The sharp rise in self-inflicted deaths in custody has focused attention upon the way that prisons seek to keep their charges safe. Juliet Lyon CBE, chair of the Independent Advisory Panel on Deaths in Custody, writes about the arrangements for preventing such deaths.

KEEPING PEOPLE SAFE – PREVENTING DEATHS IN CUSTODY

It would be all too easy to cite the life histories, vulnerability and poor physical and mental health of people in custody as an explanation for inevitably high levels of untimely and self-inflicted deaths. To do so would be to deny an inconvenient truth that very many deaths in prison custody are avoidable.

Facing facts

Stark figures, referenced in the Prison Reform Trust's Bromley Briefings Prison Factfile, show that, for prisoners, the average age of death from natural causes is just 56. And that, as well as frequent diagnosis of depression or symptoms of psychosis, 21% of men and 46% of women in prison have attempted suicide at some time in their lives compared to 6% of the general population. With such a high risk group, many in poor health, this raises questions, not only about treatment and conditions in custody, but also about scope for transfer to healthcare, compassionate release and prior use of mental health treatment orders and liaison and diversion services in police stations and courts. Through a longer lens, it raises concerns about the availability, or lack, of earlier intervention, family support and preventative treatment in the community.

Recent Ministry of Justice statistics reveal that, in the 12 months to March 2017, there were 344 deaths in prison custody. Of these, 113 were self-inflicted, over double the rate in 2013, and three were homicides. In 2016 self-harm reached a record high of 40,161 incidents of which 2,740 required hospital treatment. Members of Independent Monitoring Boards will know only too well that, alongside these dreadful numbers, there has been a sharp rise in prison insurgence and serious assaults. It is a matter of huge concern to all those who work to create safer custody and monitor treatment and conditions that prisons are less safe than they were just a few years ago.

Learning lessons

The state of our prisons acts as a barometer for the health and civilisation of our society. It falls to everyone who cares about the state of prisons, and the state of people in them, to act together to keep people safe and reduce deaths in custody. Undoubtedly lessons can, and should, be learned from detailed reports produced by the Prisons and Probation Ombudsman and coroners' reports following an inquest. Thematic reviews and reports from the Prisons Inspectorate, IMB annual reports and correspondence and internal reviews and investigations, all help Ministers and officials to gain a clear view of what has happened and what needs to be done to make prisons safer. While retrospective learning offers invaluable insights and lessons which must somehow be embedded in everyday practice, we need to move to a position where we can be 'wise before the event', see things coming, anticipate the impact of decisions and ensure that, in future, policy, practice and legislation are aligned to make certain such a terrible death toll cannot be reached again.

The Independent Advisory Panel on Deaths in Custody (IAP) is a small non-departmental public body sponsored by the Ministry of Justice, where its secretariat is based, Home Office and Department of Health. Established after the Fulton Review, the IAP acts as the primary source of advice to Ministers and officials on how to prevent or reduce deaths in state custody - prisons, approved premises, hospitals where people are detained under the Mental Health Act, immigration and detention centres and police custody. Panel members include a forensic psychiatrist, forensic psychologist, expert police clinician and a QC who specialises in human rights law. The IAP is part of a three tier Council headed by the Ministerial Board on Deaths in Custody and includes a stakeholder/practitioner group which IMB members are welcome to join (details on IAP website).

Expert evidence

Recently the IAP produced the Harris review setting out how to reduce the deaths of young adults in custody. This placed strong emphasis on good professional relationships between prisoners and staff, and prompted the white paper commitment to a ratio of one officer to six named prisoners, as well as greater emphasis on family contact, purposeful activity and time out of cell. We would hope that these and other recommendations will be reflected in future justice legislation. The state is required to comply with Article 2 of the European Convention on Human Rights and to take positive steps to protect life.

Following the self-inflicted deaths of 12 women in prison in 2016, the highest total since 2004, the IAP sought the views of members of the Ministerial board on deaths in custody, the advisory board on female offenders and 60 women prisoners, expert by experience, on how best to reduce suicide and self-harm. The five main reasons respondents gave for the sharp and sudden rise in women's deaths in custody were: a reduction in staffing levels, loss of experienced staff and accompanying reduction in activity, time out of cell and time to listen and talk; unmet mental health and drug and alcohol treatment needs; an increase in illicit drug use, intimidation, bullying and debt; a marked decrease in use of release on temporary license (ROTL), together with an increased likelihood of homelessness on release and high numbers of recalls; and the knock on effects of the hasty closure of HMP Holloway. Recommendations were made on support for community sentences, improved regimes and trauma-informed environments, better mental healthcare and counselling, timely transfer of information between agencies, increased family contact and improved preparation for release. Respondents' insights and proposed solutions have led to a set of actions by HMPPS.

Shared solutions

In collaboration with Inside Time and Prison Radio, the IAP has received over 100 letters and messages from prisoners since February. Most call for fair and decent treatment, the focus of independent monitoring. Many wrote about relationships with staff and the importance of compassion and respect not neglect or 'back-covering'. One man wrote, 'from what I have seen, officers rush around, giving little time to anything or anyone.' By contrast another wrote about 'one particular officer who can tell just by talking to me how my mood is. He notices if I am down, if I don't eat, if I don't socialise.' Some solutions do lie in improving regimes, ensuring access to Samaritan Listeners, families, fresh air and nutritious food. First nights, including first nights following a transfer, are risky times. As IMB members will know, new arrivals 'should be allocated initially to dedicated first night accommodation, if available.'

Loss of liberty should not involve loss of identity or loss of hope and certainly not loss of life. Opportunities for people in prison to take some responsibility, plan their sentence, help others are important. Revising incentives and earned privileges, re-instating ROTL and resolving the impossible situation for people stranded on long-abolished IPP sentences would put some hope back into the system. From a wider perspective, if prison were used as a place of last resort in the justice system, not as a place of safety or a capacious default social service for vulnerable people, then there would be fewer untimely or self-inflicted deaths in custody.