

Deaths in prison: A national scandal

January 2020

About INQUEST

INQUEST is an independent charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes death 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. INQUEST's Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody and is a member of the Independent Advisory Panel on Deaths in Custody.

Acknowledgements

This report was written by Rebecca Roberts, Claire Campbell and Deborah Coles with input from the INQUEST casework team and our trustee Professor Joe Sim. We would like to extend our gratitude and respect to the families with whom we have had the privilege to work alongside in the pursuit of truth, justice and accountability.

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Introduction

“Appalling inspection reports, damning inquest findings, and statistics on yet more deaths, have become so regular that those in power seem to forget these are human beings to whom the state owes a duty of care. Families continue to be traumatised, not only by the deaths, but by the failure to enact change.”
Deborah Coles, Executive Director, INQUEST

Every four days, a person in prison takes their own life – a shocking and unacceptable death toll. Levels of distress are at record high levels, with 166 recorded incidents of self-harm every day (Ministry of Justice, 2019).

For almost forty years, INQUEST has worked alongside the families of the men, women and children who have died in prison. Inquests, at which families are legally represented, are an invaluable public forum through which deaths can be scrutinised and any failures, ill treatment and neglect exposed in the hope of action being taken to prevent future deaths.

Bereaved families have been instrumental in drawing attention to deaths in custody and the need for systemic change. Too many deaths have been found to be premature and preventable.

“I am still worried for other vulnerable prisoners, who like Nicola, might not be getting the correct treatment or support. I hope that lessons have been learnt and the prison and healthcare providers put changes in place which mean that Nicola’s life has not been lost in vain. I do not want another family to have to go through what we have been through.”
Christine Lawrence, mother of Nicola Jayne Lawrence

The evidence presented in this report is gathered from our casework and monitoring of inquests, providing a unique insight into the harms and dangers of imprisonment. Containing case studies and original analysis of jury findings and coroners’ reports, it reveals the repeated and systemic failings documented at inquests across a two-year period.

This report identifies areas for immediate reform within and outside of the prison system and concludes with recommendations to end deaths caused by unsafe systems of custody. To ensure action is taken in response to post death investigations and inquest findings, we recommend the formation of a new independent body: a ‘National Oversight Mechanism’. Alongside this, INQUEST is calling for a substantial reduction in the prison population and investment in health and community-based alternatives.

Deaths in prison

Official statistics

INQUEST monitors deaths in prisons, analysing trends and patterns to inform our policy and research. 2016 was the deadliest year on record when 354 people died in prisons in England and Wales (January to December 2016). This is more than double the number of deaths (153) a decade earlier in 2009 (MoJ, 2018).

Since 2016, the number of deaths have remained at historically high levels, with little sign of significant change. Official statistics on deaths in custody are published quarterly by the Ministry of Justice (MoJ). Figure 1 provides an overview of recent trends using data on deaths in the 12 months to September 2019.

Figure 1: Deaths in prison, England and Wales (12 months to September)

	12 months to September										
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
MALES AND FEMALES											
Total	166	193	199	194	198	234	267	324	300	325	308
Self-inflicted	61	60	59	57	64	91	95	111	80	89	90
Natural causes	101	123	127	130	124	136	154	189	198	173	158
Homicide	0	1	1	1	2	3	7	5	3	5	2
Other/non-natural	4	9	12	6	8	4	11	17	17	32	2
Awaiting further information	0	0	0	0	0	0	0	2	2	26	56
Deaths per 1,000 prisoners	2.0	2.3	2.3	2.2	2.3	2.7	3.1	3.8	3.5	3.9	3.7
Self-inflicted	0.7	0.7	0.7	0.7	0.8	1.1	1.1	1.3	0.9	1.1	1.1
Natural causes	1.2	1.5	1.5	1.5	1.5	1.6	1.8	2.2	2.3	2.1	1.9

Source: Ministry of Justice (2019)

In the 12 months to September 2019, there were;

- 308 deaths in prison in total - six deaths every week
- 90 self-inflicted deaths - one self-inflicted death in prison every four days
- 158 deaths categorised as due to 'natural causes'
- 58 deaths recorded as 'other', 56 of which are awaiting classification
- two homicides
- eight deaths in women's prisons

In September 2019 a newborn baby died in HMP Bronzefield. This followed at least two other serious incidents investigated by the local NHS Trust in the previous year (Devlin & Taylor, 2019).

Alongside self-inflicted deaths in prison, there are a high proportion of premature and highly preventable deaths in which inadequate healthcare provision was a significant factor. So called, 'natural cause' deaths (as defined by the Ministry of Justice) are the leading cause of mortality in prisons and are commonly attributed to the ageing prison population. However, INQUEST's casework and monitoring show that these non self-inflicted deaths often reflect serious lapses in healthcare and therefore, applying the term 'natural' is extremely problematic (INQUEST, 2018a). The 'natural cause' death rate is almost two deaths per 1,000 prisoners, with 158 deaths in the 12 months to September 2019 (MoJ, 2019b).

In the 12 months to June 2019, there were 166 incidents of self-harm every day, a total of 60,594 incidents (compared to 25,253 a decade earlier). Self-harm levels rose by 22% from the previous year, once again reaching record highs. Incidents requiring hospital attendance increased in male establishments by almost 6% and by 32% in female establishments. In the child and youth prison estate, there was an 83% increase in self-harm incidents (MoJ, 2019b). Overall, this reflects rising levels of distress in prisons.

The harmful effects of imprisonment do not end at the prison gates. As INQUEST's recent report explains, in 2018/19, ten people died each week following release from prison (Phillips & Roberts 2019). Every two days, someone took their own life. In the same year, one woman died every week, and half of these deaths were self-inflicted. These deaths have been rising, outstripping increases in caseload.

The human stories behind the statistics

Official statistics provide useful quantitative information on trends yet the human stories behind the statistics are largely hidden from view. Families' meaningful participation in post death investigations and inquests can influence the level of scrutiny and help to shine a light behind the closed walls of the prison. This has been crucial to uncovering procedural and systemic failings of prison and healthcare providers.

Jordan Hullock was just 19 when he died of meningitis and a pre-existing heart condition. The inquest heard that Jordan was left to deteriorate in appalling conditions in full view of staff. His inquest found his death was due to 'natural causes' with serious failures and shortcomings in care during his time at HMP Doncaster. At the conclusion of his inquest in July 2019, his mother Marie commented:

"Four years on we are still devastated and angry that we have lost our loving son. We have persisted with this battle to try to get some answers and justice, not only for Jordan losing his life, but for the days and days of suffering he endured whilst he was ridiculously poorly in HMP Doncaster."

Shane Stroughton was an IPP sentenced (Imprisonment for Public Protection) prisoner who died a self-inflicted death in HMP Nottingham in 2017. The inquest in June 2019 found multiple failures, including inadequate care and support from mental health services. Following the inquest, Shane's mother Deborah, said:

“So much went wrong in Shane’s case. The IPP was vicious. He had a 2 ½ year term but did 10, and it made his mental health problems worse and also institutionalised him. He could not cope with freedom and so was recalled quickly. Nottingham was a terrible prison for him. With all that was going on there they were never going to notice a quiet boy like my Shane. So they did not notice him losing two stones of weight. And taking his TV from him at the same time as removing support and losing his cell mate was just cruel.”

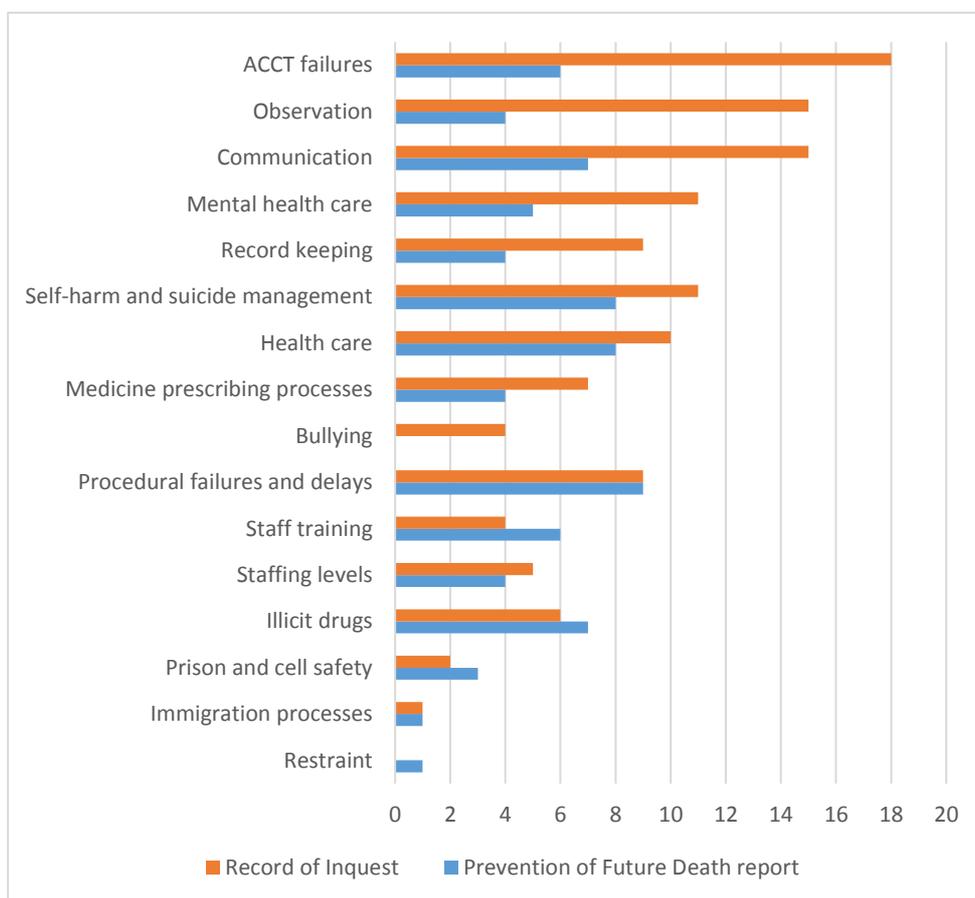
Working alongside families and lawyers, INQUEST produces case summaries in the form of press releases to draw attention to inquests and to document and disseminate the key issues that emerge. The summaries on pages 9 to 12 are drawn from media releases published online by INQUEST over a two-year period. They powerfully illustrate avoidable failings that are repeated with depressing regularity.

Learning from deaths

INQUEST holds a wealth of historical knowledge and documentation gathered through our casework, monitoring and policy work going back over four decades. Record of Inquests (ROIs) (which can include jury findings), and coroners' 'Prevention of Future Death' (PFD) reports record failings and recommendations. They have affected policy change and practice to safeguard lives but it is difficult to track progress and impact given the lack of any local or national oversight.

INQUEST identified and analysed files relating to 61 inquests that concluded between January 2018 and December 2019. The deaths occurred between December 2013 to January 2019 reflecting the time that can pass from a death to the conclusion of the investigation and inquest. Within this sample, 41 deaths were self-inflicted and 14 were non-self-inflicted. They involved the deaths of ten women and 51 men, aged between 19 years and 58 years of age. In terms of race and ethnicity, our records show that of this sample, 39 were recorded as 'White UK', 2 Asian, 2 Black African, 2 Black Caribbean, 2 Black UK, 1 Black, 2 Mixed Ethnic Background, 1 White Gypsy/Irish Traveller, 4 White Irish, 2 White British, 2 White other, and 2 Other.

Figure 2: Issues identified at prison inquests (January 2018-December 2019)



In summary, there are five main areas of concern recorded in ROIs and PFDs:

- 1. Mental health:** Inconsistent and insufficient mental health care and assessments alongside a failure to share information about risk of suicide and self-harm. Inquests often highlight that staff had an inadequate understanding of procedures for monitoring suicide and self-harm (also known as ‘ACCT’¹).
- 2. Healthcare:** Wide ranging failures to provide basic medical care. Inquests regularly reveal that the standard of care is inadequate and not in line with standard provision in the community. There is often a lack of provision for people with complex physical and/or mental health needs along with insufficient health screenings and incomplete care plans. Inquests regularly reveal failures to assess, monitor and review existing health conditions (for example, asthma and diabetes). Staff shortages, and a reliance on bank or agency staff who may lack relevant training, is a common problem. Cancelled and delayed appointments, and systems for prioritising appointments, is too often left to custody staff rather than clinicians.

¹ ACCT: ‘Assessment, Care in Custody and Teamwork’ is a care planning process for prisoners who have been identified as being at risk of suicide or self-harm.

3. **Communication:** Failures in communication between healthcare, mental health and prison staff and the inadequate recording and sharing of important medical and mental health related information.
4. **Emergency responses:** Delays in calling for emergency services, alongside poor and inadequate training of staff in first aid skills to identify medical emergencies. Failures in administering basic resuscitation procedures are regularly identified. Faulty cell bells or failure to respond to bells is also a common problem.
5. **Drugs:** Issues relate to both prescription and/or illicit drugs. For example, failure to review prescriptions and delays in accessing medication (both for physical and mental health needs). Prison and healthcare staff failing to recognise, or respond to, the risks of illicit substance misuse, warning signs of drug toxicity, and poor management of drug and alcohol withdrawal.

The issues outlined above, as documented in ROIs and PFDs, highlight very serious concerns and failings. However, there is often an inconsistency between jury findings documented in the ROIs and the recommendations then made by coroners. Coroners are often persuaded by prison authorities and healthcare providers that they have addressed problems and made changes – arguing that a PFD report is no longer necessary. This undermines the opportunity for national learning.

The purpose of an inquest is to establish how a person died. Therefore, ROIs and PFDs are often brief and narrowly focused on the direct cause and immediate circumstances. There are additional issues that often arise in post death investigations and in our casework. A dominant feature across INQUEST's work (both for self-inflicted and non self-inflicted deaths) are experiences of mental ill health of prisoners prior to and during imprisonment.

Through our casework, we are frequently struck by the inappropriate use of custody as a place of safety for people with mental ill health. This often occurs against a backdrop of failures of other state agencies to deliver services, and families who have battled for better support for their loved one.

Families regularly report struggling to get through to prisons to share concerns they have about the welfare, health or safety of prisoners (Prison Reform Trust, INQUEST & PACT, 2019). Inquests also reveal delays in transferring prisoners from prison to mental health settings.

Inquest summaries

Jan 2018 – Dec 2019

Working alongside families and lawyers, INQUEST produces case summaries in the form of press releases to draw attention to inquests and to document and disseminate the key issues that emerge.

The summaries on these pages are drawn from media releases published online by INQUEST over a two-year period. They powerfully illustrate the entirely avoidable failings that are repeated with depressing regularity.

Page 12 focuses on a series of deaths and inquests at HMP Nottingham.

Annabella Landsberg, 45, died in 2017, following severe dehydration and organ failure relating to Type 2 diabetes. Annabella was critically unwell, lying unresponsive on the floor of her cell at HMP Peterborough for 21 hours with prison and healthcare staff failing to recognise her condition. A nurse was called to assess Annabella but instead of conducting any physical observation, threw a cup of water over Annabella believing her to be faking illness. The inquest jury highlighted a catalogue of serious failures in the management and healthcare systems at the Sodexo run prison. [MEDIA RELEASE >](#)

Chris Carpenter, 34, died in August 2018 in HMP Woodhill, one month after being recalled to prison. His death was drug related. Chris had a history of mental ill health and debt from problems related to drug misuse. Concerns were raised with the safer custody team that Chris was vulnerable due to the recent death of his father. There was no evidence that any meaningful safeguards were put in place and the inquest concluded that there were a series of failures by prison and healthcare staff at the prison. [MEDIA RELEASE >](#)

Emily Hartley, 21, died a self-inflicted death at HMP New Hall in 2016. Emily had a history of serious mental ill health and it took staff two and half hours to notice that she had gone missing and to find her body, despite the fact that she should have been checked every half an hour. The jury found multiple failures including in ACCT processes, and a lack of professionalism by staff. They concluded Emily's mental state should have prompted assessment and a move to a therapeutic unit. After INQUEST alerted the coroner of a previous recommendation he had made ten years prior at the inquest into the strikingly similar death of Petra Blanksby, he repeated the recommendation, to invest in therapeutic settings. [MEDIA RELEASE >](#)

Gareth McCarroll, 41, died in 2016 less than 48 hours after arriving at HMP Altcourse. Detoxing and in severe back pain, he repeatedly asked for medical assistance. He told staff he would 'cut up' if he did not receive help. No ACCT was opened and information was not passed on to nurses, who did not even carry out mandatory observations. The inquest jury highlighted these failures and found his self-inflicted death was 'accidental'. [MEDIA RELEASE >](#)

Jamal Hussein, 32, was found with a ligature in his cell in HMP Manchester in September 2016. He died 11 days later on 13 September in hospital, on the same day he was granted bail. Jamal had a history of mental ill health and had previously been detained under the Mental Health Act. The inquest heard evidence that a series of threats were directed at Jamal whilst in prison. He suffered bruising on his face after being assaulted and reported to family members that he feared for his life. The jury found his death was a result of 'misadventure'. [MEDIA RELEASE >](#)

Jessica Whitchurch, 31, died a self-inflicted death in 2016, two days after ligaturing at HMP Eastwood Park. She had a history of mental ill health and addiction. The inquest jury identified multiple failures which contributed to her death, including inadequate communication between prison and healthcare staff after a previous ligation incident, organisational failings in staffing, and bullying by other prisoners which went unchallenged by staff. [MEDIA RELEASE>](#)

Jordan Hullock, 19, died in 2015 of meningitis, pneumonia and a pre-existing heart condition after being hospitalised from HMP Doncaster. For days he had been unable to drink or use the toilet without the assistance of his cellmate. Jordan's health rapidly declined after his cellmate was released. At one point he was found incontinent and left for over 10 hours. The inquest jury found his death was by 'natural causes' and that there were serious failures and shortcomings in his care. [MEDIA RELEASE>](#)

Marcus McGuire, 35, died a self-inflicted death in 2018. His death was the fifth in seven weeks at HMP Birmingham, which was then run by G4S. He was recalled to prison shortly after discharge from mental health detention. Weeks before his death the Ministry of Justice told G4S they had fallen below the required standard of compliance with suicide and self-harm prevention processes. The inquest jury found multiple failings in these processes contributed to his death. [MEDIA RELEASE>](#)

Matthew Gray, 32, was at HMP Norwich prior to his death in 2017. Multiple incidents of self-harm led to him being moved to segregation, after he reported threats against him by other prisoners. When forcibly returned to his wing, no action was taken to protect him. He was seen ripping up bed sheets, but it was 16 minutes before officers opened his cell and found him hanging. The inquest jury concluded his death was 'misadventure'. [MEDIA RELEASE>](#)

Michael Forster, 26, died in 2016. He had a history of mental ill health, and before being remanded to HMP Leicester had been expressing delusions. Shortly after arriving, a prison psychiatrist found Mike appeared psychotic and requested an assessment to process his removal to a secure hospital. He was awaiting that assessment and medication when he died weeks later. The inquest jury found neglect and several failings in care contributed to his self-inflicted death. [MEDIA RELEASE>](#)

Michael Judge, 32, was at HMP Swaleside when he died a self-inflicted death in 2017. He had a history of self-harm, mental ill health and substance misuse, and had faced issues with bullying and debt at the prison. The inquest jury identified a catalogue of failures in ACCT processes, including poor recording, inappropriate closure, and a failure to review available information on his history. [MEDIA RELEASE>](#)

Michal Netyks, 35, was a Polish national who died in 2017 after being unexpectedly served deportation papers on the day he was due to be released from a prison sentence at G4S run HMP Altcourse. The papers were only provided in English, and his right to appeal was not explained. The inquest jury concluded his death was a suicide, which was contributed to in part by the Home Office immigration deportation process, which prison officers are not trained in serving. [MEDIA RELEASE>](#)

Natasha Chin, 39, died in 2016, 36 hours after entering Sodexo run HMP Bronzefield. Despite being on a specialist wing for people with drug and alcohol dependencies, on the day she died she had been vomiting for at least nine hours and did not collect essential medication. Healthcare staff did not follow this up or properly respond to prison officers' requests to attend her cell. The inquest jury concluded neglect and systemic failures by prison and healthcare providers contributed to her death. [MEDIA RELEASE>](#)

Nicola Jayne Lawrence, 38, died at HMP New Hall in 2016. With a history of ill health including multiple sclerosis and drug dependency, on arrival at prison she was prescribed various medications. She was also prescribed methadone for the first time, with no consideration of the impact on other medication or communication with her MS specialist. The inquest jury found she died from a combination of methadone toxicity and multi drug administration; they identified multiple missed opportunities which may have saved her life. [MEDIA RELEASE>](#)

Rocky Stenning, 26, died in HMP Chelmsford in 2018. He had been in prison for nine days before he was found hanging. Rocky had a long history of mental ill health and previous suicide attempts following the death of his father. He had been diagnosed with bipolar disorder and had periods in mental health hospitals, including for the duration of his court case. The jury found failures to adequately assess his risk of self-harm and suicide contributed to his death. [MEDIA RELEASE>](#)

Ryan Harvey, 23, died five days after he was found hanging at HMP Woodhill in 2015. Healthcare staff were informed Ryan had learning disabilities, affecting his communication and understanding of his actions. However, this information wasn't shared, and no proper assessment was done. Ryan was seen twice with a ligature, prompting the opening of an ACCT and twice hourly observations, but the ligature was not removed. The inquest jury was deeply critical of these issues and others. [MEDA RELEASE>](#)

Sarah 'Maria' Burke, 48, died eight days after arriving at HMP Drake Hall from HMP Peterborough in 2016. She was on a wing for vulnerable prisoners and had reported distress and bullying. After a person accused of bullying entered her wing, Maria went missing and was not found for five hours. The inquest jury found this delay was a causative factor in her self-inflicted death, as well other failings including no ACCT or mental health assessment, or proper response to bullying. [MEDIA RELEASE>](#)

Sean McCann, 32, died at Sodexo run HMP Peterborough in 2016. He had a history of mental ill health, and in the weeks before his death had twice attempted suicide and repeatedly expressed suicidal ideation. Yet he was moved to a segregation cell with a broken light fitting which made a ligature point. The inquest jury found neglect contributed to his self-inflicted death, with multiple failures. [MEDIA RELEASE>](#)

Shaun Dewey, 30, died a self-inflicted death in HMP Bristol in April 2018. Shaun was remanded to HMP Hewell but moved prisons four months later in January 2018 after being attacked by other prisoners. He was on an ACCT until February. The inquest heard the ACCT should not have been closed. The jury found that there was 'uncoordinated supervision' and a failure by the prison to act sufficiently to safeguard Shaun during his struggle with anxiety, depression and separation from his family. [MEDIA RELEASE >](#)

Tommy Nicol, 37, died in 2015 after six years on an IPP sentence. When he was transferred to HMP The Mount he found they did not offer a course of therapy recommended by the Parole Board for consideration of his release. He self-harmed and when moved to segregation, began displaying psychotic symptoms. He was found hanging three days later and died in hospital. Tommy received no mental health input in the four days spent in segregation, despite spending over 24 hours in an unfurnished cell. The inquest jury recorded no critical findings, despite serious concerns of the family. [MEDIA RELEASE>](#)

Tyrone Givans, 32, died at HMP Pentonville in 2018. He was profoundly deaf and had been at the prison for under three weeks, for the most part without access to hearing aids. He had a history of alcohol dependency, depression and recent self-harm. No reasonable adjustments were made to accommodate his disability and an ACCT was not opened. Tyrone asked to move wings and reported feeling unsafe. His mattress had been slashed and he was unable to sleep as he couldn't hear if people were approaching. The jury found multiple critical failings contributed to his self-inflicted death. [MEDIA RELEASE>](#)

HMP Nottingham

In 2017 there were seven deaths at HMP Nottingham, six of which were self-inflicted, and one drug related. Five men died within weeks of each between 13 September and 12 October 2017.

In January 2018, HM Chief Inspector of Prisons issued an 'Urgent Notification' after finding the prison to be unsafe for the third consecutive inspection (Eggleton & Hilder, 2020).

In 2018 and 2019, five inquests took place. Four related to the deaths in 2017 and one from 2013.

Andrew Brown, 42, died in September 2017 from a brain injury caused by hanging. The jury found that an ACCT was closed despite Andrew disclosing intentions to harm himself. The inquest jury found several failures including an unsuitable environment on the induction wing which did not meet basic needs and failure to respond to an emergency bell. The jury highlighted that there had been no improvements made following two deeply critical inspectorate reports prior to his death. [MEDIA RELEASE>](#)

Shane Stroughton, 29, was found hanging, a day after Andrew Brown had been found on the same wing. He had been on an IPP sentence for nearly 10 years despite his original tariff being two and a half years. Shortly after release Shane was recalled to prison for absconding from Approved Premises to visit family. His brother had recently died by suicide. On arrival at HMP Nottingham he was identified as high risk after being found with a ligature in police custody. The inquest jury found multiple failings. [MEDIA RELEASE>](#)

Anthony Solomon, 38, died in HMP Nottingham in September 2017 from the toxic effects of synthetic cannabinoids. The inquest heard that none of the steps required by prison policy to respond to his drug use had been followed. The jury returned a narrative conclusion highlighting prevalence of drugs in HMP Nottingham. The jury concluded that the 40 minute delay in responding to the cell bell had denied Anthony the opportunity to receive timely medical attention. They added that staffing levels were too low, criticising the policy of benchmarking, which left one officer on the wing to perform a number of essential duties. [MEDIA RELEASE >](#)

Marc Maltby, 23, died a self-inflicted death in HMP Nottingham in October 2017, three weeks after being recalled to prison. During his initial health screening, he requested help from the mental health team. When he died 16 days later he still had not had an assessment. Marc informed staff he was receiving threats and requested to move wings but no action was taken. When he started throwing objects through the observation hatch in distress, officers responded by blocking the hatch with a table tennis table. The jury found that the placing of the table in front of the door and the subsequent actions of staff were 'inadequate'. [MEDIA RELEASE >](#)

Wayne Moore, 46, was remanded to HMP Nottingham when he died following the perforation of an ulcer in 2013. He was prescribed lifesaving medication by hospital specialists, but this information was not passed on to prison staff and his medication was withdrawn for review. The review did not take place and three days later, Wayne set fire to his cell and pleaded with prison staff to help him as his health was deteriorating. This was not communicated with healthcare staff which the jury found to be inadequate. [MEDIA RELEASE>](#)

Discussion

“The relentless focus on the issues of violence and drugs may have brought some short-term relief. However, this focus has abjectly failed to guarantee the health and safety of prisoners. Punitive regimes do not foster safety. They intensify the problems inside, alienate prisoners and reproduce the conditions that generate self-harm and self-inflicted deaths. They are more, not less, dangerous. Harsh regimes are a complacent, simplistic response to a complex problem.”
Deborah Coles, INQUEST

Despite the fact the Ministry of Justice and Ministers are well aware of the trends and failings in prison, there has been only muted official recognition of the scale and urgency of the need to address deaths in custody. This has allowed dangerous practices to persist, made worse by a revolving door of prison ministers with seven since the post was created nine years ago, five of whom have been in post in the last three years.

A national scandal

Deaths in custody are a national scandal in need of immediate and urgent attention. This view is shared by HM Chief Inspector of Prisons, Peter Clarke; “After years and years and years of the same faults, same mistakes, same admissions leading to self-inflicted deaths”, he suggested it might be time for an independent inquiry. “It is no exaggeration to say it is a scandal,” he said, “People in the care of the state are dying unnecessarily in preventable circumstances” (Grierson, 2019).

The current crisis has often been described as one of poor security, violence and drugs in the context of understaffing and underfunding. However, these so-called ‘problems’ are better understood as symptoms of the overuse of imprisonment. Prisons are not just ‘in crisis’, they are places of crisis.

Successive governments have refused to grasp the true nature of the crisis and the devastating and deadly consequences of using imprisonment to deal with social problems such as mental ill health, addictions, poverty combined with a widespread failure to treat prisoners with dignity and compassion. Reforms have focused on turning around the staffing reductions by recruiting new officers and escalating security measures such as body scanners and PAVA spray.

In August 2019, INQUEST exposed the failure of the Ministry of Justice’s £10m, Ten Prisons Project. It was revealed that the number of deaths in the 10 prisons increased by 20 percent, undermining government claims of the ‘success’ of the project to reduce violence and improve safety

(Mohidin & Grierson, 2019). An injection of resources focusing on tougher security measures and punitive responses to violence and drugs had failed to tackle underlying issues and resulted in an increased number of deaths.

As the 2015 review into self-inflicted deaths of 18-24 year olds by Lord Harris recognised, all prisoners are potentially vulnerable to a self-inflicted death. Baroness Corston in her 2007 review of women in the criminal justice system made references to bleak, stressful, unhygienic and demoralising prison environments – still relevant today as documented in INQUEST's *Still Dying on the Inside* (2018b & 2019) and multiple inspection and monitoring board reports.

Neglect, a lack of care and a culture of disbelief towards prisoners experiencing health problems and mental ill health, is a disturbing feature of our casework. Prisoners have very little autonomy or control and are completely dependent on prison and healthcare staff for their treatment and care. This puts them in a uniquely vulnerable position.

“Marcus was criminalised for mental ill health, and throughout his life was failed by the systems in place to protect him. In prison, both G4S and mental healthcare services made serious failings which we know contributed to his death. Exposing the failings in Marcus' care will not bring him back, however we hope another family will not have to go through what we have been through.

Our family know that prevention is better than cure. We have lost two brothers, who were both excluded from school. As we know thousands of working class boys are excluded or off rolled from school; many with Special Educational Needs and many vulnerable. Many will end up in prison.”
Family of Marcus McGuire

Prisoners are too regularly neglected because of failures to respond to mental health crises and medical emergencies. People are ignored because it is presumed they are faking it, or it is ‘just’ a mental health problem. Budget cuts within prisons have led to a worsening of conditions, and an intensification of existing dangers to people in prison, which as we note above, precedes the cuts that have been made.

The Independent Advisory Panel on Deaths in Custody (IAP, 2017) conducted a review of safety in prisons, collating responses from more than 100 letters and 50 telephone calls from prisoners. Prisoners described a diversity of experiences both positive and negative. They reported bullying and being treated with contempt by staff - a lack of support and empathy as well as highlighting unmet health, drug and alcohol treatment needs. While there were instances of positive support from staff, in other instances, the report recounts the ‘flippant’ attitudes of prison officers towards suicide with staff apparently ‘laughing’ and ‘goaded’ them to commit suicide.

Access to justice

“The power imbalance between bereaved families and the state is the most significant injustice of the coronial process. Yet the Ministry of Justice have disregarded the evidence and ignored the voices of bereaved families. INQUEST and the families we work with refuse to be silenced. We call on the government to act now and urgently introduce fair public funding for legal representation at inquests, to end this unequal playing field.”
Deborah Coles, INQUEST

Human rights law, in particular Article 2 of the European Convention on Human Rights (ECHR), imposes a positive duty on the state to protect the life of those in its care, including people in prison. Where someone dies in prison, it is the inquest together with the PPO investigation, which are the principal means by which the state seeks to meet its obligation to undertake a thorough and effective investigation into the circumstances in which the death occurred.

Bereaved families have a vital role to play in ensuring inquests do not merely sanction the official version of events. Skilled advocacy for the family aids the inquisitorial process and has helped to uncover systemic and practice problems. However, there is no right to automatic non means tested public funding for families’ representation. At a time when they are grieving, bereaved families are forced to engage in intrusive means testing processes for legal representation.

There are unlimited public funds available to the Prison Service, and other public bodies whose conduct may be brought into question. NHS commissioning of prison healthcare and other services and the increasing involvement of the private sector has added to the number of legal teams defending the interests and reputations of state and corporate bodies. These teams too often work together to shut down or narrow lines of enquiry and argue against critical conclusions and recommendations. Inquests should be a forum through which lessons can be learned and action taken. This undermines the preventative potential of the inquest. That failings ever come to light is often down to the sheer determination and persistence of families, their lawyers, and INQUEST.

In 2017, the MoJ spent £4.2million on Prison and Probation Service legal representation at prison inquests, while granting just £92k in legal aid to bereaved families through the Exceptional Case Funding scheme. The £4.2m from the MoJ is only a partial figure of the total spent on representing state and corporate bodies at inquests, as private prison and healthcare providers, NHS and other agencies are often separately represented (INQUEST, 2019c).

Despite clear evidence of a significant inequality of resources experienced by families, in February 2019, the government rejected the overwhelming evidence in favour of automatic legal aid funding. INQUEST's *Legal Aid for Inquests* campaign is seeking to overturn this decision and level the playing field for families (see <https://www.inquest.org.uk/legal-aid-for-inquests>).

Repeated recommendations

INQUEST's monitoring of investigations and inquests into prison deaths shows that many deaths are preventable and the result of neglect and systemic failings in care. This contravenes national and international human rights standards, including Article 2 of the European Convention of Human Rights which upholds the right to life. While the analysis conducted for this report focuses on a sample of 61 inquests that took place across two years, when reviewing the many reports conducted by INQUEST over the decades, we note the same issues coming up time and time again with depressing regularity.

Inquests and investigations often reveal that Ministry of Justice officials, prison governors, healthcare providers and others involved in the management of prisons knew and had already been warned about system failures and potential risk to life, yet failed to act upon them.

Investigations, inquests, inquiry reports, the Prison Inspectorate, the Prisons and Probation Ombudsman and monitoring board reports, jury findings and coroners' recommendations are critically important sources of evidence in identifying failures in the safety, governance and management of prisons. Jury findings are not collated at all, and while coroners' PFD reports are on the judiciary website, they are not subject to any thematic analysis or follow up at a national or local level.

At present, there is no formal national oversight of action taken in response to findings and recommendations from inquests and post death investigations. INQUEST and the families and lawyers we work with often informally perform this function. INQUEST have produced numerous submissions and publications on the failure of state agencies to act on learning and implement recommendations and the lack of accountability (accessible at www.inquest.org.uk).

Responsibility for following up issues arising from investigations and inquests does not sit with any specific organisation. At present, learning is fragmented and disparate with the result that we are seeing the same institutional and individual failings.

Conclusion and recommendations

Action to address the persistent failure of prison and healthcare services to rectify dangerous practices is long overdue.

INQUEST's work and this evidence-based report demonstrates the need for a radical transformation in the nature and culture of prisons, and in sentencing policy more generally. Many of the deaths described in this report were eminently preventable, had there been the right political and institutional will.

People in prison, like every other person, have a right to life and should not have their lives prematurely shortened by systemic failures. Successive governments have failed to take the necessary action to prevent deaths in custody and have neglected their duty of care to prisoners. This, in turn, has resulted in profound levels of unnecessary trauma and distress for many thousands of families and friends.

The government is also failing victims of crime. The dominant policy focus on increasing the number of prison places and prison officers is a tried and tested formula which has had little or no long-term impact on public protection, reconviction rates and reducing victimisation.

Prisons must be places of absolute last resort where therapeutic and rehabilitative support would allow an environment that meets international human rights standards of decency, respect and safety. This course of action will truly contribute to the safety and wellbeing of prisoners, caring staff and the wider public.

However, prisons, by their very nature, are dehumanising places which create and intensify vulnerability, exacerbated by the separation from family and friends alongside violence, bullying, loneliness and isolation. The high numbers of deaths, and unprecedented levels of self-harm, reflect the deleterious impact of the prison experience.

Even in relatively 'well-staffed' prisons we find prisoners being treated with a lack of dignity and respect, linked to neglect, mental ill health and premature deaths. A tightening of security measures is likely to have exacerbated the distress and human misery behind prison walls, posing a greater threat to life.

Alongside short-term reforms within the prison system to improve safety as identified through inquest findings, what is required is a strategic change to reduce reliance on punishment and prisons as a means for dealing with social problems. Key to this is the need for an immediate and substantial reduction in the prison population alongside an expansion of community-based support.

Criminal justice resources should be reallocated away from prisons to well-funded, well-staffed community alternatives, involving drug, alcohol and mental health services, supported by NGOs and involving the families of those accessing these services. 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.

In summary, INQUEST are calling on government to:

- 1. Halt prison building, commit to an immediate reduction in the prison population and divert people away from the criminal justice system.**
- 2. Prison staff, including healthcare staff, require improved training** to meet minimum human rights standards to ensure the health, well-being and safety of prisoners.
- 3. Ensure access to justice for bereaved families** through the provision of automatic non-means tested legal aid funding for specialist legal representation to cover preparation and representation at the inquest and other legal processes. Funding should be equivalent to that enjoyed by state bodies/public authorities and corporate bodies represented.
- 4. Establish a ‘National Oversight Mechanism’** – 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.
- 5. 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.

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