INQUEST response to the Independent Review of Sentencing 2024 - 2025

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 police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. This includes work around the Hillsborough football disaster and the Grenfell Tower Fire.

2. INQUEST have published numerous evidence-based reports and submissions on the issues arising from deaths in prison. We have also provided a unique overview of the investigation and inquest process as well as the role of inspection and monitoring bodies.[1] Our Director Deborah Coles represents INQUEST on the Ministerial Board on Deaths in Custody and was formerly a member of the Independent Advisory Panel on Deaths in Custody.

3. INQUEST's response to this Review references a recent cases which show the detrimental impact of certain sentencing decisions on both prisoners and the families of those who have died. Our response highlights cases which involve the use of recall, short sentences and post custody supervision and outlines the impact of custodial sentences on different groups such as women, people with mental ill health and neurodivergent people. It is disappointing that remand and Imprisonment for Public Protection sentences will not be considered as part of this Review and we urge the Government to act on the recommendations of previous reviews on both areas.[2]

4. INQUEST notes that this Review takes place in the context of a broken prison system with alarmingly high rates of death and self-harm: according to INQUEST's casework and monitoring there were 309 deaths in prison in 2024[3] and the latest official statistics show self-harm rates rose 13% across the estate to a new peak.[4] Against a backdrop of increases to the prison population[5] and average length of sentences[6], HMI Prisons issued four Urgent Notifications in the last reporting year and two-thirds of Independent Monitoring Boards described the physical conditions in

[1] See the INQUEST's website for more information, https://www.inquest.org.uk/justice
[2] See Justice Committee, *IPP sentences*, https://committees.parliament.uk/publications/28825/documents/173974/default/, 22 September 2022 and Justice Committee, *The role of adult custodial remand in the criminal justice system*, https://committees.parliament.uk/publications/33530/documents/182421/default/, 10 January 2023
[3] These figures were last updated 31 December. For more information see INQUEST's Deaths in Prison statistics webpage, https://www.inquest.org.uk/deaths-in-prison
[4] Ministry of Justice, *Safety in Custody statistics*, https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2024/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-september-2024-assaults-and-self-harm-to-june-2024, 31 October 2024
[5] Ministry of Justice, *Prison Population Projections 2024 to 2029, England and Wales,* https://assets.publishing.service.gov.uk/media/6750480cd12a2dad3bc97a80/Prison_Population_Projections_2024_to_2029.pdf
[6] Howard League for Penal Reform, Sentence Inflation: a judicial critique, https://howardleague.org/wp-content/uploads/2024/09/Sentencing-inflation-a-judicial-critique__September-2024-1.pdf, September 2024

prisons as "inhumane".[7] Further, it is well-established the crisis in the criminal justice system impacts people distinctly: Black and racialised people are over-represented in the prison population[8] and INQUEST's work has highlighted how their deaths are some of the most violent, contentious and neglectful in the prison estate.[9]

5. Therefore, while INQUEST welcome this Review's commitment to exploring greater use of non-custodial sentences, it is clear the Government must also consider wider changes to radically change the criminal justice system. Namely, INQUEST believes the Government should adopt a transformative approach to the criminal justice system by dramatically reducing the prison population, redirecting resources away from the prison estate and prison building programme and increasing investment in welfare, health, housing, education and social care to prevent future deaths in prison.

Theme 6: Progression of custodial sentences

Q6: *How should we reform the way offenders progress through their custodial sentences to ensure we are delivering justice and improving outcomes for offenders, victims, and communities?*

Recall

6. This Review asks for evidence on the system for recalling people to prison and the circumstances under which recall occurs. The statistics on recall not only evidence growing numbers but a system which often acts unfairly. Recent data has shown a sharp increase in the number of individuals being recalled to custody: the Institute of Government reported the number of people released and then recalled to prison has risen by 72% since 2019, accounting for 14% of the total prison population.[10] Of the 9,782 license recalls between April and June 2024, the majority were recalled *not* because they had committed further offences but for "non-compliance". As the official statistics note, "about 24% [of 9,782] involved a charge of further offending, 77% involved non-compliance, 36% involved failure to keep in touch, and 23% involved failure to reside."[11]

7. INQUEST is aware of cases of deaths of people recalled to prison which also highlight major issues in the system, such as the self-inflicted death of Mark

[7] National Preventive Mechanism, *Monitoring places of detention 15th Annual Report of the United Kingdom's National Preventive Mechanism 2023/24*, https://cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com/uploads/sites/23/2024/12/UK-NPM-15th-Annual-Report.pdf, December 2024
[8] Ministry of Justice, *Statistics on Ethnicity and the Criminal Justice System 2020,* https://assets.publishing.service.gov.uk/media/61a8705ad3bf7f055b29350c/Statistics_on_Ethnicity_and_the_Criminal_Justice_Sysytem_2020.pdf, 2 December 2021
[9] INQUEST, *Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination*, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b7f9a0d0-0f48-48a2-b995-c8870f5a5e6a, 12 October 2022
[10] Institute for Government, *The crisis in prisons,* https://www.instituteforgovernment.org.uk/publication/crisis-prisons, 3 July 2024
[11] Ministry of Justice & HMPPS, *Offender management statistics quarterly: April to June 2024*, https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-april-to-june-2024/offender-management-statistics-quarterly-april-to-june-2024, 31 October 2024

Culverhouse in HMP Woodhill.[12] Mark was recalled to prison during hospitalisation following a period of mental health crisis. Mark told officials that if he was returned to prison he would take his own life. However, Mark had no time left to serve on his license and should have been immediately released. This did not happen because there were no administrative staff working in the prison over the Easter bank holiday. The jury into Mark's inquest found the recall system to be defective as Mark was unlawfully detained for several days; a fact which the coroner found had "a clear link" with his self-inflicted death. The coroner investigating Mark's death stated that release dates should be calculated prior to a prisoner's recall to avoid unlawful detention[13] but this recommendation was rejected by HMPPS.[14]

8. Similarly, Luke Clarke was recalled to prison for failing to comply with all his license conditions in April 2020, despite being in the midst of a psychotic episode with one psychiatrist recommending he be detained under the Mental Health Act. Luke was also understood to have contracted Covid-19.[15] While in prison, no Assessment, Care in Custody and Teamwork plan (an ACCT) was opened for Luke and there were few checks made during his first night. Luke was later found ligatured in his cell. The jury at the inquest into his death concluded that fear and confusion generated by Covid-19, inadequate care by prison staff and a lack of liaison between the prison and hospital contributed to his death.

9. Nathan Forrester died in HMP Thameside July 2019 just one day after arriving in the prison on recall.[16] Nathan was drug dependent for much of his life and served short sentences in prison between 2017 and 2019 for offences related to funding his drug habits. He had engaged with treatment and rehab over the years, including while on probation, but sadly this did not have a sustained effect. He was recalled to prison in July 2019 and was noted to be withdrawing from drugs. Nathan was later found by his cellmate not to be breathing. The coroner investigating his death stated that the resuscitation attempts were of very poor quality and issued a related Prevention of Future Death report (PFD).

10. As the above cases highlight, recall to prison can be extremely disruptive and may exacerbate an individual's mental ill health. It is also clear that prisons are not equipped to address the needs of those recalled to custody and INQUEST is concerned by the use of recall for individuals in the midst of a mental health or drug related crisis.

Post custody supervision

[12] For more information see INQUEST's press release following the conclusion of the inquest into the death of Mark Culverhouse, https://www.inquest.org.uk/mark-culverhouse-closes, 24 May 2021
[13] Report to Prevent Future Deaths following the inquest into the death of Mark Culverhouse, https://www.judiciary.uk/wp-content/uploads/2021/06/Mark-Culverhouse-2021-0189.pdf
[14] Letter from HMPPS to HM Senior Coroner for Milton Keynes regarding the death of Mark Culverhouse, https://www.judiciary.uk/wp-content/uploads/2021/06/2021-0189-Response-from-HMPPS_Published.pdf
[15] For more information see INQUEST's press release following the conclusion of the death of Luke Clarke, https://www.inquest.org.uk/luke-clarke-inquest-closes, 25 August 2023
[16] For more information see INQUEST's press release following the conclusion of the death of Nathan Forrester, https://www.inquest.org.uk/nathan-forrester-inquest-closes, 20 January 2023

11. This Review asks for evidence on post sentence supervision and "how probation resource can be most effectively targeted". INQUEST's research on the deaths of individuals released from prison has shown a high number of self-inflicted deaths, particularly of women. Further, our work emphasises the need for greater independent investigation and scrutiny of these deaths.

12. Research carried out by INQUEST in 2019[17] found the number of deaths of prisoners released into the community outstripped the increase in probation caseload. Although the probation caseload doubled, almost five times more people died. People on post release supervision appear to be particularly at risk of dying from a self-inflicted death when compared to other groups, with the self-inflicted death rate fifteen times higher than that of the general population. Further, we found that the self-inflicted death rate amongst women on post release supervision was 459/100,000 in 2018/19, whereas the suicide rate among women in the general population was 4.6/100,000, suggesting that women are at a significantly greater risk of taking their own lives. More recent figures show that from April 2023 to March 2024, there were 1,404 deaths of offenders in the community, a decrease of 10% from the previous financial year. 28 per-cent of these deaths were self-inflicted.[18]

13. As our report notes, a key reason for the increase in probation cases was the Offender Rehabilitation Act 2014 which expanded probation supervision to include those on a custodial sentence of less than one year. Typically, those on short sentences are more likely to lead disruptive lives and face distinct vulnerabilities, which will have an impact on the mortality rate. Research also suggests that self-inflicted deaths are potentially linked to difficulties relating to the probation sentence, the impact of legal proceedings and changes in supervision.

14. Further, there is a comparative lack of scrutiny of post custody deaths: in 2023/24, the Prison and Probation Ombudsman commenced investigations into 360 deaths, of which only 53 related to post release deaths. It is worth remembering that there were 608 deaths of people on post custody supervision in the last reporting year (until March 2024) which serves to illustrate the lack of oversight in this area.[19]

15. While we welcome steps toward reducing the use of prison, it is critical the Government consider how further changes to the sentencing framework, such as for those facing a short custodial sentence, might impact the post custody supervision demographic and ensure adequate resources are available to support people given

[17] INQUEST, *Deaths of people following release from prison*, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=4ffc0329-5088-4708-b0e2-8d76444c92d7, November 2019
[18] Ministry of Justice, *Deaths of offenders in the community, annual update to March 2024,* https://www.gov.uk/government/statistics/deaths-of-offenders-in-the-community-annual-update-to-march-2024/deaths-of-offenders-in-the-community-annual-update-to-march-2024#:~:text=The%20number%20of%20offenders%20who,deaths)%20over%20the%20same%20period., 31 October 2024
[19] Prison and Probation Ombudsman, *Annual Report 2023/24*, https://cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com/uploads/sites/14/2024/07/15.131_PPO_ARA_2023-24_V6_WEB1.pdf

the known risks to, and rates of death of, this group. Further, it is important these deaths are independently investigated and scrutinised so potential failings in this part of the justice system can be addressed.

Theme 7: Individual needs of victims and offenders

Q7: *What, if any, changes are needed in sentencing to meet the individual needs of different victims and offenders and to drive better outcomes?*

16. INQUEST's casework has shown how the harms of imprisonment are widespread, impacting many different types of prisoners as well as their families. However, our casework has also shown the distinct impact of prison on particular groups, such as women, people with mental ill health and neurodivergent people. INQUEST have previously evidenced the impact of prison on Black and racialised people and we echo The Traveller Movement's recommendation that data on the race and ethnicity of people who receive a custodial sentence is improved to ensure proper scrutiny of sentencing patterns.

17. While it is rare for coroners to comment on issues of sentencing following a death in prison, we believe the below cases indicate the inappropriate use of prison where known risks of a custodial sentence have not been appropriately considered.

18. The deaths of women in prison, for example, show failures within the sentencing regime to properly account for the risk of prison for women. INQUEST's work on the deaths of women in prison has repeatedly shown that women who end up in prison are among the most powerless and disadvantaged in our society, largely due to traumatic life experiences such as sexual and physical abuse, mental and physical ill health, racism and discrimination, underpinned by poverty and inequality.[20] INQUEST also endorses Level-Up's response to this Review which provides evidence on the risks of imprisonment for pregnant women and mothers.

19. The self-inflicted death of 55-year-old Christine McDonald highlights the risks of a custodial sentence to vulnerable women.[21] Christine suffered from an opiate addiction and was serving a 12-week sentence in HMP Styal for convictions related to her addiction. The sentence had a huge impact on Christine and caused severe disruption to her life and family relationships. The jury at the inquest into Christine's death found it was contributed to by neglect due to a gross failure to attend to Christine's cell bell call and provide her with the necessary care.

[20] For more information, see INQUEST's report *Still Dying on the Inside, : Examining deaths in women's prisons,* https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=8d39dc1d-02f7-48eb-b9ac-2c063d01656a, May 2018 & INQUEST's written evidence to the Justice Committee inquiry on women in prison, https://committees.parliament.uk/writtenevidence/36829/pdf/, June 2021

[21] For more information, see INQUEST's press release following the conclusion of the inquest into the death of Chrstine McDonald, https://www.inquest.org.uk/christine-mcdonald-inquest-concludes, 10 May 2024

20. The death of 18-year-old Anneliese Sanderson - also in HMP Styal - shows the misuse of prison.[22] Annelise had a complex history of mental ill health, self-harm and suicide attempts. She had spent time in local authority care and had experienced significant trauma. In June 2020, shortly after turning 18, Annelise was arrested after she was witnessed trying to drink or pour petrol on herself at a petrol station and had assaulted emergency workers who tried to intervene. She was very unwell and was taken to A&E before being transferred to court. She was subsequently sentenced to 52 weeks in prison and was found ligatured in her cell in December 2020.

21. This Review will no doubt be aware of Baroness Corston's 2007 report following a string of deaths at HMP Styal.[23] In this report, Corston criticises the inappropriate use of short sentences for women, stating she was:
    a. "*dismayed to see so many women frequently sentenced for short periods of time for very minor offences, causing chaos and disruption to their lives and families, without any realistic chance of addressing the causes of their criminality*".

22. It is regrettable to see the same sentencing patterns repeated almost two decades after Corston's report, such as in the two cases cited above. The fact there was a 6% increase in self-harm incidents in the women's estate (as of June 2024)[24] and six deaths in women's prisons (as of December 2024)[25] evidences the need to stop the use of prison for women. INQUEST believes the Government should divert women away from the criminal justice system and commit to the funding of refuges and rape crisis centres, drug and alcohol support services, gender appropriate community services and small community based therapeutic centres. INQUEST welcomes the Government's initiative of a Women's Justice Board with the aim to divert women from custody, yet we note that practical initiatives designed to support this, such as women's centres, have reported uncertainty about their future funding despite evidence on their positive impact.[26] It is vital that existing projects which support women outside of the criminal justice system are fully funded by the Government.

People with mental ill health and neurodivergent people

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[22] For more information, see INQUEST's press release following the conclusion of the inquest into the death of Annelise Sanderson, https://www.inquest.org.uk/annelise-sanderson-inquest-closes, 19 January 2024

[23] A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system, https://prisonreformtrust.org.uk/wp-content/uploads/2022/08/The-Corston-Report.pdf

[24] Ministry of Justice, *Safety in Custody statistics*, https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2024/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-september-2024-assaults-and-self-harm-to-june-2024, 31 October 2024

[25] At the time of writing, INQUEST's statistics webpage references five deaths in women's prisons. However, we are aware of news reports of a further death at HMP Styal on Christmas Eve 2024. See INQUEST's webpage https://www.inquest.org.uk/deaths-in-womens-prisons and coverage in the Manchester Evening News for more information, https://www.manchestereveningnews.co.uk/news/greater-manchester-news/inmate-styal-prison-found-dead-30670740.

[26] The Guardian, *Funding gap for women's centres will mean more prison sentences, experts warn*, https://www.theguardian.com/society/2024/dec/22/womens-centres-england-and-wales-funding-gap-more-prison-sentences-experts-warn, 22 December 2024

23. It is well documented that prisons can exacerbate an individual's mental ill health and are often poorly equipped to address mental health concerns.[27] INQUEST have worked on many cases where an individual has been sentenced to prison despite knowledge of severe mental illness and/or during a mental health crisis.

24. The death of 25-year-old Andrew Shirley at HMP Hewell makes clear the need to properly consider an individual's mental health prior to sentencing.[28] Warwickshire police arrested Andrew in March 2021. Despite expressing suicidal thoughts, an intent to harm himself and concerns that his anti-psychotic medication wasn't working, he was found fit to be detained in prison and was later remanded to HMP Hewell. The nurse assigned to be Andrew's care coordinator in prison failed to read key entries in his medical notes, conduct any mental health assessment or put in place a care plan in the three weeks Andrew was in prison. Andrew died from a self-inflicted death while in the prison's segregation unit. The inquest into his death found there were a series of failures to provide the most basic care to Andrew and that no member of healthcare staff understood or took any steps to mitigate the risk that he might pose to himself.

25. INQUEST have also worked on cases whereby sentencing has proved harmful for neurodivergent people, and not enough has been done to properly consider how a custodial sentence will impact their condition. The recently concluded inquest into the death of Kay Melhuish, 36, at HMP Eastwood Park highlights these concerns.[29] Kay had mental ill health and was diagnosed with autism, ADHD and complex post-traumatic stress disorder. Her autism meant that she was sensorily sensitive, in particular to noise. When she was remanded to prison in 2022, professionals wrote to express concern about her risk of suicide and warn staff about how difficult Kay would find the prison environment. The inquest into her death heard how almost no staff read the communication plan prepared by the prison's neurodiversity practitioner. It is clear, therefore, that the prison was ill-equipped to address Kay's autism, a factor which fails to have been considered in her sentencing decisions.

26. More needs to be done to prevent the imprisonment of seriously unwell people who are at increased risk from a custodial sentence. INQUEST welcome reforms to the Mental Health Act to both remove prisons as a place of safety and introduce a time limit to transfers to psychiatric facilities. However, more must be done to strengthen the presumption against detention particularly in cases concerning mental ill health and neurodivergence to prevent future deaths.

Short sentences

[27] See, for example, INQUEST's response to the Justice Committee's inquiry into mental health in prison, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=74dc9177-91fd-4f17-b0c0-6a3d871d1a83, June 2021

[28] For more information, see INQUEST's press release following the conclusion of the inquest into the death of Andrew Shirley, https://www.inquest.org.uk/andrew-shirley-inquest, 20 January 2023

[29] For more information, see INQUEST's press release following the conclusion of the inquest into the death of Kayleigh Melhuish, https://www.inquest.org.uk/kay-melhuish-jury-finds-neglect-led-to-self-inflicted-death-of-an-autistic-woman-at-hmp-eastwood-park

27. The impact of short sentences is manifold across INQUEST's casework and further highlights the inability of prisons to provide appropriate mental or physical healthcare. This should be evidence of the need to stop the use of short custodial sentences. For example, Floyd Caruthers was sentenced to prison for just 66 days for breaching an Anti-Social Behaviour Injunction. The judge at his sentencing said there was "no evidence of any criminality".[30] In prison, Floyd was found to have an infected heart valve and did not eat for four days, but no medical personnel were called.

Conclusion

28. The prison environment is one which dehumanises and is in and of itself dangerous, as shown by the data on self-harm and self-inflicted deaths. It is worth noting that 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 with a systemic failure to enact changes in response to inquests, investigations, inspectorate, and monitoring reports.

29. INQUEST believe that, in the short-term, urgent action is needed to ensure people in prison have access to healthcare and other forms of adequate support. In the long term, we believe the Government should commit to a dramatic reduction of the prison population and more investment in alternatives to custody and public services which help address the root causes of crime and violence in society, including health, housing, education and social care.

[30] The Justice Gap, *Every four days someone take their own life in a UK prison,* https://www.thejusticegap.com/every-four-days-someone-takes-their-own-life-in-a-uk-prison/, 11 October 2024. See also INQUEST's press release following the conclusion of the inquest into the death of Floyd Carruthers, https://www.inquest.org.uk/floyd-inquest-concludes, 22 December 2022