INQUEST
TRUTH, JUSTICE & ACCOUNTABILITY

# INQUEST Submission to the Joint Committee on Human Rights: Inquiry into Mental Health and Deaths in Prison

March 2017

POLICY • ADVICE • CAMPAIGNS

# 1.0 Introduction

*Bereaved families repeatedly tell us that they want change in order to safeguard lives in the future. What is incomprehensible to them are repeated failings.*

INQUEST welcomes this inquiry. Our specialist casework on deaths in prison and associated policy work indicates that the state is reneging on its obligations under Article 2 of the European Convention of Human Rights. In failing to enforce safeguarding mechanisms, and delivering a duty of care, human rights are being violated. Our work also raises questions about the excessive and inappropriate use of custody.

Inquests repeatedly identify the failure to implement existing guidelines on the care of those at risk. A prisoner takes their own life every three to four days. Deaths occur because of inadequate medical treatment, a lack of care, neglect and inhuman treatment. Prison policies have been exposed as woefully inadequate in protecting human life. However, nothing fundamentally changes.

Bereaved families repeatedly tell us that they want change in order to safeguard lives in the future. What is incomprehensible to them are repeated failings:

> *Having seen the PPO and coroners make 'recommendations' that are time and time again not implemented, I feel hopeless, particularly when I see increased numbers of prison suicides. If people actually followed policy, implemented changes and learnt from practice there might be some hope* (Family member cited in INQUEST, 2015:34).

INQUEST has consistently made recommendations which have been ignored. This raises significant questions about democratic accountability, and the individual and collective failure of those who work in prisons to implement a safe and secure environment.

In 2004, in our evidence to the Joint Committee on Human Rights Inquiry into Deaths in Custody we stated that:

> *INQUEST has been frustrated by the failure to learn the lessons from deaths occurring in different custodial settings and the lack of joined-up learning between agencies. In our view this has resulted in more deaths occurring because of the failure to approach this serious human rights issue in a holistic way.* (INQUEST, 2004: 3)

Over a decade on, little has changed. What is needed is radical action from government which recognises that, despite the strenuous and principled efforts of some staff to provide care for prisoners with mental health conditions, there are systemic problems in delivering this care. Prisons are failing to safeguard prisoners, failing to deliver justice to devastated families and failing to offer protection to the wider community through reducing victimisation and recidivism.

# 2.0 The nature of the problem

INQUEST's extensive policy and casework, as well as recent reports from the Equality and Human Rights Commission (EHRC) (2015), the Harris Review (Secretary of State for Justice, 2015) and the Prisons and Probation Ombudsman (PPO) (2016), have consistently demonstrated a catalogue of errors and policy failures around the deaths of those with mental health conditions, and deaths in prison, more generally.

Since 1 January 2010, there have been 1673 deaths in prisons in England and Wales. Of these, 554 were self-inflicted, of which 26 (5%) were women, 76 (14%) were Black and Minority Ethnic prisoners, 88 (16%) were aged 18-24 and 3 (1%) were children (inquest.org.uk).

A review of our casework between 2014 and 2016, inquest jury findings and coroners' prevention of death reports, reveal the following concerns:

- failings in early intervention support and diversion from custody, in particular, for those with mental health issues;
- the use of prison for those charged with offences such as arson or other serious offences when the offence was related to their attempts to harm themselves;
- concerns about sentencing and allocation – magistrates and judges are still sending people to prison for their own safety, or for psychiatric reports, thus failing to consider non-custodial options;
- the failure of the Crown Prosecution Service (CPS) in relation to charging decisions;
- prison is not being used as a place of last resort;
- perfunctory screening assessments and inadequate record keeping worsened by a prison culture where over worked staff are over reliant on a tick box culture;
- failure to consider information on the PER form;
- the failure of the 'Assessment, Care in Custody and Teamwork' (ACCT) process to mitigate the punitive, and often inflexible nature, of prison regimes. Inquests frequently comment on the failings of this process;
- over-reliance on self-presentation by officers and healthcare staff;
- chronic under-resourcing and a reduction in staff capacity, morale and training, thus leading to an inability to support and detect prisoners at risk; there is no longer mandatory suicide prevention training;
- lack of staff training in mental health awareness and in the ACCT process;
- systemic lack of coordination and information exchange within prisons, between prisons and between prisons and outside agencies;

- a disconnect between prison policy and practice, a failure to adhere to national policies and practices; in particular, the on-going failure to implement policies to safeguard vulnerable detainees;

- observations not adhered to or reassessed;

- support for vulnerable prisoners was missing, particularly at crucial points such as at induction, and on many occasions a personal officer was not assigned to those at risk;

- a disturbingly high and ever increasing prison population;

- unsafe cells and access to dangerous ligature points;

- vulnerable individuals being placed in brutalising regimes, characterized by widespread violence, bullying, segregation and drug use;

- prisons ill resourced and ill-suited to meet the basic needs of detainees, those with mental health problems, children, women and others who are particularly vulnerable to suicide and self-harm;

- rehabilitation efforts being continually undermined through a lack of investment and reduction in resources resulting in poor staff training, overcrowded, bleak and unmanageable prison environments, with high levels of violence, fear and increased prisoner isolation due to long lock up hours;

- IPP prisoners and the impact on their mental health due to the uncertainty around their release date;

- inadequate and inappropriate health care and medical treatment including problems with prescriptions and monitoring of medication, failure to access mental health assessments and hospital appointments;

- Insufficient staffing levels;

- lengthy waiting times for transfer to secure hospitals where prisoners are often left in segregation;

- issues with primary and secondary healthcare providers and the involvement of the private sector with the concern that profits come before safety;

- inappropriate use of segregation, in particular for prisoners with mental health problems or on an ACCT; prisoners being left isolated in bare cells;

- behaviour associated with mental ill health is seen as a disciplinary issue and the use of segregation because of insufficient staff on normal location;

- failures to involve the family or carers in supporting prisoners at risk reinforced by the associated difficulty of passing family concerns on to the prison;

- systemic failure in provision of meaningful activity, education, training and therapeutic support contributing to impoverished environments, lack of access to exercise and fresh air, clean clothing, showers and associated high levels of self-harm and suicide.

Appendix One of this submission demonstrates many of these issues through summaries of some of our casework. It is these abject failures which have contributed to feelings of insecurity and anxiety felt not only by prisoners with

mental health conditions. As the review by Lord Harris recognised, all prisoners are potentially vulnerable to self-inflicted death (Secretary of State for Justice, 2015). Prisons by their very nature are dehumanising places which create and intensify vulnerability which is exacerbated by the separation from family and friends, endemic violence, bullying, loneliness and isolation. The increasing levels of self-inflicted deaths and self-harm reflect the deleterious impact of the prison experience.

There are a number of policies which, if implemented, would fundamentally change the current baleful situation. We highlight four here.

## 2.1 The failures of intra- and cross-organisational learning

It is now abundantly clear that there are serious, long-term deficiencies in the level of both intra- and inter-organisational learning around deaths in prison. One of the striking features of our work is the repeated experience of attending inquest after inquest where the same issues are identified.

INQUEST believes that it is time to stop making commitments to 'learning lessons' but for these commitments to be translated into practice. As the current Chief Inspector of Prisons has noted:

> *When the inspectorate makes recommendations intended to improve safety in jails, they should be taken seriously. All too often, they are not. I've found it extraordinary that some of the most difficult and challenging prisons we've been to are those where our recommendation[s] have simply not been implemented or apparently not been taken seriously. Some of them are quite shocking – seventy recommendations and perhaps fifteen have been achieved. In one recently we'd made twenty recommendations about safety and only two had been achieved.* (Peter Clarke, cited in James, 2017: 14)

How the State reacts to the deaths of citizens in its care is an indication of how seriously it takes the protection of human rights. One important function of an Article 2 investigation and inquest is that systemic failures and evidence of any inhuman and degrading treatment that relates to the circumstances of the death, alongside the procedural duty to reduce risks and learn lessons, should be examined. Multiple inquests, inquiry reports, Inspectorate and monitoring reports, jury findings and coroners' reports have made recommendations putting the State on notice of risks to the health and safety of people in custody. And yet no framework exists to ensure that these warnings are adequately responded to. This not only discredits the process but creates a culture of complacency.

The Government's response to the Harris Review in December 2015 specifically rejected the recommendations concerning the lack of oversight, accountability and learning lessons on the basis that existing mechanisms were adequate. It also rejected the recommendation that families should receive non-means tested public funding for their legal representation at inquests (https://www.gov.uk/government/news/government-response-to-the-harris-review).

At present, there are fragmented, ad hoc initiatives lacking in continuity. Recommendations are not monitored or followed up in any systematic way. Jury findings are not collated or published and, whilst Coroners' reports are now published, there is no audit or follow-up to ascertain the impact of these reports at a national or local level and there is no power to compel action to be taken. To the extent that change is achieved, it is often not sustained. Actions peter out only to be raised again several years later by different bodies while deaths continue to occur in circumstances involving the same issues and failures.

INQUEST believes that there is an overwhelming case for the creation of a national oversight mechanism tasked with the duty to collate, analyse and monitor learning outcomes and their implementation arising out of custodial deaths. This mechanism would be accountable to Parliament to ensure parliamentary oversight. It must also provide a role for bereaved families and community groups to voice their concerns so providing a mandate for its work (INQUEST, 2012a).

Parliamentary oversight (possibly by a Parliamentary Select Committee) should annually review and monitor inquest conclusions and Prevention of Further Death reports to track issues and trends. All relevant oversight bodies should be required to feed into this review process. The Ministry of Justice should provide a response to the annual review, to ensure a high level of political focus and scrutiny. Sustained learning should be centralized and rolled out nationally rather than locally or regionally.

## 2.2 Accountability and corporate manslaughter

Effective structures of accountability sit at the heart of the reforms needed to fully implement a different approach. Misconduct and disciplinary action, employment consequences and successful prosecutions should play a central role in that change. However, where a criminal offence is suspected in the context of prison deaths, it is INQUEST's view that any target of legal action should not only or necessarily be one or several individuals. Since the causes of such deaths are often systemic and routinized, the CPS should give greater consideration to prosecuting the prison as the body corporate potentially responsible for these deaths.

On 1st September 2011, the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHAct) was extended to the prison service, so that a prison, through the actions or inactions of its senior management, can be accountable for deaths within its walls. A prosecution under the Act requires a failure in the way in which the organization is managed or organized which amounts to a gross breach of its duty of care. This, in turn, requires evidence that the failure fell "far below what can reasonably be expected". That may include considering the "attitudes, policies, and systems of accepted practices" of the organization, while a substantial element of the failure must be at senior management level.

Since 2011, despite the consistent, yearly increase in prison deaths, there has not been a single prosecution under the CMCHAct. It seems almost inconceivable that none of these deaths involved at least sufficient evidence for a prosecution under the Act. In this context, we reiterate the fundamental issue in this submission: namely that a constant stream of inquest findings, inspectorate, investigation and monitoring reports, and inquiries into prisons from Baroness Corston to Lord Harris, reveal systemic failings and have produced rigorous, evidence-based recommendations to protect the health and safety of prisoners and staff. The vast majority of these have been systematically ignored. However, this evidence would strongly indicate that in the case of many deaths in prison, management was likely to be aware of risks to which they failed to respond, a key element of the senior management failure test under the law.

Many deaths in prison appear prima facie to result from gross breaches in the duty of care. The time is overdue for the CMCHAct to be tested there. A successful prosecution would provide a powerful, symbolic message that prison deaths cannot continue without legal accountability. As Lord Ramsbotham has noted:

> *Until and unless named individuals are made responsible and accountable for ensuring that things happen, nothing will happen…As poor and inconsistent management, manifested in the failure to implement lessons learned, is behind most of the findings, I hope that a system is developed*

> *that holds named managers to account for overseeing policy implementation and improving practice.* (cited in INQUEST, 2012b: 11)

## 2.3 Diversion from custody

In 1975, The Butler Committee acknowledged the limitations of health care provision in prison and recommended offenders be diverted to health care services outside prison at the earliest possible opportunity. For Butler, "when there is no risk" to the public:

> *"… the question should always be asked whether any useful purpose would be served by prosecution…these remarks apply in cases of homicide or attempted homicide or grave bodily harm as in less serious cases."* (Butler Committee, 1975: 266)

During the 1980s, Conservative governments developed an explicit policy of diverting offenders with mental health problems from the criminal process. Though this policy failed, the Home Office (1990: para 12.20) confirmed diversion was essential as the very "fact of imprisonment" means prisons "are not conducive to a healing environment". Alongside this, Home Office circular No 66/90 stated in cases of mental disorder "careful consideration should be given to whether prosecution is required by the *public interest*" (emphasis added).

The Woolf Report (1991: para 10.115) also emphasised diversion, noting that "the majority of these offenders, if facilities were available, would be dealt with more appropriately elsewhere than in prison". Emphasis on diversion was further endorsed in Custody, Care and Justice which noted that, *"Prison is not a suitable place for people suffering from serious mental disturbance"* (Home Office, 1991: para 9.9).

The Reed Report (1992 para, 11.74) similarly called for diversion, stating that *"mentally disordered offenders should, wherever appropriate, receive care and treatment from health and personal social services rather than custodial care".*

With the increasing influence of the idea of "healthy" and "heath promoting prisons" in the late 1990s and early 2000s, prisons during this time were considered places suitable for people with mental health problems and consequently calls for diversion waned. In more recent times, there has been a revival of calls for diversion. The influential Bradley Review (2009) called on the government to once again focus on diverting individuals with mental health conditions away from the criminal process. Subsequently the government green paper, Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders, recognised that:

> *The criminal justice system is not always the best place to manage the problems of less serious offenders where their offending is related to their mental health problems*. (Ministry of Justice, 2010: para. 122)

On 27 March 2011, the then Justice Secretary Kenneth Clarke called for a national diversion scheme and for the creation of a "Health and Criminal Justice Programme Liaison and Diversion Development Network" by no later than 2014. This national scheme would coordinate the assessment of mental health problems of offenders and ensure they were undertaken by fully trained staff at police stations and courts. Despite high profile political misgivings, a number of local diversion schemes were put in place by local authorities and the NHS from 2012.

By the beginning of 2016, local diversion policies covered 50% of the population and, in July 2016, it was announced that additional funding had been secured to develop a National Liaison and Diversion Service, with coverage expected to reach 75% of the population by 2018 (NHS England, 2016).

## 2.4 Human rights and mainstreaming mental health policies

The Joint Committee on Human Rights (JCHR) has emphasised its commitment to a human rights-based response to the deaths of prisoners with mental health conditions. INQUEST has always been strongly committed to such an approach, particularly in ensuring that the state complies with Article 2 of the Human Rights Act, the right to life. Sentencing decisions and policy choices which fail to recognise the risks posed by imprisoning a vulnerable group are compromising the obligation of care under Article 2.

INQUEST is clear that approaching self-inflicted deaths through human rights can only be developed if the wider culture of the prison system encourages its nurturing. The principles outlined by the World Health Organisation (WHO) provide the basis for developing a coherent and coordinated approach through:

- diverting people with mental disorders towards the mental health care system;
- providing prisoners with access to appropriate mental health care treatment;
- ensuring the availability of psychosocial support and rationally prescribed psychotropic medication;
- providing training to staff;
- providing information/education to prisoners and their families on mental health issues;
- promoting high standards in prison management;
- encouraging inter-sectoral collaboration;
- promoting the adoption of mental health legislation that protects human rights;
- ensuring that the needs of prisoners are included in national mental health policies and plans (http://www.who.int/mental_health/policy/development/MH&PrisonsFactsheet.pdf).

Building a human rights approach around these principles would also ensure that policies for those with mental health conditions in prisons would be 'mainstreamed' so that these prisoners would have access to services without being stigmatised; that all services involving physical, psychological and emotional support would be coordinated and integrated; that psychological services would have the same parity with other medical specialisms and that all health care professionals would be involved in supporting their diverse needs (Masters et al, 2014).

# 3.0 Conclusions and recommendations

This inquiry is taking place at a moment of profound crisis in the prison system. This, in turn, is having a detrimental impact on the safety and security of prisoners and on those staff who are attempting to work constructively with prisoners.

There is an unacceptable death toll which highlights how the measures and institutional culture that should protect prisoners from human rights abuses have repeatedly failed. Prisons are repositories for some of the most disadvantaged groups in society. They are ineffective and expensive and are failing, as demonstrated by the high reconviction rates. At worst, they further damage prisoners resulting in avoidable deaths.

The policies suggested in this submission will only succeed if there is a serious commitment by government to reduce the severity of sentencing in England and Wales thereby drastically reducing the prison population. High prison populations do not necessarily make for a safer society, as the experience of the USA indicates. For INQUEST, the current debate around prison safety with its constant focus on the use of illegal drugs inside, the cuts to the prison budget and the issue of vulnerability, although very important, misses three key points. First, it obscures the issue about the use of legal drugs in prison, the high rates of medication and their role in controlling prisoners. Second, it obscures the failure of the state to provide a safe and secure environment for all prisoners and not just the vulnerable few. Finally, it ignores the fact that even in the pre-cuts era, the levels of self-inflicted deaths and self-harm were unacceptable. What is required is a new and radical approach.

INQUEST recommends that:

3.1 Prisons should be used only as a last resort for those who present a significant risk to others. They should not be the default response. Diversion to health, welfare and other well-funded community schemes with built-in legal safeguards, is the proper response to deal with the complex needs of those with mental health conditions. In the event that prison is necessary, there should be investment in local and smaller prison units with an emphasis on therapeutic environments managed by well-trained staff. Sentencers must divert individuals with mental health ill health and learning disabilities away the criminal justice system. Treatment and rehabilitation must be the preferred option.

3.2 Local and national diversion schemes should be prioritized built on the principle of prevention. There should be a radical redirection and reallocation of criminal justice resources; in-depth training for all criminal justice personnel in mental health awareness; integrated coordination and communication between criminal justice and social service personnel; and specialist services for women and those from black and minority ethnic communities.

3.3 The principles from the World Health Organisation outlined here provide the basis for developing a coherent, coordinated policy response for those with mental health issues. On such a basis, the human rights of prisoners with mental health conditions can be upheld.

3.4 An effective mechanism in the form of a central oversight body must be stablished as a matter of urgency. This body would be tasked with collating and constantly auditing across the relevant sectors, and report publicly on the accumulated learning from inquest outcomes and those recommendations from PPO investigations, HMIP/IMB recommendations and Coroners' reports pertinent to custodial health and safety. This would ensure greater transparency in terms of tracking whether action has been taken to rectify dangerous practices and systemic failings.

3.5 Where failures are identified, then full consideration should be given to a prosecution under the Corporate Manslaughter and Corporate Homicide Act. The Crown Prosecution Service should prosecute the prison as the body corporate potentially responsible for the death(s) in question.

3.6 To ensure fairness and equality and proper scrutiny of custodial deaths families of the deceased should have access to non-means tested legal aid for representation through the investigation and inquest process.

INQUEST believes that implementing these recommendations will generate a significant reduction in rates of self-harm and self-inflicted deaths amongst those with mental health conditions in prison. They will further their human rights, impact positively on recidivism and victimisation rates and will contribute to a sense of safety and security for prisoners, staff and the wider community.

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## INQUEST, March 2017