Major Reviews of Deaths in Custody: Common themes and findings

I. Introduction

This paper presents common findings and recommendations identified through a review of six major reports that have investigated the experiences and treatment of adults and children who have died of self-inflicted deaths whilst in custody. Several other publications that contribute to the body of knowledge on self-inflicted deaths in custody were also reviewed, but were mostly found to reflect the content of the larger reports. The major reports were two publications by the Prisons and Probation Ombudsman; a thematic review by the Chief Inspector of Prisons; a thematic review by the Youth Justice Board, and two reviews of self-inflicted deaths in custody published by INQUEST and the Prison Reform Trust.

II. Approach

The paper is a review of common findings and recommendations, rather than a rigorous and systematic review of all published evidence. It is based on reports and reviews identified by a literature search by the MoJ library, a search of official websites (including the MoJ, YJB, PPO and HMIP), and by recommendations from the Review panel.

Reports that clearly met the following criteria were included:

a) Contain a clear focus on lessons learned from self-inflicted deaths in custody (instead, for example, of suicide prevention guidelines, mental ill health, general prison reports);
b) Relevant to the experience of 18-24 year olds in custody; and
c) Review lessons from at least ten cases of self-inflicted deaths (rather than in-depth reviews of specific self-inflicted deaths in custody).

Three key reports were immediately identified as meeting all the criteria:

- Fatally Flawed: Has the State Learned Lessons from the Deaths of Children and Young People in Prison, *Prison Reform Trust,* INQUEST, 2012.
- Learning from PPO Investigations: Self-Inflicted Deaths in Prison Custody 2007-2009, *Prisons and Probation Ombudsman,* June 2011.
- Learning from PPO Investigations: Risk Factors in self-inflicted deaths in prisons, *Prison and Probation Ombudsman for England and Wales,* April 2014.

In addition, the following three reports were included after recommendation by the Review panel.

- In the Care of the State? Child Deaths in Penal Custody in England and Wales, *Goldson, B and Coles, D*, INQUEST, 2005
- Suicide is Everyone's Concern: A Thematic Review, *HM Chief Inspector of Prisons for England and Wales,* May 1999
- Deaths of Children in Custody: Action Taken, Lessons Learned, *Youth Justice Board/Bwrdd Cyiawnder Leuenctid,* 2014

A number of other reports were examined which are listed in the bibliography. These are not included in this summary as they were not as directly relevant to the question for this specific review looking at the key findings and recommendations for overall

self-inflicted deaths in custody of 18-24 year-olds. Some of these other reports are likely to be included in the wider systematic review of the literature.

III. Common key findings identified within the reports:

A complete list of the key findings from the major reports is included in Annex A. In order to identify the most pervasive issues, key findings that appeared in three or more of the major reviews are reproduced below. It is worth noting that not all key findings resulted in recommendations, and as a result these key findings do not mirror the recommendations set out in section IV.

1) People in custody who died of self-inflicted deaths were very likely to have histories of mental ill health

Evidence:
In the Care of the State page xiii and page 24

Fatally Flawed, 2012: page 1

PPO, 2011: page 11 [77% of the 158 cases reviewed]

PPO, 2014: page 16 [76% of the 316 cases reviewed were identified as having mental ill health issues]

2) People who died of self-inflicted deaths were very likely to have histories of attempted suicide and self-harm

Evidence
Fatally Flawed, 2012: page 1

PPO, 2011: p12 [There was a history or identified risk of self-harm or attempted suicide in 72% of the 158 cases reviewed]

PPO, 2014: p16 [76% of the 316 cases included in the sample had a history of self-harm and/or attempted suicide]

3) A large minority had been exposed to intimidation and/or bullying whilst in prison

Evidence
Fatally Flawed, 2012: page 1

PPO, 2011: page 13 [20% of the sample of 158 cases had been exposed to bullying or intimidation from other prisoners]

YJB,, 2014; page 33 [What We Still Need to Do – 'We must work with custody providers to help them to address bullying]

4) A large minority were dependent on drugs and/or alcohol

Evidence
Fatally Flawed, 2012: page 1

PPO, 2011: page 10 [28% of the sample of 158 cases reviewed]

PPO, 2014: page 18 [19% of prisoners were dependent drug or alcohol users and a further 17% were frequent users – 316 cases reviewed]

It is worth noting that this proportion is lower than that of the general prison population, estimated by OASys assessments[1] as 41% of those assessed and sentenced to prison having a drug problem, and 27% having an alcohol problem (these figures are not mutually exclusive, so a number will have had both a drug and an alcohol problem).

5) The systems (ACCT) set up to safeguard prisoners from self-inflicted deaths were inadequate for the majority of prisoners who died of a self-inflicted death

Evidence
Fatally Flawed, 2012: page 1

PPO, 2011: page 12 [ACCT documents were correct for only 40% of cases - from a sample of 158 cases]

PPO, 2014: page 17 [In the last few days before their death, only 7% were assessed as 'high risk of suicide' - from a sample of 316 cases]

6) Prisoners held on remand were disproportionately more likely to die from a self-inflicted death than sentenced prisoners

Evidence
PPO 2011: Nearly half of all prisoners were not sentenced at the time of death (41% remand, 7% convicted unsentenced)

PPO 2014, Page 12: Remand prisoners, including those convicted but not sentenced made up 46% of deaths but only 13% of the prison population

These findings are reflected in published Safety in custody statistics, hence included even though only referenced in two of the major reports. It is not clear why those on remand are disproportionately more likely to die from a self-inflicted death, e.g. whether it is the uncertainty of being remanded in custody without sentence, or whether it is the nature of the remand prisons.

[1] Based on offenders in custody or under probation supervision at 31 December 2012, who had a full, valid OASys assessment completed during 2012.

IV. Common key recommendations identified within the reports

As for the key findings, a complete list of the recommendations from the major reports is included in Annex A. Even though the key findings had many similarities, the resulting recommendations were more disparate. As a result, some recommendations that appeared in only two of the major reports are reproduced below.

1) **Information Sharing: A review of how the ACCT system is operated and how risk factors are identified, shared between agencies and acted upon should be conducted.**

   This review should aim to improve the accuracy of assessments and prisons considering all sources of relevant information about risk (such as from police records, escorts, healthcare staff, courts and families).

Evidence
Fatally Flawed, 2012: Recommendation 8, page 58

PPO, 2014, Recommendation 1 page 24

In the Care of the State, Recommendation 5, page 103

YJB, 2014: Page 34 'We must continue to improve information-sharing'

2) **Mental health provision: A review and improvement of all mental health screening and services provided in prisons to those at risk of a self-inflicted death.**

Evidence
Fatally Flawed, 2012: page 58, Recommendation 9

PPO, 2014: page 24, Recommendation 4

YJB, 2014: page 35, 'We must work with providers to better understand how to best support children identified as being at risk of suicide or self-harm'

3) **Processes: Existing suicide prevention strategies and initiatives should be reviewed and a new/improved suicide prevention strategy should be developed in prisons.**

Evidence
In the Care of the State, page 103

HMIP, 1999: Key recommendation 9

4) <u>Facilities and regime:</u> There should be greater emphasis placed on providing a therapeutic environment and treatment for prisoners.

Evidence
Fatally Flawed, 2012: Recommendation 3, page 57

In the Care of the State, page 103

V. Next steps

This review does not replace the need for a full and systematic review of the literature (both academic and other, including grey literature), and the scope and specification of such a review is currently under development.

Officials are meeting on 3rd June to agree the process for commissioning the systematic review under the existing contract between the Independent Advisory Panel for Deaths in Custody and Greenwich University.

Following that meeting a scope will be drawn up setting out the specific terms of the systematic review, including search terms and timescales, for discussion with the university.

Bibliography

Major reports:

In the Care of the State? Child Deaths in Penal Custody in England and Wales, *Goldson, B and Coles, D*, *INQUEST,* 2005

Suicide is Everyone's Concern: A Thematic Review, *HM Chief Inspector of Prisons for England and Wales,* 1999

Learning from PPO Investigations: Self-Inflicted Deaths in Prison Custody 2007-2009, *Prisons and Probation Ombudsman,* 2011

Learning from PPO Investigations: Risk Factors in self-inflicted deaths in prisons, *Prison and Probation Ombudsman for England and Wales,* April 2014

Fatally Flawed: Has the State Learned Lessons from the Deaths of Children and Young People in Prison, *Prison Reform Trust, INQUEST*, 2012

Deaths of Children in Custody: Action Taken, Lessons Learned, *Youth Justice Board/Bwrdd Cyiawnder Leuenctid,* 2014

Other reports reviewed:

Annual Reports & Accounts: April 2000-2001, *HMP Prison Service,* 2001

Learning from PPO investigations: Violence reduction, bullying and safety, *Prisons and Probation Ombudsman, 2011.*

Learning from PPO investigations into three recent deaths of children in custody, *Prisons and Probation Ombudsman , 2013.*

Report of an Independent Investigation into the Case of AB, *Rob Allen, 2011.*

Prisons and Probation Ombudsman: Annual Report 2011-2012, *Prisons and Probation Ombudsman, 2013*

Same Old... the experiences of young offenders with mental health needs, *Transition 2 Adulthood, www.t2a.org.uk, 2013*

The Care of Looked After Children in Custody, *HMIP, 2011*

Young Adults in Custody: The Way Forward, *Transition 2 Adulthood, www.t2a.org.uk, 2013*

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Annex 1: Key findings and recommendations

- **Fatally Flawed: Has the State learned lessons from the deaths of children and young people in prison? Prison Reform Trust,**

Key findings (page 1)

The information and evidence collated for this report revealed common themes in the experiences and treatment of children and young people who died in prison between 2003 and 2010.

These overlapping findings included that children and young people in custody:

1) were some of the most disadvantaged in society and had experienced problems with mental health, self-harm, alcohol and/or drugs;

2) 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;

3) 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 prison;

4) were placed in prisons with unsafe environments and cells;

5) Experienced poor medical care and limited access to therapeutic services in prison;

6) Had been exposed to bullying and treatment such as segregation and restraint;

7) Were failed by the systems set up to safeguard them from harm.

8) The report also found there had been inadequate institutional responses to the deaths of children and young people in prison.

Key Recommendations (page 57)

This report documents the vulnerabilities and needs of children and young people in conflict with the law and illustrates how they continue to be placed in unsafe institutions that are ill-equipped to deal with their complex needs. The organisational learning drawn from the statistics and individual stories in this report must be used, both in the community and in the secure estate, to ensure the needs of these children and vulnerable young people are identified and better supported at the earliest possible stage.

The following are recommendations for change with the aim of preventing further deaths of vulnerable children and young people in prison:

1) The custody threshold should be raised to ensure imprisonment becomes a true last resort, and is reserved for the minority of children and young people who commit

serious violent offences and who pose a significant risk to others. Prison should not be the default response to low-level persistent offending.

2) Minor offences and anti-social behaviour committed by children and young people should be viewed as a public health, rather than criminal justice, issue and diverted to the health, welfare and other agencies which are best-placed to address them.

3) A new, distinct secure estate with an emphasis on therapeutic environments and interventions should be developed for the minority of children and young people whose offending is so serious that only a secure placement can be justified.

4) A common assessment framework which is built on a shared understanding of vulnerability should be developed for use by welfare and criminal justice professionals, so as to avoid the arbitrary distinction made by many statutory services between children and young people.

5) Sentencers must be better aware of the principles and sentencing guidelines which should underpin their decisions about the use of prison for children and young people.

a) Comprehensive training should be provided for sentencers (in both youth and adult courts) and their legal advisers to enable better identification of complex needs, vulnerability and the court's options under mental health legislation.
b) Full up-to-date information on locally available alternatives to custody for children and young people should be available to the courts.

6) Research on the distinct support needs of 18-24 year olds in prison, how they differ from those of adult prisoners, and how they are best identified and addressed should be urgently undertaken.

7) A clear system for identifying and managing looked after children and care leavers in prison, and ensuring the input of all statutory partners including social workers, youth offending practitioners and staff in the secure estate, should be introduced.

8) A review of the operation of the ACCT scheme as it applies to children and young people in particular should be conducted with a view to improving the accuracy of assessments and providing better support to those identified as at risk of harm.

9) Substantial improvements are needed in the availability and quality of mental healthcare provided to children and young people in prison.

a) Imminent changes to healthcare provision in prisons should be taken as an opportunity to drive up standards.
b) Procedures for transferring prisoners out of the secure estate under mental health legislation should be re-examined, and, where necessary, updated with new guidelines.

10) Delays in the inquest process must be addressed as a matter of urgency to ensure bereaved families do not have to wait years to hear the circumstances of a relative's death in prison, and that organisational learning from deaths is timely.

11) Families bereaved by a death in custody should automatically qualify for non-means tested public funding to enable their legal representation at inquests.

12) All coroners' Rule 43 recommendations and juries' narrative verdicts should be publicly accessible through a national database and analysed, audited and brought to the attention of Parliament to ensure responses from relevant Ministers.

13) An Independent Review should be established, with the proper involvement of families, to examine the wider systemic and policy issues underlying the deaths of children and young people in prison. As a starting point the Ministerial Council on Deaths in Custody should commission a new working group of the Independent Advisory Panel to draw together the specific learning from recent deaths of children and young people and identify issues for an Independent Review to consider.

- **Suicide is Everyone's Concern: A Thematic Review by HM Chief Inspector of Prisons for England and Wales, May 1999**

Key Recommendations (end of the review)

1) Ministers and the Director General of the Prison Service should declare a commitment to reduce suicides in prisons in England and Wales. A suitable key performance indicator for suicide prevention should be introduced.

2) Ministers and the Director General of the Prison Service should endorse the principles of "a healthy prison" given in this report which should be used to take forward the treatment of prisoners and the management of staff in every Prison Service establishment.

3) Coroners' officers should be advised that relatives of prisoners would benefit from early information about the process of an inquest and that regular and sensitive contact with them would be helpful.

4) This review should be brought to the attention of coroners.

5) Consideration should be given to offering support similar to a witness service in coroners' courts for relatives of prisoners who wish to benefit from it.

6) Independent monitoring of investigations should take place and the results published. We recommend to the Secretary of State that the remits of either the Ombudsman or Her Majesty's Inspector of Prisons are re-examined to take account of this.

7) It should be a priority to use the principles of a healthy prison in order to identify establishments in which the treatment of prisoners is undermined by inappropriate cultures; alternative healthy cultures should be promoted.

8) The Prisons Strategy Board should endorse the full implementation of the current strategy for suicide prevention as applied to training prisons.

9) The Prisons Strategy Board should develop a new strategy for suicide prevention in local prisons, based on principles described in this review.

10) The full impact of a death in custody must be understood by the Prison Service and effective contingency plans provided in all establishments.

11) The Prisons Strategy Board should introduce suicide prevention strategies for female prisoners and young prisoners which are based on the different needs of these groups.

12) Line managers should be accountable for the detailed implementation of appropriate suicide prevention strategies in all establishments and effective contingency plans in the event of a death in custody.

❖ **Learning from PPO Investigations: Risk Factors in Self-Inflicted Deaths in Prisons, April 2014**

The report reviews data collected relating to 261 self-inflicted deaths in custody investigated by the PPO between 2007 and 2013.

Key findings highlighted in the Executive Summary (page 6) are:

'Although various different groups of prisoners were looked at, the findings about the assessment and management of their risk were broadly similar. Too often prison staff placed too much weight on judging how the prisoner seemed, or 'presented' rather than on indications of known risk, even when there had been recent acts of self-harm.'

Other findings include:

1) risk changes over time and in response to context and events;

2) contact with health services was common in the final 72 hours and represents a key opportunity for suicide prevention;

3) prisoners often withhold their distress from staff and other prisoners, and processes must be in place to respond effectively when family or friends raise concerns;

4) reception screening needs to take fully into account concerns raised by police, escort services or the courts; and

5) Prison Service Instructions should list being held on remand as a risk factor and the risk factors for suicide and self-harm should be presented clearly and concisely.

Lessons to be learned (page 24)

1) There should be clear local procedures which require prison and healthcare staff in reception to actively identify risk factors together based on checks of relevant documents such as the Person Escort Record, pre-sentence reports, NOMIS, and clinical records. Reception screening needs to take fully into account concerns from others about an individual's risk to themselves, such as the police, escorts, the courts and families.

2) Evidence of risk should be fully considered and balanced against how the prisoner presents themselves. Reception staff should record what factors they have considered and the reasons for decisions.

3) An individual's level of risk is not fixed. Distressing and stressful events can have a sudden and critical impact. Where such information is known, staff working closely with the prisoner should be made aware.

4) A third of the prisoners had seen healthcare staff in the 72 hours before their death. This represents a key opportunity to intervene. Healthcare staff need to be confident about initiating and using ACCT monitoring and be clear when to share concerns about prisoners more widely. Similarly, prison staff need to ensure, particularly in reception, that healthcare staff are given all relevant information about risk and that this is discussed with them.

5) Many prisoners will attempt to withhold the extent of their distress from staff and other prisoners. In this context it is important to act promptly on any concerns family and friends convey to the prison.

6) NOMS should amend PSI 64/2011 to set out a clear, standardised list of risk factors for suicide and self-harm which includes being held on remand as a risk factor for suicide.

❖ **Learning from PPO Investigations: Self Inflicted deaths in prison custody 2007-2009, Prisons and Probation Ombudsman Investigations**

Key findings cited in the foreword:

1) Remand prisoners and recently imprisoned prisoners account for the greatest proportion of self-inflicted deaths,
2) Those charged with violent offences (particularly against a loved one) are at a high risk of suicide.
3) …frequently instances of bullying or intimidation from other prisoners featured in our investigation reports, and
4) Often…arrangements following Assessment, Care in Custody and Teamwork (ACCT) closure are less than robust.

❖ **In the Care of the State? Child Deaths in Penal Custody in England and Wales, Barry Goldson and Deborah Coles, INQUEST, 2005**

Key features of child prisoner deaths (under-18) from the conclusion (p. 103):

- Multiple and inter-locking modes of disadvantage that beset child prisoners.
- A relational 'pathway' between public care and penal custody for significant numbers of child prisoners.
- System strain as a result of hardening policy responses to child offenders and penal expansion, including: overcrowding, hastily implemented and thus incomplete 'assessments' and competing operational pressures that fundamentally compromise the 'duty of care'.
- 'Placements' in penal custody that are not only unsuitable in nature but are also inappropriate by location. In other words, manifestly 'vulnerable' children detained in Prison Service institutions and children 'placed' at great distance from their home area thus rendering regular family visits near impossible.
- Inadequate intra-agency and inter-agency communication and information exchange.
- Hostile institutional cultures predicated upon bullying and intimidation.

- The institutional (mis)conceptualisation of 'need' and 'manipulation'.
- The corrosive impact of penal custody on child prisoners.
- Persistent problems associated with the physical infrastructure of penal custody, particularly Prison Service custody, including cell design and access to ligature points.
- Poor medical care and limited access to specialist 'therapeutic' services.
- A failure to implement suicide prevention guidelines.
- The intrinsic degradation imposed by institutional responses to 'vulnerable' child prisoners, including the use of 'strip' conditions, isolation and surveillance (as distinct from watchful care).
- Continuing deficits in terms of openness, transparency, rigour and independence with regard to investigative processes following child deaths in penal custody.
- The institutionalised marginalisation of the bereaved and the inequality of arms between state agencies and families.

❖ Deaths of Children in Custody: Action Taken, Lessons Learned, Youth Justice Board/Bwrdd Cyiawnder Leuenctid, 2014

Chapter 7: What we still need to do

We must improve support and outcomes for looked-after children

Of the 16 boys who have died, we know that at least 11 had at some time been subject to care orders. Many of them had spent time in care. Children who have looked-after status before they enter custody are over-represented in the youth justice system and in the secure estate (Schofield et al, 2012). It seems possible that they are even more disproportionately represented in death in custody statistics. We know that looked-after children need better support in custody, and that is why we funded the appointment of dedicated social workers in under-18 young offender institutions (under-18 YOIs), whose job it is to ensure that looked-after children are assisted, represented and that their needs are met. We have developed the service specification for these social workers to ensure that their responsibilities in this area are clear. We have also required under-18 YOIs, for the first time, to collect data about the looked-after children in their care so that we can develop a better understanding of the issues they face to inform future service provision. In 2014, we will review the provision to see whether further changes to the specification are required.

We must work with custody providers to help them to address bullying

Bullying presents a major challenge in the secure estate (Gyteng et al, 2013). We are working alongside secure estate providers to develop and share effective practice (such as the use of Restorative Justice) to tackle bullying and violence within the secure estate, and to invest in the physical environment of the establishments we commission. We want staff in secure establishments to better understand the causes and impact of bullying and to better address the needs of both victims and perpetrators.

We must continue to listen to children about what they need to keep safe and to understand how custody affects them

In Chapter 5 we described some of the steps we have taken to ensure that children in custody have their voices heard. We are committed to doing more to understand what children in custody feel that they need, and to ensuring that they have independent support to make this clear. The PPO now has a role in investigating complaints from children in secure training centres (STCs), and we continue to work with HM Inspector of Prisons and the Managing the Quality of Prison Life team to make sure that we get regular feedback from children in custody.

We must continue to improve information-sharing

The information we share with professionals and families about the systems and processes for children going into custody needs to be better. We are improving the information available on our web pages and we are committed to raising awareness of what professionals and families should do if they have concerns about a young person in custody.

We will also continue to find ways to improve the quality of information shared with the YJB Placement Service and the secure estate when a child enters custody, to ensure that all those involved understand fully the young person's risks, and concerns that have been identified by the workers and professionals who know them best. We will do this through:

- renewed efforts to work with YOTs to reduce the number of missing documents at the point of entry to custody
- work to better quality assure Placement Information Forms
- the implementation of *AssetPlus*
- the roll-out of the Y2A Portal
- our contribution to the NOMS-led work to revise the Person Escort Record, which plays a key role in communicating risks during a time when there are frequent handovers of responsibility.

We will also support the research, commissioned by the Independent Advisory Panel on Deaths in Custody,[21] to assess the efficacy of information-sharing between YOTs and the secure estate for assessing and managing the risk of self-harm and suicide by children and young people.

We must work with providers to better understand how to best support children identified as being at risk of suicide or self-harm

When children and young people in custody are at risk of harm, self-harm or suicide, they need extra support and supervision that recognises their needs. We recognise the concerns raised by the PPO about whether the Assessment, Care in Custody and Teamwork (ACCT) system is sufficiently child-focused. In the year ahead we will be working with NOMS to consider this issue, including whether changes need to be made to ACCT in the short-term and, in the longer term, to think about whether ACCT is the appropriate framework for supporting at-risk children in under-18 YOIs.

We must ensure that children's safety is the key consideration when we are planning the future of the secure estate

Our thoughts now turn to the long-term future of the secure estate, and our work with the Ministry of Justice (MoJ) to shape custody for children in a way that keeps them safe, and focuses on ensuring children return to their home communities with a positive and purposeful future ahead of them.

The YJB is working alongside the MoJ as it seeks to transform youth custody. We are committed to the belief that the secure estate for children and young people should be recognised as specialist provision, and commissioned services should recognise the distinctive approach required. We recognise that the future commissioning programme needs to take account of the need to ensure that change is carefully managed across the secure estate to minimise any risks to the safety of young people and the stability of the estate. We are keen to ensure that evidence-gathering and a lessons-learnt process are built into the implementation plan for the new Secure College model for youth custody recently announced by government. In order for young people to engage effectively in custody, it is a prerequisite that they feel safe there, so ensuring safety, stability and security will be particularly critical during the development of the model.