

Written evidence submitted by INQUEST (PPW0026)

Summary of recommendations

1. Commit to an immediate reduction in the prison population in Wales.
2. Halt prison building and redirect resources for investment in welfare, health and social care.
3. Facilitate diversion from the criminal justice system.
4. Sentencing policy should be reviewed.
5. Build a national oversight mechanism to implement official recommendations.
6. Full consideration should be given to prosecutions under the Corporate Manslaughter and Corporate Homicide Act.
7. Ensure access to justice and learning for bereaved families.

About INQUEST

8. INQUEST welcomes the opportunity to respond to this Welsh Affairs Committee inquiry.
9. 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. Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people.
10. 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
11. INQUEST has published numerous reports² 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.
12. INQUEST has recently submitted evidence to the Justice Committee's 'Prison Population 2022' Inquiry³. We gave oral and written evidence to the Joint Committee on Human Rights (JCHR) inquiry on Mental Health and Deaths in Prison and 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.⁴ These reports are worth considering in the context of possible plans to expand the provision of prison in Wales.

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 Available to view [here](#).

⁴ A summary and link to the CPT report is available [here](#).

Response

13. 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 in the longer term.
14. Deaths in custody 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 society.
15. 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. INQUEST recommends an immediate halt to prison building and calls for urgent reforms to be focused on sentencing policy, promoting well-funded alternatives to custody, investing 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.
16. This response focuses on addressing the potential for new prisons in Wales and provision for women and young people.

Deaths in custody

17. 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.
18. 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.
19. 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.
20. These deaths are all the more concerning because the same failings and criticisms have been repeated time and again. Coroner after coroner has highlighted systemic issues 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.
21. 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”*⁵. 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.

Prison provision in Wales

22. The issues highlighted above are relevant to prisons in Wales and to prisoners from Wales incarcerated in prisons in England.

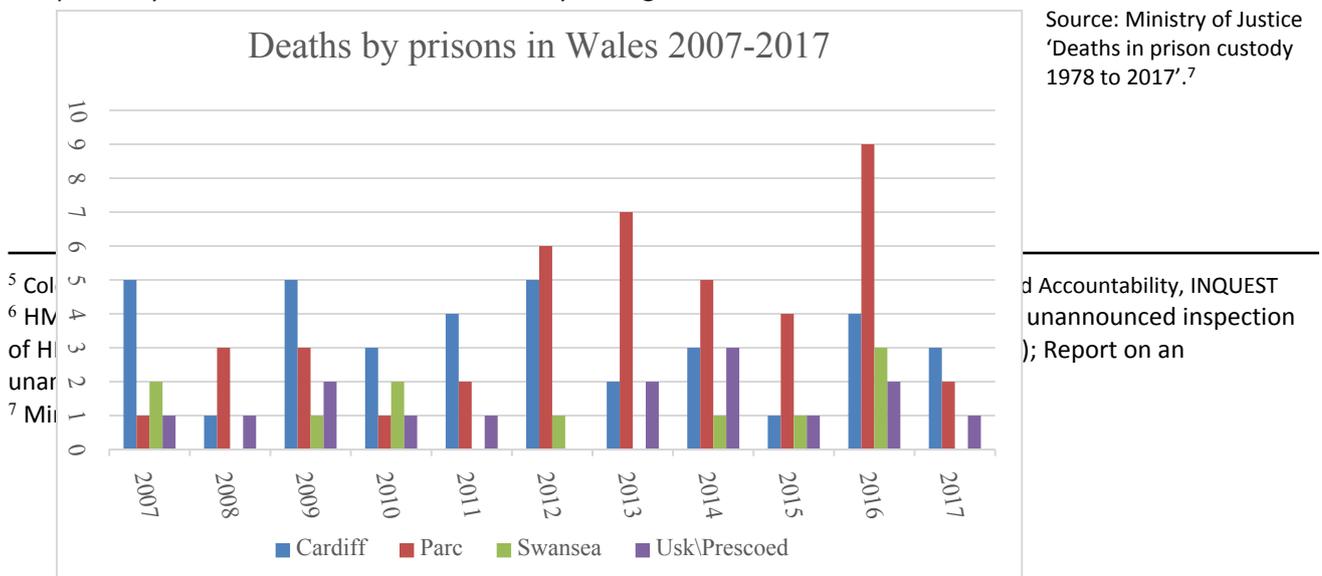
23. There are five prisons in Wales holding adult males (Berwyn, Cardiff, Swansea, Parc, Usk & Prescoed). There is one secure children’s home in Wales, Hillside SCH and one Young Offender Institution, Parc YOI in Bridgend. There are no Secure Training Centres or women’s prisons in Wales.

24. HM Chief Inspector reports on prisons in Wales⁶ have highlighted concerns about deaths, self-harm and prison safety:

- a. HMP Swansea (2018): “There had been four self-inflicted deaths since our last inspection, all of which occurred within the first seven days of arrival”
- b. HMP & YOI Cardiff (2016) “There had been seven deaths in custody since the previous inspection, three of which were self-inflicted”
- c. HMP & YOI Parc (2016): “In the previous six months, 234 prisoners had been involved in 386 self-harm incidents, higher than at similar prisons. There had been 454 assessment, care in custody and teamwork (ACCT) case management documents for prisoners at risk of suicide or self-harm opened in the previous six months, a rise since the last inspection. The reasons for these high indicators included the availability of NPS and subsequent debt and bullying. There had been two self-inflicted deaths since our last inspection, and the prison had implemented the recommendations from the subsequent Prisons and Probation Ombudsman (PPO) reports.”
- d. HMP & YOI Parc, Young Persons Unit (2018): “In our survey, nearly two-thirds of boys, 63%, said they had been victimised by others which was much worse than the comparator of 31%, and 37%, against 12%, said that they had been hit, kicked or assaulted. In addition, 44% of boys said that they had been victimised by staff.”

25. Between 2007 and 2017 there were 105 deaths in prisons in Wales (Cardiff, Parc, Swansea, Usk/Prescoed), of which 33 have been classified as self-inflicted.

26. In 2016 there were 18 deaths, the highest on record. In 2017, there were 6 deaths. This reduction is welcome, but it should be noted that deaths in custody are an embedded and ongoing feature of the prison system. The numbers of deaths may rise again.



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27. INQUEST would like to draw the Committee's attention to the evidence-based recommendations of the Harris review⁸ into self-inflicted deaths of 18-24 year olds in custody and Baroness Corston's review⁹ of women in the criminal justice system. 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.
28. Baroness Jean Corston's ground-breaking review of women in the criminal justice system documented the wide range of harms experienced by women prior to, during and after imprisonment, including mental illness, substance abuse, eating disorders, domestic violence, child-care issues, lone parenthood, poverty, isolation and unemployment. The Review called for 'a distinct, radically different, visibly led, strategic, proportionate, holistic, woman-centred, integrated approach'.
29. There has been a lack of progress on Corston's key recommendations to significantly reduce the women's prison population to an absolute minimum, support and sustain community based services, and build small custodial units for the small number of women who may require some form of containment. If these recommendations had been followed, prison places would be required for no more than around 125 women in England and Wales (around 3.2% of the women's prison population, estimated to pose a possible risk).
30. Corston recommended the dismantling of the women's prison estate and an expansion of gender-specific support in the community through a network of women's centres alongside the introduction of small custodial units.
31. In his review, Lord Harris pointed out that 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.
32. Data provided to INQUEST by Dr Rob Jones from the University of South Wales show that the average number of Welsh women in prison in England in 2017 was 259. More than half (58%) of all Welsh women are held in HMP Eastwood Park in Gloucestershire. In 2016, there were seven deaths in HMP Eastwood Park, three of which were self-inflicted and four were non self-inflicted.
33. In the latest inspection report from HMP Eastwood Park¹⁰, the Chief Inspector noted;

⁸ Harris, T. (2015) Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted deaths in Custody of 18-24 year olds. <http://iapdeathsincustody.independent.gov.uk/harris-review/>

⁹ Corston, J. (2007) A Review of Women with Particular Vulnerabilities in the Criminal Justice System, Home Office

¹⁰ HMIP (2017) Report on an unannounced inspection of HMP Eastwood Park

- a. “Levels of violence had increased, and while most problems were minor, and the number of serious violent incidents was not high, more women in our survey than previously and compared with similar prisons said they had felt unsafe at some time or that they had been victimised by other prisoners”.
 - b. “Good joint working between clinical and psychosocial substance misuse services ensured treatment continuation on release. There had been a recent spike in post-release overdose related deaths. A review of these deaths highlighted issues around joint working between the prison and Welsh drug services, and action had been taken to improve this process”
34. The continuing and unacceptable death toll in prison has been attributed by some to budget cuts, overcrowding, poor prison conditions and fewer and newer, less experienced staff. While increased levels of investment and capacity 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.
35. Inquests repeatedly highlight failures to enact safeguarding mechanisms, implement suicide prevention guidelines and deliver a duty of care, sometimes amounting to neglect.¹¹ Prison policies have been exposed as woefully inadequate in the provision of a safe environment and protecting human life, most acutely during the ongoing crisis.

Recommendations

36. **Commit to an immediate reduction in the prison population in Wales.** 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.
37. **Halt prison building 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, 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. Women centred services established in the wake of the Corston report are instructive here and women’s centres should be expanded across Wales rather than introduce new women’s prisons. 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 review¹² should be urgently reviewed and implemented.
38. **Facilitate diversion from the criminal justice system.** People with mental ill health and learning disabilities should be diverted from the criminal justice system. Instead of imprisonment, treatment and support should 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.

¹¹ More information on the death of Dean Saunders is available [here](#). You can explore press releases on similar inquest conclusions [here](#).

¹² Corston, J. (2007) A Review of Women with Particular Vulnerabilities in the Criminal Justice System, Home Office

- 39. 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 crime rates.
- 40. Build a national oversight mechanism to implement 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 Future 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.
- 41. 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).
- 42. 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 Coroner¹³ and in two recent reviews by Dame Elish Angiolini¹⁴ and Bishop James Jones¹⁵. 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 so that self-harm and deaths in custody can be drastically reduced and families can be spared the trauma that many experience under the current system.

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¹³ Chief Coroner (2017) Report of the Chief Coroner to the Lord Chancellor. Fourth Annual Report 2016-2017

¹⁴ Angiolini, E. (2017) Report of the independent review of deaths and serious incidents in police custody

¹⁵ Jones, J. (2017) 'The patronising disposition of unaccountable power': A report to ensure the pain and suffering of the Hillsborough families is not repeated