INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST submission to
Prison Population 2022: Planning for the future, Justice Committee
January 2018

1. INQUEST welcomes the opportunity to respond to this Justice Committee inquiry. The context is particularly grave and a time of increased public and parliamentary disquiet about the state of prisons and concerns about prison safety.

About INQUEST

2. INQUEST is the only charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. INQUEST's specialist casework focuses on deaths in prison and other forms of detention, and mental health settings, as well as deaths where wider issues of state and corporate accountability are in question, such as Hillsborough and Grenfell Tower. Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people.

3. INQUEST's Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody, and was until recently a member of the Independent Advisory Panel on Deaths in Custody. She was an advisor to the Harris Review into self-inflicted deaths in custody of 18-24 year olds published in 2013, and advisor to the Corston Review on women in prison published in 2007. Many of the recommendations of these reports are outstanding, and relevant to this inquiry. [1]

4. INQUEST has published numerous reports[2] on the failure of state agencies to learn and implement lessons from deaths in custody and prison, including *Stolen Lives and Missed opportunities: The deaths of young adults and children in prison* (March 2015), *Preventing the deaths of women in prison: the need for an alternative approach* (2013), *Learning from Death in Custody Inquests: A New Framework for Action and Accountability* (2012), *Fatally Flawed* (October 2012), and *Dying on the Inside - Examining women's deaths in prison* (2008). These publications remain relevant, particularly due to the failure of successive governments to take seriously, and act upon, recommendations from official inquiries and coroners reports.

5. INQUEST has recently given oral and written evidence to the Joint Committee on Human Rights (JCHR) inquiry on Mental Health and Deaths in Prison. We also contributed to the Council of Europe's Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment (CPT) inspection of UK detention, including prisons, which made a number of recommendations to the UK government.[3] These reports also raise important points, relevant to your inquiry.

Response

6. Deaths are at the sharp end of issues concerning the treatment of those in the criminal justice system. They are often reflective of historic patterns in the characteristics of the prison population, many of whom are vulnerable and disadvantaged members of our society. As such, we will focus on addressing the following questions posed by the committee:
    - 'What is Her Majesty's Prison and Probation Service's current capacity to manage safely and effectively the prison population?'

[1] INQUEST's submissions to these inquiries and links to the final reports are available here.
[2] All INQUEST books and publications are available for free download here.
[3] A summary and link to the CPT report is available here.

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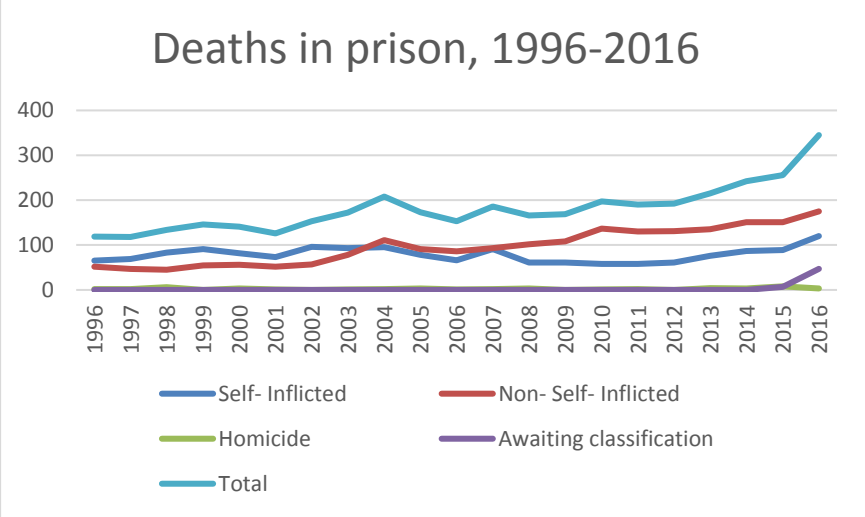
- 'What are the implications of the likely rise in the population for the resources required to manage prisons safely and effectively?'

7. Prisons are unsafe environments. Deaths in prison are an unacceptable, yet persistent long-term feature of the criminal justice system. Continuing deaths are evidence of the inability of successive governments to safely and effectively manage the prison population.

8. In the 20 years between 1996[4] and 2016[5]: the annual number of self-inflicted deaths in prisons in England and Wales ranged between 58 and 96 per annum, until 2016 when there were 120 deaths, the highest number on record. There were 1,653 self-inflicted deaths over the period. Including self-inflicted, non-self-inflicted deaths, and homicides, a total of 3,801 people died in prisons in England and Wales.



9. In 2016, there were a total of 345 deaths in prison, the highest number on record. In 2017, 275 people died in prison; 66 of those deaths were self-inflicted, 149 non-self-inflicted, and two were homicides. A further 58 deaths await classification. While this apparent reduction (pending future reclassifications of deaths) is welcome, the overall figures return to a number consistent with patterns over recent decades. Now is not the time for complacency.

10. Over the last 10 years the number of non-self-inflicted deaths in prison has risen. The rate of 'natural cause' deaths per 1,000 prisoners has gone from 1.06 in 2006, to 1.72 in 2015, and 2.30 in 2016.[6] Rises in the prison population, the vulnerabilities and health needs of those imprisoned, and the ageing prison population are factors. However, we have serious concerns about poor prison healthcare, for both physical and mental health. Conclusions from inquests indicate that poor healthcare provision in prison and the community is a factor in many deaths often registered as 'natural'. A growing ageing prison population will further put pressure on health services.

11. The recent report on Liverpool prison is one of the most damning reports to be written by the Prison Inspectorate. As with Nottingham prison (and the Inspectorate's first use of the Urgent Notification protocol) where the Inspectorate found serious safety failures repeated from earlier inspections, previous recommendations for improving the Liverpool regime have been effectively ignored. We also note that despite all the failures at Liverpool prison, NHS England are cutting the healthcare budget. Since 2011 there

[4] Detailed Home Office statistics pre-1996 are not available. Full stats available on INQUEST website here.
[5] Many recent deaths are not yet classified, so beginning from 2016 is most accurate.
[6] MOJ Safety in custody statistics, Deaths in prison custody 1978 to 2016 (available here)

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have been at least 17 self-inflicted deaths in the prison, many raising concerns about the level of healthcare provided.

12. INQUEST works with the families of the men, women and children who have died in prison. In all cases the state had a duty to care for their relatives. Our monitoring of the investigations and inquests into prison deaths shows that many of these deaths are preventable and the result of systemic failings in care. Each death represents a failure of the state to protect the individual concerned. This contravenes national and international human rights standards, including Article 2 of the European Convention of Human Rights which upholds the right to life.

13. These systemic failures are all the more concerning because the same failings and criticisms have been repeated time and again. Coroner after coroner has highlighted systemic failures and the inappropriate use of prison for a range of groups who simply should not be there. Meanwhile a stream of post-death investigations, inspectorate and monitoring reports and official inquiries into prisons have produced evidence-based recommendations into what needs to change. Too many of these have been systematically ignored.

14. In particular, we note the evidence-based recommendations of the Harris review into self-inflicted deaths in custody (July 2015) and Baroness Corston's review of women in the criminal Justice system (March 2007). Both were set up in response to concerns about prison deaths and were informed by hearing from the families of those who have died in prison about the journey of their loved ones into the criminal justice system and how they had tried to get help from a range of health, education and welfare services.

15. Numerous recent inquest conclusions have reflected widespread concerns about reductions in staffing levels. A small number have also evidenced issues with the management of drugs known as New Psychoactive Substances (NPS) in prison, though the effect of NPS in record death rates has been broadly overstated. Indeed staffing, drugs, drones and mobile phones have been the focus of Government responses and debates on prisons. This obscures the issue of high rates of legally prescribed medication and their role in controlling prisoners, the plight of mentally ill people in prison and the disturbing number of self-inflicted deaths.

16. The continuing and unacceptable death toll in prison cannot solely be attributed to recent policy decisions such as budget cuts, fewer and newer, less experienced staff. The latest crisis has been intensified and worsened by the recent cuts worsening conditions. However, while increased levels of investment may decrease harm for short periods, a long-term view shows that, particularly in terms of self-inflicted death, such reductions in harm will only ever be short-lived.

17. From almost 40 years of specialist casework and monitoring of deaths in prison, it is clear the sources of harm in prisons are systemic: as the data on the numbers of deaths above indicates, deaths have always been an endemic part of the prison system. This speaks to the reality of prisons. It speaks to the way prisons are used as a dumping ground, to warehouse social problems such as mental ill health, addiction, poverty and homelessness. As Lord Harris said in his review, all prisoners are potentially vulnerable as prisons by their very nature are dehumanising places which create and intensify vulnerability, exacerbated by separation from family and friends, endemic violence, bullying, lack of meaningful activity, boredom, loneliness and isolation.

18. Mark Saunders, whose son Dean died in HMP Chelmsford in 2016, joined INQUEST in giving oral evidence to the recent JCHR inquiry on Mental Health and Deaths in Prison.[7] He told the committee: "*In this country*

[7] Joint Committee on Human Rights (Wednesday 8 March 2017), Uncorrected oral evidence: Mental Health and Deaths in Prison. Available: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/mental-health-and-deaths-in-prison/oral/48600.pdf

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we do not give a death sentence, but for everyone who has taken their life in prison that is exactly what they got." Dean was imprisoned on remand during a mental health crisis. An inquest jury found neglect contributed to his death, with serious failings in both mental health care and the prison system. This is sadly a common theme in many inquests, which repeatedly highlight failures to enact safeguarding mechanisms, implement suicide prevention guidelines and deliver a duty of care, sometimes amounting to neglect.[8] Prison policies have been exposed as woefully inadequate in the provision of a safe environment, protecting human life; most acutely during the ongoing crisis.

19. The lessons to be learned from the contents of post death investigations, inquest findings and reports have been too frequently lost in that they were *"analysed poorly or ignored; misunderstood or misconstrued; dissipated or dismissed"* (Coles and Shaw, 2012)[9]. The fact that the same concerns keep being raised suggests a widespread apathy, indifference and institutional resignation from those organisations charged with a duty of care to prisoners. The inability of the current system to deliver sustained change arising from previous deaths allows dangerous practices to linger across the prison putting prisoners at risk. This points to the abrogation of responsibility at all levels of the prison service and successive governments, alongside impunity for institutions linked to the state.

20. Prisons are repositories for some of the most disadvantaged people in society and fail to protect those in its care as shown by our casework. They are also failing victims of crime. More prison places and more prison officers are a tried and tested formula which has had little or no impact on prisoner rehabilitation, public protection or reducing victimisation.

21. These issues can only be addressed with long term, decisive action addressing the excessive and inappropriate use of custody. The government must halt the prison building programme, tackle sentencing policy, promote well-funded alternatives to custody, invest in healthcare, social housing and education. The evidence for each of these actions as more effective, economically rational and socially just than resort to imprisonment is overwhelming. Until there is a dramatic reduction in the use of prison and a redirection of resources into community alternatives, then needless deaths and harms will continue.

RECOMMENDATIONS

22. **Commit to an immediate reduction in the prison population.** Prisons should only be used as a last resort and should not be the default response to social issues, such as disadvantage and ill health. Prisons cannot and should not be used as a place of safety. Probation services are in disarray and there is a lack of confidence in these services. Sentencers need to be subject to regular training and education about alternatives to prison and the availability of voluntary sector services that can offer holistic person centred approaches to those in conflict with the law. Women centred services established in the wake of the Corston report are instructive here, albeit there are concerns about their sustainability due to lack of funding. In the event that some form of confinement is absolutely necessary and only used as a last resort, there should be local and smaller units with an emphasis on therapeutic environments managed by well-trained staff. The recommendations of the Corston Report and Harris review [10]should be urgently reviewed and implemented.

23. **Halt the prison building programme and redirect resources for investment in welfare, health and social care.** Criminal justice resources should be reallocated and invested in drug and alcohol support services,

[8] More information on the death of Dean Saunders is available here. You can explore press releases on similar inquest conclusions here.
[9] Coles, D. & Shaw, H. (2012) Learning from Death in Custody Inquests: A New Framework for Action and Accountability, INQUEST
[10] Corston, J. (2007) A Review of Women with Particular Vulnerabilities in the Criminal Justice System, Home Office

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mental health services, housing and community-based therapeutic centres. Welfare, health and social care in the community is both a humane and sustainable response to dealing with social problems, which cannot be meaningfully addressed through the criminal justice system as illustrated by the revolving door nature of the prison population.

24. **Facilitate diversion from the criminal justice system.** People with mental ill health and learning disabilities must be diverted, and treatment and support must be the preferred option. There should be in-depth training for all criminal justice personnel in mental health; integrated coordination and communication between criminal justice and social service personnel; and specialist services for disadvantaged groups, such as for women and black and minority ethnic communities.

25. **Sentencing policy should be reviewed**. It does not follow that high rates of imprisonment lead to low levels of crime as the experience of the USA indicates. Similarly, it does not follow that low rates of imprisonment lead to high rates of crime as the experience of the Scandinavian countries indicate. We would therefore suggest that the Committee explores the culture of sentencing in England and Wales, its relationship to the rising prison population and its impact, or non-impact on the rate of recorded crime.

26. **Build a national oversight mechanism implementing official recommendations.** The lack of statutory enforcement and oversight of safety recommendations is putting lives at risk. INQUEST believes that there is an overwhelming case for the creation of a national oversight mechanism on deaths in custody. This body would be tasked with monitoring, auditing and reporting on the accumulated learning from post death investigations by the Prison and Probation Ombudsman, inquest outcomes and recommendations from HM Inspectorate of Prisons and Independent Monitoring Boards. This would ensure greater transparency in terms of tracking whether action has been taken to rectify dangerous practices and systemic failings. Parliamentary oversight (possibly through a select committee) should annually review and monitor prison inquest findings and Coroners Prevention of Further Death reports to track issues and trends. The Ministry of Justice and NHS England should provide a response to the review to ensure a high level of political focus and accountability.

27. **Full consideration should be given to prosecutions under the Corporate Manslaughter and Corporate Homicide Act,** where ongoing failures are identified and the prison service has been forewarned (as with Liverpool and Nottingham prisons).

28. **Ensure access to justice and learning for bereaved families**. To ensure fairness and equality where there is a death, families should be allowed access to justice through non-means-tested public funding for representation at inquests as recommended by the Chief Coroner[11] and in two recent reviews by Dame Elish Angiolini[12] and Bishop James Jones[13]. This would ensure proper public scrutiny, equality of arms with state funded or corporate lawyers and would help maximise the preventative potential of coroner's inquests and help to facilitate learning.

[11] Chief Coroner (2017) Report of the Chief Coroner to the Lord Chancellor. Fourth Annual Report 2016-2017
[12] Angiolini, E. (2017) Report of the independent review of deaths and serious incidents in police custody
[13] Jones, J. (2017) 'The patronising disposition of unaccountable power': A report to ensure the pain and suffering of the Hillsborough families is not repeated

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