INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

Prisons Strategy White Paper: INQUEST's response

4 February 2022

Introduction

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question.

2. We have published numerous evidence-based reports and submissions to parliamentary committees and independent reviews on the issues arising from deaths in prison. We have also provided a unique overview of the investigation and inquest process and the role of inspection, monitoring and oversight bodies. Our Director Deborah Coles represents INQUEST on the Ministerial Board on Deaths in Custody and is a panel member of the Independent Advisory Panel on Deaths in Custody.

3. Given the ongoing crisis in prisons, the publication of the Prisons Strategy White Paper provided the Government with an ideal opportunity to give serious consideration to the future direction of penal policy. INQUEST believes the White Paper fails to grasp this opportunity.

Prison Expansion

4. The Preface and Chapter One of the White Paper outline the future of the prison system. As part of the biggest prison building programme in more than 100 years, 18,000 new and 2000 temporary places will be added to the current system. The White Paper also comments that new prisons will be designed differently to generate better environments and will utilise technology to facilitate the work of the new prisons. Two hundred and ninety new ligature free cells will be introduced to ensure the safety of prisoners. The White Paper's discussion about these issues is concerning for several reasons.

5. First, in 1983 the then Home Secretary announced the biggest prison building programme of the twentieth century. This programme did little to reduce crime and victimisation, nor did it alleviate the prison crisis. Forty years on, prisons are still in crisis and are failing at every level: there is no relationship between imprisonment and crime rates; reconviction rates remain high; high rates of deaths and self-harm endure; and

endless inspection reports repeat the same recommendations which are rarely implemented, as this submission indicates below.

6. Second, building more ligature free cells is unlikely to alleviate the inherent harms of imprisonment. There is value in ensuring cells are ligature free, although a commitment to only 290 such cells is miniscule given the proposed expansion of the estate by 18,000 places. It amounts to 1.6% of the new cells being built. However, prison cells will still not be 'safe' as the prison environment is one which dehumanises and is in and of itself dangerous. Widespread structural issues in prisons underpin self-harm and self-inflicted deaths in prison – these are issues which INQUEST, through its casework, has illuminated and evidenced for over 40 years.

7. Third, rather than building new prisons, and increasing their prison populations, a number of jurisdictions are reducing their rates of incarceration, including traditionally punitive nations such as the USA and Russia as well as the Netherlands, Scotland and Northern Ireland: in this context then, it has been noted that 'England and Wales, therefore, are set to buck a national, a regional and a global trend'.[1]

8. Finally, expanding the number of prisons will ensure the continuation of the criminalisation of Black and racialised groups and their overrepresentation in prisons.[2] Prison expansion is therefore antithetical to the project of racial equality. Her Majesty's Inspectorate of Prisons' (HMI Prisons) survey data consistently points to BAME prisoners reporting worse experiences on many important areas compared to white prisoners. In INQUEST's view, prison expansion will intensify this overrepresentation and further disadvantage these groups.[3]

9. Indeed, while the White Paper's Overarching Equalities Statement[4] recognises that "some prisoners with the protected characteristics … are likely to continue to be over-

[1] Pakes, F., Prison numbers set to rise 24% in England and Wales – it will make society less safe, not more, *The Conversation*, https://theconversation.com/prison-numbers-set-to-rise-24-in-england-and-wales-it-will-make-society-less-safe-not-more-172566 30 November 2021

[2] Lammy review: final report, https://www.gov.uk/government/publications/lammy-review-final-report September 2017

[3] See also a joint letter from Clinks, INQUEST and others on the lack of focus on racial disproportionality in the Prisons White Paper, https://www.clinks.org/publication/prison-strategy-white-paper-lost-opportunity-address-racial-disparity, February 2022

[4] Prisons Strategy White Paper, Overarching Equalities Statement, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1038766/pswp-equalities-statement.pdf, December 2021

represented in the offender population and impacted disproportionately by the proposals by virtue of this", the Government seems not to accept this as a reason to question prison expansion. INQUEST is also of the view that measures in the Police, Crime, Sentencing and Courts Bill will further entrench racial inequalities in prisons and the wider criminal justice system for Black and racialised groups and for Gypsy, Roma and Traveler communities.

10. INQUEST believes the prison population should be radically reduced through changing sentencing policy, as has happened in the USA,[5] stopping the prison building programme, drastically reducing the remand population (who accounted for 27% of self-inflicted deaths in custody in 2019),[6] closing older, dilapidated institutions and redirecting criminal justice expenditure away from prison building and towards well-funded, well-staffed, rehabilitative-orientated, community alternatives for those with drug, alcohol and mental health issues, the homeless and non-violent offenders including the vast majority of women prisoners.

Self-Harm and Deaths in Prison

11. Chapter Two discusses tackling violence, preventing harm and promoting good order and discipline. However, the White Paper is alarmingly evidence-light. It ignores the research, casework and policy proposals developed by INQUEST whose work over the last four decades has pointed to the punitive nature of prison regimes, the systemic indifference towards prisoners and the state's failure to fulfil its duty of care as being central factors in self-harm and self-inflicted deaths in custody, as well as other non-natural deaths.[7]

12. The latest figures on prison deaths, published on January 27 2022 paint a damning picture of the state's ongoing, abject failure to prevent these deaths. This time last year INQUEST predicted that, in the midst of a second wave of Covid-19, the worst was yet to come. Sadly, the government did not act and we were proven right.

[5] Pakes, F., Prison numbers set to rise 24% in England and Wales – it will make society less safe, not more, The Conversation, https://theconversation.com/prison-numbers-set-to-rise-24-in-england-and-wales-it-will-make-society-less-safe-not-more-172566 30 November 2021

[6] Prison Reform Trust, Bromley Briefings Prison Factfile, http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Winter%202021%20Factfile%20final.pdf, Winter 2021

[7] INQUEST, Deaths in Prison: A National Scandal, https://www.inquest.org.uk/deaths-in-prison-a-national-scandal January 2020, January 2020

13. In the 12 months to December 2021 there were a total of 371 deaths of people in prison, representing the highest annual number of deaths ever recorded, with more than one death a day. This is despite recent reductions in the prison population. There were 4.7 deaths per 1,000 prisoners, also representing the highest ever rate of deaths. Of these deaths:

    - 250 deaths were classed as 'natural causes', though INQUEST casework and monitoring shows many of these deaths are premature and far from 'natural'. This is a 13% increase from the previous 12 months.
    - 86 deaths were self-inflicted, an increase of 28% from the previous 12 months.
    - 34 deaths were recorded as 'other', of which 4 were 'non-natural' and 30 await classification.
    - There was also one homicide.

14. Of these, six of the deaths were in women's prisons, three of which were 'natural cause' and three await classification. Younger people were most likely to die self-inflicted deaths in prison and 69% of all deaths of people aged between 18 and 39 were self-inflicted deaths in 2021. The statistics also include data on ethnicity, however it offers inadequate information and analysis. The longer-term data shows that, even without accounting for Covid-19 related deaths, this year and the past five years have seen the highest ever numbers and rates of deaths in prison. Since the pandemic began in March 2020 to 31 December 2021 177 people in prison died within 28 days of a positive Covid-19 test. With INQUEST's own data we estimate that 98 of these deaths were in 2021.[8]

15. Furthermore, official inquires such as those conducted by Baroness Jean Corston and Lord Toby Harris[9] which recommended radically reducing the prison population and developing a network of integrated well-funded community alternatives, operating with well-trained staff, are not acknowledged in the White Paper. Lord Harris, whose Independent Review, commissioned by the then Justice Secretary, concerned the deaths in custody of 18-24 year olds. It was clear about the way forward:

    "The 87 cases we examined in detail demonstrated that many of the young people's problems and vulnerabilities, including mental health issues, had been evident from an early age. We had to ask the question, why were so many of these young adults in custody in the first place? Prison should be used as a last resort. Much more needs to be

[8] INQUEST, Ministry of Justice Safety in Custody Statistics, https://www.inquest.org.uk/moj-data-jan2022, January 2022

[9] The Corston Report, The Corston Report: A review of women with particular vulnerabilities in the criminal justice system, https://webarchive.nationalarchives.gov.uk/ukgwa/20130206102659/http:/www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf March 2007; The Harris Review, Changing Prisons, Saving Lives, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/439859/moj-harris-review-web-accessible.pdf, July 2015

done to address these problems and to divert these young people from the criminal justice system at an earlier stage in their lives. What is more a reduction in the overall prison population would make it easier for prisons to provide an environment that meets appropriate standards of decency, safety and respect.

That is why the Review concludes that further action needs to be taken to divert more young people out of custody and out of the criminal justice system in general. Cross-governmental input is needed to address the needs of troubled children and young adults and to ensure that problems are identified and effectively addressed at an early age. Custody should be used as a last resort, and those who pass sentence in the courts need to have the right information available to them, particularly given the vulnerabilities of this age group.

Prison is a hugely expensive intervention, and yet the benefits of this spend are questionable, with a relatively low impact on crime. Rates of re-offending are high, particularly among young adults. Reinvestment and redirection of resources to the health and welfare system and community alternatives to custody will better provide the specialist help tailored to the individual's needs."[10]

16. Further, the White Paper collapses drugs, violence, crime in prison, self-harm and self-inflicted deaths together under the general rubric of prisoners being 'at risk'. But these are quite distinct issues and to treat them as synonymous is at best mistaken, at worst disingenuous.

17. For INQUEST, these complex behaviours have very different causes and outcomes and should be separated out. In collapsing them together, the context for self-harm and self-inflicted deaths, as well as 'natural' deaths, is missing. For over 40 years, INQUEST's casework has repeatedly shown that the prison environment is crucial for understanding why prisoners self-harm, take their own life or why some suffer 'natural' deaths: the underlying causes are to be found in appalling prison conditions, the trauma-inducing prison environment, the indifference of prison staff in answering cell bells, the failure to provide prisoners with their legal, medically prescribed drugs, the overall abject failure of the state to fulfil its duty of care and, in general, the systemic failure of those who manage the system to enact learning from post death investigations, reports and inquests.

[10] The Harris Review, Changing Prisons, Saving Lives, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/439859/moj-harris-review-web-accessible.pdf, July 2015

18. In 2018, HM Chief Inspector of Prisons brought a number of these themes together in an Urgent Notification letter about HMP Exeter:

"During the inspection we saw many examples of a lack of care for vulnerable prisoners which, given the recent tragic events in the prison, were symptomatic of a lack of empathy and understanding of the factors that contribute to suicide and self harm … In the context of a prison with significant levels of vulnerability among prisoners, and where suicide and self harm are at such high levels, it was shocking to see the way in which cell call bells were routinely ignored by staff. Given that the prison is now much better staffed, this was inexcusable. Inspectors saw bells going unanswered even when staff were doing nothing else."[11]

19. HM Chief Inspector of Prisons issued a similarly troubling Urgent Notification to HMP Chelmsford in 2021, a prison that has seen a repeated pattern of deaths.[12] Inspectors found many of the same failings with regard to suicide prevention and the ACCT system in the prison:

"At our 2018 inspection we raised serious concerns about the prison's work to prevent suicide or self-harm. Despite our recommendations and the subsequent intervention of the Prisons and Probation Ombudsman, outcomes had deteriorated. Eight self-inflicted deaths and four non-natural deaths had occurred since our last inspection; this is also the fourth consecutive inspection where we have reported increases in the rate of self-harm. We found many weaknesses in the assessment, care in custody and teamwork (ACCT) and other preventative processes, failings in night safety procedures and a lacklustre approach to the use of data and action planning."

20. Furthermore, the harms generated by the prison environment are experienced differently, and often more negatively, by Black and racialized groups, women, young people, older prisoners and transgender prisoners. It is these negative experiences which provide a further key context for self-harm and self-inflicted deaths amongst these groups.

21. On any of these issues it is notable that within the White Paper the voices of prisoners, and their families (including those bereaved) are missing. Even in the document's

[11] HM Chief Inspector of Prisons, Urgent Notification : HM Prison Exeter, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/05/Exeter-UN-letter-and-debrief-for-publication.pdf May 2018

[12] HM Chief Inspector of Prisons, Urgent Notification, HMP Chelmsford https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/08/26aug-sofs-chelmsford-UN-letter-FINAL.pdf, August 2021

reference to an 'Enhanced Support Service' following a self-inflicted death there is a lack of detail and no discussion at all of any engagement envisaged with bereaved families. Over the last four decades, the voices of these families have been central to INQUEST's campaigning and policy work to generate long-term, systemic change thereby preventing future deaths.[13]

Women in Prison

22. Chapter 4 discusses women in prison. This discussion should be seen in the context of the Government's proposals to add 500 new places to the women's estate when the vast majority of women are incarcerated for non-violent, petty property offences and are serving short sentences: 'in 1993 only a third of custodial sentences given to women were for less than six months - in 2019 it was nearly double this (62%)'.[14] This indicates an over-reliance on prison, and also makes clear the Government are not following academic research in this area, nor the work of charities like INQUEST and Women in Prison who have called for the implementation of radical decarceration policies for women in prison. We note also the National Audit Office's recent report on outcomes for women in the criminal justice system, which highlights the limited progress of the Government's Female Offender Strategy and its weak overall governance and accountability.[15]

23. Indeed, fifteen years after the publication of the Corston Report,[16] the White Paper fails to consider Corston's recommendations for radically changing penal policy with respect to women in prison. Simply adding 500 new places to the women's estate will not work in terms of ensuring women's safety and security while reducing crime and victimization.

---

[13] INQUEST, Evidencing Truth to Power, The Work and Impact of INQUEST, https://www.inquest.org.uk/impact-2016-2018 May 2019

[14] Prison Reform Trust, *Bromley Briefings Prison Factfile*, http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Winter%202021%20Factfile%20final.pdf, Winter 2021

[15] NAO, Improving Outcomes for Women in the Criminal Justice System, https://www.nao.org.uk/report/improving-outcomes-for-women-in-the-criminal-justice-system/#, January 2022

[16] Corston, J, The Corston Report: A review of women with particular vulnerabilities in the criminal justice system, https://webarchive.nationalarchives.gov.uk/ukgwa/20130206102659/http:/www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf, 2007

24. Following the Corston Report, INQUEST published 'Dying on the Inside: Examining Women's Deaths in Prison',[17] which provided a detailed analysis of women's deaths and documented families' experiences. This was followed by a 2014 report, 'Preventing the Deaths of Women in Prison'.[18] Then, in May 2018, INQUEST published 'Still Dying on the Inside', with its Executive Director Deborah Coles stating:

    "Since the Corston Review, there has been little systemic change and for far too many women, prison remains a disproportionate and inappropriate response. The persistence and repetition of the same issues over an eleven-year period reveals nothing less than a glaring failure of government to act.

    While Ministers continue to drag their heels on the women's justice strategy, which was due in 2017, women continue to die. Government must work across health, social care and justice departments to dismantle failing women's prisons and invest in specialist women's services."[19]

25. Our report included the stories of women who have died in prison and made the following recommendations:

    - Redirect resources from criminal justice to welfare, health, housing and social care.
    - Divert women away from the criminal justice system.
    - Halt prison building and commit to an immediate reduction in the prison population.
    - Review sentencing decisions and policy.
    - Urgently review the deaths of women following release from prison.
    - Ensure access to justice and learning for bereaved families.
    - Build a national oversight mechanism for implementing official recommendations.[20]

26. Prisons are not safe environments for women, nor indeed, as recent deaths have shown, for their babies. Quite simply, pregnant women should not be in prison. In September 2019, a newborn baby died in HMP Bronzefield; another baby was stillborn in HMP

[17] INQUEST (2008) Dying on the Inside: Examining Women's Deaths in Prison, https://www.inquest.org.uk/dying-on-the-inside, April 2008

[18] INQUEST, Preventing the deaths of women in prison, https://www.inquest.org.uk/preventing-deaths-of-women-in-prison, January 2014

[19] INQUEST (2018) Still Dying on the Inside: Examining deaths in women's prisons, https://www.inquest.org.uk/still-dying-on-the-inside-report, May 2018

[20] Ibid

Styal in June 2020. The Ministry of Justice does not routinely collect or publish data on miscarriages, stillbirths and neo-natal deaths, so the number of deaths of babies born to imprisoned mothers may be higher.[21]

27. The White Paper does recognise the negative impact prisons can have on women, particularly the disproportionate number of incidents of self-harm. The Ministry Of Justice advocates 'trauma-informed services' for women in prison. INQUEST is of the view these services should be developed *outside* prisons as prison itself is a trauma-inducing environment; this requires redirecting resources into community, health, welfare and specialist, women-centred, culturally specific services.[22] Such services should also be part of the wider strategy of decarceration referred to above. Regrettably, the White Paper fails to develop the discussion of these services in any depth, particularly in relation to introducing culturally specific trauma services. As INQUEST stated in 2018 in 'Still Dying on the Inside':

    "The women who end up in prison are amongst the most powerless and disadvantaged in society largely due to traumatic life experiences of: sexual and physical abuse, domestic violence, exploitation, periods of homelessness, institutional care, self-harm, educational disadvantage, trafficking, racism, drug and alcohol misuse and mental illness, underpinned by poverty and inequality."[23]

28. Therefore, trauma-informed services need to be integrated with each other, be gender and culturally specific, be constructed *outside* prison and recognise institutionalised racism and sexism, key points which are either missing or are underdeveloped in the White Paper.

Transparency and Accountability

29. Chapter Six discusses transparency and accountability. This is another significant, missed opportunity. The White Paper makes prison governors responsible for delivering policy to an unacceptable level in terms of their own health and safety. It further emphasises the role of Key Performance Indicators (KPIs) in measuring performance. However, KPIs

[21] INQUEST, Deaths in women's prisons, https://www.inquest.org.uk/deaths-in-womens-prisons, January 2022

22 Coles, D., Failing healthcare in jails is killing female prisoners, The Guardian, https://www.theguardian.com/commentisfree/2019/apr/05/healthcare-jails-killing-female-prisoners-black-women-annabella-landsberg, April 2019

[23] INQUEST, Still Dying on the Inside: Examining deaths in women's prisons, https://www.inquest.org.uk/still-dying-on-the-inside-report, May 2018

have been tried previously in the criminal justice system and have proved to be problematic.[24] Even if KPI data were accepted as an adequate tool for measuring performance, there is no mechanism for independently verifying these data, nor do they always reflect how relationships work and the kind of regime in operation in individual prisons.

30. INQUEST'S casework has shown that there is an enduring, significant democratic deficit in terms of holding the state to account for deaths in custody.[25] Not only is there a deeply ingrained culture of immunity and impunity which remains embedded in many prisons, but also the mechanisms for ensuring oversight and accountability are brittle. Recommendations made by HMI Prisons which are designed to make individual prisons accountable are often not implemented, partially implemented or simply ignored.

31. This was a key issue addressed by HM Chief Inspector of Prisons and which is ignored in the White Paper. In his final annual report as HM Chief Inspector Peter Clarke pointed to the lack of progress in this area. He noted that even when he had issued Urgent Notifications concerning particular prisons, they had been slow to respond. In the case of Bedford prison's record on keeping prisoners safe:

"Work to address weaknesses in suicide and self-harm prevention processes had been far too slow to develop following the Urgent Notification issued in September 2018. Leadership of safer custody had been weak, having been led by four different managers since the inspection. A strategy had only just been published but even this did not adequately address the unique challenges faced by the prison."[26]

32. In the case of Exeter:

"Equality and diversity had not been prioritised, despite being the subject of a main recommendation. Nobody had been leading in this area until the equality adviser took up post in January 2019 and, until that point, there had been little meaningful work to

[24] Prison Reform Trust, A Measure of Success: An analysis of the Prison Service's performance against its Key Performance Indicators 2003-2004, http://www.prisonreformtrust.org.uk/Portals/0/Documents/A%20Measure%20of%20Success%202004%20-%20KPIs.pdf, August 2004

[25] See, for example, INQUEST submission to the Justice Committee Prison Governance Inquiry, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=d3257f83-8ead-4a95-be71-816910d155bd, May 2019

[26] HMI Prisons, Annual Report 2019 -20, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/927361/hmi-prisons-annual-report-accounts-201920.pdf, October 2020

understand and respond to the needs of prisoners with protected characteristics. The first equality action team meeting for a year took place in April 2019 but without prisoner representation."[27]

33. In terms of the Inspectorate's recommendations more generally:

"Overall, progress had not been satisfactory. Inspectors found that insufficient or no meaningful progress had been made against half (50%) of the recommendations reviewed. Inspectors judged that no meaningful progress had been made against 18%, insufficient progress against 32%, reasonable progress against 29% and good progress against 21%."[28]

34. In October 2019, Parliament's Justice Committee heard evidence from a number of witnesses who:

"raised concerns about the effectiveness of the oversight regime, particularly HMPPS's [Her Majesty's Prison and Probation Service] poor response to HMIP recommendations. Peter Clarke, [the former Chief Inspector of Prisons] said that 2018–19 was the third year running that fewer recommendations were achieved than not achieved. He said that 'When you look at the five prisons [now six] that have so far been subjected to the urgent notification process, one of the common factors is an utterly appalling response to recommendations in the past. How that was allowed to happen for so long is still something of a mystery to me, but I hope that in the future transparency and accountability is seen as a strength, not a weakness, on the part of the Prison Service.' He felt there needed to be better support and intervention from senior leadership to demand a better, more positive response from local establishments and agreed that responsibility for that sat with HMPPS and the Ministry."[29]

35. In January 2020, INQUEST published 'Deaths in Prison: A National Scandal'. In contrast to the White Paper, this document outlined a clear strategy for developing mechanisms to make prison staff responsible and democratically accountable for deaths in custody. Post-death investigations and inquests into state related deaths show time and time again that many are preventable and are the result of neglect and systemic failings in care. Officials and Ministers repeat the empty words that 'lessons will be learned'. Yet

[27] Ibid

[28] Ibid p. 23

[29] The Justice Committee, Prison Governance, https://publications.parliament.uk/pa/cm201919/cmselect/cmjust/191/19109.htm, October 2019

the recommendations of coroners, independent reviews, investigations and inspections are being systematically ignored. Our recommendations for change are as follows:

- **Establish a 'National Oversight Mechanism'.** This proposes a new and independent body tasked with the duty to collate, analyse and monitor learning and implementation arising out of post death investigations, inquiries and inquests. This body must be accountable to parliament to ensure the advantage of parliamentary oversight and debate. It should provide a role for bereaved families and community groups to voice concerns and provide a mandate for its work.

- **Ensure accountability for institutional failings that lead to deaths in prison.** For example, full consideration should be given to prosecutions under the Corporate Manslaughter and Corporate Homicide Act, where ongoing failures are identified and the prison service and health providers have been forewarned. The reintroduction of The Public Authority (Accountability) Bill would also establish a statutory duty of candour on state authorities and officers and private entities.[30]

36. These recommendations are not considered in the White Paper.

Deaths in the Community

37. Chapter Three discusses the transition from prison to the community. Resettlement Passports are proposed as the vehicle for reforming the current situation. But this proposal raises significant issues. As the leading criminologist Stanley Cohen observed in the 1980s, alternatives to custody may simply lead to a further extension of surveillance and widening of the punishment net into the community with the risk that more people will be drawn into the criminal justice system. [31] If so, this could lead to greater social exclusion for those who do not have such a passport, thereby creating a new hurdle for their social inclusion.

38. INQUEST has concerns about deaths of people on post-custody supervision following release from prison and has made a number of recommendations for reducing the catalogue of deaths in this area. There has been a historical lack of scrutiny of who is

[30] INQUEST, Deaths in prison: A national scandal, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=bb400a0b-3f79-44be-81b2-281def0b924b, January 2020

[31] Cohen, S, Visions of Social Control, Cambridge: Polity Press, 1985

dying, the broader context in which these deaths take place and the inadequacies of housing and community support. INQUEST's recommendations to prevent deaths of people on post-custody supervision include:

- **National review.** The government should proceed with its national review of deaths of people on post-release supervision in the community following a custodial sentence to establish the scale, nature and cause of the problem.
- **Data.** More detailed and accurate data should be made available on such deaths, along with regular reporting to the Minister responsible and Parliament alongside the publication of an annual report.
- **Investigations.** Deaths of people on post custody supervision should be investigated by an independent body with adequate resources allocated to allow this to happen. There needs to be a threshold for this with a range of factors taken into account.
- **Improved scrutiny and learning.** The Government needs to confirm oversight at a local and national level.[32]

39. These recommendations are not considered in the White Paper.

Conclusion

40. The White Paper is a significant missed opportunity to break with the past and develop an alternative set of prison policies which would reduce crime, protect the public, ensure the safety of prisoners and staff and reduce victimisation. Failing to draw upon a considerable evidence-base and wedded to an ideological commitment that the key to "bring[ing] down stubbornly high rates of reoffending, cut crime and protect the public from harm" (Page 4) is the expansion of the prison estate, this White Paper repeats the same errors which have been made in the past. It also supports policies which have failed to build and deliver a safe and secure environment for prisoners, their families and for the wider society. In INQUEST's view, and based upon evidence we have accumulated over 40 years, the prison expansionist policies suggested in the White Paper simply will not work.

[32] INQUEST, Deaths of people following release from prison, https://www.inquest.org.uk/deaths-following-release-from-prison-report November 2019

41. Indeed, we fear that the combination of increased criminalization, net widening and the impact of austerity and inequality on services in the community – particularly in the provision of services around mental health and substance misuse – will mean more and more people will be drawn into the criminal justice system with predictably devastating consequences for prisoners and their families.