Written evidence submitted by INQUEST (REM0007)

[Note: This evidence has been redacted by the Committee. "***" represents redacted text. Text in square brackets has been inserted where text has been redacted.]

Introduction

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. 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.

2. INQUEST welcomes the Justice Committee's new inquiry into adult custodial remand. As INQUEST have previously highlighted[1], prisons are, by their very nature, dehumanising places which create and intensify vulnerability which is exacerbated by separation from family and friends alongside violence, bullying, loneliness and isolation. The situation is worse for remand prisoners as they have a heightened risk of self-inflicted death[2] and often experience poorer regimes.[3]

3. As this Committee notes, the population of prisoners on remand increased during the COVID-19 pandemic. So too did the rate of self-inflicted deaths of remand prisoners. However, as INQUEST's evidence to this inquiry emphasises, the risks associated with remand prisoners and the lack of support provided to them have been long-standing problems within the prison estate.

4. In this submission, we provide an overview of the serious implications of adult custodial remand. Our evidence is informed by our specialist casework and expertise on investigations and inquests into deaths. We highlight key failings identified during the inquests into four deaths of remand prisoners and outline recommendations for change to prevent future deaths.

Key concerns

5. *Self-inflicted deaths.* INQUEST's primary concern with respect to adult custodial remand is the increased risk of self-inflicted death it presents to vulnerable prisoners with complex needs. Prisoners detained on remand, whether they are awaiting conviction or sentencing, are exposed to distinct risk-factors.[4] For example, remand

---

[1] INQUEST, January 2020, Deaths in prison: A national scandal, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=bb400a0b-3f79-44be-81b2-281def0b924b

[2] Ministry of Justice, January 2022, Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2021, Assaults and Self-harm to September 2021, https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2021/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-december-2021-assaults-and-self-harm-to-september-2021 , The rate of self-inflicted deaths per 1,000 prisoners was 2.5 for prisoners on remand (an increase from 1.7 in 2020) and 0.8 for sentenced prisoners (an increase from 0.7 in 2020).

[3] HMI Prisons, August 2021, Remand prisoners: A thematic review, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2012/08/remand-thematic.pdf

prisoners are at a higher risk of self-inflicted death and self-harm because they may be entering prison for the first time. Many prisoners on remand will also be experiencing complications or separations in family relationships as well as a loss of employment and accommodation. Others might be troubled by their upcoming court dates.

6. *Data on deaths of remand prisoners.* The available data on the adult remand population makes clear the prevalence of self-inflicted death. While remand prisoners only account for 16%[5] of the prison population, they make up 37% of self-inflicted deaths in the estate.[6] This is the greatest proportion of self-inflicted deaths of remand prisoners since 2015, when 40% of self-inflicted deaths were of remand prisoners. To illustrate the recent increase of self-inflicted deaths of remand prisoners, there were 32 self-inflicted deaths of remand prisoners in 2021 compared to 13 in 2020.[7]

7. According to INQUEST's casework and monitoring of official statistics, over the five-year period from 30 April 2017 to 30 April 2022, 55% of adult remand deaths were self-inflicted, compared to 20% of adult non-remand deaths. Our monitoring has also highlighted HMP Durham, Wandsworth and Leeds as prisons of key concern, with 15, 14 and 13 deaths of adult remand prisoners in each of the prisons, respectively, over the same five-year period. INQUEST notes with concern there is currently no available data on the number of incidents of self-harm within the adult remand population.

8. *Lack of support.* INQUEST's casework has shown a lack of specialised support available to the adult custodial remand population, which is even more troubling given the risks and complex needs of this group outlined above. Specific problems in ensuring appropriate support for remand prisoners include:

    - A lack of or poorly carried out mental health and reception screening assessments, even when records indicate an individual's level of risk.
    - A lack of or inadequate information sharing during handovers between prisons, particularly following court appearances, and a lack of awareness from prison staff to mitigate the emotional burden court appearances, refused bail applications and adjourned court hearings can have on prisoners in accordance with the PSI Managing prisoner safety in custody: 64/2011.
    - A lack of or inadequate requests for information from primary healthcare and community mental health services once a prisoner is identified as vulnerable.
    - Poor recording keeping, particularly with respect to an individual's level of risk known as Assessment, Care in Custody and Teamwork (ACCT) documentation.

---

[4] Zhong et al, February 2021, The Lancet, Risk factors for suicide in prisons: a systematic review and meta-analysis, https://www.thelancet.com/action/showPdf?pii=S2468-2667%2820%2930233-4

[5] Prison Reform Trust, 2022, Bromley Briefings Prison Factfile Winter 2022, http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Winter%202022%20Factfile.pdf

[6] Ministry of Justice, January 2022, Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2021, Assaults and Self-harm to September 2021, https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2021/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-december-2021-assaults-and-self-harm-to-september-2021

[7] Answer to Lord Patten's February 2022 Written Question to Ministry of Justice on Prisoners on Remand: Suicide, HL6296, https://questions-statements.parliament.uk/written-questions/detail/2022-02-21/HL6296/

- Infrequent and poorly conducted welfare checks on remand prisoners.
- A lack of robust channels of communication for families' concerns about their relative's health and wellbeing, with communication to the Safer Custody team often not being passed on to the relevant teams or members of staff.
- Inadequate coordination between relevant teams within prisons to care for remand prisoners, such as between healthcare, mental health and substance misuse teams.
- A lack of access to rehabilitative aspects of the prison regime, such as the key worker or offender supervisor schemes, and to purposeful activity. There is evidence of remand prisoners being expected to seek help from the prison, rather than the prison being proactive in approaching remand prisoners to offer support.
- A lack of access to regular visits, particularly during COVID-19.

9. *Inappropriate use of remand.* A recurring theme in INQUEST's casework on remand prisoners is the wholly inappropriate use of adult custodial remand. Many of the remand cases INQUEST works on relate to individuals with acute mental ill health. Some of our most concerning cases have shown the inappropriate use of custodial remand, for example, remanding prisoners to await psychiatric reports or using remand to prison as a place of safety. While INQUEST welcomes proposals to remove the latter provision as part of the Government's plans to reform the Mental Health Act[8], we are disappointed that related legislation has not yet been introduced.

10. *Overuse of remand.* It is widely accepted that remand prisoners awaiting trial are to be treated in accordance with the principle of presumption of innocence.[9] Yet the high and increasing[10] numbers of remand prisoners awaiting trial calls the application of this principle into question. The majority of the adult custodial remand population are accused of non-violent offences (52%).[11] It is of concern that 10% of individuals remanded to custody by Magistrates' courts are eventually acquitted. This figure rises to 11% for those remand by the Crown Court, suggesting remand is not being used as a last resort.[12]

11. The rates of those detained on remand rose significantly during COVID-19. However, INQUEST reminds the Committee that the use of remand imprisonment was already going up in 2019 before the pandemic.[13] Lengthy delays to criminal proceedings caused by a significant court backlog also predated the pandemic, with the number of cases in the Crown Court backlog increasing by 23% between March 2019 to March

---

[8] Department for Health & Social Care, January 2021, Reforming the Mental Health Act, https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act

[9] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2017, Remand detention, https://rm.coe.int/168070d0c8

[10] As at 31 December 2021, the remand population was 12,780 which is the second highest quarterly figure since 2008. See Ministry of Justice, January 2022, Offender management statistics quarterly: July to September 2021, https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-july-to-september-2021/offender-management-statistics-quarterly-july-to-september-2021

[11] Ibid

[12] Prison Reform Trust, 2022, Bromley Briefings Prison Factfile Winter 2022, http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Winter%202022%20Factfile.pdf

[13] Ibid

2020.[14] This indicates that the overuse of remand detention predates COVID-19 and is linked to sentencing patterns and criminal justice policy.

12. *Race.* The remand population is disproportionately BAME: people from Black or minority ethnic backgrounds make up 34% of those held on remand according to the latest figures for England and Wales.[15] In 2020, 40% of White defendants were remanded in custody compared to 51% of Chinese or Other defendants, 49% of Black defendants and 47% of Mixed defendants.[16] Larger proportions of defendants from Black, Asian and Chinese or Other ethnic groups who were remanded in custody were acquitted or not tried (ranging from 13% to 15%) compared with defendants of White and Mixed ethnicities (9% and 10% respectively).[17]

13. INQUEST is deeply concerned by the absence of official figures on the number of deaths of BAME prisoners within the adult remand population despite evidence of racial disproportionately. INQUEST's monitoring of deaths from official figures and our casework shows that of the total 216 deaths of *all* adult remand prisoners over the five-year period from 30 April 2017 to 30 April 2022, 44 of these deaths were of BAME prisoners. Deaths of Black and mixed-race adult remand prisoners accounted for 55% of deaths of BAME adult remand prisoners while deaths of Asian adult remand prisoners accounted for 36%.

Case studies

14. We highlight below four INQUEST cases which further illustrate the above issues.

15. **[Name]** was [30-40] years old when he died [in 2019], having hanged himself in his cell [a few days] prior while on remand in [prison]. He had only been at the prison for [less than a week]. It was [his] first time in prison.

    [He] had a history of mental ill health and was at risk of self-inflicted death and self-harm. [He]had a diagnosis of depression for which he received medication in the community and was going through the breakdown of a relationship. On arrival at the prison, [he] told a senior officer that he was a suicide risk. However, this information was not passed on within the prison. Further, concerns about [his] risk of suicide from a close friend were reported to [location] Police who then contacted [the prison] – these concerns were never passed on to the mental health team or staff involved in [his] ACCT review. There were also delays in administering [his] anti-depression medication. An ACCT review on [date] reduced [his] level of risk from 'raised' to 'low'. [He] was found hanging in his cell [later] that day.

---

[14] National Audit Office, October 2021, Reducing the backlog in criminal courts, https://www.nao.org.uk/wp-content/uploads/2021/10/Reducing-the-backlog-in-criminal-courts.pdf

[15] The Guardian, March 2022, Proportion of remand prisoners who are minority ethnic rises 17% in six years, https://www.theguardian.com/society/2022/mar/17/proportion-of-remand-prisoners-who-are-minority-ethnic-rises-17-in-six-years#:~:text=crime%20on%20bail.-,At%20the%20end%20of%20September%202019%2C%209%2C602%20people%20were%20in,2021%20the%20figure%20was%2012%2C990

[16] Ministry of Justice, December 2021, Ethnicity and the Criminal Justice System 2020, https://www.gov.uk/government/statistics/ethnicity-and-the-criminal-justice-system-statistics-2020/ethnicity-and-the-criminal-justice-system-2020

[17] Ibid

The inquest into [his] death concluded that issues in record keeping and information sharing at [the prison] possibly contributed to his death. ***

16. **[Name]** was [18-25] years old when he died in segregation while on remand at [prison] on [date] 2019. He was remanded [a few months prior].

    On arrival at [prison], [he] disclosed he had self-harmed in the months prior to his arrival and that he had a history of depression for which he was prescribed antidepressants. Following an adjudication hearing on [date] 2019, [he] was sentenced to [several] days in segregation. Prison policy requires a healthcare professional to screen people within two hours of being segregated to assess their risk. However, a nurse did not conduct the required face to face assessment but instead made an assessment based on her previous knowledge of [him] because she did not believe he was at risk.

    [He] was kept in segregation for six hours. Hourly checks were not carried out due to staffing shortages. [He] was then found unresponsive with a ligature and subsequently died. The inquest concluded that [his] death was misadventure.

    The coroner's Prevention of Future Deaths report noted staffing at the prison and the recording and systems relating to hourly checks as matters of concern. ***

17. INQUEST notes the deaths of [these men] both took place at [the same prison], a prison of particular concern with regard to self-inflicted deaths (INQUEST's monitoring shows there have been [5-10] self-inflicted deaths since 2017). [This prison] currently holds [over 600] remand prisoners, which is [over 60] per-cent of its entire population. According to the latest HMI Prisons report on [the prison], inspectors found little in place to support or occupy remand prisoners, with serious problems in ensuring visits for remand prisoners three times a week.[18] This is just one of many critical inspection reports on the poor conditions for prisoners on remand in England and Wales.[19]

18. **[Name]** was 30-40 years old when he died a self-inflicted death on [date] 2018 at [prison A]. [He] had been remanded to [prison B] in [month] 2017 awaiting trial but was moved to [prison A] in 2018 for his own safety after being attacked by other prisoners.

    Following the attack on [him] at [prison B], he self-harmed and was placed on an ACCT. The procedures commenced again after his transfer to [prison A] in [month] 2018 but ended [a month later]. The inquest into his death heard that his ACCT should not have been closed.

    The jury at the inquest into [his] death concluded that he died as a result of suicide and that [at times, issues were not picked up by the systems in place] ***.[20] The jury also identified 'a failure to act sufficiently' on signs of risk.

---

18 ***

19 HMI Prisons, August 2021, Remand prisoners: A thematic review, https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2012/08/remand-thematic.pdf

20 ***

The Prevention of Future Deaths Report[21] issued by the coroner raised specific concerns about the support for remand prisoners. It noted statistics on the higher rates of deaths of remand prisoners. The coroner stated his concerns over the risks facing remand prisoners and recommended such risks should be: considered in training for staff; frequently highlighted as an issue for prison staff and mental and physical health teams; highlighted as a risk in ACCT documentation; and reflected in national guidance on the management of prisoners at risk of harm to self, others and from others (***). ***

19. **[Name]**, a mixed-race Black woman, was [30-40] years old when she died on [date] 2016 at [prison]. By the time of her death, [she] had been on remand for [several] months for the sole purpose of obtaining [number] psychiatric reports to establish whether she was fit to plead for an alleged offence which occurred whilst she was a sectioned inpatient at a mental health unit. The finalization of the report had been delayed.

    Throughout her life, [she] struggled with mental ill health. In prison, [her] mental health deteriorated. Prison staff treated [her] extremely distressed behaviour as a discipline issue: the prison put her on a basic regime and denied her visits from family and lawyers in breach of her human rights. On [date] 2016, [she] was found dead with a ligature around her neck. The inquest concluded that unacceptable delays in psychiatric assessment, inadequate treatment for her high levels of distress, and the failure of prison psychiatrists to manage [her] medication contributed to her death. ***

Recommendations

20. As highlighted above, there are severe risks associated with adult custodial remand which are often inadequately managed. INQUEST's recommendations for change are as follows:

    - **Radically reduce the use of adult custodial remand.** The use of imprisonment for people who have not yet been tried or sentenced should be used as a last resort given the well documented increased risk of death for people on remand. The high and increasing population rate of remand prisoners clearly show this is not happening. We believe the use of adult custodial remand must be urgently reduced and community alternatives better utilised. The use of remand for individuals awaiting psychiatric reports should also end.

    - **End adult custodial remand for women.** It is now accepted across Government that women in prison are at a higher level of risk due to their complex needs and vulnerabilities.[22] The risks of detention alongside the risks of being on remand are well known. INQUEST has long called[23] for the Government to develop well-funded alternatives to custody for women.

---

[21] ***

[22] Ministry of Justice, June 2018, Female Offender Strategy, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719819/female-offender-strategy.pdf

[23] See INQUEST's 2018 report Still Dying on the Inside, https://www.inquest.org.uk/still-dying-on-theinside-

- **Improve data collection on adult custodial remand.** Official statistics on the remand population are inadequate and inconsistent. Steps should be made to disaggregate MOJ Safety in Custody statistics on the rates of self-harm by remand prisoners. The MOJ should also routinely publish data on the mental health needs of the remand population such as the number of remand prisoners on an ACCT and the number of remand prisoners who have received or are awaiting a mental health assessment to better understand this population's level of risk and mental health need. This data should be further disaggregated by type of remand, time spent on remand and by protected characteristics.

- **Address racial disproportionality within the remand population.** Remand is disproportionately used for BAME people. This is part of a broader pattern of discrimination within the criminal justice system.[24] There is an urgent need to strengthen the consistency of data on race and adult custodial remand. Specifically, steps should be made to publish data more regularly on the ethnicity of people detained on remand and disaggregate current MOJ Safety in Custody statistics on self-harm and self-inflicted deaths within the remand population by race.

- **Develop a National Oversight Mechanism for implementing official recommendations**. INQUEST's casework on remand deaths continues to show deaths occurring in the same prisons, from the same issues. As recommended by this Committee in its report on the Coroner Service[25], a new national oversight body should be established which would have a duty to collate, analyse and monitor learning and implementation arising out of investigations into state-related deaths. This is the only way to secure proper cross-sector learning and prevent future deaths.

April 2022

---

report and INQUEST's June 2019 update to Still Dying on the Inside, https://www.inquest.org.uk/2019-update-still-dying

[24] The Lammy Review, 2017, An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf

[25] Justice Committee, May 2021, The Coroner Service, https://committees.parliament.uk/publications/6079/documents/75085/default/