INQUEST
Working for truth, justice and accountability
30 1981-2011

• Advice • Support • Information • Policy • Research • Campaigning

Winners of the Longford Prize 2009 and the Liberty/JUSTICE Human Rights Award 2007

Submission to
Lord Harris Review: self-inflicted deaths of 18-24 year olds in prison 2007 - 2014

September 2014

(Data collected up until September 4)

Contents

Executive summary

Since April 2007 96 young people aged 18-24 years have taken their own lives in prison. INQUEST's specialist casework with bereaved families and associated research and policy work over the last 30 years has shown repeated patterns of systemic neglect and poor care and safeguarding which continue to plague the criminal justice system. While the Assessment, Care in Custody and Teamwork (ACCT) was set up as a holistic care plan attentive to prisoners' vulnerabilities, it has failed to mitigate the punitive and often inflexible nature of prison regimes. There is an adult-centric approach to child and young people's custody focused on punishment, rather than one based on containment, welfare and protection. [1]There is a need for a specialised level of care which acknowledges the needs of a younger cohort with a range of social and complex emotional issues.

Rehabilitation efforts have been continually undermined by institutional and political complacency. A lack of investment and reduction in resources has resulted in poor staff training, overcrowded, bleak and unmanageable prison environments, increased prisoner isolation due to long lock up hours and unjustifiable communication and information failures that have blurred levels of responsibility in the protection of a young person.

Following consultation with bereaved families, it is clear that in many cases the young people who died were failed by a range of services well before they entered custody. As INQUEST's co-director Deborah Coles suggests, *"these deaths are the most extreme outcome of a system that fails some of society's most troubled and disadvantaged young people, many just out of childhood."*[2]

Many young people enter prison because of unaddressed social, emotional and health problems. They have led disrupted lives, characterised by social exclusion, bereavement, unequal opportunity, experience of abuse and trauma, self-harm, mental illness, learning difficulties and drug misuse. Prison experiences are manifestations of early life failures, exacerbating feelings of anxiety, aggression and emotional instability. More fundamentally state institutions, both within prisons and across the community, are reneging on their obligations under article 2 of the European Convention of Human Rights; by failing to enforce safeguarding mechanisms and delivering a duty of care, a series of human rights are being violated.

While unlawful behaviour must be challenged, and some young people will have to be imprisoned for society's protection, prison should always remain the last resort. Combined with multiple disadvantage and inequalities, their age marks them out as particularly vulnerable. Transition to Adulthood research shows that 18-24 years olds are still maturing at the emotional and cognitive level, and that life-changing events can have an extremely de-stabilising effect on this group.[3] State authorities must prioritise the welfare of a young person and offer community alternatives where family and rehabilitation play a key role and can address the multi layered reasons behind offending.

This submission draws on INQUEST's long-standing research on deaths of young people in custody. We outline recurring themes and concerns regarding the treatment and care of young prisoners which are as follows:

[1] Coles and Shaw (2012): Physical Control, Strip Searching and Segregation' in 'Waiting to be Found: Ed Andrew Briggs, The Tavistock Clinic Series.

[2] INQUEST Press Release (13 August 2014) INQUEST Response to PPO Report on Self-inflicted Deaths of 18-24 year olds in Prison: http://www.inquest.org.uk/media/pr/inquest-response-ppo-report-self-inflicted-deaths-18-24-year-olds-prison

[3] Transition to Adulthood (T2A) Alliance (18 July 2014) Response by the Transition to Adulthood Alliance (T2A) to the Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 year olds

1) The individuals who took their lives were some of the most disadvantaged in society, had an unequal start in life, education, health and opportunity and had experienced problems with mental health, self-harm, alcohol and/or drugs.

2) Despite their vulnerability, young people had not been diverted out of the criminal justice system at an early stage and had ended up remanded or sentenced to prison.

3) Prior to custody, individuals had significant interaction with community agencies yet there were often failures in communication and information between these agencies and prisons receiving young people.

4) Treatment of young people in custody did not factor in age; too often a punitive and generic approach, insensitive to the specific needs of 18-24 year olds, was used.

5) Prison cells remained unsafe environments with long lock up hours and staff shortages, heightening feelings of isolation for vulnerable prisoners.

6) Support for young people was missing, particularly at crucial points in their custody such as their induction, and on many occasions a personal officer was not assigned to those at risk.

7) Unchecked bullying remained prevalent and there were no consistent processes for reviewing and addressing intimidation or violence.

8) The prison environment, impoverished regimes and conditions (as documented by HM Inspectorate of Prisons) and staff behaviour exacerbated the risk of suicide and self harm.

9) Delays in the inquest process results in some bereaved families waiting years to ask questions and hear about the circumstances of a relative's death in prison, impacting on their bereavement and frustrating the learning process.

10) There has been inconsistent advice and support to families following a death, and legal representation for families bereaved by a death has been hampered by cuts to legal aid, resulting in an inequality of arms.

11) There is no effective mechanism to monitor, audit and follow up recommendations from the investigation and inquest process resulting in a lack of effective cross sector accountable learning. As a result the deaths continue.

INQUEST's expertise

1. INQUEST was founded in 1981. It is a small charitable organisation with a staff team of seven and the only organisation in England and Wales that provides a specialist, comprehensive advice service to bereaved people, lawyers, other advice and support agencies, the media, MPs and the wider public on contentious deaths and their investigation.

2. Our organisation has a proven track record in delivering an award-winning, free, in-depth complex casework service on deaths in state detention or involving state agents. It works on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability. It monitors public interest inquests and inquiries into contentious deaths to ensure the issues arising inform our strategic policy and legal work. As a result, INQUEST possesses a unique body of knowledge, experience and expertise on issues surrounding contentious deaths and their investigation.

3. Reflecting this, INQUEST was the sole non governmental member of the Forum for Preventing Deaths in Custody and was represented on the Ministerial Roundtable on Prison Suicides and the Independent Police Complaints Commission Advisory Board. It is now on the Ministerial Board on Deaths in Custody which has replaced both the Forum and Roundtable. Its co-director Deborah Coles is also a founding member of the cross government sponsored Independent Advisory Panel on Deaths in Custody.

4. INQUEST has been working to identify trends and concerns emerging from the deaths of children and young people in custody since 1990. Through our specialist casework service we have worked with and supported the families of the children and young people who have died in custody (and those advising them) through the investigation and inquest process. Drawing on this experience and evidence, INQUEST has previously raised concerns about the effectiveness of the state's investigative processes for identifying and rectifying dangerous practices and procedures in order to ensure that lessons are learned and further fatalities prevented. In 2005 we published a detailed analysis of the problem in the book *In the care of the state? Child deaths in Penal custody in England and Wales by* Barry Goldson and Deborah Coles (INQUEST's Co-Director). It concluded that children should not be imprisoned save for in child centred Local Authority Secure Children's Homes (SCHs). In 2008 INQUEST published *Dying on the Inside: Examining Women's Deaths in Prison* by Deborah Coles and Marissa Sandler which provided a comprehensive examination of our casework with the families and legal representatives of the 115 women who had died in prison across 1990-2007, over a fifth of whom (21 per cent) were between 18 and 21.

5. INQUEST has also published reports on the deaths of individual children and young people in custody and made both written and oral submissions about the deaths of children and young people in custody to other parliamentary inquiries relevant to this area including the inquiry into deaths in custody conducted by the Parliamentary Joint Committee on Human Rights (JCHR) (which reported in December 2004) and the JCHR inquiry into restraint in Secure Training Centres in 2007 and the Ministry of Justice & Department for Children, Schools and Families 'Review of Restraint' (which reported in December 2008).

6. We have recently analysed the statistics and information drawn from INQUEST's casework with the families of children and young people (24 years old and younger) who died in custody between 2003-2011 for our *Fatally Flawed* publication. This was an exhaustive piece of evidence based research, acting as the primary resource when calling for an independent review into deaths of young people and children in custody. The publication has also contributed extensively to INQUEST's submission to the recent Justice Select Committee Inquiry into Youth Justice (April 2012) to which INQUEST's co-director Deborah Coles gave oral evidence alongside the mother of Adam Rickwood, the youngest person ever to die in penal custody in the UK.

7. Our evidence to the Lord Harris review draws on this knowledge, experience and expertise on issues surrounding the deaths of children and young people in custody. It focuses on the deaths of young people (i.e. those aged 18-24 years old) but also includes evidence relating to the deaths of children (aged 10-17 years old) who, though they fall outside the current remit because of their chronological age, share many characteristics and vulnerabilities with young people in custody.

8. It has been properly conducted inquests into custodial deaths, where the families of those who have died have been legally represented, that have exposed the regimes and conditions operating within the closed world of penal custody and how children and young people are treated. The investigations and inquests into the deaths of children and young people have revealed common and repeated systemic failures that continue

to be reproduced by the practices and processes of imprisonment. After extensive lobbying by INQUEST, working with Peers and a coalition of penal reform and human rights NGOs, the Corporate Manslaughter and Corporate Homicide Act 2007 was introduced to hold state institutions accountable for any misconduct that contributed to the death of a person in their custody. The most troubling aspect of INQUEST's work however, is the failure of state bodies and agencies to act on the compelling evidence from numerous PPO investigations, inquest findings, coroners' reports resulting in the relentless number of preventable deaths.

Introduction

If Jimmy's death can prevent other families from going through this terrible ordeal, our suffering will not have been in vain.

Fran Butcher, partner to and mother of James Connolly's two children, died at age 23 (HMP Chelmsford, 2008)

"We would like answers as to why my son had to lose his life in a state-run establishment that should have been protecting his wellbeing."

Dawn Spiller, mother of Billy Spiller, died at age 21 (Aylesbury YOI, 2011)

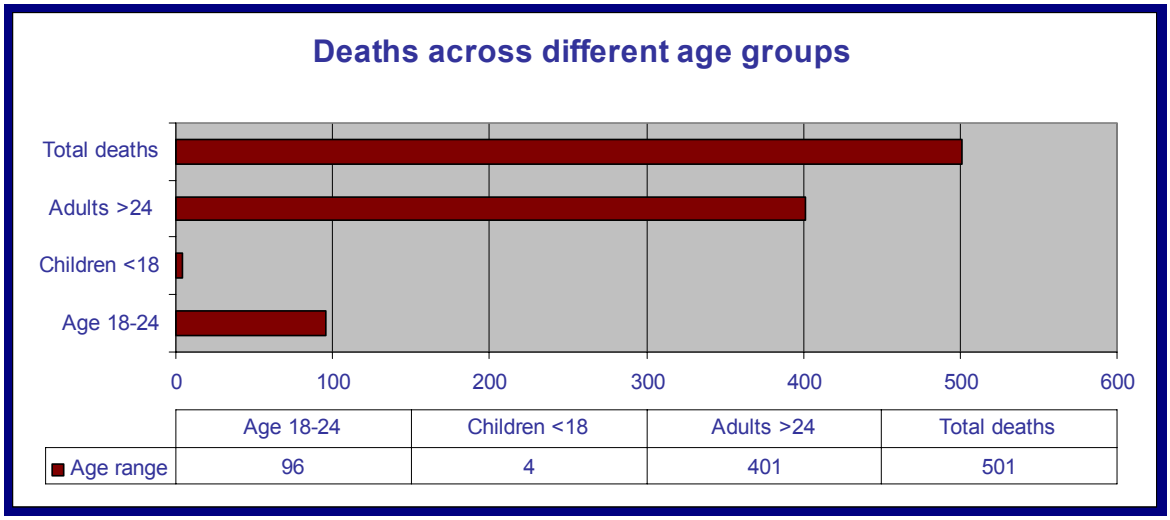
"I feel distraught that Jake could have been moved to a safer cell the night he hung himself. Every day we have to wake up to this nightmare that Jake died and some officers could have helped him."

Liz Hardy, mother of Jake Hardy, died at age 17 (HMYOI Hindley, 2012)

"Steven was let down by mental health services before he even arrived at Glen Parva. He was let down again in Glen Parva. I just wanted Glen Parva to look after him."

Lynda Davison, mother of Steven Davison, died at age 21 (HMYOI Glen Parva, 2013)

INQUEST has interrogated an array of data looking into the deaths of young people, aged 18-24 years old, in prison from the beginning of April 2007 until September 4 2014, During this period, INQUEST has calculated a total of 96 deaths, with young prisoners making up 19 per cent of the total prison deaths - the equivalent of more than 1 young prisoner dying every month.



With 13 deaths reported this year, and a greater likelihood of further increases as we approach stressful periods for prisoners such as Christmas, INQUEST continues to see the repetition of systemic failures and a complacency around the need for action to be taken. Through our

continual engagement with bereaved families, and a range of statistical and casework data, we have identified recurring problems relating to the safety and welfare of young people in custody.

The children and young people who died in prison were failed by the very systems set up to safeguard them from harm. Disturbingly many engaged in acts of serious self harm and suicide attempts involving ligatures for the first time, begging questions about the culture and environment in prison which propels young people into this type of behaviour. In particular, serious questions need to be asked about how young individuals entering custody for the first time have learnt to form ligature points and hang themselves in the most unlikely of ways. The culture in prisons is fast becoming one where self harming behaviour is normalised and accepted by many staff members, and often actively encouraged through shout-outs and intimidation by other prisoners.

The rolling out of the ACCT process has failed to deliver an effective care planning system, or to identify and support those at risk of self-harm. INQUEST is frustrated to see the same issues coming up time and time again. Repeated patterns of failure and misconduct include: lack of staff training in the ACCT and emergency procedures; communication breakdown between different state agencies and prisons, within institutions and between prison staff healthcare staff; unchecked bullying due to procedural failures; inadequate assessment of vulnerabilities; inappropriate placement and treatment of those with mental health problems, self harm history, drug/alcohol misuse and learning difficulties; mental health distress and associated behaviour treated as a discipline rather than a medical problem; the inappropriate and over use of segregation; lack of family involvement in supporting vulnerable prisoners; and unsafe cells with ligature points.

The most alarming fact is that these failures continue to be widespread and endemic features of the prison estate, despite consistent recommendations following inquests, investigations and reports. The Prison Service continues to act with impunity and to ignore a duty of care to those young people in its custody. There often appears an institutional resignation to these deaths. Other evidence highlights a further deterioration in prisoner support given current problems of overcrowding, poor prisoner-staff relationships and long lock up hours. The problems stem from a series of factors including, budget reductions, policy implications and a lack of training for prison staff. And with the ill conceived and dangerous future plans to build a super prison and secure colleges, concerns for prisoner welfare and safety should remain a top priority.

The economics of incarceration are yet another damning indictment of prison effectiveness. According to the Ministry of Justice's (MOJ) own reports, the average annual cost per prisoner in a male closed YOI is £41,818 for ages 15-21 and £100,388 for ages 15-17.[4] This level of ineffective spending is even more startling when considered with MOJ findings that "58 per cent of young adults (18-20 year olds) released from custody in the first quarter of 2008 were reconvicted within a year."[5]

INQUEST believes that a consideration of under-18s by this review is essential given the need to understand the vulnerabilities of children and young people who end up in custody. Moreover if we were to consider the harrowing case of Jake Hardy, a 17 year old that died at HMYOI Hindley, if his death occurred 5 months later he would have died at the age of 18. Yet because of an arbitrary distinction between the age groups this meant that his case was not eligible for review,

---

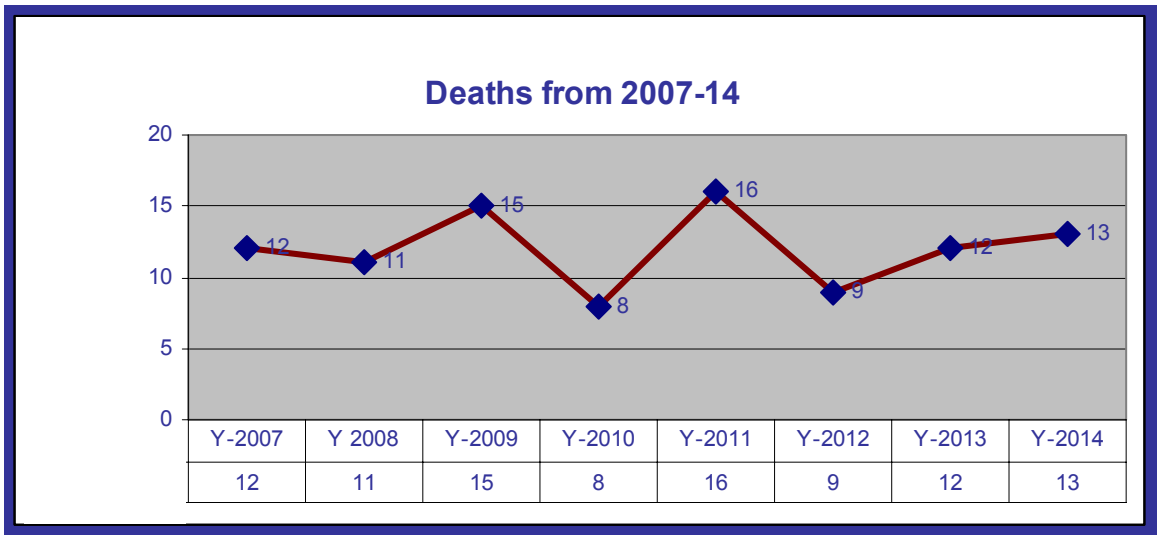
[4] Ministry of Justice (2013) Costs per place and costs per prisoner, National Offender Management Service Annual Report and Accounts 2012-13: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251272/prison-costs-summary-12-13.pdf

[5] Ministry of Justice (2014) Proven re-offending statistics quarterly July 2011 to June 2012 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192631/proven-reoffending-jul-10-jun-11.pdf

despite his story offering a prime example of fundamental systemic failings. With this in mind we have referenced the deaths of children intermittently as part of our call for a complete overhaul of the way in which the criminal justice system deals with children and young people in conflict with the law.

Snapshot: deaths of young people in prison[6]

- 96 young people have taken their lives from April 2007, with 2013 (12) and 2014 (13 for the 9 months covered) marking an upward trend in self-inflicted deaths (see below).
- Since 2007 there have been 501 total self-inflicted deaths and 18-24 year olds account for almost one-fifth of this number.
- Over the last 7 years we have seen the equivalent of more than 12 deaths per year, also comparable to 1 death per month. For this year (9 months covered) we have seen the equivalent to 1.4 deaths per month.
- Monitoring of self harming behaviour has been very poor whereby 65 of the 96 prisoners were not placed on an ACCT at the time of their death.
- White prisoners make up the majority of self-inflicted deaths (73), jointly followed by Black (9) and Asian prisoners (8).
- Self-inflicted deaths are highest among those who have been sentenced (53 per cent) followed by individuals on remand (28 per cent).
- Death by hangings accounts for 93 per cent of all fatalities and more than half of self-inflicted deaths occurred in a single cell (53 per cent). 9 of the deaths were in single occupancy double cells.
- The prisons revealing the highest rates of self-inflicted deaths were HMYOI Glen Parva, with 10 deaths occurring, and HMP Chelmsford with 8 deaths since 2007.
- Since 1990, there have been 31 child self-inflicted deaths and 4 of which have occurred in the Lord Harris review period.



Common themes

INQUEST has catalogued a range of issues and failings in the identification and management of young and vulnerable prisoners. It is with much sorrow and frustration that we record the same patterns of neglect and incompetence which INQUEST has found in the 30 years it has

[6] All statistical information compiled in this report (i.e. in sections: *snapshot: deaths of young people in prison, Further review of deaths by characteristics* and *appendix*) has been taken from MOJ, NOMs notifications

investigated custodial deaths. There remains an unacceptable degree of impunity for prison establishments, linked to the state, and by consequence measures of accountability and transparency are continually undermined. INQUEST's findings are underpinned by a plethora of accounts including Coroner recommendations, jury findings, Prisons and Probation Ombudsman (PPO) reports and prison inspectorate surveys.

INQUEST has also included a breadth of stories about the young people who died whilst in prison. These stories have been compiled with the help of families and family lawyers and reflect the evidence obtained from inquests. Some families have requested that we ensure anonymity when speaking about their loved ones who died in custody. As such in 2 cases we have not named those individuals and have used a shorthand reference instead.

The pre custody journey – multiple disadvantage and age

Many of the young people who die in prison face a series of disadvantages, which date well before their journey into custody. As noted by Goldson and Coles, the common characteristic shared by a young cohort of prisoners stretches across *"poverty; family discord; public care; drug and alcohol misuse; mental distress"* accompanied by other factors of *"homelessness; isolation; loneliness* [and] *circumscribed educational and employment opportunities."*[7]

In particular early experience of state care, mental health issues, learning difficulties and disabilities are key factors underpinning vulnerability. A common thread between these wide ranging characteristics is the impact they have on a young individual's emotional and physical welfare; their capacity to deal with life changing circumstances such as going into prison and their ability to withstand the extreme and often brutal and dehumanising conditions of prison life. INQUEST finds that custodial experience exacerbates and compounds these early life disadvantages; a punitive response, devoid of any rehabilitative capacity refuses to acknowledge the many imported vulnerabilities and disadvantages young prisoners come in/arrive with. Studies cited in the Bromley Briefing Factfile have found that among young people in prison[8]:

- 23 per cent of young offenders have learning difficulties (IQs of below 70) and a further 36 per cent have borderline learning difficulties (IQ 70-80);
- Fewer than 1 per cent of all children in England are in care, but looked after children make up 33 per cent of boys and 61 per cent of girls in custody and;
- 52 per cent of young offenders were permanently excluded from school.
- 16-24 year-olds are more likely than any other age group to become a victim of crime.

In addition, it is important to identify an underlying vulnerability linked to age. The term vulnerability does not always prove useful for assessments and sentencing, and is complicated by contradictions as to how it is applied to young people. For example, currently the concept is explicitly factored in when reaching court decisions on remand (with respect to type of remand and subsequent placement only) however it is not a clear factor determining sentencing decisions. Vulnerability does remain important however; it can mitigate the severity of sentencing i.e. whether to pass a custodial sentence or not, and upholds the court's obligation to protect the "welfare of…young person" as "an offender or otherwise" under the Children and Young Persons Act 1933.

7 Goldson, B & Coles, D. (2005) In the Care of the State? Child Deaths in Penal Custody in England and Wales, London: INQUEST

8 Prison: the facts Bromley Briefings Summer (2014) Prison Reform Trust: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Prison%20the%20facts%20May%202014.pdf

Long standing research indicates that cognitive development and maturity will typically continue until the mid twenties[9]. So while those aged 18-24 years are often attributed "adult" status (in terms of prison placement and sentencing) this ignores the confusion and anxiety faced by young individuals who are managing a combination of circumstantial and life changes. According to MOJ reports, young prisoners are more likely to self-harm than older prisoners and self-harm is more likely to occur in the early stages of custody for this group.[10]

"*Young adults caught up in the Criminal Justice System spend their 'age of possibilities' with very limited options and even more limited support. At an age when young people develop their identity, their aspirations and their ambitions in life, young adults in the Criminal Justice System are immersed in a culture and a community of offending, cut off from the opportunities that could help them move on. Contrasted with the experience of the increasing numbers of young adults entering higher education, the common description of prisons as 'universities of crime' is more appropriate than ever".*[11]

These factors however, are not considered at the systemic level and we find a contradictory set of welfare and punitive policies in the treatment of young people. For example, Transition to Adulthood research shows that age 19 is the peak offending period for males, yet support services end at 18 when they become 'adults'[12].

Ben Grimes was 18 when he took his life at HMYOI Portland in 2009. From an early age Ben suffered a disrupted upbringing and was put into care. He was in contact with the youth justice system and was diagnosed with conduct disorder, attachment disorder and possible attention deficit hyperactivity disorder. Having initially been placed on remand at HMYOI Feltham, he was sentenced to his first custodial sentence of five years' imprisonment and sent to HMYOI Portland at 24 hours' notice.

Ben's support worker gave evidence on the devastating impact such a quick transfer so far from home would have had on Ben. Upon arrival to Portland, Ben had also told prison officers he struggled to read and write, yet this was not factored in when they gave him written material intended to relieve his anxiety. As Ben's mother, Lisa has said, it was these "institutional and systemic failures in the care of young people" which let her son down.

According to prison staff accounts, Ben did not overtly present suicidal tendencies and so was not on an ACCT document at the time of his death. Yet as the family lawyer said "*the fact that such vulnerabilities are sometimes difficult to spot makes correctly following procedures, and ensuring the right information and support is available to those with responsibility for prisoners' welfare, all the more important.'* Because of Ben's specific vulnerabilities, which related to his early care experience, young age and his emotional and learning difficulties, this should have triggered close monitoring and support. Moreover, with the Christmas period approaching, a particularly hard time for prisoners who are separated from family, safeguarding measures should have been even stronger.

While outside the current age remit, and time span of the review, the memory of 16 year old Joseph Scholes who died in Stoke Heath YOI during 2002, should remain fresh in our minds. His early age trauma of suffering repeated sexual abuse by a family member contributed largely to his emotional instability. In his later years, he became increasingly distressed and started to

9 Transition to Adulthood (T2A) Alliance. Pathways from Crime Ten steps to a more effective approach for young adults in the criminal justice process: http://www.barrowcadbury.org.uk/wp-content/uploads/2012/05/T2A_Pathways-from-Crime_online-ver2.pdf London: T2A Alliance

10 See table 2.4 Ministry of Justice (2014) Safety in Custody Statistics update to March 2014, London: MOJ

11 http://www.t2a.org.uk/wp-content/uploads/2011/09/T2A-Universities_of_Crime.pdf

12 Transition to Adulthood (T2A) Alliance (18 July 2014) Response by the Transition to Adulthood Alliance (T2A) to the Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 year olds

self-harm. This culminated in him attempting suicide by taking an overdose and trying to jump from a window in 2001.

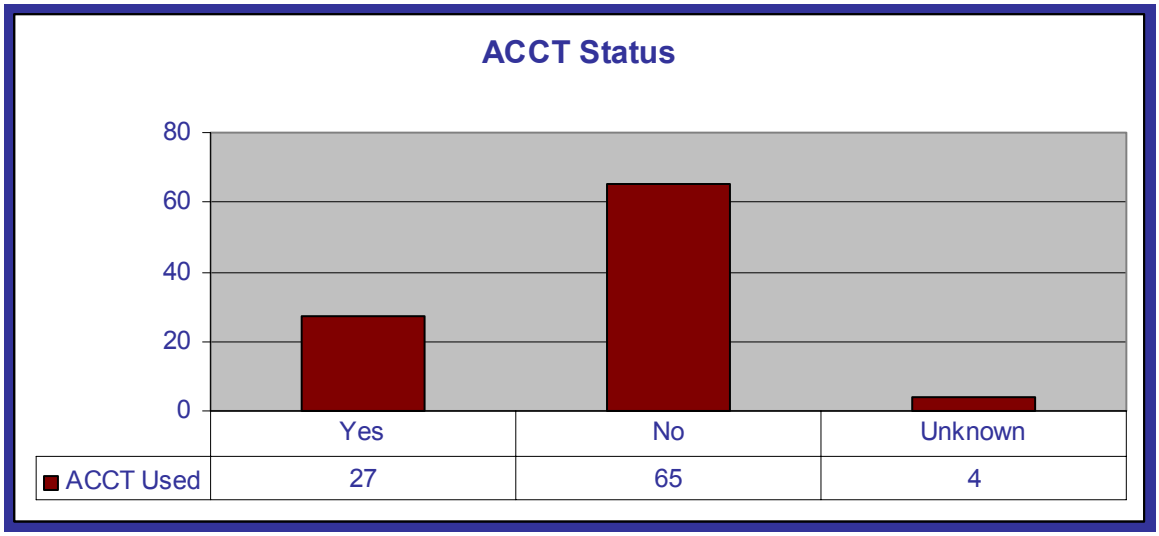
Joseph was placed in a children's home after his mother found it difficult to manage his challenging behaviour. Soon after being there, he got into trouble with other children and was charged with robbery. As it turned out, he had played a peripheral role in an incident where he had gone out drinking with a group of children who had demanded the money and mobile phones of another group of children they encountered on the streets. When Joseph was sentenced, both his vulnerability and low level offence were acknowledged by the Crown Court Judge. It was recognised that he had not threatened or committed any physical violence and that his self harming and alleged sexual abuse should be 'most expressly drawn to the attention of the authorities'.

Given Joseph's recognised vulnerability, the Youth Justice Board had the power to place him in a secure children's home or secure training centre; however, no such placement was available and he was sent to HMYOI Stoke Heath. Joseph was placed in a cell under intense observation and wore a canvas garment with Velcro fastenings, described at the inquest as a 'horse blanket', under which he was naked. Joseph repeatedly told staff that he would kill himself if he was moved to a normal location in the YOI as he feared being sexually abused. Nevertheless, staff proceeded with an incremental transition to the main YOI by moving him into a cell in the health care centre where he was less intensely observed.

Nine days after arriving at Stoke Heath, Joseph made a noose from a bed-sheet and hung himself from the bars of his cell. Joseph left a message for his mother and father telling them he couldn't cope and that 'I tried telling them and they just don't fucking listen.'

Information sharing

INQUEST has identified major failures in information exchange between community agencies and prisons that have undermined effective risk assessments of young prisoners. This poor communication flow may help to explain why 68 per cent of the 96 prisoners had not been identified as being at risk of harm and were not on an open ACCT, despite many having self harming histories and mental health issues.



More alarmingly, these failings are higher than our previous findings documented in the *Fatally Flawed* report covering 2003-10, which found that half were not on ACCTs. In its separate findings, the 2013 Prison and Probation Ombudsman report also stated:

"We continue to investigate deaths where reception health screening has been poor. In many cases, previous records are not examined, either because they have not arrived with the prisoner or are simply not taken into account… There is too much reliance on information from the prisoner…"[13]

The limited enforcement and effectiveness of ACCT raises serious questions about the training and awareness of this safeguarding mechanism and its practical application in the context of staff shortages. In other words, can we be confident that such mechanisms will be implemented by staff who are already struggling to manage their duties? INQUEST also believes that such deaths could have been avoided were there a better understanding of "high risk" and tailored assessments attentive to young people's specific needs. Instead there has been a large reliance on self-reporting, which have proven inadequate, particularly as young people are often reluctant to tell officers about their self-harming behaviour due to a fear of being singled out. Given the endemic masculine culture in prisons, the ability to express emotional vulnerability becomes even harder.

If prison officers and social workers in the secure estate are to fulfil their duty to hold young people who are locked up safely, it is essential that they be alerted to any factors which may increase vulnerability at the earliest possible stage. Relying on ASSET and the other forms which should precede arrival in prison may not be sufficient, given known delays in transferring files from YOTs and probation to the secure estate and concerns over the accuracy of some information on assessment forms. Other alarming examples of mismanagement include prison staff having information about a young person's self-harming behaviour to hand, yet failing to identify them as high risk. The Prison and Probation Ombudsman (PPO) has stressed the requirement of ACCT to be treated as a "live plan"; a review which is continually updated to reflect the risk factors for the individual as they change. However, this is not always achieved and in many cases, triggers or warning sign sections are not completed. This is worsened by a prison culture where staff are over reliant on forms and not the relationship between human beings during initial assessment. A tick box culture prevails that undermines confidence to use appropriate professional judgement.

While tighter observation and ACCT enforcement is necessary, more fundamental questions have to be asked about whether the ACCT can mitigate the punitive and often inhumane aspects of prison life. As INQUEST Co-Director Deborah Coles has noted, "the *starting point is that extremely young people are being remanded and sentenced to custody…in institutions that do not have the resources, facilities or trained staff to keep them safe…."*[14]

Billy Coulson was 18 years old when he took his life at Chelmsford Prison in 2008. He had only spent 3 days in prison before he was found hanging in his cell. There were concerns raised about his risk of self-harm whilst in custody by numerous people including his sister and a case worker at Newham YOT, who he was under the jurisdiction of. The case worker visited Billy at the court and returned to alert the prison that Billy was acting strangely and was a high risk of self harm, due to his previous attempts. A call was made the following day to the Duty Governor at Chelmsford to inform them of Billy's high risk of self harm, and another call was made by the caseworker to the health care wing to reiterate concern for Billy. She was told staff were fully qualified and he would be assessed. Despite this and having a history of self-harm, Billy was not put on an ACCT.

When Billy arrived at the prison reception the Prisoner Escort Form (PER) note which identified Billy as a risk from self harm was discussed with prison staff. Billy then saw a nurse who he did

[13] Prison and Probation Ombudsman Annual Report 2012-2013 (2013) http://www.ppo.gov.uk/docs/PPO_Annual_Report_2012-13.pdf

[14] .Coles, D "Teenagers' deaths in custody are needless", Guardian (2011) http://www.theguardian.com/commentisfree/libertycentral/2011/may/06/teenagers-deaths-custody-needless

not tell about his history of self-harm or any psychiatric help he had received in the past. Because of this, he was not identified as being at any risk. The inquest returned a narrative verdict stating that there were 'serious communication failings within Chelmsford Prison' and missed opportunities to act on vital information provided by people who worked closely with Billy and knew him well, resulting in a failure to open an ACCT and monitor Billy accordingly.

Bullying, segregation and restraint

Conditions and treatment experienced by young people in prison are widely documented by government statistics, prison inspectorate reports, investigation reports and inquest evidence. These findings correspond with INQUEST's casework where bullying, segregation, and restraint are found across the prison system and are linked to failures in detection and support. Young people and children are detained in unsuitable and damaging environments and their experiences are often characterised by intimidation, violence and degrading treatment such as strip-searching, segregation and restraint. HMYOI Glen Parva has been cited as one such regime characterised by persistent bullying and endemic violence[15]. Following an unannounced inspection, the HM Chief Inspectorate of Prison found that half of prisoners felt unsafe at some point during their custody; significant levels of under-reporting of recorded assaults; inadequate support for victims of bullying, with many staff viewing violence as an inevitable aspect of prison life.

Ryan Clark, the 17-year-old boy who took his life in April 2011 at Wetherby YOI suffered physical threats and verbal abuse in the run up to his death. The jury concluded that Ryan's death was accidental, and that his actions were a "cry for help" in the face of distressing shout outs and frequent intimidation. The jury reached a damning conclusion which included a failure to register vulnerabilities and susceptibilities such as his placement in care since he was 16 months old; the absence of a personal officer scheme to quell bullying and intimidation; and an ineffective policy response to 'shout outs'.

The use of restraint by staff on children and young people is also a common feature of prison life. In a joint review of the experiences of children in custody, HM Inspectorate of Prisons and the Youth Justice Board, found that a third of boys and a quarter of girls in prison had been physically restrained. The report also found that black boys were disproportionately likely to be restrained by staff compared to white boys. The dangerous and ultimately lethal use of restraint on children in prison first came to public attention as a result of the deaths of 15 year old Gareth Myatt and 14 year old Adam Rickwood in secure training centres.

Often hostile and brutalising environments, it is deplorable that these regimes hold vulnerable prisoners who suffer from an array of complex social and physiological needs and have a history of self-harm. Many young prisoners experience a constant feeling of fear, are traumatised by early life events (such as bereavement, previous care or abusive backgrounds) and are extremely isolated due to their very little contact with staff and time outside cells. [16]

Christopher Neale was aged 19 when he hung himself in Glen Parva YOI in 2011 - just 10 days after being sentenced. According to a Prevention of Further Deaths (PFD) report, Christopher was apprehensive about his ability to cope with prison for the first time and had applied for "vulnerable prisoner" status during a transfer from HMP Nottingham to Glen Parva. There is no evidence that these fears were communicated with prison staff at Glen Parva. After one day of being placed in this prison he was assaulted by another prisoner, at which point he was moved to another unit for his own safety. A PFD report stated that his personal officer had not made any

[15] HM Inspectorate of Prisons, Report on an unannounced inspection of HMYOI Glen Parva 31 March – April 2014 (6 August 2014)

[16] The Howard League for Penal Reform, Briefing Paper on prison overcrowding and suicide, October 2005, http://www.howardleague.org/fileadmin/howard_league/user/pdf/PrisonOvercrowdingAndSuicide.pdf

contact with him and that this could have provided him with support and monitored his progress during a difficult transitory period. Two days after Christopher was moved, another prisoner from the unit he had come from was also moved to this unit. Fearing his arrival, Christopher told guards he was scared he might be attacked again; officers poorly managed this risk by keeping Christopher locked up in his cell – taking him out only for meals and short intervals. During that same week Christopher was found hanging in his cell.

Jake Hardy was 17 when he hung himself in his cell at HMYOI Hindley in 2012, and died 4 days later at hospital. A vulnerable boy with a history of self-harm, Jake had repeatedly told officers he was being bullied, yet insufficient steps were taken to protect him. Prior to custody, Jake had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder, had been given a statement of special educational needs, and was under the care of the local mental health team. Hindley was informed of all of this information, together with the fact that he had been bullied at school. Another issue is that Jake was allocated a Personal Officer who had very little engagement with him throughout his time in Hindley despite being aware of the bullying he was facing.

A jury concluded that a series of 12 individual failures contributed to the death of this child in prison and that preventative measures could have saved Jake's life. Following this verdict, Elizabeth Hardy, Jake's mother, spoke of her grief and disappointment in hearing this: *"Every day we have to wake up to this nightmare that Jake died and some officers could have helped him. Jake was too vulnerable and should never have gone to a place like Hindley to start with. I kept my son safe for 17 years yet Hindley couldn't keep him safe for two months."*

Abdullah Hagar "Joker" Idris was 18 years old when he was found hanging from a pipe on Christmas morning in HMP Chelmsford, 2010. The inquest considered his treatment as a young asylum seeker from Darfur and the support offered to him during his custody. Whilst Abdullah had taken his life after threats of immediate deportation, he also suffered from frequent intimidation and assaults by fellow inmates and consequential punishment and segregation by prison governors (who did not view him as a vulnerable young person). Despite having a history of self-harm, prison officers failed to allocate Abdullah a personal officer and social services closed their file shortly after he turned 18. There were serious questions as to whether Abdullah could have been placed elsewhere. He had history of serious self-harming and was remanded for a small criminal offence which was linked to mental health problems.

Mental health

Mental health problems across the prison population have been met with little understanding in terms of treatment and placement. INQUEST's research, presented in Fatally Flawed report, covered self-inflicted deaths from 2003-10 and showed that 51 per cent of those who had died had a history of self-harm, while 48 per cent suffered from mental health issues.[17] More pronounced findings have also been documented by the Prison and Probation Ombudsman Learning Lessons Bulletin 2014.[18] In a sample of 80 self-inflicted deaths, 67 per cent of the young adults had mental health needs, and 27 per cent had previously been admitted for psychiatric care.

Despite repeated inquests outlining the lethal consequences of poor mental health awareness and treatment, training is still seriously lacking and prison officers have very little understanding of how to deal with mental illnesses:

[17] Coles, D & Edmundson (2012) Fatally Flawed, London: Prison Reform Trust

[18] Prison and Probation Ombudsman, Learning Lessons Bulletin: Young Adult prisoners (July 2014) http://www.ppo.gov.uk/other-reports-and-publications.html

"Prison officers have the most contact with prisoners on a day-to-day basis, and as such often act as their primary carers [yet] only about a quarter of prison officers interviewed had received mental health training awareness..."[19]

The prevalence of mental ill health of young people in prison often associated with previous experience of trauma and abuse also raises the issue of the prison environment and how impoverished regimes and hostile environments can intensify levels of anxiety and exacerbate mental ill health. Prisons are places of punishment and control, rather than rehabilitation and therapy. Investment in diversion and liaison schemes is vital as well as earlier intervention and proper resourcing of community child and adolescent mental health services and therapeutic placements. For severe disorders, options to detain individuals under section 3 of the Mental Health Act can be more appropriate.

CGL was 22 years old when he took his life in HMP Brixton in 2007 – battling with schizophrenia his distinct needs were not detected at the point of his death. Following a string of transfers he was sent to Brixton and placed in the Health Care Centre where the prison consultant psychiatrist assessed him. The psychiatrist knew of CGL's history of self-harm, however claimed that his "unusual" psychotic symptoms and better functioning outside his cell raised the possibility of exaggeration. CGL's family refuted this, finding him dishevelled and terrified, where he had grown his finger nails long to "defend himself". A nurse on the healthcare wing also described CGL as suffering from low moods, neglecting his personal hygiene, and in fear of being raped on ordinary location (OL).

Despite CGL's unstable mental health his ACCT was closed and he was transferred to OL. Moreover no communication of his mental illness and self-harming history was shared with prison officers, leading one staff member to refer to this as an endemic problem: "[a] blinkered culture" between prison and healthcare staff, with each "keeping to its own side".

On the night of his death, CGL was placed in a cell with another prisoner suffering from acute alcoholic dementia. Because of staff shortages, there were longer than usual lock hours that night, meaning CGL was left unattended for a considerable time. It was not until another prisoner noticed him hanging in his cell, having suspended himself from the window frame by a neck ligature made from a sheet. When the cell was opened, CGL was found dead whilst his cellmate was sitting on his bed, drinking tea and rolling a cigarette.

BB was 22 years old when he suffocated himself with a plastic bag on the healthcare unit at HMP Wormwood Scrubbs in 2009. BB had begun to behave strangely in mid 2008, becoming increasingly withdrawn and paranoid. A number of appointments were made for him to seek help from mental health team in the community and his family thought he was improving. However, out of the blue he was arrested after a serious assault in July 2009.

On arrest he was assessed as suffering from a serious mental illness and taken to hospital where he remained for two weeks for assessment. The working diagnosis was a possible schizophrenic condition. He was then charged and appeared in court the same day, a Saturday, a day when the mental health diversion team were not present in court. The clinicians treating him asked that he be returned to hospital. The police and CPS objected to this however, on the basis that medium secure provision was not safe enough given the nature of the offence so he was remanded to prison.

BB was referred to hospital and seen by a psychiatrist who supported his move to a psychiatric unit when a bed was to become available. The inquest heard that this could take some time as beds were limited and in demand and patients in the community were given priority. Whilst on

[19] The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system (April 2009)

the Healthcare Wing of HMP Scrubbs, BB was able to obtain a black bin liner to suffocate himself with. Ease of access for high risk patients underpinned a critical narrative verdict and PFD recommendations, banning the use of plastic bags in the unit.
Since, BB's death, there has been another death in similar circumstances at HMP Peterborough: 41 year old Diane Waplington was discovered unresponsive in her cell on 16 May 2014 having placed a plastic bag over hear head. The Inquest into her death is yet to be listed.

Contact with family

Access to family can be an important stabilising influence, helping to mitigate feelings of distress when being sent to prison. They can also be an important resource for staff particularly when an individual has been identified as at risk. Despite this, families reported frequent difficulties in contacting prisons to document their concerns with prison staff, with switchboards unanswered and no designated family liaison officer to pass information on to. Even where a contact has been made there have been cases where warnings were not passed on.

Relocation to an unknown and intimidating environment can be a source of trauma and requires many to move long distances from their home where contact with parents and children is nearly impossible. For women with children family interaction can play an even more crucial role. On average 18,000 children each year are separated from their mothers as a result of imprisonment and many of these women self harm primarily as a means of coping with isolation and separation from family and children[20].

Mahry Rosser was 19 years old when she was found unconscious in her cell at HMP New Hall in April 2011. She used the hand rail in the toilet area to tie her ligature. This was not the first time she tied a ligature around her neck. Mahry had a long history of self harm and suicide attempts. She came from South Wales and lived there with her grandmother from the age of three. At age 16 she was detained at a secure children's home and later was sentenced to 3 years detention for robbery. There after her life was spent being moved from one establishment to another. She spent time in Eastwood Park, Downview and Peterborough prison and in 2010 she was eventually transferred to New Hall.

The Prison Probation stated in their investigation report that there was a systemic failure in her care and she was transferred around the women's estate without adequate regard for her substantial needs. In particular a criticism was made regarding the decision to move her to New Hall taking her away from her family and home area. During her time at New Hall, she consistently told staff of her distress of being too far away from her family to receive visits and her wish to transfer to Eastwood Park to be closer to them. Many of her acts of self harm were recorded as a consequence of her continued frustrations at being far away from her family. In his assessment of Mahry's case, Nigel Newcomen, Prisons and Probation Ombudsman for England and Wales, said: "*Unfortunately, this report sets a catalogue of failures which calls the whole process into question…Her needs could have been better managed by a more holistic, multi disciplinary approach…"*

Unsafe cells and ligature points

Death by hangings accounts for 93 per cent (89) of all self-inflicted deaths and 53 per cent (51) of the young people who died in prison were placed in a single cell (see appendix). INQUEST research has also shockingly revealed that out of 96 cases of self-inflicted deaths only 1 person was in a "high-risk" cell at the time of death and 9 had been placed in single occupancy double cells, despite repeated evidence of bunk beds being used for ligature points. Sadly these statistics alone demonstrates the systemic and widespread failures across the prison estate. The

[20] Preventing the Deaths of women in prison: the need for an alternative approach (June 2013) http://inquest.gn.apc.org/pdf/briefings/Oct2013_updated_INQUEST_Preventing_deaths_of_women_in_prison.pdf

prison system - differentiated by populations, regime standards and prison infrastructures – fails to protect vulnerable young people by removing potential ligature points and recording self harm triggers.

The case of Chay Pryor, an 18 year old with Attention Deficit Hyperactive Disorder and a history of self-harm who died in August 2008 in HMP High Down, was a telling example of such neglect. Having requested to speak with the Samaritans, he was left unsupervised to make a call in a Listeners Suite where he was found hanging 53 minutes later. Concerns had previously been raised about ligature points but no action was taken in response to these concerns.

Nicholas Saunders was 18 when he hanged himself and died at HM YOI Stoke Heath in 2011. The inquest heard that information about a previous suicide attempt and Mr Saunders' vulnerability was not transferred with him from a previous prison and heard concerns about the cell design. Nicholas was able to hang himself from an elaborate ligature from either end of a light fitting in his cell. The light fitting was sufficiently robust to take Mr Saunders' weight (74 kilograms). Importantly, his death may well have been preventable had action be taken in response to a previous death where a similar light fitting had been used by another young prisoner who took his life at the same prison in January 2005. The inquest also heard that staff at Stoke Heath had adopted a practice of tolerating young prisoners suspending washing lines made out of torn bed sheets from fixtures in their cells.

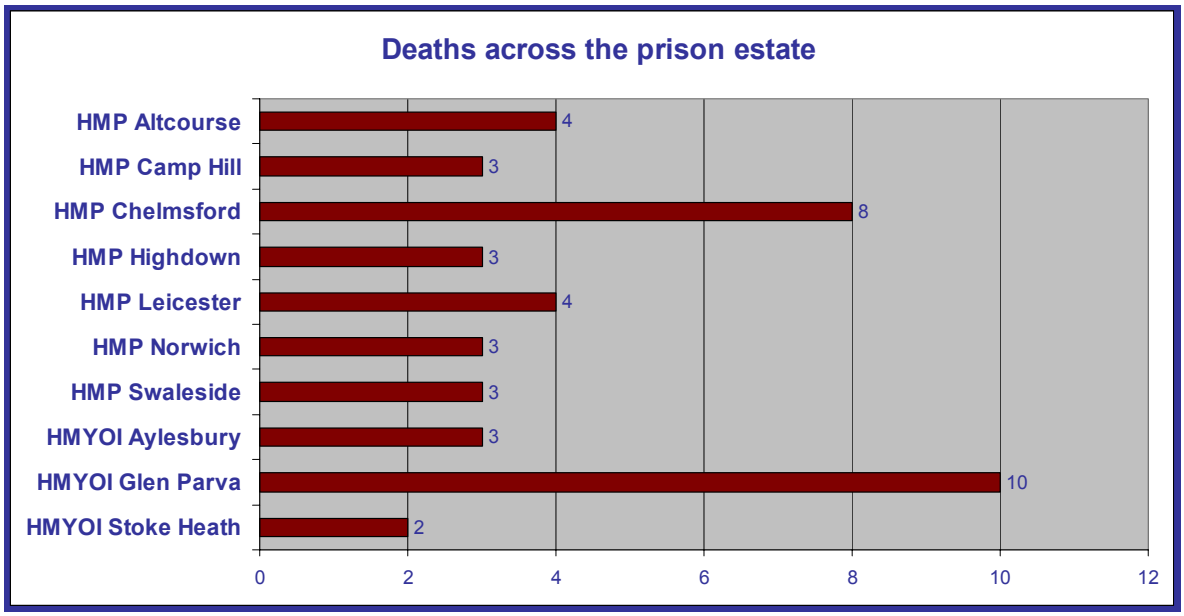
Amy Friar was 24 years old when she was found hanging in her cell at HMP Downview on 30 March 2011. Her mother had described her as a quiet child. Her dad had committed suicide when she was very young and this impacted on her mental health. She had a problem with drug and alcohol use and this led to her committing offences. She spent most of her young life in prison. Amy was on suicide and self harm management programme when she was found hanging. She used exposed heating pipes that ran below her cell window to tie a ligature. An inquest into her death identified serious issues in relation to suicide and self harm procedures and especially the quality of checks on prisoners and the lack of meaningful interaction and conversation with vulnerable prisoners. However the Coroner did not allow any questions to be left to the jury on these issues and the issues around ligature points were also not explored.

Since Amy Friar's death, there has been a further self-inflicted death in HMP Downview. Two years after Amy died, another woman, Cherylin Norrell-Goldsmith also hanged herself using the exposed pipes over her head in the toilet area of her cell. Exposed pipes being used as a ligature point has been a common feature in the deaths of women in prison. Previously in 2008, West Yorkshire Coroner, David Hinchcliff had made a recommendation for boxing in pipework in order to reduce the number of ligature points in New Hall following the death of Kelly Hutchinson in 2006 who was 22 years old at the time of her death.

Persistent failures – HMYOI Glen Parva

Ranked as having the highest number of self-inflicted deaths of 18-24 year olds, HMP YOI Glen Parva has been at the heart of the prison reform debate and concerns around the incarceration of young people. Poor care management, overcrowding (currently holding a population of 659) and an austere, restrictive environment have been some of the key problems referred to.

Since April 2007 there have been 10 self-inflicted deaths of young people. A HMIP inspection report in August 2014 identified Glen Parva as of serious concern, with "a *direct link between the high levels of bullying and…self-harm* and that *"prisoners at risk of suicide or self-harm had increased by 32 per cent*" and 28 per cent of them were *"locked in their cells during the working day."*



Steven Davison was 21 years old when he took his life at HMYOI Glen Parva in 2013. He had suffered from severe mental health problems and was diagnosed with a Personality Disorder whilst spending time in a psychiatric unit prior to custody. Steven had carried out a number of suicide attempts which ranged from jumping out of windows and overdosing. His reason for being sent to Glen Parva has come under severe criticism; Steven was found with a knife which he had threatened to cut his throat with and was allegedly sent to prison to protect him from himself. The jury heard from Steven's mother that his placement in prison was a sad consequence of not having enough beds to accommodate him at the local psychiatric ward.

During Steven's initial screening, the duty nurse assessed him. She identified him as not at risk, despite being presented with information about several attempts of suicide including his overdose. It was later revealed that this particular nurse had been working for 2 years at Glen Parva without any ACCT training and had only received training one month prior to Steven's inquest. The timing of the training has raised questions about whether the training would have been carried out were it not for her giving evidence at the inquest this month.

The most important failures however related to the lack of support Steven received after hearing of particularly distressing news. Whilst on the phone to his girlfriend, she told him that she was ending their relationship. She then told him that his grandfather had died – a relative whom Steven was very close to. Steven was visibly upset and had always referred to girlfriend as being both, a protective factor and his main support. Prison staff were aware of Steven's strong reliance on his girlfriend and it is not clear why this incident did not trigger an immediate ACCT case review. This is especially alarming as staff also knew that he had self-harmed on that very day – burning his arm with a lighter.

PPO report into his death declared that training in self harm prevention was poor, with a predominant reliance on "personal presentation" for risk assessment. Clear signs of risk were recorded in the run up to Steven's death. For example the night before his death, one prison officer noted that Steven had made cuts to his upper thighs inscribing self-abusive words with a pair of nail clippers. After making one last call to his mother, Steven was discovered the next evening hanging from a ligature point.

A few months after Greg Revell, an 18-year-old boy, was also found hanging in HMYOI Glen Parva in 2014. What is particularly striking is that his deaths smacks of the same failings and vulnerabilities shared by Steven. Identified as a troubled boy with severe mental health problems many of those close to Greg raised concerns that his life would be endangered by imprisonment.

In court Greg had shown great distress, crying as the judge sentenced him and revealing visible marks around his neck following a suicide attempt the previous night. When Greg was placed in Glen Parva, his mother contacted the prison and expressed her concerns about Greg's fragile state of mind, and was assured he would be cared for. Despite this, he was not put on formal observations and hanged himself on his second day of custody. Greg's mother was told initially that he was placed in a cell with bunk beds on his own however this information has later contradicted by other sources indicating a single cell location. Crucially it was later discovered that Greg's risks were not identified under the same Nurse who had never received ACCT training, despite 2 years employment, and who had decided not to place Steven on an ACCT.

Emergency response

On a more general note, failures in emergency response are shown up time and time again. Concerns include delays in transfers to hospital following a life threatening casualty, employment of appropriate healthcare equipment, and unfamiliarity with national policy regarding emergency response. For example in the case of Steven Davison, prison and healthcare staff appeared to have a partial understanding of national protocol when managing his self-inflicted injury. Once a blue code call is given, this should immediately alert ambulance services to arrive at the scene, however this was not done in Steven's case. While this did not directly contribute to Steven's death, INQUEST has found that Glen Parva is currently breaching national protocol through its local policy. The prison requires the Duty Manager to seek guidance from a healthcare specialist before making a decision to call the emergency service.

Best Practices – Learning Lessons

Evidence-led research shows that deaths can be avoided should the right measures be employed to address risks. Very recently the Juvenile Unit of HMYOI Parc was identified as one such example of progress which had identified and rectified past failures. In a report last month, the HM Inspectorate of Prisons has identified Parc as having comparatively low levels of self-harm and strong safeguarding measures which were largely due to following actions:

- A well-structured induction programme adapted to suit each individual, with thorough background checks carried out for risk assessment.
- Well attended safeguarding and daily morning meetings allowing for effective communication to staff on risks and good information sharing on vulnerable prisoners.
- All separated children having access to a full activity regime, exercise and a daily shower.
- Good staff-children relationships and positive modelling, with rewards and sanctions scheme well managed and valued by the children.

If imprisonment is to be justified - and justified only as a last resort for young people - then smaller units such as HMYOI Parc Juvenile Unit, with a cellmate population of 50 must be the preferred option. Comparing the outcomes of the former with other prisons such as, HMYOI Glen Parva (currently holding a population of 659) demonstrates localised provisions to be the most effective measure. It is this kind of foresight and investment which would lead to reduced costs in terms of fewer deaths and a reduced likelihood of re-offending with better rehabilitation.

The proposals to build a 'secure college' fly in the face of evidence-based research indicating the benefits of small, local and intensively staffed units. Instead, the government is launching a dangerous plan to build extra-large custodial settings where young people, with a range of complex emotional needs, are placed in austere and dehumanising environments. Bundling prisoners together is endangering the lives of many. Signs of deteriorating mental health and self harming behaviour are less likely to be monitored and positive relationships between prisoners and staff will be jeopardised further – meaning higher levels of isolation and anxiety.

Narrative verdicts and Prevention of Further Deaths reports

INQUEST's monitoring work also looks at the progress of prison care management through narrative verdicts and Prevention of Further Deaths (PFD) reports. Narrative verdicts are the conclusions drawn from inquest juries and can outline the key issues of concern or relevant disputed facts when it comes to a contentious death. PFD reports, previously known as Rule 43s, are carried out under the new powers of coroners who can draw matters of concern to relevant authorities to prevent further deaths and recommend institutional change in the event of a previous failing.

Countless issues and concerns have been highlighted about the treatment and care of children and young people in prison. The regimes and conditions which these groups are placed in have been criticised widely by a plethora of organisations charged with the inspection and monitoring of prisons, backed up by repeated recommendations from the Prison Inspectorate, Prison and Probation Ombudsman, Coroners reports and critical comment from jury findings. And yet systemic failings repeat themselves with depressing regularity. The fact that the same concerns keep being raised suggests a widespread feeling of apathy, indifference and institutional resignation from those organisations charged with a duty of care to prisoners and a degree of impunity for institutions linked to the state.

INQUEST has also produced its own sample of 23 Coroner recommendations and narrative findings, which reveals similar failings to other findings. The need for better communication and information sharing (within and between prisons and other statuary bodies), mental health awareness and training in ACCT was stressed in all cases. With regards to ACCT training INQUEST has recorded dire examples of staff working with vulnerable prisoners and having little to no knowledge of ACCT procedures. The practical application of ACCT has also come under heavy criticism by the recent Learning Lessons PPO report 2014, where Nigel Newcomen referred to a "personal crisis and utter despair of those involved [in applying the ACCT]" and *"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 specified timescales or information is not recorded."* The case of 18 years old Nicholas Saunders, who died at Stoke Heath YOI in 2011, is one such example of this. During the inquest, the jury unanimously found that information of a closed ACCT was not passed from the previous institution to the receiving one so that those responsible for Nicholas were not aware of his previous suicide attempt or the closed ACCT. Contributing factors leading to his death included "the lack of factual information being readily available to those responsible for the welfare of Nicholas".

In September 2012 INQUEST published a widely praised report: '*Learning from Death in Custody Inquests*'[21]. The report was a critical review of narrative verdicts and coroners rule 43 reports returned at inquests and what changes need to be made to ensure that there is accountable learning. The report argued that the absence of a mechanism to capture and act upon the rich seam of data available from well conducted and costly inquests leads to unnecessary further loss of life. While the coronial service can and does make a vital contribution to the prevention of deaths that input is being undermined, as there are no established mechanisms for monitoring compliance with and or action taken in response to failings identified in narrative verdicts/findings or in response to rule 43 reports/Prevention of death reports. Jury findings are not collated and published and whilst Coroners reports are now published on the judiciary website there is no follow up to ascertain the impact of these reports at a local and national level.

[21] Coles, D. & Shaw, H. (2012) Learning from Death in Custody Inquests: A New Framework for Action and Accountability London: INQUEST

There is an urgent need for a stronger focus on the implementation of PFD reports and a need to monitor progress more consistently, at both a local and national level particularly for those prisons with extremely poor standards. This Chief Coroner should play a vital role in carrying out this oversight. Currently, the only light shed on failures is often through the actual occurrence of another prison death, revealing similar failings to past deaths.

Post-death family liaison and legal representation for families

Following a custodial death, INQUEST has observed some poor enforcement of family liaison common standards and principles. Problems have arisen where no family liaison officer has contacted the family, and where timely dissemination of information regarding the family's rights to help and support during the inquest process has been lacking. Families have also reported no or very little access to information about their entitlements to financial compensation for funeral costs and independent advice about a death in custody. This is in spite of clearly set out guidelines by the Independent Advisory Panel, which have been accepted by a range of custodial organisations, investigatory bodies and the Department of Health. Good practice is where all the agencies involved with a family post death ensure the prompt provision of advice and support to a bereaved family. For a comprehensive set of guidelines on good practice regarding post death family liaison, please consult INQUEST's recommendations in section *"Notification of the Death"* in *Unlocking the Truth.*[22]

Moreover, the current inquest process is beset with practical problems including lengthy delays, which are distressing, and interrupt the bereavement process for families. The Independent Advisory Panel on Deaths in Custody has gathered data from coroners which showed that, between August 2010 and January 2011, approximately 25 per cent of deaths in custody inquests were taking more than two years to complete. The reasons given by coroners for the delays included outstanding investigations by other bodies such as the PPO and resources. Whilst there has been an improvement in the timeliness of PPO investigations, delays continue to prevent coroners from making recommendations to prevent further deaths. Coroners are often reassured by the Prison Service that safeguarding actions have been taken, however they have very little opportunity to scrutinise this. With a nod to coronial practice, it is often variable and whilst there are some excellent coroners who ensure thorough scrutiny of prison deaths, some other coroners will limit the scope and inquest remit.

Bereaved families have a vital role to play in ensuring inquests do not merely sanction the official version of events. Indeed, they and their legal representatives have been instrumental in exposing "*systemic and practice problems that have contributed to deaths. Many of the changes to…training and guidance, changes to the law…increases in information entering the public domain…and public awareness of the issues have been a direct consequence of the deceased's family's participation in the inquest proceedings and lobbying…for change*."[23] Skilled advocacy for the family aids the inquisitorial process and can contribute to the making of coroner reports for the prevention of future deaths.

Coles and Shaw have explained that families *"hope their questions will be answered and their concerns addressed. Instead they can be left feeling that they have been further damaged by the investigation and inquest which in turn exacerbates their anger and grief."*[24]

[22] Coles, D. & Shaw, H. (2007) Unlocking the truth: families' experiences of the investigation of deaths in custody London: INQUEST

[23] Coles, D. & Shaw, H. (2007) Unlocking the truth: families' experiences of the investigation of deaths in custody London: INQUEST

[24] Coles, D. & Shaw, H. (2007) Unlocking the truth: families' experiences of the investigation of deaths in custody London: INQUEST

It is essential, therefore, that families are supported to participate at every stage in the investigation and inquest process as fully and as openly as possible. Families should automatically be eligible for non-means tested public funding to cover the costs of legal advice and representation and subsistence costs for the inquest hearings. Yet this right of access is often denied to families. Karen Gammon, the mother of the recently deceased Amy Friar, referred to her own troubles: *"This inquest has been a very difficult experience, made harder by the lack of financial assistance from Legal Aid, and initially the prison HMP Downview, which meant that I was not able to attend and hear all the evidence.*

Lawyers instructed on behalf of a prison, the Prison Service and other public bodies whose conduct may be subject to scrutiny during the inquest are paid for from public funds. For example, the Ministry of Justice incurred legal representation costs of £2.7 million in relation to inquests into deaths in prison. In contrast, the entire amount spent on the exceptional legal aid budget (i.e. for all cases covered by that scheme and not just family representation at death in prison custody inquests) in the same period was £1.6 million.[25] This translates into a significant inequality of arms between bereaved families and the public institutions who may have failed the children and young people in their care. If we are serious about learning from tragedy, families whose children have died whilst in the care of the state must not be precluded from involvement in subsequent investigations because of financial concerns.

Inquests do not fully explore issues of procedure and policy. Deaths are considered in isolation from one another without an overview of systemic factors which may have contributed to a pattern of similar deaths. The findings of previous inquests or inquiries into deaths involving similar factors or within the same institution are very often not considered. The restricted remit of the inquest also means that it does not enable an in-depth analysis of sentencing policy and allocation. Therefore a key concern for families, as to why the young people were imprisoned in the first place, is outside the scope of the inquest and further frustrates the learning process.

The most troubling aspect of INQUEST's work is the failure of state bodies and agencies to act on the compelling evidence from numerous PPO investigations, inquests findings, coroners' reports resulting in the relentless number of preventable deaths. The inquests and investigations into the deaths of children and young people should be a forum through which lessons can be learned. However lessons are far too frequently lost, they are analysed poorly or ignored; misunderstood or misconstrued; dissipated or dismissed.[26]

Further review of deaths by characteristics

Below is a review of the characteristics shared by the young people who took their lives in prison and their experiences, including a review of any safeguarding measures enforced prior to their death.

Age

From 2007 to September this year there have been 501 total self-inflicted deaths and 18-24 year olds have accounted for almost one-fifth of this number – see graph in appendix. The overall presence of young people in prison is a cause for concern; young adults aged 18-24 constitute less than 10 per cent of the general population, yet make up more than a quarter of the sentenced prison population.[27] Meanwhile, the highest deaths were recorded among the 21 year olds age-group (20), accounting for 21 per cent, followed by 18 year olds (16), accounting for 16

[25] See answers to parliamentary questions from Jeremy Corbyn MP, House of Commons, 18 January 2011

[26] Deborah Coles and Helen Shaw: *Learning From Death In Custody Inquests*: *A New Framework For Action and Accountability* INQUEST 2012

[27] John Collins and Gemma Lousley, *Sentencing young adults: Getting it right*, (July 2011) http://www.barrowcadbury.org.uk/wp-content/uploads/2011/09/CJAgettingitright1.pdf, Criminal Justice Alliance

per cent. Our casework shows that while a number of young people remain vulnerable and should be protected under a duty of care; their needs are often neglected due to a mistaken belief that they have reached adulthood. In some cases we have seen the cessation of social service support and files closed once a person has reached 18 despite visible signs of emotional vulnerability and an inability to cope without support.

Ethnicity

76 of the 96 prisoners who took their lives were white prisoners (79 per cent), despite only making up 74 per cent of the prison population[28] - see graph in appendix. 9 of those who took their lives were Black (9 per cent), 8 Asian (8 per cent) and 3 were mixed race (3 per cent). Disproportionate deaths of white prisoners are consistent with other findings[29] and some accounts refer to the greater presence of faith and cultural networks for Black and minority ethnic groups (BME) in prison, providing them with greater support during difficult periods. Further arguments also refer to a greater stigma associated with self-harm among BME groups.

Gender

To date 4 young women have taken their own lives in prison (4 per cent) compared with 92 young men (96 per cent) - see graph in appendix. On first impressions this number may seem insignificant; however as INQUEST has shown in *Preventing the deaths of women in prison,* women only constitute 5 per cent of the overall prison population.[30] The specific needs of girls and young women have been neglected and there is a lack of gender specific provision. Many young women enter the criminal justice system as a result of unmet welfare needs including neglect, abuse and poverty. Women also account for high levels of self harming incidents often linked to previous experiences of abuse and trauma and separation from children, whereby self harm is used primarily as a means of coping with grief and isolation.[31]

Prison status

53 per cent of those who took their own lives had been sentenced and 28 per cent were on remand – see graph in appendix. For those sentenced prisoners, increased anxiety and feelings of abandonment can follow conviction or sentence. The realisation by that person that they face long-term imprisonment can be a very daunting prospect, particularly in the days after sentencing where risk of self harm and suicide is increased. Meanwhile remand may also destabilise an individual's emotional welfare due to the high level of uncertainty around sentencing. Quite often it may be the young person's first experience of custody. They are likely to be scared, anxious, susceptible to bullying; and distance from family and home for the first time compounds these feelings of anxiety. It is well documented in Prison Service suicide prevention policies that these factors can increase the risk of suicide and self harm - particularly as the young person's normal support mechanisms from family and friends are not readily accessible.

Recommendations

This report documents the vulnerabilities and needs of 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 statistics and common themes identified in this report must be used as

[28] Institute of Race Relations, *Criminal Justice System Statistics*, 2014 http://www.irr.org.uk/research/statistics/criminal-justice/#_ednref1

[29] See parliamentary publications http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1506.htm

[30] Preventing the Deaths of women in prison: the need for an alternative approach (June 2013) http://inquest.gn.apc.org/pdf/briefings/Oct2013_updated_INQUEST_Preventing_deaths_of_women_in_prison.pdf

[31] Preventing the Deaths of women in prison: the need for an alternative approach (June 2013) http://inquest.gn.apc.org/pdf/briefings/Oct2013_updated_INQUEST_Preventing_deaths_of_women_in_prison.pdf

a resource to learn from past failures and to implement policy and institutional change. This applies to the treatment of vulnerable young people in prisons and to an improved community support network which allows for the identification of such individuals at the earliest possible stage.

The following are recommendations for change with the aim of preventing further deaths of young people in prison.

National and policy considerations

1. Prisons must be used only as a last resort for those who present a significant risk to others. Prison should not be the default response and diversion to health, welfare and other alternatives to custody, such as community schemes, are best-placed to deal with the complex needs of young people.
2. In the event that prison is necessary, there should be investment in local and smaller prison units with an emphasis on therapeutic environments and interventions and increased staff who are adequately trained and want to work with young prisoners.
3. A review of the ACCT scheme, focusing on a specific assessment and identification of young people's vulnerabilities, and their difficulties in communicating emotional instability.
4. Best practices across the prison landscape should be identified and held up as templates for other prisons, with better incentive schemes for staff to improve the Prison Service; and greater penalties for prisons who have failed to deliver training in risk identification.
5. 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.
6. Families bereaved by a death in custody should automatically qualify for non-means tested public funding to enable their legal representation at inquests.
7. All coroners' PFD recommendations and juries' narrative verdicts should be publicly accessible through a national custody death database and analysed, audited and followed up and brought to the attention of Parliament to ensure responses from relevant Ministers.
8. There is an overwhelming case for the creation of an effective mechanism in the form of a central oversight body. This body would be tasked with the duty to collate, analyse critically and constantly audit across the relevant sectors, and report publicly on the accumulated learning from inquest outcomes and those recommendations from PPO investigations, HMIP/IMB recommendations pertinent to custodial health and safety.

Local and institutional responses

9. Sentencers must divert individuals with mental health illnesses, learning difficulties and drug/alcohol addiction away from the criminal justice system. Treatment and rehabilitation must be the preferred option.
10. Sentencers must be fully informed about the range of community provision available for young people and must not impose prison sentences because of a lack of appropriate facilities or provision. They need to be aware of the types of institutions they are sending young people to.
11. A better functioning of community support is needed to identify both, those at risk of offence and those leading disruptive lives such as, looked after children and care leavers, individuals with mental health issues and/or drug and alcohol misuse. Preventative measures should include the input of all statutory partners i.e. social workers, youth offending practitioners and staff in the secure estate.

12. A structured induction programme in prison, identifying self-harm triggers is necessary in preventing deaths. Greater attention needs to be given to information accessibility and support for those identified as at risk of harm.

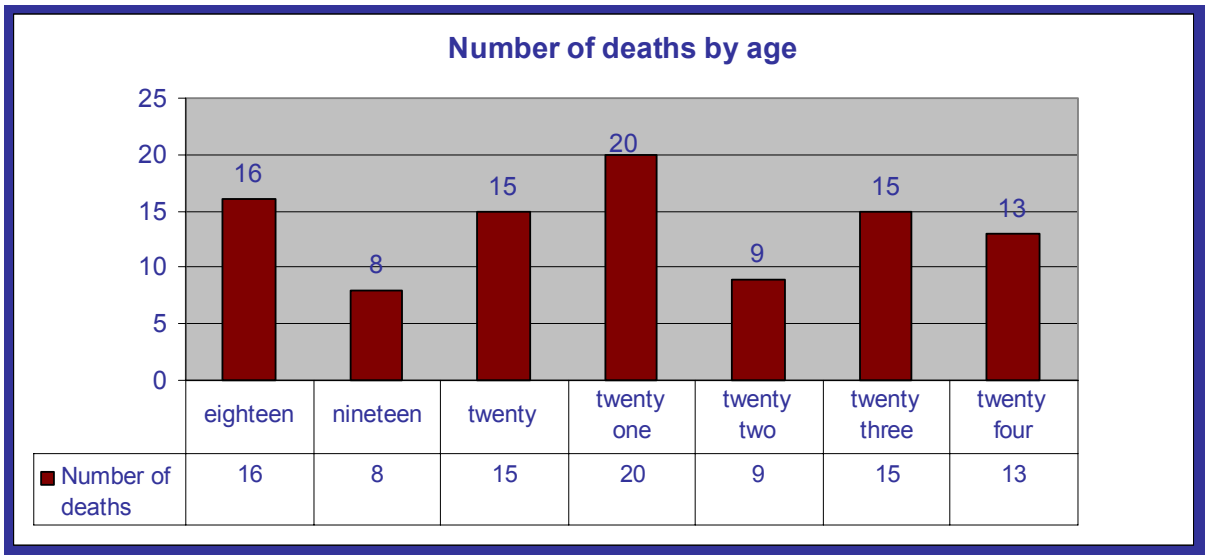
13. Consistent processes for regular monitoring and reviews of bullying must be enforced, and staff capacity increased to support prisoner and staff relationships, with a particular emphasis on the personal officer scheme. Regular staff meetings must be held to ensure the necessary flow of information concerning prisoner risks.

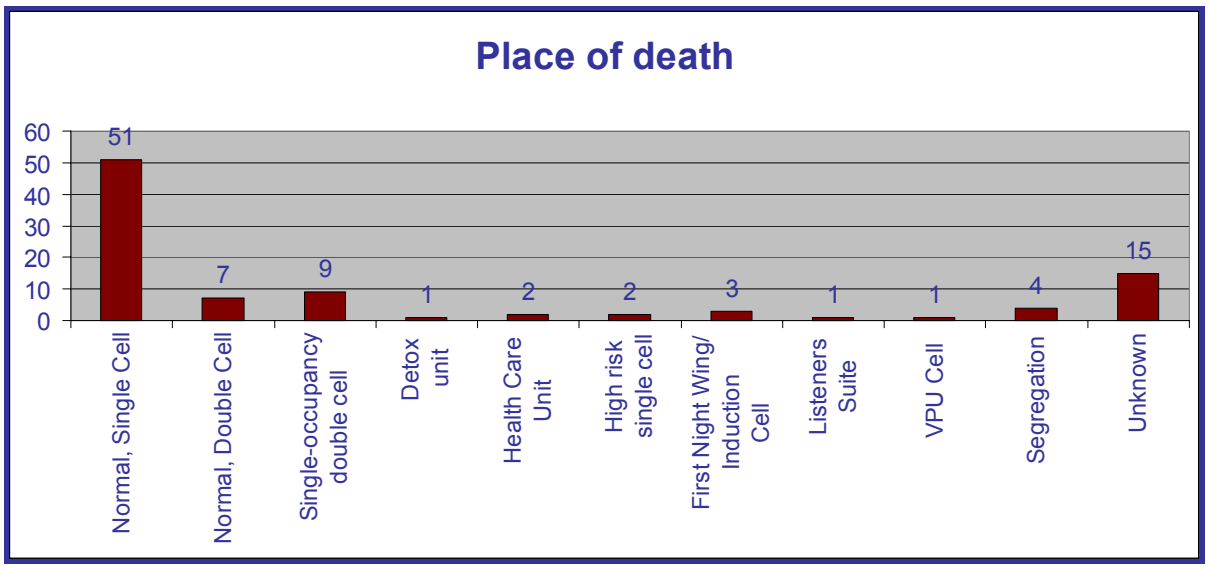
Concluding comments

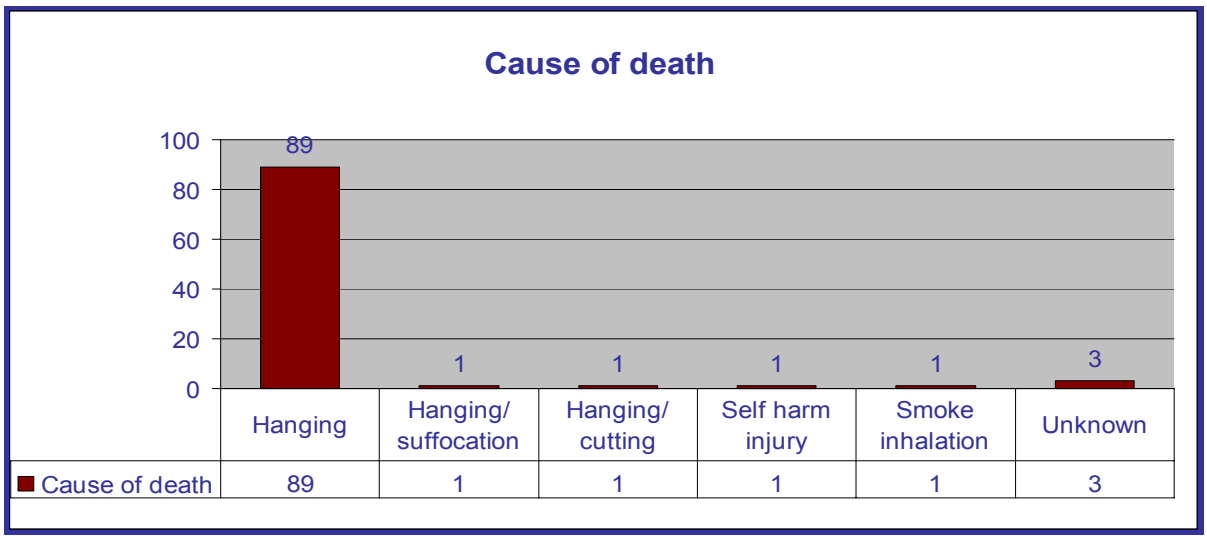
The countless stories of young people who took their lives in prison show that such deaths are not isolated cases, but part of a deeply worrying pattern. Time and time again systems set up to safeguard children and young people miserably fail as revealed by a succession of investigations, reports and critical inquest outcomes. The proper protective measures and institutional culture that should protect young people in prison from human rights abuses can no longer be left to the state to determine as they have repeatedly failed young people. Prison is an ineffective and expensive intervention that does not work as shown by the high reconviction rates. We need to fundamentally rethink the way we treat children and young people in conflict with the law. To ignore this serious human rights issue means the tragic loss of young lives will continue to shame our prison system and subsequently our society as a whole.

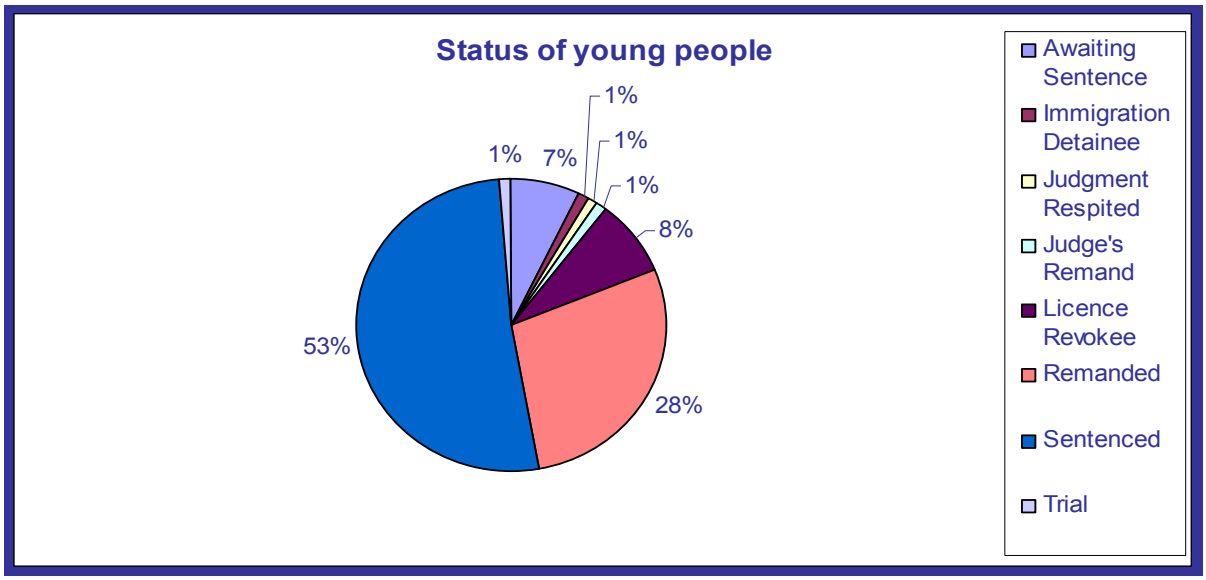
Appendix

The graphs below contain additional information relating to the characteristics of young prisoners who took their lives and their circumstances during April 2007 and September 4, 2014.









Awaiting Sentence	Immigration Detainee	Judgment Respited	Judge's Remand	Licence Revokee	Remanded	Sentenced	Trial
7	1	1	1	8	27	50	1