the investigation.

Example (confidential):

[REDACTED]

Investigations following a death

There should be better learning and understanding within the prison estate of the long term importance of prisons and YOIs becoming more able to identify poor practice and failing systems and improve them speedily. Information gathering when something goes wrong is an absolutely key step in that process, and in the long term will help to make these places safer, better places to work. A more co-operative approach is needed, as are more robust systems in place for the gathering of all relevant documents following a death in custody and a procedure for these to be securely held before being passed to the PPO and/or police and/or Coroner.

Whilst we consider that there has been an improvement in the quality of the investigations carried out by the PPO, including by the increasing use of independent organisations to carry out clinical reviews, given that the PPO's reports and transcripts of interviews with staff are one of the main sources of information for the Coroner, we consider that there could be further improvements. In particular, the quality of information obtained from staff and the chances of being able to interview key individuals is likely to be improved by PPO investigators attending the prison in a more timely manner following a death. Further, we would suggest that some PPO investigators would benefit from increased training on how to question relevant individuals as we have found that the transcripts of interviews reveal that staff are usually asked leading questions which limits the amount of useful information provided and often means that key information is lost.

Our view is that the recent decision to publish all Preventing Future Deaths reports made by Coroners is very positive and will assist families and their representatives in understanding whether similar failures have occurred at institutions previously. However, it is our experience that some Coroners remain unwilling to prepare PFD reports or are only willing to prepare reports on very narrow issues. There is also, in our view, an over-reliance by some Coroners on assurances from the prison service and other agencies that changes have been made which, as evidenced by the examples set out above, is not always the case and the same failings are occurring in deaths at the same prisons years later. The reluctance to prepare PFD reports when systemic failings have occurred undoubtedly reduces the chances of lesson learning as it means that there is often never a public record of what changes were required following a person's death. It is unclear to us to what

extent PPO recommendations are analysed and shared within NOMS (and other agencies that work within prisons) to ensure that lessons are learnt across the whole of the prison estate, rather than just within a particular institution but our experience shows us that the same failings are occurring across institutions and so although PPO recommendations and PFD (or Rule 43) reports may lead to improvements within a particular institution, this does not necessarily translate to the whole of the prison estate. We would suggest that this is something which needs to be explored by the Review.

Contact with families after a death

Generally, the families that we have represented have not had particularly positive experiences with regard to contact with a prison following the death of their family member. Some families we have represented have had no contact whatsoever from the prison after the death and some have found the contact to be unsympathetic and insensitive. One matter which we have particularly noted is that the person who is often allocated as the family liaison person from the prison and who has contact with the family in the early days following a death, is also a senior officer or governor who supports staff at the inquest itself or who gives evidence at the inquest. This dual role can undermines any support that has previously been offered to the family and we would suggest that any person allocated as a family liaison officer should not then be a person who gives evidence at the inquest or provides a support role to staff at the inquest. We have represented one family who had a positive experience in respect of support following the death of their son in that the prison service funded their travel and accommodation expenses during the inquest, which was particularly important as their son had died in a prison hundreds of miles from home. Whilst the family did not have a particularly positive experience in respect of the remainder of the liaison support offered, the fact that the prison funded their accommodation and travel expenses was positive. However, this is not automatic and our view is that this should be offered in every appropriate case, in the same way that funeral expenses are funded by the Ministry of Justice following a death in custody.

Legal aid and legal representation

Currently, there is no automatic entitlement to legal aid to enable families of those whose loved ones have died in custody to be represented at the inquest. This is in stark contrast to the Ministry of Justice who are always represented at such inquests and whose legal representation is funded from the public purse. This inequality of arms simply serves to replicate the experiences that those who have died had whilst in custody. Those bereaved families have been thrown into a legal process which is not of their choosing. The inquest is usually the only forum in which they are allowed to put questions to witnesses and truly understand how their loved one came by his or her death and so, our view is that if families wish to be assisted by legal representation, they should have the same entitlement as the Ministry of Justice and their employees.

In order to apply for legal aid, families have to complete lengthy and invasive means assessments forms to prove their financial eligibility. This is the case for family members who do not even wish to participate in the inquest but, by the very nature of their relationship to the deceased, are assumed by the Legal Aid Agency to have an interest in the outcome. Without fail, the completion of these forms exacerbates a family's distress. During a period when they are grieving, are often in the dark about the circumstances surrounding their family member's death

and are attempting to prepare for an inquest which will be traumatic and upsetting, they are required to complete lengthy assessments of their financial circumstances. Whilst there is provision for the financial eligibility limits to be waived in inquest cases, it is our experience that this only occurs in very exceptional circumstances and even then, only for families who are on the cusp of financial eligibility.

Even if financially eligible, a family must then demonstrate that there has been an arguable breach of Article 2 ECHR or that there is a wider public interest before the next hurdle for funding is passed. Finally, the family must demonstrate that they require legal representation to effectively participate in the inquest. Unfortunately, the Legal Aid Agency do not accept that the fact that your child has died in the care of the state and that the prospect of questioning individuals who were involved in that care is, in itself, a barrier to effective participation. Increasingly, our experience is that unless you can demonstrate a significant mental health problem or learning disability, the LAA will reach the conclusion that a family can represent itself. The same approach is not taken in respect of the Ministry of Justice or individual staff.

Staff training

Our experience is that those working in the youth estate have a far better understanding of the needs of young prisoners than those working in the adult estate. Our experience shows us that staff needs specific training in working with young people. Such training needs to include how best to communicate with young people, mental health awareness, working with individuals with learning difficulties and disabilities, training in risk assessment and identifying risk factors. In every case in which we have acted for bereaved families, inadequate staff training has been an issue.

Example (confidential):

[REDACTED]

Listeners

Our experience is that younger prisoners do not frequently take up the offer of speaking with a Listener and we consider that this may be because Listeners are often presented as part of a 'checklist' of support rather than their role being properly explained.

Example (confidential)

[REDACTED]

Family support network

We have set out above some concerns regarding communication with family members which, in our experience, is very poor and the families that we have represented, despite having been the main source of support for very vulnerable teenagers in the community, are then completely excluded when their child enters custody. This inevitably leads to important information not being passed on and to families being unable to offer as much support as possible from the outside as they are unaware of what has been happening in their child's life.

A number of the families we have represented have sought to contact the prison to raise concerns about their family member. The only number which is readily available is the main reception number. This means that families often are unable to speak with an appropriately qualified person, that key information is not communicated or that key information is not recorded. It would help if every prison had a specific safer custody telephone line which family members can contact to raise concerns - this number should be provide to family members when a person is remanded to custody and should be easily available to the public e.g. on the Ministry of Justice's website.