

THE
HARRIS
REVIEW

Changing Prisons, Saving Lives

Report of the Independent Review
into Self-inflicted Deaths in Custody
of 18-24 year olds





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Presented to Parliament by
the Secretary of State for Justice
by Command of Her Majesty

July 2015

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Review conducted by Lord Toby Harris and the Harris Review panel, which consisted of Deborah Coles, Stephen Cragg, Philip Leach, Dinesh Maganty, Matilda MacAttram, Richard Shepherd, Graham Towl and Meng Aw Yong, and supported by the Secretariat, Deborah Browne, Graham MacKenzie, Robyn Malan de Merindol and Tom Shaw.

[This information is also available at www.gov.uk/moj and <http://iapdeathsincustody.independent.gov.uk/harris-review/>]



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The personal observations of those who have first-hand experience of the situations that we can otherwise only read about have been an invaluable source of evidence to this report. We are indebted to those individuals currently in custody who took the time to write to the Review, either by responding to the Call for Submissions, or by completing the questionnaire that we distributed to a small number of institutions. Similarly, we would like to thank those who left messages for us on the National Prison Radio Helpline. We would also like to extend particular thanks to the young adults who came to see us in September 2014, facilitated by User Voice, and spoke expressively and bravely about their own experiences in custody. During our visits to establishments, we also heard some very heartfelt and poignant accounts from the young adults we met there. We are immensely grateful for the honesty and the insight of these contributions, which we considered very carefully.

There were too many valuable contributions to this Review for us to name them individually. However, those who responded to our Call for Submissions, who participated in our events, or who provided oral evidence to the panel are listed in Appendices 4-6 of this report, and further details are available on the website at <http://iapdeathsincustody.independent.gov.uk/harris-review>. We would not have been able to complete this work effectively without the expert, knowledgeable perspectives to which we were fortunate to have access.

We would like to thank the governors and the staff at the establishments we visited, who provided honest, provocative and sometimes distressing accounts of their experiences of deaths in custody, often working within the constraints of severe resource pressures. We would also like to offer our appreciation to the establishments that facilitated our evidence gathering, including the questionnaires distributed to prisons, the calls to Prison Radio Hotline, and the visits by the researchers we commissioned to conduct a qualitative analysis of staff perspectives.



The Review was also facilitated by support we are thankful to have received from MoJ Analytical Services, both in terms of the contract management of the research we commissioned externally, in advising the panel and providing an initial summary of key relevant reports, and in particular for conducting for us the analysis of 30 years of NOMS data relevant to deaths in custody. This comprehensive analysis has never been attempted before and it is now a legacy of the Review, on which future research and analysis can be founded.

We considered extensive case material on the 87 individual deaths that we examined, which would not have been possible without the co-operation of the PPO, individual coroners, and NOMS Equalities, Rights and Decency Group. We are much obliged for the effort put in to collating this material on our behalf.

Our engagement with young adults was facilitated by the IMBs of the relevant prisons, for which we are very grateful, in particular to the IMB's of HMYOI Aylesbury, HMP/YOI Isis, HMP Norwich and HMP Rochester. In addition, we appreciate the support from Prison Radio in obtaining the oral recordings of prisoner views following the interview with Lord Harris.

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Foreword

By the Chair of the Harris Review, Lord Toby Harris

When I was approached about chairing this review, I was aware that the task I was taking on would be daunting. At the time, I was told that this Review was a “once in a generation opportunity” to have an impact on the lives of some of the most vulnerable people in our society. Nonetheless, it is only after spending 12 months steeped in the case histories of the 87 young people that we considered in detail and the rest of the extensive and diverse range of evidence that we have considered, that the full weight of that sentiment has become clear.

In particular, listening to the harrowing stories of families who have lost their loved one through a self-inflicted death in custody has been a humbling experience, and one that the panel and I will remember for a long time. We will also remember the frank, insightful, and often very brave, accounts given to us by the young adults who were, or who still are, in custody. Their narratives have brought home to us more than anything else that, whatever the events that led to them ending up in custody, those young people were also someone’s son or daughter, sister or brother, partner or even parent. They also left behind fellow-prisoners with whom they may have shared a cell, or who were in the cell next door, whose lives will never be the same again because of the impact of such a young and tragic death.

Nor do the reasons why these young adults were in custody alter the State’s duty of care to them. They have had their liberty taken from them as punishment for the crimes of which they have been convicted. In some instances, they were awaiting sentencing following conviction. However, in others they had been remanded in custody because they had not yet come to trial, so in the eyes of the law they remained innocent. Many of them were undoubtedly vulnerable and some will have been psychologically immature whatever their chronological age.

However, whatever their particular reasons for being in custody, their experiences during this time should not have been such that they added to their distress or increased their vulnerability, particularly to the point that they might have wanted to take their own lives. And no-one should be under any illusions, prisons and young offender institutions are grim environments: bleak and demoralising to the spirit.



In July 1910, when he was Home Secretary, speaking in the House of Commons, Sir Winston Churchill said:

“The mood and temper of the public in regard to the treatment of crime and criminals is one of the most unfailing tests of the civilisation of any country. A calm and dispassionate recognition of the rights of the accused against the State, and even of convicted criminals against the State, a constant heart-searching by all charged with the duty of punishment, a desire and eagerness to rehabilitate in the world of industry all those who have paid their dues in the hard coinage of punishment, tireless efforts towards the discovery of curative and regenerating processes, and an unflinching faith that there is a treasure, if you can only find it, in the heart of every man.”¹

This is a message that we want all who read this report to bear in mind as they consider our conclusions and recommendations. Young adults in custody, and indeed those under 18 who share similar characteristics, are young, vulnerable and still developing individuals who need to be nurtured and supported safely to navigate through the complexities of their lives into purposeful, mature adulthood.

Having said this, as we progressed through the last year and considered what was said to us by various stakeholders, what we saw during prison visits, and what we heard from families, young adults, and professionals and non-government organisations working in the area, it became increasingly clear that it would be wrong to look at our task narrowly.

The pathway that leads a young adult in custody to consider taking their own lives is a long and complex one, and includes potential points where other decisions or interventions along the way could have resulted in a more positive outcome. While, as this Report will demonstrate, we need to look closely at internal prison processes and the dynamics of the prison environment, we also need to look more fundamentally at the prison regime and the purpose of prison itself. We need to look at why so many young people are in prison. This is because we feel there are questions about whether other decisions earlier in their lives might have meant that some of them need not have been in prison in the first place. But it is also because reducing the numbers in prison to those for whom a custodial sentence is unavoidable would enable more resources to be devoted to keeping those who are in prison secure, safe and receiving appropriate therapeutic or rehabilitative interventions.

¹ HC Deb 20 July 1910, vol 19 cols 1326-57 (Houses of Commons Debate 20 July 1910 volume 19 column 1326-57). <http://hansard.millbanksystems.com/commons/1910/jul/20/class-iii>. Accessed 11 March 2015.





Our recommendations need to be considered together alongside similar and corroborative findings from numerous other reports, including the recently published Thematic Review by the Prison and Probation Ombudsman report (Learning from PPO Investigations: Self-inflicted deaths of prisoners – 2013/14, March 2015) and the report of the House of Commons Justice Committee (Prisons: Planning and Policies – HC309, March 2015).

While there is no magic bullet – If there was a simple and easy solution no doubt it would have been implemented years ago – some radical changes are needed if we are to bring about a reduction in the number of deaths of young people in our prisons. Not to implement our recommendations would mean that the opportunity to reduce the number of deaths of people, of all ages, has not been taken and people will continue to die alone and miserable in prisons in one of the richest countries in the world.

However, the prize if we use this opportunity to make substantive changes to how we perceive, manage and support vulnerable young people far outweighs the cost and effort that we realise implementation will take. As of 31 December 2014, 101 people under 24 have died in our prisons since April 2007, another 14 since the cohort whose case studies we considered in detail for this report. We owe it to those whose deaths could have been prevented, and their families, to make changes and ensure that the young adults who are now in our prisons, and the children who are currently living the complex and troubled lives that may lead them into custody, are not left to the same fate, but are supported and enabled to be the productive citizens that they have the potential to become.

The acknowledgement section of this report demonstrates the huge number of individuals and organisations to whom we are indebted for enabling us to reach our conclusions. I would also like to offer particular thanks to my Panel colleagues (their experience and professional skills are described in Appendix 1), whose insight and wisdom has been so helpful throughout and to our Stakhanovite Secretariat, led by Dr Deborah Browne, without whom we would not have been able to produce a report that is so comprehensive and thorough.





Executive Summary

- i. The Review started its work in April 2014 and presented its report to the Minister for Prisons, Probation and Rehabilitation exactly twelve months later. It had been asked to examine whether appropriate lessons had been learned from the self-inflicted deaths in custody of 18-24 year olds that had occurred after ACCT was fully rolled out in April 2007, and if not, what lessons should be learned and what actions should be taken to prevent further deaths. Our report is summarised over the next few pages. However, it needs to be emphasised that there is no simple and easy solution. The weight of the evidence we considered showed us that we needed to look broadly at the reasons why so many young people² die in custody and our recommendations reflect that broad view.
- ii. Every single one of the deaths that we considered represents the heart-breaking loss of someone's son or daughter, brother or sister, partner or parent. In all cases, the State had a duty to care for them. The reasons why those young people were in custody do not alter that duty. Each of those deaths represents a failure by the State to protect the young people concerned.
- iii. That failure is all the greater because the same criticisms have occurred time and time again. Our findings echo the criticisms and recommendations made consistently and repeatedly throughout the last fifteen years and more. Lessons have not been learned and not enough has been done to bring about substantive change. This time, following this Review, it must be different. Radical changes will be necessary and there must be commitment to support vulnerable young people, both before and after their contact with the Criminal Justice System. The objective of policy must be to assist them to become productive citizens, to desist from crime and to keep them safe. If the government does not act decisively then the distressing cases we have considered will be repeated and more young lives will be wasted.
- iv. Our conclusions and recommendations have not been reached lightly. They are all derived from the evidence we have received and reviewed: Chapter 1 of this report describes how comprehensive this has been. Submissions were received from 54 organisations and individuals. We consulted senior experts and professionals and conducted 26 hearings and a number of meetings and seminars. We visited prisons and Young Offender Institutions. We spoke to the families of the young adults and children who died. We took a number of opportunities to speak to young adults who had themselves previously been in custody, or who were still in custody during the course of the Review. We conducted a survey of young adults in a number of institutions and, in addition, received 50 audio submissions from prisoners following the interview with Lord Harris and subsequent broadcasts on National Prison Radio.

² For the purposes of this report, the term 'young adult' applies to those individuals aged between 18 and 24; the term 'young people' is used to refer to those individuals aged under 24.

- v. We commissioned both a literature review to examine what has already been found in this area, and also unique independent qualitative research on staff experience, knowledge and views. We arranged for an analysis to be conducted of nearly forty years of data on self-inflicted deaths between 1978 and 2014, the first time such an analysis had been conducted.
- vi. We negotiated unprecedented access to documents concerning the cases within the scope of the Review, which enabled us to consider each case in as much detail as possible. This included, where available, the Prison and Probation Ombudsman reports on the deaths, the inquest findings and any coroner's report on preventing future deaths. We also engaged the services of a team of forensic psychiatrists to analyse the contents of the clinical reviews carried out as part of the investigations by the PPO, again the first time that this has been done.
- vii. We examined in detail the lives of the 87 young people (four children and 83 young adults aged from 18 to 24) who died between April 2007 and December 2013. These were vulnerable young people who should never have been left in a position where they became so desolate and distressed that they harmed themselves, intentionally or otherwise, seriously enough to result in death.
- viii. The disturbing vulnerabilities that they faced are described in detail in chapters 4, 5 and 6 of this report. Some of the young people had had chaotic lives and complex histories. Some had been subject to child abuse, been exposed to violence or suffered high levels of bereavement. Others had been in foster and residential care. For some, these vulnerabilities were overlaid with negative stereotypes associated with being from BAME backgrounds, such as those concerning gangs or religion.
- ix. In many instances, these factors were further compounded by mental health issues, or by a lack of maturity, associated with the developmental stage in young adults where brain structures and coping strategies are still evolving.
- x. The Review concluded that all young adults in custody are vulnerable. Moreover, the separation of young people from their families and support networks is likely to lead to loneliness and to exacerbate vulnerabilities. This has wide implications for the way in which prisons and YOIs should operate.
- xi. That is why in chapter 2 of the report we consider the purpose of prison. No-one should be under any illusions: prisons and YOIs are grim environments, bleak and demoralising to the spirit. Our visits to these establishments, and our discussions with young adults, and with staff and other stakeholders, including HM Chief Inspector of Prisons, confirmed this. What is more, this harsh environment, the impoverished regimes (particularly with current staff shortages) and the restrictions placed on young adults because of their IEP status or because of local policies on the management of gangs, all combine to make the experience of being in prison particularly damaging to developing young adults.

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- xii. In practice, it is clear that young adults in prison are not sufficiently engaged in purposeful activity and their time is not spent in a constructive and valuable way. Current restricted regimes do not even allow for the delivery of planned core day activities that might help with rehabilitation. Our evidence demonstrates that young adults do not have enough activities, such as education or work, which will enable them to live purposeful lives. Additionally, we heard frequent examples of medical and mental health appointments being missed because there are not sufficient staff available to escort the patient. Clearly this is something that needs to be tackled before prisons can start to satisfactorily address the needs of vulnerable young adults. The Review concluded that overall the experience of living in a prison or a Young Offender's Institution is not conducive to rehabilitation.
 - xiii. There needs to be an inherent shift in the philosophy of prison in this country, and so we are recommending that the Ministry of Justice publishes a new statement on the purposes of prison, where the primary purpose is rehabilitation, and which acknowledges that all persons deprived of their liberty shall be treated with respect for their human rights.
 - xiv. The delivery and implementation of the new statement of purpose of prison needs to be led from the top, with ministers and senior leaders taking responsibility for this and indeed for all the actions we set out in this report.
 - xv. Chapter 3 of this report sets out the importance of leadership in enabling a cultural change within our prisons, so that the young adults being rehabilitated there are valued and nurtured towards safer, more productive lives.
 - xvi. By and large, the policies that NOMS promulgates through Prison Service Instructions are sound and, if implemented, would deliver good practice. However, we question how NOMS leaders can effectively assure themselves or ministers that these policies are being delivered and complied with, without more effective processes in place to govern and monitor their implementation.
 - xvii. The Review was surprised by the apparent lack of awareness centrally about the number of functional safer cells in individual establishments, and that data is not collected centrally by NOMS of the number of hours prisoners spend out of their cells on purposeful activity (only hours worked in industry are counted). NOMS management have no proper means of assessing whether sufficient care is being given to vulnerable young adults or, indeed, whether minimum standards are being met. Performance management needs to include adequate assessment of these vital issues. A senior member of staff in NOMS supported by a dedicated unit should be set up to make sure that the particular needs of young adults are recognised and met.
 - xviii. A disconnect between what those in charge think should be happening and what is actually happening is also something that the panel observed in individual prisons. It is, of course, the case that the governor should play an essential role in setting the values by which staff engage with prisoners. This is a key leadership function.

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- xix. Governors need to set an example from the top and instil in their prison a new culture, which recognises and supports the specific needs of young adults. A frequent issue raised by governors was one of resources. They explained that delivering a safe and supportive service is increasingly challenging against a backdrop of public service reforms; there is pressure to deliver more with less financial resource. Notwithstanding these pressures, the Review feels that in order effectively to manage, rehabilitate and keep safe vulnerable people in custody, including but not limited to young adults, then the workforce needs to be trained and developed to a higher professional standard.
- xx. Chapter 3 notes that relationships with mature adults are necessary for young adults as part of their social development, and that all young adults need a significant adult in their lives. A central recommendation of this Review is that within the prison this role, and responsibility for the care and safety of each young adult, is taken on by a new role: the Custody and Rehabilitation Officer (CARO). The CARO, which should be a more consistent and professional replacement for the personal officer scheme, needs to be a specialist, suitably trained professional, with a small enough case load so that enough time can be given to each vulnerable adult.
- xxi. As already outlined, Chapters 4 to 6 describe some of the key vulnerabilities of young adults in custody that appear to contribute to distress and self-harm. Young adults are still developing physically and neurologically and the evidence is clear that they continue to do so well into their mid-twenties. This can impact not only on their behaviour, but on their ability to cope with custody and being separated from their families. The Review is recommending that, as well as chronological age, maturity should be a primary consideration in making decisions relating to diversion, sentencing and, where a custodial sentence must be given, how and where a young adult should be accommodated.
- xxii. The issue of bullying was raised frequently in the evidence we received and arose often in the individual cases we considered. We were surprised that NOMS does not have a discrete policy concerning bullying and we recommend that a Prison Service Instruction is developed to address this widespread problem.
- xxiii. The Review considered the evidence about the range of vulnerabilities that apply to young adults in custody and concluded that much more needs to be done to support young adults both before and after they have contact with the Criminal Justice System. Young adults who have been in care, for example, need particular support, and local authorities need to be held to account for discharging their statutory duties for young adult care leavers who are in custody.
- xxiv. There must be parity of health care services in prisons and YOIs with those in the community and NHS England and Local Health Boards in Wales should commission the services necessary to do this and deliver what we have proposed.

- xxv. The 87 cases we examined in detail demonstrated that many of the young people's problems and vulnerabilities, including mental health issues, had been evident from an early age. We had to ask the question, why were so many of these young adults in custody in the first place? Prison should be used as a last resort. Much more needs to be done to address these problems and to divert these young people from the criminal justice system at an earlier stage in their lives. What is more a reduction in the overall prison population would make it easier for prisons to provide an environment that meets appropriate standards of decency, safety and respect.
- xxvi. That is why the Review concludes that further action needs to be taken to divert more young people out of custody and out of the criminal justice system in general. Cross-governmental input is needed to address the needs of troubled children and young adults and to ensure that problems are identified and effectively addressed at an early age. Custody should be used as a last resort, and those who pass sentence in the courts need to have the right information available to them, particularly given the vulnerabilities of this age group.
- xxvii. Prison is a hugely expensive intervention, and yet the benefits of this spend are questionable, with a relatively low impact on crime. Rates of re-offending are high, particularly among young adults. Reinvestment and redirection of resources to the health and welfare system and community alternatives to custody will better provide the specialist help tailored to the individual's needs.
- xxviii. Once in custody, more needs to be done to support young adults and moderate the impact of the custodial experience. Families can and should play an important role in this. At present, interaction between the prison and families is inconsistent, often inadequate and sometimes inconsiderate. One of the roles of the CARO must be to ensure better links are maintained with the families of young adults, ensuring they are involved in the management of vulnerability.
- xxix. Despite the prevalence of mental health issues in custody, we have seen stark evidence that vulnerable young adults are not getting access to the support and treatment they need. Their CARO should build a supportive relationship with them and make sure their health, education, social care and rehabilitation needs are met. An Individual Custody Plan (ICP) should be developed for each young adult, following a multi-disciplinary, holistic needs assessment. This assessment process – which the Review calls the Safety and Vulnerability, Risk Assessment and Support (SAVRAS) process - should be co-ordinated by the CARO, but should include input from a multi-disciplinary team, particularly health and mental health. Information should be gathered by the CARO, but all of those involved need to be responsible for the effective flow of information to inform the ICP. NOMS and Healthcare providers should jointly own the responsibility for prevention of self-harm and self-inflicted deaths in custody.



- xxx. Throughout this Review, we have been struck by how poor information exchange appears to be, and Chapter 6 highlights, in particular, problems around the sharing of health and mental health information. Whether it is between Departments, between prison and YOI establishments, or between individuals within an establishment, information is falling through gaps and lives are being put at risk as a result. The Secretary of State for Justice should introduce legislation to create a statutory duty of cooperation that should cover the sharing of information with the Prison Service. This duty should be placed upon those organisations that have direct engagement with the Prison Service (including health practitioners, mental health services, police etc.).
- xxxii. Chapter 7 of the report focuses on the processes that follow a self-inflicted death. It is clear from our analysis of recommendations made by the PPO and the findings of inquests that emergency response procedures need to be improved more consistently across the estate. Prisons and YOIs were often insensitive in the way in which they engaged with bereaved families immediately after the incident that led to the death. NOMS policy relating to the process that should be followed after a self-inflicted death appears to be reasonably comprehensive and well thought out. However, in practice, it is often not properly implemented, or is interpreted inconsistently at a local level.
- xxxiii. Following a death, there should be a duty of candour upon NOMS and its staff both towards those organisations responsible for managing the post-death processes (such as the PPO and the coroner) and the families and friends of the deceased young adult.
- xxxiiii. The Review recommends that the powers of the PPO should be strengthened and arrangements to follow up actions following a PPO report and inquest findings should be enhanced. Parliament should have a much greater role in oversight of the inspection process, which should be made independent of the Ministry of Justice, and in driving the changes that are needed. This will help ensure that processes are more transparent and fair.
- xxxv. We acknowledge that it will be difficult for those organisations that are the subject of our recommendations to take the specific actions that we are proposing in the context of the financial constraints that they, like all government departments, currently face. In particular, it is clear that NOMS cannot deliver these recommendations without a significant investment of resources. In the longer term, we are confident that this investment can be funded through the savings delivered by earlier intervention and diversion from the CJS.
- xxxvi. Delaying action until the resource position is easier is not an option. Unless progress is made on the proposals that we have made, young people will continue to die unnecessarily in our prisons and we will continue to waste countless millions of pounds in failing to rehabilitate those who could be rehabilitated, in locking up those for whom a non-prison option would be more appropriate, and in failing to intervene early enough to prevent people from entering the criminal justice system in the first place.



1. Introduction

- 1.1. On 6 February 2014 the Justice Secretary announced an independent review into self-inflicted deaths in National Offender Management Service custody of 18-24 year olds in England Wales. Lord Toby Harris, Chair of the Independent Advisory Panel on Deaths in Custody (IAP), was invited to lead the Review. Lord Harris extended an invitation to join the Review panel to all of his colleagues on the IAP, all of whom individually decided to accept the invitation and commit to the challenging one year schedule for the Review.
- 1.2. The Terms of Reference for the Review (see appendix 2) were to examine self-inflicted deaths since 1 April 2007 and to assess “...whether appropriate lessons have been learned from those deaths and if not, what lessons should be learned/what actions should be taken to prevent further deaths”.

“...issues with communication, informal/verbal and formal documentation, adherence to procedures and the level of observations were all contributing factors in the death...”

(Quote from Coroner’s report following an inquest).

- 1.3. The Review has been welcomed by a range of other stakeholders. It has been described as “*a unique opportunity for expert scrutiny of systemic failings in the penal system that have culminated in the tragic deaths of so many young adults in custody*” (Howard League Submission to the Review³, page 1).
- 1.4. Indeed, the last 15 years in particular have seen growing concern about the problem of deaths in custody. In 1999, the HM Chief Inspector of Prisons published a thematic review *Suicide is Everyone’s Concern*⁴. Despite the change in prison landscape, many of the themes that were raised in that report, such as the importance of effective induction/ reception processes, disseminating lessons learned, and the need for local accountability, were also raised in more recent reports, including the report *Fatally Flawed: Has the state learned lessons from the deaths of children and young people*

3 Submission to the Harris Review received from Howard League for Penal Reform on 28 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

4 HM Chief Inspector of Prisons (1999). *Suicide is Everyone’s Concern*. A thematic review by HM Chief Inspector of Prisons for England and Wales, May 1999. London: HMIP. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/suicide-is-everyones-concern-1999-rps.pdf>. Accessed 9 March 2015.

*in prison?*⁵, published jointly by the Prison Reform Trust and INQUEST in 2012, and the Prisons and Probation Ombudsman 2015 report '*Learning from PPO Investigations: Self-inflicted deaths of prisoners.*'⁶

- 1.5. Right from the very start, we would like to express our concern that the same problems are being reported from so many different sources and over such a long period of time. Despite being clearly articulated repeatedly in numerous reports, the extensive work of this panel has found that the lessons are clearly not being learned, and not enough has been done to bring about substantive change.

The Context behind the Commissioning of this Review

- 1.6. Although not involving a young adult, we feel that the context around which this Review was commissioned starts with the disturbing case of Joseph Scholes, a 16 year old whose death in Stoke Heath Young Offender Institution in 2002 prompted calls for a public enquiry. Joseph's case is set out here in a separate text box.
- 1.7. While the calls for a public enquiry were rejected by the government, pressure continued to grow to make changes to how deaths in custody were investigated. The Parliamentary Joint Committee on Human Rights (JCHR) (Third Report, 2004-2005 session)⁷ called for a body to address its concerns about the national problem of deaths in custody. This led to the setting up of a Ministerial Roundtable on Suicide and the Forum for Preventing Deaths in Custody. However, the JCHR felt that these structures did not have the necessary powers or resources to intervene effectively, and called for a review of their functions. This Review, led by Robert Fulton, recommended in 2008⁸ the creation of a new structure to replace both the Roundtable and the Forum.

5 Prison Reform Trust & INQUEST (2012). *Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?* London: PRT. <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Fatally%20Flawed.pdf>. Accessed 31 March 2015.

6 Prisons and Probation Ombudsman (2015). *Learning from PPO Investigations: Self-inflicted deaths of prisoners – 2013/14* <http://www.ppo.gov.uk/wp-content/uploads/2015/03/self-inflicted-deaths-2013-14-Final-for-publication-5.pdf>. Accessed 11 March 2015.

7 House of Lords/House of Commons Joint Committee on Human Rights (2004). *Deaths in Custody - Third Report of Session 2004-05*. London: TSO. <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/15.pdf> Accessed 30 March 2015.

8 Fulton, R. (2008). *Review of the Forum for Preventing Deaths in Custody*. London: Ministry of Justice. <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2010/02/The-Fulton-Report-2008.pdf>. Accessed 11 March 2015.

Case of Joseph Scholes (extract adapted from *Fatally Flawed* Report, p. 3).

Joseph Scholes was nine days into a two-year sentence for robbery when he died in Stoke Heath YOI in March 2002. Joseph had a troubled early life, allegedly the victim of sexual abuse by a member of his father's family from the age of six. As he grew older, his distress led to self-harm and he first attempted suicide in 2001 by trying to jump out of a window. He received a community sentence following an altercation with ambulance workers. When his behaviour became too difficult for his mother, he was taken into local authority care and placed in a children's home. A week later, Joseph was with a group of children from the home who demanded money and mobile phones from another group of children, and he was charged with robbery. His impending court appearance caused an increase in anxiety and self-harming behaviour. When he was sentenced, it was noted that he only played a peripheral role in the incident, and that pre-sentence reports from social workers, YOT workers and a consultant psychiatrist all highlighted Joseph's vulnerability. The judge stated that he wanted the warnings about Joseph's self-harming and alleged sexual abuse 'most expressly drawn to the attention of the authorities'. Although the YJB could have placed him in a secure children's home or secure training centre because of his vulnerability, no placement was available and he was sent to HM YOI Stoke Heath. Joseph's mother also telephoned Stoke Heath, to inform them of the risk. Joseph was placed under intense observation, but was not seen by a psychiatrist. He repeatedly told staff that he would kill himself if he was moved to a normal location in the YOI, but nonetheless staff proceeded with an incremental transition, firstly moving him to a cell in the health centre where he was less intensely observed. Nine days after arriving at Stoke Heath, Joseph made a noose from a bed-sheet and hung himself from the bars of his cell. His body was discovered by a maintenance worker who had been to unblock toilets. Joseph left a message for his mother and father telling them he couldn't cope and that "I tried telling them and they just don't fucking listen". The inquest into his death heard from a number of experts that Joseph should not have been placed in the YOI. The jury noted in their verdict that "risk was not properly recognised and appropriate precautions were not taken to prevent it".

Sources: This extract has been adapted from: Prison Reform Trust & INQUEST (October, 2012). *Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?* The original was adapted from INQUEST case notes; INQUEST notes of interview with Yvonne Bailey for *In the Care of the State: Child Deaths in Penal Custody in England and Wales* (INQUEST, 2005), transcript of inquest hearing; inquest jury's narrative verdict; Rule 43 recommendations of HM Coroner for Mid and North Shropshire, JP Ellery; Report of Robin Hughes, Independent Consultant commissioned by Trafford Area Child Protection Committee for a Part 8 Case Review.

- 1.8. The Government's response was to establish the Ministerial Council on Deaths in Custody (MCDC), which is jointly sponsored by the Home Office, the Department of Health and NOMS on behalf of the Ministry of Justice (MoJ). The MCDC became operational on the 1st of April 2009. Beneath the MCDC, sits the Independent Advisory Panel (IAP) on Deaths in Custody, which provides independent expert advice to the MCDC, guidance on policy and best practice across sectors, commissions' research and makes recommendations to Ministers and the heads of key agencies. Jointly, the IAP and the Ministerial Council are tasked to bring about a continuing and sustained reduction in the number and rates of deaths of people detained in all forms of state custody in England and Wales.
- 1.9. Despite these important steps towards improving how deaths in custody are monitored, pressure on MoJ to take further action increased. A range of reports were published that demonstrated concern about how children and young adults were managed in prisons. For example:
- The Prison Reform Trust and INQUEST report *Fatally Flawed* (already mentioned above) considered the circumstances surrounding a number of self-inflicted deaths between 2003 and 2010. It concluded, among other things, that many young people and children whose deaths were self-inflicted shared common traits, and, importantly, that successive governments had not learnt the lessons from those deaths.
 - The Youth Justice Board's *Deaths of Children in Custody* report in 2014 highlighted the fact that two of the 16 self-inflicted deaths of children in custody since 2000 had happened as late as January 2012.⁹
 - There were two notably critical inspections early in 2013; the first an unannounced inspection in January of HM YOI Feltham A,¹⁰ which holds boys under 18 years of age, and the second following quickly in March of HM YOI Feltham B,¹¹ which holds young adult males aged 18-20 years. Both reports raised serious concerns about the safety of the young people in the institutions and the levels of violence. In particular, the report on Feltham B, was described by Nick Hardwick, the Chief Inspector of Prisons, as "one of the most concerning we have published recently" (2013, page 5).

9 Youth Justice Board (2014). *Deaths of Children in Custody: Action Taken, Lessons Learnt*. London: Youth Justice Board of England and Wales. <http://www.justice.gov.uk/news/press-releases/yjb/yjb-publishes-report-deaths-of-children-in-custody-action-taken,-lessons-learnt>. Accessed 10 February 2015.

10 HM Chief Inspector of Prisons (2013a). *Report on an unannounced inspection of HMP/YOI Feltham, 21 – 25 January 2013*. London: HMIP. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/prison-and-yoi-inspections/feltham/feltham-a-annual-report.pdf>. Accessed 10 February 2015.

11 HM Chief Inspector of Prisons (2013b). *Report on an unannounced full follow-up inspection of HMP/YOI Feltham, 18 – 22 March 2013*. London: HMIP. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/prison-and-yoi-inspections/feltham/feltham-b-annual-report.pdf>. Accessed 10 February 2015.

- In April 2014, HM Inspectorate of Prisons (HMIP) published a report on the unannounced inspection of HM YOI Brinsford (18-20 year olds), which took place in November 2013. Nick Hardwick commented “*these are the worst overall findings my inspectorate has identified in a single prison during my tenure as Chief Inspector. Across all of our four tests of a healthy prison, we found outcomes to be poor*” (2014, page 5).¹²
- 1.10. Recognising that something needed to be done about the treatment of young adults in custody, MoJ launched a public consultation in November 2013 on *Transforming Management of Young Adults in Custody*.¹³ This opened the prospect of significant changes, including possible legislative reforms, to the way in which young adults are managed in custody. However, the government’s response to the consultation was deferred.
 - 1.11. When the decision to commission an Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds was announced, it was also announced that the responses to the consultation would be viewed alongside the findings of the Review. We trust that the recommendations of this report will be fully incorporated into any policy changes that are eventually implemented to improve the safety and well-being of young people in custody.

The Review Process

- 1.12. The Harris Review began in April 2014 and ended when this report was handed to ministers a year later. During the course of the year, the panel undertook a challenging and comprehensive schedule to examine whether appropriate lessons had been learned from the self-inflicted deaths in custody of 18-24 year olds, and to identify what further actions need to be taken. This included meeting 3-4 times a month in order to consider and discuss the evidence.
- 1.13. A full description of the different methods used and processes undertaken can be found in Appendix 3. Among other things, however, the Review published a Call for Submissions in May 2014, which enabled us to consider the views and evidence of 54 organisations and individuals who responded.

12 HM Chief Inspector of Prisons (2014). *Report on the unannounced inspection of HM YOI Brinsford, 4-15 November 2013*. London: HMIP. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/04/Brinsford-2013.pdf>. Accessed on 27 February 2015.

13 Ministry of Justice (2013b). *Transforming Management of Young Adults in Custody Consultation*. London: TSO. https://consult.justice.gov.uk/digital-communications/young-adults/user_uploads/transforming-management-of-young-adults-in-custody.pdf. Accessed 27 February 2015.

- 1.14. We commissioned specific pieces of research that will provide a fundamental contribution to the knowledge base of deaths in custody. These studies, which will be referred to throughout the report and can be accessed through the Harris Review website, are as follows:
- The University of Greenwich were commissioned to carry out a Literature Review: Understanding and Addressing Self-Inflicted Deaths in Prison amongst Those Aged 18 – 24: A literature Review;
 - RAND Europe & the Prisons Research Centre, University of Cambridge were commissioned to carry out a qualitative analysis of staff perspectives: Self-Inflicted Deaths in NOMS' Custody amongst 18–24 Year Olds: Staff Experience, Knowledge and Views;
 - MoJ Analytical Service and NOMS analysts were commissioned to conduct an analysis of nearly forty years of data: Self-Inflicted Deaths in Prison Custody, 1978-2014, England and Wales;
 - One of the Panel members, Dr Dinesh Maganty, supported by forensic psychiatrists who were independently commissioned to produce The Harris Review: Analysis of the Clinical Reviews (& Case Summaries). This is described in more detail in Appendix 3.
 - NOMS and MoJ Internal Audit and Assurance examined relevant material from an initial analysis of the Measuring the Quality of Prison Life (MQPL) data set: Measuring the Quality of Prison Life (MQPL) and the Harris Review; Self-inflicted death in custody among 18-24 year olds. The MQPL, which the panel felt was potentially a rich, untapped source of data, is described in more detail in Appendix 3.
- 1.15. The Review also considered oral evidence from a range of stakeholders, including conducting 26 stakeholder hearings, a separate set of hearings with family members, a public hearing, and a seminar for local and community groups. We held a number of round-table events, including one on the characteristics of young adults, and others on liaison and diversion.
- 1.16. Every panel member took time to visit a number of different prisons or YOIs so that they could develop a better understanding of the context of custody, and could take advantage of the opportunity to speak to staff and young adults. Nine prisons and YOIs were visited in total.
- 1.17. We also undertook a targeted survey of young adults currently in a prison or Young Offender Institution (YOI), in order to better understand their very particular perspective,¹⁴ which yielded 65 questionnaire responses.¹⁵ In addition, we received 38 audio submissions from prisoners in response to an interview given by Lord Toby Harris on National Prison Radio and a series of adverts on it soliciting comments.

14 Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

15 55 questionnaires were received from young adults, with another 10 from adults.

- 1.18. Most importantly, we reviewed in detail case material for each of the 83 young adults and 4 children who died through self-inflicted death between April 2007 and December 2014. This process is described further in Appendix 3.
- 1.19. The evidence that we gathered through these different routes is discussed throughout this report, and further details, where possible, are available on the Harris Review website. Before we present the findings of this intense programme of work, however, this section continues by providing a broader introduction to the topic on which we have spent so much time.

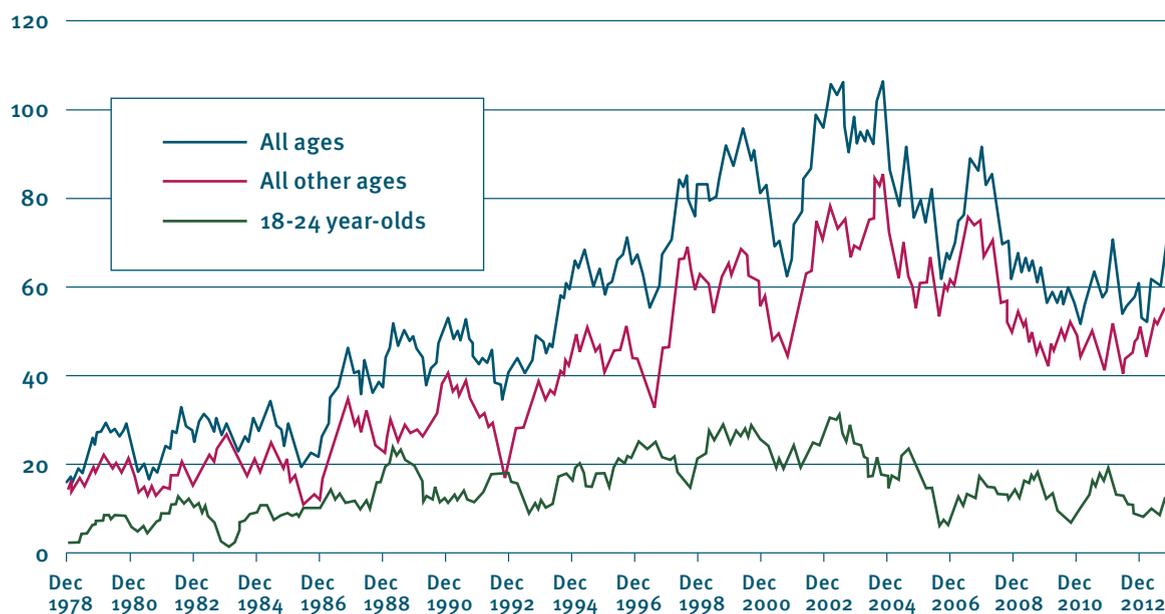
Self-Inflicted Deaths in Custody in England and Wales

- 1.20. A self-inflicted death (SID) is defined by the MoJ as any death of a person who has apparently taken his or her own life, irrespective of intent. This not only includes suicides but also accidental deaths as a result of the person's own actions. This classification is used because it is not always known whether a person intended to commit suicide.
- 1.21. This section provides an overview of self-inflicted deaths in England and Wales between 1978 and March 2014, with particular reference to 18-24 year olds. It is made possible because of the unique data analysis commissioned by the Harris Review, and carried out on our behalf by analysts in MoJ and NOMS.¹⁶
- 1.22. Figure 1.1, as outlined here, shows the number of self-inflicted deaths in custody in the 12 months to each month over this time period. There were a total of 2,039¹⁷ self-inflicted deaths between 1978 and March 2014 (with 2,014 from 1978-2013 and an additional 25 in the first three months of 2014).

16 Ministry of Justice (2015). *Self-inflicted Deaths in Prison Custody in England and Wales between January 1978 and March 2014*. London: Ministry of Justice. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

17 Ministry of Justice (2015). *Self-inflicted Deaths in Prison Custody in England and Wales between January 1978 and March 2014*. London: Ministry of Justice. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Figure 1.1: Number of Self-inflicted Deaths in Custody, Running 12-Month Totals



- 1.23. If we consider calendar years, the number of self-inflicted deaths generally increased in each year from 1978, when there was a total of 16 incidents, peaking in 2004 with 96 incidents. Between 2005 and 2011, with the exception of 2007, the number of incidents per year generally declined, with 58 incidents in 2010 and 2011, the lowest recorded numbers in almost 2 decades. The total number of incidents has increased in recent years with 61 and 75 incidents in 2012 and 2013, respectively. This increase appears to have continued beyond the data covered in the analysis conducted for the Review with 84 self-inflicted deaths from January to December 2014.
- 1.24. The number of self-inflicted deaths amongst 18-24 year olds has followed a broadly similar trend to the overall group, with some differences. The number of incidents amongst 18-24 year olds generally increased from 1978, peaking with 26 incidents in each of 1999, 2000, and 2003. Since 2003 the number of incidents per year has been lower: there were six incidents in 2006, the lowest number of incidents amongst 18-24 year olds in a 12 month period since the 12 months up to July 1984 (and the lowest number in a calendar year since 1983). From 2007-2013, the total number of incidents in each calendar year has varied between 8 and 17.
- 1.25. Taking the relative prison population size into account, Figure 1.2 captures the rate of self-inflicted deaths from 2002 to 2013. In 2002, there were 1.33 incidents per 1,000 prisoners within the overall prison population. The rate subsequently decreased in the following years, with the exception of 2007, reaching a low of 0.68 incidents per 1,000 prisoners in 2010 and 2011, before increasing to 0.89 incidents per 1,000 in 2013.

Figure 1.2: Rate of Self-inflicted Deaths per 1,000 Prisoners (2002-2013)



1.26. The rate of self-inflicted deaths amongst 18-24 year olds has tended to vary, due to the smaller numbers within the group. In 2003 there were 1.20 incidents per 1,000 18-24 year olds within the prison population. Since then, the rate has generally declined, with the lowest rate of 0.29 incidents per 1,000 18-24 year old prisoners in 2006. Similar to the trend for all prisoners, the rate of self-inflicted deaths increased in 2013 for 18-24 year olds.

1.27. Table 1.1 summarises the figures of those young adults who have taken their own lives between April 2007 and the end of 2014. The deaths from 2007 to 2013 represent the 87 cases that this Review has considered in detail, while the remaining columns in blue show the deaths for 2014. April 2007 is when the Assessment, Care in Custody and Teamwork (ACCT), the new care planning system for prisoners identified as at risk of suicide or self-harm, was introduced.

Table 1.1. Self-inflicted deaths in custody of children and young adults
April 2007 - December 2014.

Gender and Age	2007 (from April)	2008	2009	2010	2011	2012	2013	Total	2014	Total
Male 18-24	11	12	15	8	14	9	12	81	14	95
Female 18-24	0	0	0	0	2	0	0	2	0	2
Totals	11	12	15	8	16	9	12	83	14	97
Male 15-17	1	0	0	0	1	2	0	4	0	4
Female 15-17	0	0	0	0	0	0	0	0	0	0
Totals	12	12	15	8	17	11	12	87	14	101

1.28. We will examine some of the factors that may be contributing to the disturbing increases in Self-inflicted deaths in custody in the last few years at various points throughout this report. We will also examine some of the political, resource and population pressures that impact on the ability of NOMS safely and effectively to manage the prison population in Chapter 2.

Young Adults in Custody

- 1.29. It is important to provide some context to the 18-24 cohort that is the focus of this Review. As of 30th September 2014, there were 17,945 young adults who were 18-24 years of age in NOMS custody (21% of the prison population).¹⁸
- 1.30. While that the term ‘young adult’ is somewhat nebulous, often referring to anyone between 16 and 30 years, in the context of the UK Criminal Justice System (CJS), there is a statutory distinction made between young adult offenders who are aged between 18 and 20 years old and adult offenders who are aged 21 or over.
- 1.31. As is set out in the MoJ consultation document *Transforming Management of Young Adults in Custody* (November, 2013) the situation with respect to young adults who are aged 18 or over but younger than 21 is as follows:
- “Under the current legal framework, young adults cannot be sentenced to imprisonment or committed to prison for any reason.¹⁹ Instead the vast majority of young adults are held in Young Offender Institutions (YOIs).²⁰ Of the young adults held in these institutions, most, but not all, of them are subject of Detention in a Young Offender Institution²¹ (DYOI) or – in the most serious cases – custody for life”²² (MoJ, 2013, page 4).²³*
- 1.32. In practice, YOIs that have a sole purpose of accommodating 18-20 year olds have been used less frequently over the last few years. The reasons for this, and the implications for young adults, are discussed later in the report (see Chapter 4).
- 1.33. At this point, however, we will provide more detail on the young adults whose deaths led to this Review.

18 Ministry of Justice (2014a) *Offender Management Statistics Bulletin*, England and Wales. Quarterly April to June 2014. *Ministry of Justice Statistics Bulletin*, 30 October, 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/368368/offender-management-statistics-april-june-2014.pdf. Accessed 2 April 2015.

19 There are certain exceptions, see Powers of the Criminal Courts (Sentencing) Act (PCCSA) (2000). s. 89 (2). Retrieved from: <http://www.legislation.gov.uk/ukpga/2000/6/contents>. Accessed 11 March 2015.

20 Ibid

21 Imposed under s.96 PCCSA 2000.

22 Imposed under ss.93 and 94 PCCSA 2000.

23 Ministry of Justice (2013b). *Transforming Management of Young Adults in Custody Consultation*. London: TSO. https://consult.justice.gov.uk/digital-communications/young-adults/user_uploads/transforming-management-of-young-adults-in-custody.pdf. Accessed 27 February 2015.

Self-Inflicted Deaths in Young Adults

- 1.34. The Terms of Reference for the Review asked that we should take into account deaths of young adults aged 18-24 in prisons and Young Offender Institutions in England and Wales, and that we should examine cases since the roll-out of ACCT was completed on 1st April 2007.
- 1.35. We would have liked to have included in our examination all deaths that occurred right up until we finished writing our report. However, our analysis of the cases (see Appendix 3 for further details) included scrutiny of the coroner's and PPO reports. Practically speaking, only the cases where at least some of information was published and available could be included in the analysis. By the end of December 2014 there had been 101 self-inflicted deaths of young adults (including four children) since April 2007. However, sufficient details were not available of those that occurred after January 2014, and they were therefore not included in the detailed analysis.
- 1.36. Between April 2007 and December 2013, there was a total of 83 self-inflicted deaths of young adults in NOMS custody. Of these, two were young women. Based on self-declared ethnicity, NOMS data suggests that 68, or just over 80%, were white, 9 were black, 4 were Asian, 1 was of mixed race and 1 is described as 'other'.²⁴
- 1.37. Table 1.2 describes the breakdown of ages of these 83 young adults.

Table 1.2: Age breakdown of the 83 young adults who died from self-inflicted deaths between April 2007 and December 2013²⁵

Years of age	18	19	20	21	22	23	24
Number of cases	14	7	12	18	8	12	12

- 1.38. Twenty-nine of the young adults were on remand, including three who were convicted but waiting to be sentenced. Seven of those on remand were 18 years of age, but most of them (19) were 21 or over.
- 1.39. Roughly three-quarters of those convicted had been found guilty of violent offences, such as violence against the person,²⁶ although what this meant in practice varied quite widely. Of those sentenced approximately 80% had received a custodial sentence of more than 12 months imprisonment.

24 Information summarised from NOMS data in Harris Review (2015). Examination of PPO Clinical Reviews. Consideration conducted on behalf of the Harris Review by Ambreen Aslam, Sunil Routhu, Matthew Tovey and supervised by Dr Dinesh Maganty. For further details, please see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

25 This information is obtained from the Harris Review analysis of the case material. Further details are outlined in Appendix 3.

26 Ludlow, A., et al (2015). *Self-inflicted Deaths in NOMS' Custody amongst 18-24 Year Olds*. Staff Experience, Knowledge and Views, <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 1.40. The statistical analysis conducted for us by Ministry of Justice Analytical Services, highlighted that between 1978 and March 2014, 26% of all of the deaths of the young adults (18-24) who died in that time died within the first week of their arrival to prison. The analysis also showed that 46% died within the first month, and 86% died within the first six months.²⁷
- 1.41. Table 1.3²⁸ shows how long each young person had been in custody at the time of their deaths. Almost a half (48%) of the deaths on which data is available happened in the first three months of custody. Over three quarters (77%) were within the first year.

Table 1.3: Length of Time in Custody before Death

Time in Custody	Number of Deaths
On day of Arrival	2
2 to 7 days	10
>1 week to > 1 month	12
1 month to < 3 months	19
3 months – 1 year	24
Over 1 year	19
Unknown	1

²⁷ Ministry of Justice (2015). *Self-inflicted Deaths in Prison Custody in England and Wales between January 1978 and March 2014*. London: Ministry of Justice. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²⁸ Harris Review (2015). Examination of PPO Clinical Reviews. Consideration conducted on behalf of the Harris Review by Ambreen Aslam, Sunil Routhu, Matthew Tovey and supervised by Dr Dinesh Maganty. For further details see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Self-Inflicted Deaths in Children Under 18

- 1.42. Although the Terms of Reference of the Review did not require us to examine the deaths of the children who had died since 2007, it was specified that we take account of learning which has been undertaken in respect of the youth estate. The panel felt that it was very important, given the closeness in age and stage of development of the young adults, to consider the deaths of the four children under 18 who had died during the same period.
- 1.43. The views of those who responded to the *Call for Submissions* strongly back up this view. For example, the Prison Reform Trust pointed out in their submission “*the exclusion of children from its parameters presents a missed opportunity, not least because many of the young people aged 18-24 who have died in prison will spend time in custody as children*” (page 1).²⁹
- 1.44. All of the children who died were male. Two of them were 17 years old, and two of them were only 15. Three of the boys were sentenced. Only one was on remand, and he had been in custody for only 19 days when he died.

Case Examples of those who died

- 1.45. While it is important to set out the data on all of the young people that we have considered as part of this Review, statistics on their own do not capture the essence of the personal details that marked the tragedies experienced by the families of those who have died. We would like to end our introduction to the report with some short reminders of who these children and young adults were.
- 1.46. Each of their individual stories are unique, but they often illuminate the issues that we explore in this Review and when we look at them together the same themes, the same failings and the same mistakes are tragically repeated time and time again. As the Prison and Probation Ombudsman in his most recent learning lessons report puts it, “*It is ... troubling that many investigations repeated criticisms that we have made before*” (page 3).³⁰
- 1.47. Please note that in what follows unless a case history is taken directly from another published report or from an already published submission, we have changed all names of the children and young adults we refer to, in order to respect their anonymity. This practice is used throughout the report.

29 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

30 Prisons and Probation Ombudsman (2015b). *Learning from PPO Investigations: Self-inflicted deaths of prisoners – 2013/14*. London: PPO. <http://www.ppo.gov.uk/wp-content/uploads/2015/03/self-inflicted-deaths-2013-14-Final-for-publication-5.pdf>.

Case of Luke

Luke was an 18 year old white British male, who had a diagnosis of ADHD and a history of self-harm. He had previously been in custody in the youth estate. He committed acquisitive crimes to feed a drug and alcohol habit. Despite being put on ACCT during a previous short stay in custody and despite being recorded with high risk of self-harm by a doctor who examined him in police custody, when the nurse saw him at reception to the prison did not see a risk of self-harm. The documents that should have accompanied him from police custody, and that recorded details of his vulnerabilities, were never found.

Within his first few weeks in custody he had already been involved in a number of incidents with other prisoners, and was eventually held in segregation a month after his arrival. He spoke to the Listeners. A month after this, an officer referred him to the Mental Health In-reach team. The PPO noted that this form was returned to be recompleted, which was contrary to procedure. A couple of days later, Luke self-harmed and took a small overdose. An ACCT was opened the following day, which the PPO noted should have been opened a day sooner. He again spoke to a Listener at this point, and it appeared he asked every night to speak to a Listener.

The evening before he died, Luke had to wait to use the phone to speak to the Samaritans, because another prisoner was using the phone. He was eventually brought to a Listener Suite to use the phone because he could not get a good reception in his cell. The phone call lasted 53 minutes, and he was left unmonitored and locked in the suite during this time. The PPO described the suite as 'littered with ligature points.' He was found by an officer hanging from a metal conduit in the ceiling, using a torn bed sheet.

Billy Spiller³¹

Billy's case is described in the Barrow Cadbury Trust report *Stolen Lives and Missed Opportunities*. He was 21 when he died on 5th November 2011, where he was removed from Aylsebury YOI. Earlier support and diversion would have helped to address his offending behaviour. The prison experience did not seem to be the most effective way of helping him.

His mother is quoted in *Stolen Lives and Missed Opportunities*³² (Executive Summary, page 6) as saying:

“Throughout Billy’s life I tried to get proper care and support for him but all the doors were shut in my face. From the moment he was sentenced to imprisonment, I knew that they wouldn’t be able to look after him. They should have diverted him from the courts or made sure that everybody in the prison had training to deal with him. It is really important to get rid of the stigma around mental health and to recognise that people like Billy need treatment and not punishment.”

Peter

Peter was 17 years old when he hanged himself. He died in hospital on 24 January 2012. Peter had a number of characteristics, which in the view of the PPO, indicated his vulnerability: it was his first time in custody, he had been diagnosed with a conduct disorder and ADHD, he had a statement of special educational needs, he had recently self-harmed and had thoughts of killing himself. Even though this information was passed to the YOI on his arrival, Peter was not monitored. When Peter was sentenced to a further 6 months for another offence, the YOT recommended that he be moved to a Secure Training Centre or specialist unit because of his vulnerabilities. Peter was, however, returned to the YOI. Peter reported being bullied and from the PPO report it is clear that staff neither supported nor protected him. The Coroner states in her inquest finding that Peter was not protected from the behaviour or other young people towards him and this contributed to his death. The PPO made a total of 26 recommendations for the YJB, the Prison Governor, NOMS and Healthcare.

31 INQUEST & T2A (2015). *Stolen Lives and Missed Opportunities: The deaths of young adults and children in prison*. London: Barrow Cadbury Trust. http://www.barrowcadbury.org.uk/wp-content/uploads/2015/02/Inquest-Report_finalversion_Online.pdf. Accessed 20 March 2015.

32 *Ibid*, p.6.

2. The Purpose of Prison

- 2.1. Our experiences of the past year have left us with a strong sense of what unpleasant places prisons can be. The experience of living there certainly appears more conducive to punishment than rehabilitation. This permeates much of the evidence we have considered, and has led us to believe that the first issue we must consider in this report is what should be the purpose of prison.
- 2.2. We acknowledge that this must include protecting the public and preventing those being held from escaping, and also ensuring that the sentence of loss of liberty is enforced.
- 2.3. However, the evidence we have considered has demonstrated that beyond these objectives there is something more profound than this that makes the custodial experience particularly distressing, especially for vulnerable young adults.
- 2.4. As well as hearing about their experiences directly from young adults themselves (highlighted by the quotes in the textbox opposite) and by seeing first-hand the physical environment during our prison visits, we have heard directly the experiences of the families and loved ones of those who have died, and their distress at not being able to support their family member through the ordeal of prison. One family told us:

*“When [he] first came to the telephone I could hear his voice choking, holding back tears. By the time he left the telephone he was back to his normal self so I felt that he was being taken care of. Two days later he was dead. [He] should not have been left in a cell.”*³³
- 2.5. Accounts such as these have caused us to question whether, in delivering the sentence of the court to ensure loss of liberty for the offender, the prison environment needs to be as harsh and comfortless as these young people have found it to be, and furthermore whether this is actually in the best interests of their mental well-being and rehabilitation.
- 2.6. In this chapter, we are going to look at what is currently considered to be the purpose of prison, taking into account political and other influences that might impact on that. We will look at evidence considered about the importance of the prison regime and the physical environment in which young adults are held and whether this is conducive to their well-being and rehabilitation. We will take into account the importance of safety in prison, and will end with our conclusions about what the purpose of prison needs to be.

33 INQUEST (2015). *Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds*. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2/>

The experiences of young adults

“Sometimes prison makes you feel trapped in you feel like der aint nothing good in your life” (sic, 21 year old young man).

“...they haven’t made me phill beter or safer I haven’t had no support since I have bin here...” (sic, 23 year old young man).

“At sixteen years old I already felt very alone, and then I went into [prison’s name]. There was no-one to talk to... I put on a brave face... I was full of fear...” (Young woman who spoke to the panel).

“You have a dilemma: fight to stand up for yourself and so lose privileges, or co-operate and you get bullied. Officers don’t see this: they want an easy shift or they are waiting for more staff to turn up” (young adult who spoke to panel).

“They forget dat were young n doing long sentences. They forget that were just like any other young person. I been away from my family since 18 so I feel lonely anyway. It makes it worst that I feel like the Gov’s target me because im young” (21 year old young man).

Source: Responses to the targeted survey of young adults in custody, and Hearing with young adult ex-offenders.

The Delivery and Function of Prisons

- 2.7. The National Offender Management Service (NOMS) is an Executive Agency of the Ministry of Justice. NOMS function is to “*make sure people serve the sentences and orders handed out by the courts, both in prisons and in the community.*”³⁴ It does this by commissioning services from a mix of public and private sector providers; which includes HMPS, private providers of prison, the National Probation Service and Community Rehabilitation Companies.³⁵
- 2.8. HM Prison Service’s statement of purpose states that “*We keep those sentenced to prison in custody, helping them lead law-abiding and useful lives, both while they are in prison and after they are released. We work with courts, police and local councils, as well as voluntary organisations, to do this...*”³⁶
- 2.9. In its evidence before the Justice Committee in 2009,³⁷ Her Majesty’s Prison Service (HMPS) explained that its role was to serve the public by keeping in custody those committed to it by the courts. HMPS also said that its duty was to look after them with humanity and help them lead law-abiding and useful lives in custody and after release.
- 2.10. But NOMS and HMPS, and how they deliver their function, are properly influenced by the policies of the Government of the day. When HMPS presented the evidence to the Justice Committee referred to in paragraph 2.9, the then Parliamentary Under Secretary David Hanson MP, explaining the purpose of imprisonment, said:

*“First of all, it is to provide an element of punishment, which involves the deprivation of liberty and all the consequences that has for the prisoner. It also, in my view, has to be about rehabilitation for the individual, so that when they leave our care in prison... they return to society as better individuals. That means that we have to...equip them for the challenges in outside life and help them to potentially look at some of the issues that have arisen in their criminal behaviour to date... We need to, in my view, use the prison system to punish, to reform, to challenge some of the assumptions that have led to that criminal behaviour, whatever they may be, and ultimately, to rehabilitate and reintegrate back into society.”*³⁸

34 National Offender Management Service (online, no date). *About us, What we do*. Departments, Gov.uk website. Retrieved from: <https://www.gov.uk/government/organisations/national-offender-management-service/about>. Accessed 20 March 2015

35 Ministry of Justice (2013c). *Transforming Rehabilitation: A strategy for Reform*. Response to Consultation CP(R)16/2013, May 2013. London: TSO. <https://www.gov.uk/government/policies/reducing-reoffending-and-improving-rehabilitation/supporting-pages/transforming-rehabilitation>. Accessed 1 April 2015.

36 HM Inspectorate of Prisons (online, updated February 2014). *About HMI Prisons*. Retrieved from: <https://www.justiceinspectors.gov.uk/hmiprison/about-hmi-prisons/#.VXF1QIocRBQ>. Accessed 20 March 2015. website. Retrieved from: <https://www.gov.uk/government/organisations/national-offender-management-service/about>. Accessed 20 March 2015

37 House of Commons Justice Committee (2009) Twelfth Report of Session 2008–09, Role of the Prison Officer London, TSO. <http://www.publications.parliament.uk/pa/cm200809/cmselect/cmjust/361/36102.htm>. Accessed 20 March 2015.

38 House of Commons Justice Committee (2009). Twelfth Report of Session 2008–09, Role of the Prison Officer. London: TSO. <http://www.publications.parliament.uk/pa/cm200809/cmselect/cmjust/361/36102.htm>. Accessed 20 March 2015.

- 2.11. This ultimate aim to “rehabilitate and reintegrate back into society” is one that the panel feels is unfortunately not given the due precedence it warrants, either in HMPS’s statement of purpose or in any current description of what prison is for.
- 2.12. In January 2015, the Secretary of State for Justice at the time of writing, the Rt Hon Chris Grayling MP (Lord Chancellor and Secretary of State for Justice), delivered a keynote address at an event hosted by the Prison Reform Trust and Centre for Social Justice. The views expressed on sending people to prison could be described as emphasising a more punitive purpose. He explained:

“I believe that sending people to prison is necessary ... the right thing to do. I believe in locking up people who commit crimes. I don’t agree with those who say we send too many people to prison. Almost everyone who ends up inside has committed multiple offences ... if anything we sometimes wait too long to send them to prison. By the time they end up there, they have become embedded in a life of crime... yes, I do believe in prison. It protects society from those who would harm it, and by taking persistent offenders off the streets, it gives respite to the communities that they blight. It should always be there as a punishment, and deterrent.”³⁹

- 2.13. Mr Grayling’s position advocating stricter regimes and a harsher prison life has been documented through media stories such as the 2012 Daily Mail headline “*I’ll stop our jails being like holiday camps, says new minister for justice*”.⁴⁰
- 2.14. One aspect of this new policy approach included restricting prisoners’ access to books as a perk and privilege. This particular aspect of the policy was ruled unlawful by the High Court in December 2014.⁴¹
- 2.15. The emphasis on the rehabilitative purpose of prison was an interesting aspect of the judge’s ruling. Mr Justice Collins said “*a book may not only be one which a prisoner may want to read but may be very useful or indeed necessary as part of a rehabilitation process*”.⁴²
- 2.16. The delivery and functioning of prisons is also influenced by population pressures, which, political views on the effectiveness of prison aside, continue to increase and inevitably has an impact on the capacity of NOMS to manage those in custody.

39 Prison Reform Trust (2015, 26 January). *Chris Grayling’s speech on Conservative justice policy*. PRT website - Press & Policy: News. http://www.prisonreformtrust.org.uk/PressPolicy/News/vw/1/ItemID/257?dm_i=47L,34VQL,6JSCMH,B8JCo,1. Accessed 21 March 2015.

40 Slack, J. & Chapman, J. (2012, 19 September). *I’ll stop our jails being like holiday camps, says new minister for justice*. *Mail Online*. <http://www.dailymail.co.uk/news/article-2205824/Ill-stop-jails-like-holiday-camps-says-new-minister-justice.html>. Accessed 21 March 2015.

41 Travis, A. (2014, 5 December). *Book ban is unlawful, court rules*. *The Guardian* (online). Retrieved from: <http://www.theguardian.com/society/2014/dec/05/prison-book-ban-unlawful-court-chris-grayling>. Accessed on 21 March 2015.

42 Ibid

- 2.17. As of 31st December 2014, the total prison population was 84,691, which is almost double the figure it was in the early 1990's.⁴³ Between 1993 and 2013, the average prison population in England and Wales increased from 44,552 prisoners to 84,249 prisoners. Most prisoners have been sentenced to immediate custody (77% of the prison population in December 2014, with 7% recalled to prison for breaking the conditions of their release, 14% on remand, with the remaining 2% classified as being non-criminal).⁴⁴
- 2.18. The MoJ has explained the primary reasons for this increase as:⁴⁵
- The sentenced population increased after 1993 because the courts sentenced more offenders to prison each year between 1993 and 2002, and because offenders have been staying in prison for longer;
 - The annual number of people sentenced to immediate custody for indictable offences increased by around 36,000 between 1993 and 2002;
 - From 1999 to 2011, the average time served in prison increased from 8.1 to 9.5 months for those released from determinate sentences.⁴⁶
- 2.19. By the time this report is published, a new government will have formed and ministers will, no doubt, be exerting their own political views and influence over how NOMS delivers its polices and how young adults experience the regime. By the end of this chapter, we will provide some recommendations that we feel should provide parameters around which future policies about the purpose of prisons should be based, regardless of political affiliations, as we believe our recommendations are essential in order to prevent further self-inflicted deaths.
- 2.20. Next, however, this chapter will consider the current prison regime and key aspects of prison life that impact on how a young adult experiences prison and accesses rehabilitative programmes.

43 Ministry of Justice (2015a). Offender Management Statistics Bulletin, England and Wales. Quarterly July to September 2014. *Ministry of Justice Statistics Bulletin*, 29 January 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399234/offender-management-statistics-bulletin-july-sept-2014.pdf. Accessed 21 March 2015.

44 Ministry of Justice (2014b). Offender Management Statistics Bulletin, England and Wales: Quarterly – October to December 2013; Annual – January to December 2013. *Ministry of Justice Statistics Bulletin*, 30 April 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305741/offender-management-statistics-october-december-2013.pdf. Accessed 21 March 2015.

45 Ibid

46 Excluding those on life or other sentences with unspecified end points – i.e. 'indeterminate' sentence.

Prison Regime and Experience

- 2.21. During the course of this Review, we were told repeatedly by young adults who are, or who have been, in custody that the experience of being locked up increases their feelings of vulnerability and isolation. In response to the survey questionnaire we distributed in a number of prisons,⁴⁷ many young adults gave responses such as “*being banged up all of the time*” as being one of the negative aspects about prison that made them feel vulnerable, and “*more times out of cell*” as something that would make them feel better.
- 2.22. A prisoner who responded to our Call for Submissions told us (page 3):
- “First and foremost is the occupation of the mind, there is nothing worse than being locked up for the majority of the day...Work or education but gym time, exercise time and association time all help to break up the day...library and books should be easily accessible...games like chess, cards, snakes and ladders...The importance of contact with loved ones and friends should never been underestimated.”⁴⁸*
- 2.23. In their response to the Call for Submissions, the Criminal Justice Alliance highlighted the potential link between increased vulnerability and the number of hours prisoners are locked in their cells and the reduction in the number of hours of purposeful activity. They commented “*restricting books, television and artistic materials also limits the activities of prisoners who face being locked up for longer due to staff shortages. All of these factors may in the future be shown to increase prisoner vulnerability and a propensity to self-harm.*”⁴⁹
- 2.24. The concept of being ‘locked up for the majority of the day’ is a disturbing one, particularly in relation to young, developing adults and children who have greater needs for physical activity and stimulation. Nonetheless, examples have been raised many times throughout this Review.
- 2.25. Having spoken at length with staff from prisons and in NOMS HQ about the prison regime, we are aware that many prisons are currently operating on a ‘restricted regime’ due to staff shortages. This includes increased need to use staff on ‘detached duty’ away from their home establishments, who are not familiar with local arrangements. The issue of staff shortages will be explored in Chapter 3, while this section will focus on the impact of impoverished regimes on young adults.

47 Harris Review (2015). Young Adult Engagement with the Harris Review. For further information see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

48 Submission to the Harris Review received from an individual serving Prisoner on 12 August 2014. In respect to the privacy of the individual, full submission details are not published on the Harris Review website.

49 Submission to the Harris Review received from the Criminal Justice Alliance on 29 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 2.26. When asked to explain the difference between purposeful activity, regime hours and time out of cell, NOMS response to the Review was that “*purposeful activity is defined as time spent working (in industry or other services), attending education or undertaking interventions. Time out of cell is broader, encompassing other prisoner activities such as association and domestics. Regime hours can be used to mean either of these*” (2015, page 10).⁵⁰
- 2.27. Our own experience, particularly when we spoke to young adults during our visits to establishments, and the range of evidence to which we have had access, makes it abundantly clear to us that young adults’ experience in prison is by and large not purposeful, frequently not meaningful and above all impoverishing to the spirit. For example:
- When we reviewed the detail case material the 83 young adult cases that the Review considered, one of the emerging conclusions concerned the negative impact that the prison regime had on an individual’s mental state, through inability to participate in purposeful activity, including gym or work related tasks, and also to take part sufficiently in association;
 - During our Public Hearing in September 2014, one of the key concerns of those present was the nature of activity and regimes in prisons and their impact on prisoner well-being;
 - The literature review that we commissioned ‘Understanding and Addressing Self-Inflicted Deaths in Prison amongst Those Aged 18 – 24: A literature Review; University of Greenwich’⁵¹ concluded that those who are at risk of self-harm are likely to be bored. In addition, it recognised the importance of staff being able to deliver prison regimes with empathy.
- 2.28. Of particular weight is the submission from HM Chief Inspector of Prisons, who noted:
- “Our inspection reports document that if young adults are given enough purposeful activity to keep them occupied they will behave better within a custodial environment and it becomes a safer place. However, in some establishments (Rochester 2012) the opposite was happening and security was maintained by locking young adults [in] their cells for long periods which restricted their access to activities and created tensions when they were unlocked. Across our inspections of young adult YOIs we found too many prisoners locked up during the core day. Time out of cell was considerably less than the published core day and/or recorded unlocked time”* (2014, paragraph 23).⁵²

50 Answers from NOMS (2015) to Supplementary Questions asked by the Harris Review in September & November 2014, and additional information provided by Michael Spurr following his evidence session received on 3 February 2015. For further information, see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

51 University of Greenwich (2015). Understanding and Addressing Self-Inflicted Deaths in Prison Amongst Those Aged 18 – 24, London, Harris Review. For further information see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

52 Submission to the Harris Review received from HM Chief Inspector of Prisons on 24 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2/>

- 2.29. In answer to a question on what proportion of time prisons and YOIs are on a 'restricted' regime, NOMS reported that only sixteen institutions were identified as being of particular concern in the summer of 2014 due to operational pressures, staff shortages and a higher than expected prison population (page 15).⁵³ From the evidence of what we have seen and heard, including HMCIP reports,⁵⁴ however, the Review feels that a much larger proportion of the estate is currently impacted in this way. We have heard, for example, that there tends to be a knock on effect to prisons when staff are put on detached duty to another, more resource-stricken, institution (for example at hearings with the PGA⁵⁵ and the POA;⁵⁶ see also the Justice Committee report).⁵⁷ The Review heard that an additional 9 prisons have some detached duty staff to support them. Prisons from which staff were detached also had to restrict their regimes. This was managed centrally to provide some oversight.⁵⁸
- 2.30. The HMCIP Annual report for 2013/14 highlighted *“too many prisons lacked sufficient activity places to ensure all prisoners had good access to education or vocational training. Only 22 prisons inspected had enough activity places for the population. This shortfall continued to be a particular problem in local prisons, as well as those holding young adults. Many prisons offered part-time education and vocational training to manage these shortfalls. The widespread and unacceptable failure to fill the places that were available not only continued but had deteriorated. Three-quarters of all prisons inspected failed to use their activity places, leaving prisoners without work or training when they need not have been”* (page 43, HM Chief Inspector of Prisons for England and Wales Annual Report 2013–14).⁵⁹

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- 53 Answers from NOMS (2015) to Supplementary Questions asked by the Harris Review in September & November 2014, and additional information provided by Michael Spurr following his evidence session received on 3 February 2015, accessible from <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.
- 54 HM Chief Inspector of Prisons (2014). *Annual Report 2013-14*. London: TSO. https://www.justiceinspectors.gov.uk/hmiprison/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-14.pdf. Accessed 28 March 2015.
- 55 Stakeholder Hearing 16 (6 November 2014), Prison Governors' Association. Summaries of hearings can be accessed at: independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-Prison-Governors-Association.pdf.
- 56 Stakeholder Hearing 17 (6 November 2014), Prison Officers Association. Summaries of Hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.
- 57 House of Commons Justice Committee (2015). *Prisons: planning and policies – Ninth Report of Session 2014-15*. London: TSO. <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmjust/309/309.pdf> accessed 30 March 2015. [harris-review-research-2](http://iapdeathsincustody.independent.gov.uk/harris-review-research-2).
- 58 Harris Review Panel Meeting 10 (20 November 2014). Can be accessed at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/Harris-Review-Meeting-20-November-2014-Minutes.pdf>.
- 59 HM Chief Inspector of Prisons (2014). *Annual Report 2013-14*. London: TSO. https://www.justiceinspectors.gov.uk/hmiprison/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-14.pdf. Accessed 28 March 2015.

- 2.31. As well as acknowledging that these problems were due to staff shortages, the report also blamed weak administration, poorly managed activity waiting lists and insufficient management attention.
- 2.32. NOMS answer to the Review on the issue of restricted regime goes on to explain that *“the restriction of regimes is part of ordinary operational contingencies and is a process of identifying the reduced level of activity needed to meet the requirements of safety, security, resilience and sustainability; and the number of staff required to deliver that level of activity reliably.”* However, it is also explained that *“the judgement about what is safe, decent, secure, resilient and sustainable is a dynamic operational one informed by the particular circumstances of each prison to which a restricted regime is applied. The nature of restrictions... include...shortening the ‘core day’... closing some activities early on some days; limiting some recreational activity over the weekends...”* (page 15).⁶⁰
- 2.33. Later in this report we will be looking at the specific needs of young adults, and in particular the needs of many vulnerable young adults in custody. For now, it is enough to point out that from what we have seen, current restricted regimes do not even allow for the delivery of planned core day activities that might help with rehabilitation; indeed we heard frequent examples of medical and mental health appointments being missed because there are not sufficient staff to escort the patient. Clearly this is something that needs to be tackled before prisons can start sufficiently to address the needs of vulnerable young adults.
- 2.34. In Norway, the principle of normality is applied when considering sentencing; the punishment is the restriction of liberty; no other rights are taken away by the sentencing court. Their policy states therefore that the sentenced offender has all the same rights as everyone else who lives in Norway. Furthermore, no-one serves their sentence in Norway under stricter circumstances than are necessary for the security of the community; therefore offenders are placed in the lowest possible security regime.⁶¹

60 Answers from NOMS (2015) to Supplementary Questions asked by the Harris Review in September & November 2014, and additional information provided by Michael Spurr following his evidence session received on 3 February 2015, accessible from <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

61 Kriminalomsorgen (2015). *Directorate of Norwegian Correctional Services* (information in English). Retrieved from: <http://www.kriminalomsorgen.no/information-in-english.265199.no.html>. Accessed 30 March 2015.

2.35. The importance of ensuring that young adults receive sufficient purposeful activity and time out of cell cannot be underestimated. Indeed, its importance is set out in numerous internationally-agreed standards, including:

- The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) Standards, which state:

*“A satisfactory programme of activities (work, education, sport, etc.) is of crucial importance for the well-being of prisoners. This holds true for all establishments, whether for sentenced prisoners or those awaiting trial...The CPT considers that one should aim at ensuring that prisoners in remand establishments are able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activity of a varied nature. Of course, regimes in establishments for sentenced prisoners should be even more favourable.”*⁶²

- The UN Standard Minimum Rules for the Treatment of Prisoners state that *“sufficient work of a useful nature shall be provided to keep prisoners actively employed for a normal working day.”*⁶³

2.36. In 2009 the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) noted that the authorities in the UK were *“fully aware of the importance of offering a satisfactory programme of activities to all prisoners, remand and sentenced, both to provide meaningful activity in prison and to prepare inmates for life in the community.”* Nonetheless, they concluded *“...in all the prisons visited too many prisoners were either not involved in any sort of meaningful activity or were offered minimal opportunities.”*⁶⁴

2.37. In terms of daily exercise, The European Prison Rules⁶⁵ (Rule 27) state that *“Every prisoner shall be provided with the opportunity of at least one hour of exercise every day in the open air, if the weather permits”* and that the prison regime *“shall allow all prisoners to spend as many hours a day outside their cells as are necessary for an adequate level of human and social interaction”* (Rule 25(2)).

62 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2015). CPT Standards (CPT/Inf/E (2002) 1 - Rev. 2015 English). Strasbourg: Council of Europe. Retrieved from: <http://www.cpt.coe.int/en/documents/eng-standards.pdf>. Accessed 11 March 2015.

63 United Nations (1955). *Standard Minimum Rules for the Treatment of Prisoners*. Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. Retrieved from: <http://www.ohchr.org/Documents/ProfessionalInterest/treatmentprisoners.pdf>. Accessed 30 March 2015.

64 Council of Europe (2014). *Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 18 November to 1 December 2008*. Strasbourg: Council of Europe. Accessed 30 March 2015.

65 Council of Europe (2006). Recommendation Rec (2006)2 of the Committee of Ministers to member states on the European Prison Rules (Adopted by the Committee of Ministers on 11 January 2006 at the 952nd meeting of the Ministers' Deputies). Retrieved from: <https://wcd.coe.int/ViewDoc.jsp?id=955747>. Accessed 30 March 2015.

- 2.38. The UN Standard Minimum Rules for the Treatment of Prisoners similarly require “at least one hour of suitable exercise in the open air daily if the weather permits.”⁶⁶
- 2.39. In its 2009 report on prisons in the UK, the CPT reiterated that “the basic requirement of at least one hour of outdoor exercise every day is a fundamental safeguard for prisoners” and called upon the UK authorities to ensure that prisoners were “guaranteed this basic requirement.”⁶⁷
- 2.40. Despite this, the Review was disappointed to note that currently the Residential Services Prison Service Instruction (PSI 75/2011) only stipulates that *prisoners are afforded a minimum of 30 minutes in the open air daily* (page 9, para 2.21).⁶⁸ While it is recognised that there may be specific circumstances where the minimum requirements cannot be met, at present there is little transparency about when such special circumstances apply, and where appropriate standards are failing to be met. There is simply not sufficient data available on the number of hours spent outside a cell and/or purposeful activity – or indeed whether that activity is meaningful or rehabilitative. Consequently there is no means of assessing the impact that a more limited regime has on rehabilitation, or the psychological damage that our evidence suggests may be associated with it. Because there is no data concerning the number of hours spent outside a cell, either for purposeful activity or exercise, the Review believes that a record must be kept and published of the time spent outside of their cells for every prisoner, including when participating in purposeful activity; this information must be collated nationally for management information purposes and to enable future analysis of the quality of prison life.

66 United Nations (1955). *Standard Minimum Rules for the Treatment of Prisoners*. Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. Retrieved from: <http://www.ohchr.org/Documents/ProfessionalInterest/treatmentprisoners.pdf> on 30 March 2015

67 Council of Europe (2014) *Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 18 November to 1 December 2008*. Strasbourg: Council of Europe.

68 NOMS (2011a). *Prison Service Instruction 75/2011 (Residential Services)*. London: NOMS. <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-75-2011-residential-services.doc>. Accessed 25 March 2015.

Incentives and Earned Privileges Scheme

- 2.41. The Incentives and Earned Privileges (IEP) scheme was introduced in 1995 with the aim of enabling prisoners to earn additional privileges by demonstrating responsible behaviour and participation in work or other constructive activity. The policy is set out in PSI 30/2013⁶⁹, which has been updated frequently, most recently to reflect the outcome of the legal challenge on receipt of books from family and friends.
- 2.42. The scheme operates on four levels: Basic, Entry, Standard and Enhanced, with the Basic level theoretically giving the prisoner access to the minimum, legal and decent requirement of a regime. Good behaviour and engagement with rehabilitation and other activities enables access to higher levels of privilege and incentives that improve the regime experience. Inappropriate behaviour and non-compliance can lead to the loss of privileges.
- 2.43. The Review has found that there is widespread concern about the IEP scheme, its implementation in practice, and its impact on the well-being of vulnerable young adults in particular.
- 2.44. In his evidence before the Review⁷⁰, Nick Hardwick HM Chief Inspector of Prisons, observed that HMIP felt that IEP is an ineffective behaviour management tool. He was concerned that some prisoners may not have opportunities within the regime to demonstrate the behaviour required to get to the enhanced level of IEP and that the system is not perceived to be fair.
- 2.45. Echoing the concerns of Mr Justice Collins when he ruled that banning books was unlawful, Safe Ground⁷¹ in their response to the call for submissions noted that recent changes to the IEP scheme meant that *“education is more of a privilege and can be removed as part of punishment... For young people this may be unnecessarily counterproductive approach to encouraging engagement”*.
- 2.46. We are also concerned that IEP does not take into account the impact of what may seem like small privileges have on mental well-being in the austere prison environment. The PPO submission referred us to their findings “that fatal incidents occurred disproportionately among prisoners on the lowest (basic) level of privileges, which reduces protective factors such as association, activities and access to television” (page 4).⁷²

69 NOMS (2015). *Prison Service Instruction 30/2013 (Incentives and Earned Privileges)*. London: NOMS. <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2013/psi-30-2013-1.doc>. Accessed 18 March 2015.

70 Stakeholder Hearing 4 (22 May 2014), Her Majesty’s Inspectorate of Prisons (HMIP). Summaries of hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.

71 Submission to the Harris Review received from Safe Ground on 2 October 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

72 Submission to the Harris Review received from the Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 2.47. While we asked NOMS for data on the numbers of those who died who were on IEP, unfortunately data on this has only been collected since 2013, and too many cases that year were not recorded on the database for an analysis to be carried out.⁷³
- 2.48. The PPO submission⁷⁴ pointed out that 16% of the 18-24 year olds in their sample of Self-inflicted deaths were on basic level, compared to 6% of adult prisoners. This reflects our concern that it is particularly difficult for less mature young adults to adhere to the scheme, and so they are more likely to lose out on privileges, such as access to television, that are more likely to act as a protective factor than with more self-sufficient adult prisoners. Not only have young adults not developed the skills to control their behaviour, but they lack the ability to fully anticipate the longer term consequence of their actions when they don't comply with the scheme. The particular developmental and maturity issues of young adults are elaborated on in more detail later in this report.
- 2.49. The Samaritans' submission to the Review also points out how vulnerable prisoners may not be able to benefit from the IEP scheme, because they lack the skills to achieve a higher level, or because their difficult behaviour results in losing privileges. They said *"someone who is vulnerable and lacking self-esteem may not apply, or feel able or equipped, to access opportunities which may earn them privileges. Similarly, someone with mental health problems or learning disabilities may not present as being able to accept their situation. They may be downgraded to basic privileges. In this case the IEP scheme might work as a punishment rather than an incentive for some vulnerable prisoners"* (page 9).⁷⁵
- 2.50. The Office of the Children's Commissioner expressed concern about the consequences for young people whose particular vulnerabilities might make them more susceptible to regime restrictions. Their submission points out that they are *"particularly concerned that behaviours arising from mental health problems, neurodisability and prior trauma may be responded to merely as behavioural infractions and that isolation practices – loss of association, reduction of IEP levels, and segregation – may result"* (page 2).⁷⁶

73 Answers from NOMS (2015) to Supplementary Questions asked by the Harris Review in September & November 2014, and additional information provided by Michael Spurr following his evidence session received on 3 February 2015, accessible from <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>, page 11, question 33.

74 Submission to the Harris Review received from the Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

75 Submission to the Harris Review received from Samaritans on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

76 Letter in support of submission to the Harris Review received from Office of the Children's Commissioner on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 2.51. Our discussions with young adults in the establishments we visited have also helped us to understand how difficult it can be for them, particularly given their lack of maturity, to continue on a reasonable level of earned privilege. In addition, we have been struck by how desolate the daily regime can be for vulnerable young adults who lose the few comforts that distract them from their anxieties and loneliness.
- 2.52. The Prison Governors' Association (PGA) told the Review that they considered the changes that were made to the IEP scheme in November 2013 were 'unfathomable'. It was their view that for a new entrant to prison, the austere entry level is not helpful. They felt that another negative consequence of the new scheme is that when a prisoner changes from remand to sentenced status, they are put on the entry level of the scheme, even if they were on standard or enhanced level before. In the view of the POA this *“does not fit in with the ethos of the scheme which is supposed to be partly incentive and causes unnecessary tension between staff and prisoners”* (page 5).⁷⁷

⁷⁷ Stakeholder Hearing 17 (6 November 2014), Prison Officers Association. Summaries of hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.

Regime and Gangs

- 2.53. The Review has found that the prison experience and the effective implementation of planned regimes can be influenced heavily by policies, or lack of policy, and practices on dealing with gangs and gang culture.
- 2.54. Our prison visits showed us that individual establishments operated different local practices on how they dealt with gang issues, with some running regimes to facilitate minimum contact between known ‘gangs’. This suggests that young adults involved must be experiencing increased vulnerability, regardless of whether or not they felt their access to core day activities were compromised.
- 2.55. NOMS did not refer to the issue of gangs in their submission. The Review was not able to identify any strategic response or guidance on how prisons should respond to gangs, or whether, as in practice, it supported regimes being built around the movements of different ‘gangs’. In their submission to the Review, Safe Ground explained that the response to dealing with the issue of ‘gangs’ *“may in fact entrench and support the kinds of segregation and separatism experienced by many young people. This could perhaps be challenged rather than colluded with, but would require significant cultural confidence and a leadership and operational team equipped with the skills and values to shift the existing divisions”* (page 2).⁷⁸
- 2.56. In her oral evidence before the Review⁷⁹ in October 2014, Baroness Lola Young explained that her own Review had *“found that the approach to young Black men and Muslim men’s behaviour is often intelligence and risk – led. Assumptions can often be made about gang or terrorist activity which can be influential in these assessments. Mistrust then builds because funding is directed to anti-gang and anti-terror programmes and activities.”*
- 2.57. Certain groups and individuals are likely to be disproportionately labelled as being involved in gangs. This may be no more than normal association between those with a similar outlook. A subtlety of approach is therefore needed to avoiding stigmatising such groups and individuals, whilst at the same time addressing the real problems that arise as a result of genuine violent gang behaviour that exists outside prison being replicated within it. It is all the more surprising therefore that there is so little guidance from NOMS centrally on such matters.
- 2.58. We feel that there needs to be a more evidence informed, strategic approach to managing risks around perceived gang membership and gangs themselves, and where it impacts on regime this needs to happen in a co-ordinated and purposeful manner, focusing on the safety and well-being of staff and young adults.

78 Submission to the Harris Review received from Safe Ground on 2 October 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

79 Stakeholder Hearing 15 (30 October 2014), Baroness Lola Young. Summaries of hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-Baroness-Young.pdf>

The Physical Environment

2.59. During our visits to establishments, it was apparent how grim the physical environment was in which these vulnerable young adults were living. Far from the holiday camps referred to by the Daily Mail, most prisons and YOIs are severe and uncompromising environments.

2.60. When HMIP published their report on the unannounced inspection of HM YOI Brinsford (18-20 year olds), which took place in November 2013, they were unhappy enough with the physical environment to include photographs of what they saw in the report. Nick Hardwick reported:

“Communal areas were dirty and in need of refurbishment and many cells could only be described as squalid. Many were filthy and covered in graffiti, but most striking was the condition of windows. We entered a significant number of cells where window panes were missing and prisoners were forced to improvise coverings. In our view many of these cells were not, at the time, fit for occupation” (2014, page 5).⁸⁰

2.61. HMIP were also concerned about the utilisation of Segregation units within Brinsford and the lack of justification for the placement of prisoners within segregation, especially those who were on an ACCT. They said *“Too many prisoners in crisis and on ACCT case management were held in segregation and in special accommodation without the circumstances having been justified... The use of the segregation unit was high. However, access to data was problematic and the lack of a segregation management and review group meant that the prison was unaware of patterns, trends or issues”* (pages 12 & 13).⁸¹

2.62. While Brinsford was considered particularly severe by the inspectors, the Review panel, who visited Brinsford, also felt that some of the other establishments that we visited were not in good physical condition. As with a restricted regime, we felt that the environment seemed designed to be punitive rather than rehabilitative.

2.63. The condition of the physical environment, and its impact on mental well-being was raised by the group of young adults who came to speak to the panel in September 2014. A number of them had spent time in both the under 18 estate and the young adult estate, and had been struck by the stark difference in the physical environments. One young person commented *“at [Secure Training Centre], rooms are brightly painted. In prison they are really dull, which makes the environment worse. It’s like a rainy, dreary day... doesn’t do anything for the spirits.”*⁸² They also suggested that they would have liked the opportunity to decorate their own cells as part of their work in prison.

80 HM Chief Inspector of Prisons (2014). *Report on the unannounced inspection of HM YOI Brinsford, 4-15 November 2013*. London: HMIP. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/04/Brinsford-2013.pdf>. Accessed 27 February 2015.

81 HM Chief Inspector of Prisons (2014). *Report on the unannounced inspection of HM YOI Brinsford, 4-15 November 2013*. London: HMIP. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/04/Brinsford-2013.pdf>. Accessed 27 February 2015.

82 Stakeholder Hearing 14 (4 September 2014) User Voice. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/User-Voice.pdf>.

Nicholas Saunders

Adapted from T2A/ INQUEST (2015) 'Stolen Lives and missed opportunities' p.28.

Nicholas Saunders died on 2 April 2011 at HMP Stoke Heath. His offence related to the possession of an offensive weapon in a public place. This was his first time in prison. He was 18 years old.

Nicholas suffered from ADHD and was in local authority care from the age of seven until he was 16 years old. His probation officer did recommend community disposal at his pre-sentencing review, but it appears that the judge decided that prison was the right place for him.

He started his sentence in HMP Woodhill. After a serious attempt to take his own life, staff realised he was particularly vulnerable. He was referred to the mental health in-reach team and was prescribed anti-depressants. An ACCT document was opened, closed and re-opened. Staff described Nicholas as a very likeable lad who was clearly vulnerable. When Nicholas became very upset after receiving a letter from his ex-girlfriend with a picture of a baby, who he thought was his son, a prison officer sat with him in his cell and went through the letter with him, so putting his mind at ease.

On 15 February Nicholas was transferred to Stoke Heath. At his inquest, which took place in October 2012, the jury found that the ACCT document was never transferred from Woodhill to Stoke Heath. This resulted in all the valuable information recorded on this document about his risk management being completely lost. The inquest jury identified this as a contributory factor to his death. It also became apparent that staff at HMYOI Stoke Heath had not have any knowledge of his previous suicide attempt.

Within six weeks of arriving at Stoke Heath, Nicholas was discovered hanging in his cell from a ligature attached to a light fitting. Ten years ago, in 2005, another 18 year old prisoner Karl Lewis also used the light fittings in his cell to hang himself in Stoke Heath. HM Coroner J Ellery said in his report that consideration needed to be given to changing the light fittings to prevent ligatures being attached. .

- 2.64. The use of segregation by Prison officers to address young adults with challenging behaviour and the implications that this has for an individual young adults mental wellbeing was highlighted by the PPO in their submission (pp 4 to 5),⁸³ when they explained that prison staff sometimes used segregation to attempt to manage behaviour. They said *“in a minority of cases prisoners were transferred between segregation units at different establishments when their behaviour became overwhelming.”*
- 2.65. During some of our prison visits, it was noted by more experienced staff, including a Governing Governor that young adults were less likely to complain about their physical environment than others. We were told that older adults were unlikely to accept the conditions that many young adults were placed in.
- 2.66. On a related theme, the PPO recently published a report (March 2015), *‘Learning from PPO Investigations: Why do women and young people in custody not make formal complaints’* which looked into the reasons why in these two distinct groups there was a reluctance to utilise the formal PPO complaints process. Their conclusion was that *“...participants did not use the internal complaint system were mainly to do with fear of reprisal and a lack of confidence in the system. There was widespread mistrust of the internal complaints system and a belief that formal complaints were a waste of time as they would not be dealt with, or would be tampered with by staff.”*⁸⁴
- 2.67. While the physical condition of the prisons and YOIs is of concern to the panel, particularly given the vulnerable young adults who live in them, a particular issue that we have given some time to is how safe the physical environment is for vulnerable people, and in particular the safety of so-called ‘safer cells’.

83 Submission to the Harris Review received from Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

84 Prisons and Probation Ombudsman (2015a). *Learning from PPO Investigations: Why do women and young people in custody not make formal complaints?* London: PPO. http://www.ppo.gov.uk/wp-content/uploads/2015/03/Why-do-women-and-young-people-in-custody-not-make-formal-complaints_final.pdf. Accessed 11 March 2015.

Safer Cells

- 2.68. All of the children, and 78 of the 83 young adult cases that we looked at, died as a result of hanging through utilisation of a ligature point, such as a window, light fittings or upturned beds, within their cells. In 26 of our 87 cohort cases, including two of the children, the deceased was on an open ACCT at the time of their death⁸⁵. If vulnerable young adults are to be accommodated in a prison environment, then it is essential that one of the purposes of this environment is to keep them safe, including safe from hurting themselves, where this is possible.
- 2.69. During our sessions hearing from the families of those who had died, concern over how easy it was for their family member to find a ligature point was raised repeatedly. One family member said “cells could be much safer. *If they don’t have the opportunity then they would not be able to do it.*” Another commented “*there needs to be attention paid to unsafe cells where ligature points have been used for hangings*” (page 26).⁸⁶
- 2.70. Of particular concern were examples of deaths that occurred where previous learning was not applied, and there was plenty of evidence from our examination of the recommendations made following a death that lessons were not being learned.⁸⁷ One parent explained:

“Our son hanged himself in a cell in which some weeks earlier another young man had died using the same method from bunk beds. Previously the Prison Ombudsman had recommended that should inmates be occupying a cell on their own then bunk beds should be removed from these cells. When the Ombudsman followed up his recommendation he found that it had not been acted upon. Had the bunk beds been removed from single cell occupancy when recommended our son may still be alive” (INQUEST, 2015, page 26).⁸⁸

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- 85 Harris Review (2015). Examination of PPO Clinical Reviews. Consideration conducted on behalf of the Harris Review by Ambreen Aslam, Sunil Routhu, Matthew Tovey and supervised by Dr Dinesh Maganty. <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>
- 86 INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>
- 87 Harris Review (2015) Examination of the PPO, Rule 43/ Regulation 28 Prevention of Future Death reports on cohort cases. For further details, see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.
- 88 INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 2.71. The data analysis carried out by Ministry of Justice Analytical Services on self-inflicted deaths between 1978 and March 2014 showed that for both the wider adult group and for young adults, the most commonly used ligature points were a window, a bed, door/gates and light fittings (page 35). Other ligature points included walls, conduits/ piping and even toilets and sinks. The analysis also showed that the most common ligature types included bedding, belts, clothing and shoelaces among others (pp 34-35).⁸⁹
- 2.72. In 2005 MoJ published a ‘Safer Cellular Accommodation Guide’, which has since been revised with the latest version issued in October 2013. This provides prison establishments with the required technical information for the provision of safer cell accommodation for both new build and refurbishment cells. It includes detail of the structure of the cell, and all ancillary components, particularly seeking to address the removal of ligature attachment points as far as possible. It provides a useful checklist that establishments can use as a self-audit, as well as simple instructions about how to test for possible ligature attachment points.
- 2.73. As well as comprehensive technical and practical guidance for establishments, the guide points out that a holistic approach is needed to manage risk, so that as well as removing ligature points, staff should refer to policy on safer custody, as set out in PSI 64/2011. It also takes into account management processes that need to be in place if a cell into which a vulnerable prisoner is being kept does not meet guidance on standards, as set out in PSI 17/2012⁹⁰
- 2.74. The policies and guidance set out in the ‘Safer Cell Accommodation Guidance’ and the Safer Custody PSI are thorough and comprehensive. It is, unfortunately, impossible to ascertain whether cells that are intended to be ‘safer’ are actually maintained and managed according to the guidance, whether as a matter of routine, or in cases of urgent requirement (for which the guidance also provides).
- 2.75. Despite persistent questioning, the Review was not able to obtain any information from NOMS about how many ‘safer cells’⁹¹ are currently in operation across the Estate. There appear to be a few reasons for this, the first being that apparently there is no central record kept of what cells have been built or refurbished to safer cells standard. Although *“all new or refurbished cells delivered by MoJ [Estates Directorate] since 2008 have been built to this standard,”* there is *“no assurance that they have been maintained*

89 Ministry of Justice (2015). *Self-inflicted Deaths in Prison Custody in England and Wales between January 1978 and March 2014*. London: Ministry of Justice. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

90 NOMS, (2012b). *Prison Service Instruction 17/2012 (Certified Prisoner Accommodation)*. London: NOMS. <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2012/psi-17-2012-certified-prisoner-accommodation.doc>. Accessed 13 March 2015.

91 *“Safer cells are designed to make the act of suicide or self-harm by ligaturing as difficult as possible. However, no cell is totally safe, and where a prisoner is accommodated in a safer cell this forms only a part of the package of support measures that are put in place to manage the risk of self-harm or suicide”* - NOMS document 2015a, page 5, question 12.

to this standard.” It has also been pointed out that “establishments have also carried out refurbishments to upgrade cells to meet the standards”, and again there is no central record of this work (see NOMS document 2015b, page 12).⁹²

- 2.76. When asked whether ‘safer cells’ are effective or not, NOMS responded “the introduction of safer cells was followed by a reduction in the number of self-inflicted deaths, and whilst it is not possible to prove this, it is reasonable to believe they were a contributory factor” (2015a, page 16).⁹³
- 2.77. The case of Nicolas Saunders, which was described in the T2A/INQUEST report *Stolen Lives*⁹⁴, is summarised in a text box on page 60. In their report T2A/INQUEST (2015) list three cases of young adults who died after that point, all using light fittings as ligature points. From careful review of our own case notes, we have identified a further two cases who also used light fittings as ligature points, after Nicholas’ death (in total 11 of our cohort died using a light fitting as a ligature point).
- 2.78. When the Review identified that light fittings were a concern, we asked NOMS “why are light fittings in safer cells not tested for load-bearing?” NOMS answer was “Light fittings are not tested for load bearing because there is no expectation that will ever bear a load” (page 12).⁹⁵ The analysis conducted by Ministry of Justice Analytical Services on self-inflicted deaths of 18-24 year olds between 1978 and March 2014 showed that light fittings were the fourth most commonly used ligature point for self-inflicted death (page 35). In that time period, there were 84 deaths using light fittings, and 29 were young adults (18-24) (page 35).⁹⁶

92 Answers from NOMS (2015) to Supplementary Questions asked by the Harris Review in September & November 2014, and additional information provided by Michael Spurr following his evidence session received on 3 February 2015. Can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

93 Answers from NOMS (2015) to Supplementary Questions asked by the Harris Review in September & November 2014, and additional information provided by Michael Spurr following his evidence session received on 3 February 2015. Can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

94 INQUEST & T2A (2015). *Stolen Lives and Missed Opportunities: The deaths of young adults and children in prison*. London: Barrow Cadbury Trust. http://www.barrowcadbury.org.uk/wp-content/uploads/2015/02/Inquest-Report_finalversion_Online.pdf. Accessed 20 March 2015.

95 Answers from NOMS (2015) to Supplementary Questions asked by the Harris Review in September & November 2014, and additional information provided by Michael Spurr following his evidence session received on 3 February 2015. Can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

96 Ministry of Justice (2015). *Self-inflicted Deaths in Prison Custody in England and Wales between January 1978 and March 2014*. London: Ministry of Justice. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

2.79. Given that NOMS has acknowledged that the use of safer cells might be a contributory factor to reducing self-inflicted deaths, the Review was very concerned that NOMS is not able to say how many cells across the estate are currently maintained to safer cell standard. It is imperative that NOMS records this data so that it can more effectively (among other things):

- Assure local and national management that there is sufficient accommodation across the estate for the most vulnerable prisoners;
- Assure local and national management that safer cells are being effectively used and maintained across the estate;
- Analyse data on use of safer cells to ascertain if their use reduces rates of Self-inflicted deaths and self-harm; and
- Assess whether the costs of maintaining safer cells is offset against savings for other mechanisms for managing vulnerable prisoners.

2.80. Given that part of the purpose of prison is to keep young adults safe, then reviewing policy and management assurance practices on safer cells is imperative. Our analysis of the deaths of our cohort has led us to believe that many of these vulnerable young adults were going through a period of particular distress that would have passed, if they had not been spending so much time inside their cell with nothing to do other than stare at potential ligature attachment points, and if more had been done to remove those ligature points, they might not have died.

2.81. In saying this, it also important to note that we do not agree that it is always appropriate to move a vulnerable young adult from their familiar cell into a different – albeit ‘safer’ environment. Changes to environment, like any transfer in custody (illustrated further in chapter 4), can increase vulnerability. We note that the submission from the PPO pointed out that “*a fifth of the young adults (20%) had moved cells in their last 72 hours... a move... can mean losing the support of a friendly cell mate of familiar faces*” (page 10).⁹⁷ Instead, vulnerable young adults should be in safer cells to begin with.

⁹⁷ Submission to the Harris Review received from Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Safety and the Human Rights Context

- 2.82. The Review considers that the safe and humane treatment of prisoners in a supportive and rehabilitative environment needs to have a more central place in prison policy in England and Wales.
- 2.83. The Human Rights Act (HRA) introduced the rights contained in the European Convention on Human Rights (ECHR) into domestic law, and imposes a duty on public authorities to act compatibly with the ECHR (section 6 HRA). Included within the substantive rights protected by the ECHR are the right to life (Article 2 ECHR), the prohibition of torture and inhuman or degrading treatment or punishment (Article 3 ECHR), the right to respect for private and family life, (Article 8 ECHR) and the prohibition of discrimination (Article 14 ECHR).
- 2.84. With regard to people detained in custody by the state, Articles 2, 3 and 14 of the European Convention establish certain positive obligations, alongside common law duties, to protect prisoners, to prevent injury or death, and to prevent discrimination. Articles 2 and 3 also contain duties to conduct effective and timely investigations when prisoners die or are injured. It is recognised that the deprivation of liberty creates particular vulnerabilities for those detained by the state and accordingly the obligations on the state are increased in such circumstances.
- 2.85. The Joint Committee on Human Rights has noted that Article 3 is also relevant to the conditions which may form the background to some self-inflicted deaths in custody⁹⁸ (para. 37.37) It noted that:

“In relation to a self-inflicted death, there will be a breach of Article 2 ECHR if the authorities knew, or ought to have known, that there was a real and immediate risk of self-inflicted death, and, if so, that they did not do all that could reasonably have been expected of them to prevent that risk being realised”⁹⁹ (JCHR).¹⁰⁰

98 House of Lords/House of Commons Joint Committee on Human Rights (2004). *Deaths in Custody - Third Report of Session 2004-05*. London: TSO. <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/15.pdf>. Accessed 30 March 2015.

99 See, for example, *Keenan v UK* (2001). ECHR No. 27229/95. <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-59365>; *Younger v UK*, (2003) ECHR No. 57420/00. http://www.rechtsveven.info/Content/Menneskerett/CaseLaw/Judgments/00_057420.html; *Renolde v France*, (2008) ECHR No. 5608/05. <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-88972>; *Jasinska v Poland* (2010). ECHR No. 28326/05. <http://hudoc.echr.coe.int/sites/eng-press/pages/search.aspx?i=003-3149973-3503437>; *De Donder and De Clippel v Belgium*, (2011) ECHR No. 8595/06, <http://hudoc.echr.coe.int/webservices/content/pdf/003-3769655-4309313>; *Çoselav v. Turkey*, (2012) ECHR No. 1413/07. <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-113767>; all accessed 1 April 2015.

100 House of Lords/House of Commons Joint Committee on Human Rights (2004). *Deaths in Custody - Third Report of Session 2004-05*. London: TSO. <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/15.pdf>. Accessed 30 March 2015.

2.86. The Review also notes that the European Prison Rules¹⁰¹ include among its basic principles that:

- All persons deprived of their liberty shall be treated with respect for their human rights
- Restrictions placed on persons deprived of their liberty shall be the minimum necessary and proportionate to the legitimate objective for which they are imposed
- Prison conditions that infringe prisoners' human rights are not justified by lack of resources.
- Life in prison shall approximate as closely as possible the positive aspects of life in the community.

Conclusions and Recommendations on the Purpose of Prison

2.87. The Harris Review believes there needs to be a radical shift in the philosophy of detention.

2.88. In Norway, the principle of normality is applied when considering sentencing; the punishment is the restriction of liberty; no other rights are taken away by the sentencing court. Their policy states therefore that the sentenced offender has all the same rights as everyone else who lives in Norway. Furthermore, no-one serves their sentence in Norway under stricter circumstances than are necessary for the security of the community; therefore offenders are placed in the lowest possible security regime.¹⁰²

2.89. It is our conclusion that the purpose of prison is to hold safely and securely those people sent there by the courts, either because they have been sentenced to imprisonment or because they have been remanded in custody while awaiting trial or sentencing. A prison should provide to those in custody a regime whose primary goal is rehabilitation.

2.90. The penalty of imprisonment is the removal of liberty; all persons deprived of their liberty shall be treated with respect for their human rights (including the European Convention on Human Rights) and their individual protected characteristics (as defined by the Equality Act 2010).¹⁰³ Restrictions placed on persons deprived of their liberty shall be the minimum necessary and proportionate to the legitimate objective for which those restrictions are imposed. Life in prison should approximate as closely as possible the positive aspects of life in the community.

101 Council of Europe (2006). *Recommendation Rec (2006)2 of the Committee of Ministers to member states on the European Prison Rules* (Adopted by the Committee of Ministers on 11 January 2006 at the 952nd meeting of the Ministers' Deputies). Retrieved from: <https://wcd.coe.int/ViewDoc.jsp?id=955747>. Accessed 30 March 2015.

102 Kriminalomsorgen (2015). Directorate of Norwegian Correctional Services (information in English. Retrieved from: <http://www.kriminalomsorgen.no/information-in-english.265199.no.html>. Accessed 30 March 2015.

103 *Equality Act 2010, chapter 15*. <http://www.legislation.gov.uk/ukpga/2010/15?type=Finjan-Download&slot=00055C1&id=0330D6BB&location=oA643C09>. Accessed 1 April 2015.

2.91. The recommendations of the Review that relate to this chapter are:

Fundamental Recommendation:

1. MoJ must publish a new statement setting out that the purpose of prison is to hold safely and securely those people sent there by the courts, either because they have been sentenced to imprisonment or because they have been remanded in custody while awaiting trial or sentencing. A prison should provide to those in custody a regime whose primary goal is rehabilitation. The penalty of imprisonment is the removal of liberty; all persons deprived of their liberty shall be treated with respect for their human rights (including the European Convention on Human Rights) and their individual protected characteristics (as defined by the Equality Act 2010). Restrictions placed on persons deprived of their liberty shall be the minimum necessary and proportionate to the legitimate objective for which those restrictions are imposed. Life in prison should approximate as closely as possible the positive aspects of life in the community.

Primary Recommendations:

2. In line with the European Convention on Prevention of Torture (CPT), all young adults in custody must be able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activity of a varied nature. Levels of purposeful activity must be sustained for prisoners on all levels of the IEP scheme.
3. We recommend that the application of the current IEP scheme must urgently be reviewed so that the shortcomings associated with the current scheme be addressed and resolved. With immediate effect prisoners must not be automatically downgraded to the entry level of IEP on return to the prison following sentencing.
4. HMIP must conduct a thematic review on Safer Cells, which includes an analysis of what the right number of safer cells is for each prison and YOI. The review should identify which prisons are maintaining enough cells at the correct 'Safer Cells' level. Once this is established, whether the prison continues to maintain the right level should become a standard part of HMIP inspection process.
5. NOMS must identify and keep a record of the number of certified 'Safer Cells' (PSI 17/2012) both in use and available for use across the estate.
6. NOMS must develop and publish a distinct policy for management of gangs, including an identification of what strategies are most likely to deliver better outcomes in relation to the management and support of those individuals who may be perceived as being part of a gang.

Secondary recommendations:

7. All young adults should spend at least 8 hours a day outside of their cell and must be entitled to at least one hour of daily exercise in the open air every day. NOMS must record details of instances when a prisoner has not been able to comply with these minimum standards.
8. Any young adult where there are current concerns about their vulnerability recorded as part of their SAVRAS should not have their regime (IEP) status downgraded.
9. All light fittings within cells should as standard be tested to ensure that they are not able to bear the weight of a young adult before any cell can be signed off as being fit for purpose as a safer cell.
10. Window design in safer cells should allow an air flow and be free of possible attachment points for a ligature.
11. Each establishment, guided by instructions from NOMS if necessary, should review their estate and their population demographics and make a formal ongoing assessment of the minimum number of “Safer Cells” that are considered necessary to accommodate those requiring this additional protection.
12. NOMS should provide sufficient capital funds to allow for the building or the modernisation of sufficient cells to “Safer Cell” standards to meet that assessment and also for the subsequent maintenance of the sufficient cells to that standard.
13. All cells that have achieved certified to “Safer Cell” standards should then be maintained to that standard unless there is a documented decision by the Governor to allow the “Safer Cell” designation for that cell to cease.
14. Every prison should record and publish details of the time spent out of the cells for every prisoner; including time spent engaging in purposeful activity out of their cells. This information should be collated nationally for management information purposes and also to enable further analysis of outcomes.

3. Leadership & Ownership of Prisoner Safety and Rehabilitation

- 3.1. In Chapter 2, we set out what we believe should be the purpose of prison in terms that take into account that loss of liberty does not mean that individuals should be subject to unsafe and potentially damaging regimes.
- 3.2. This chapter looks at what is needed to bring about this shift in the way in which prisons operate, focussing on leadership at national level and within individual prisons and what needs to be done to ensure that responsibility is taken for each young adult's journey through custody.

Central Leadership

- 3.3. In 1999, the then Chief Inspector of Prisons, General Sir (now Lord) David Ramsbotham wrote in his thematic review *Suicide is Everyone's Concern*:

“Central to my recommendations is the need for a ringing declaration from the Home Secretary, through the Director General, to everyone in the Prison Service, that suicide and self-harm can and will be reduced, and that accountability for delivering that reduction begins at the top and goes right down to the bottom” (1999, page 5).¹⁰⁴

That remains as true now as it did then, although the overall responsibility for prisons has now passed to the Secretary of State for Justice from the Home Secretary.

- 3.4. We start from the premise, therefore, that leadership in providing more effective support to vulnerable people in prison begins right from the top. As an executive agency of the Ministry of Justice, NOMS is subject to ministerial pressures and policy changes. The potential consequences of this were demonstrated in Chapter 2, with the Secretary of State's decision to restrict access to books in prisons. We believe that the substance of the new statement of purpose of prisons, to keep prisoners safe, transcends politics and should be endorsed by new ministers regardless of their affiliation.

¹⁰⁴ HM Chief Inspector of Prisons (1999). *Suicide is Everyone's Concern*. A thematic review by HM Chief Inspector of Prisons for England and Wales, May 1999. London: HMIP. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/suicide-is-everyones-concern-1999-rps.pdf>. Accessed 9 March 2015.

- 3.5. We noted with interest the point made by the Prison Officer's Association (POA) in their submission to the Review that "*the Prison Service has a 5 year cycle of change dictated by Government and General Elections. Political Parties often use the Criminal Justice System as a political football, headline grabber and potential vote winner.*" They also point out that this leads to "*frustrated prisoners whose lives and rehabilitation pathways are irrevocably disrupted*" (2014, page 1).¹⁰⁵
- 3.6. While ministers, on behalf of the public, will wish to respond firmly to crime and to criminals, this should be done with an understanding of the grim reality of prison life. Leadership, from the Secretary of State downwards, means ensuring the public are better educated about what needs to be done to deliver safe and effective rehabilitation.
- 3.7. The Howard League for Penal Reform told us that a light needs to be shone on the decision making around sending vulnerable people to prison, and that more needs to be done to ensure those who make the decisions understand what is needed.¹⁰⁶ We agree that it is necessary that those in leadership roles understand the complexities of many of those who are in prison and our obligations to keep them safe.
- 3.8. In April 2014, BBC Three broadcast *Dead Behind Bars*¹⁰⁷, as part of their Crime and Punishment season that took a more sympathetic approach to the vulnerabilities of young people in prison than the traditional media narrative. We feel that the Ministry of Justice has a duty to promote material that provides a more balanced view to the public about the experiences of those who end up in custody as children and young adults, and how they need to be supported.
- 3.9. The Review considers it is imperative that leadership and responsibility for driving change and taking action to reduce the numbers of deaths in custody is demonstrated from the top. Ultimately, the minister needs to feel responsible for each life in custody, and should respond to each death. The Review is of the view that it should be part of the role of the Minister for Prisons to phone each family after there has been a death.
- 3.10. In practice, of course, NOMS is subject to policy decisions that are developed centrally in MoJ, often by officials (MoJ and NOMS) who have insufficient understanding of the operational context and do not collaborate with those who can support them to write effective policies that affect prisons. MoJ needs to take a proactive leadership role in ensuring that the policies they propound do in fact have a positive impact on vulnerable people in custody, and support NOMS in undertaking the cultural shift that is necessary to enable change.

105 Submission to the Harris Review received from Prison Officer's Association on 28 August 2014. Submissions can be accessed at:<http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

106 Stakeholder Hearing 12, (17th July 2014) The Howard League. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.

107 BBC Three (2014) *Dead Behind Bars* (programme no longer available online) <http://www.bbc.co.uk/programmes/bo41ybob>. Accessed 10 March 2015.

- 3.11. Although MoJ published a consultation on young adults in custody in 2013, it was in the absence of an existing cohesive strategy for this age group. In her response to our Call for Submissions, Francis Done pointed out “*there is no effective national leadership, or commissioning function, for this age group exercised at national level by either NOMS or the Ministry of Justice resulting in an inadequate response to the needs of this group*” (page 2).¹⁰⁸
- 3.12. While NOMS has now appointed a Deputy Director to lead on young adults, the role is subsidiary to a wider role managing the under 18 estate. We feel that this needs to change, and that a senior person in NOMS, also at Deputy Director level, should have sole responsibility for young adults: their needs are considerable and unique, and this will be described in more detail in Chapter 4. As highlighted earlier on in the report, young adults constitute 21% of the prison population (paragraph 1.29). A suitably resourced unit is needed to support the Deputy Director, driving the changes recommended in this report through to implementation and developing and maintain for NOMS a cohesive and effective strategy on young adults (18-24 years).

Ownership of a Cohesive Strategy

- 3.13. During the course of the Review, the panel has been concerned by the ‘disconnect’ between different parts of NOMS. The organisation does not seem to operate as a cohesive, organised whole with a central strategy that underpins its work. While we anticipate that the new statement of purpose that we propose will facilitate a more united sense of intention, we are concerned that senior management does not always know what is happening in prisons, or, for that matter, in other parts of NOMS HQ.
- 3.14. An example of this has already been provided in the previous chapter, where it was described how NOMS was not able to provide the Review with data on safer cells – information that the panel felt should be important to help assure senior management about its safer custody practices.
- 3.15. Another disturbing example is that prisons are not required to record the number of hours that prisoners spend each day in purposeful activity. This chapter will highlight how sufficient purposeful activity and time out of cell is essential to help reduce the numbers of self-inflicted deaths. The fact that Governors and NOMS management are not able to assess through effective analysis of the data whether sufficient care is being given to vulnerable young adults, or indeed if they are meeting minimum standards is of concern. Performance management relating to both an individual’s performance and the Prisons overall performance rating needs to include adequate assessment of these vital issues.

¹⁰⁸ Submission to the Harris Review received from Frances Done on 9 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 3.16. We were also surprised at how many examples of what we felt were good practice and of activities that might help reduce distress and deaths in young adults were *not* articulated to the Review by senior staff in NOMS, including in NOMS' official submission.
- 3.17. The Review considered a number of Prison Service Instructions (see Appendix 8, Out of Committee Papers), that were felt to be relevant to the Review. By and large these were well thought out documents that if fully implemented would be beneficial. However, the evidence we received and our own observations suggested that often their intentions were not matched by delivery.
- 3.18. The Review was concerned that many perceive there to be a principle that underlies all Prison Service Instructions in that they must be declared to be financially cost neutral, even though there is no requirement specified within PSI 29/2012.¹⁰⁹ The Review is concerned that many who draft these instructions are not provided with the required skills needed to cost the likely impact, whilst also being concerned over the lack of collaboration with those, such as strategy/finance, who understand the operating model and will be able to advise. One potential consequence of this is that the focus on the impact upon resources could mean that less effective options are preferred, and that options that may have minimal resource impacts and yet may bring greater potential benefits are neglected even though they might help to save lives. More worrying was our sense that PSIs are often impact neutral only by assertion and that with the resources available to Governors they are unachievable or can only be achieved at the expense of other desirable policies.
- 3.19. It is our belief that NOMS should consider policies in terms of the benefits they deliver and their effectiveness rather than any resource implications. Comprehensive impact assessments are necessary for all policies, and these should be conducted in consultation with the relevant professionals and experts. The costs of implementation must be considered and weighed appropriately with the benefits. If the benefits are sufficient, then they are worth paying for.
- 3.20. As said earlier, the PSIs that underpin NOMS policies appear to be comprehensive and well thought out, but they are not always being delivered in the way that was intended. We are not advocating that all PSIs must be delivered to the letter, and we acknowledge that local conditions might sometimes make it appropriate for alternative action. However, if autonomy is given for local implementation of mandatory actions in PSIs, then there needs to be an effective mechanism (which is more comprehensive than current auditing processes) for checking that they are being sufficiently complied with or that the reasons for not complying are appropriate and proportionate.

¹⁰⁹ NOMS (2012a). *Prison Service Instruction 29/2012 (The Instructions System – The Approval and Implementation of Policy and Instructions)*. London: NOMS. <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2012/psi-2012-instructions-system.doc>. Accessed 25 March 2015.

- 3.21. This is particularly true for PSIs that concern safer custody. Moreover, the same principle also applies to recommendations from the PPO and coroners' Reports to Prevent Future Deaths as failure to implement these can contribute to the subsequent death of a vulnerable person. An example of this was already given in chapter 2 (paragraph 2.69), where the tragic case of a young man who hanged himself from a bunk bed was described. If the PPO recommendation to remove bunk beds from a cell in which an individual was being placed on their own had been acted on, that particular ligature point would not have been present at that time.
- 3.22. We examined the recommendations included in reports from the PPO and Coroner's inquests for the 87 cases (83 young adults and 4 children) for which we had data available. Over the course of the 6 and a half years that were in the scope of this Review, there were 145 recommendations concerning ACCT, 33 recommendations concerning transfer of information between those bodies responsible for the care of these young adults, and 30 regarding internal communication within the establishment. In particular, recommendations concerning mandatory actions within PSI 64/2011 (Safer Custody) had regularly not been adhered to.¹¹⁰
- 3.23. This was reinforced by both the PPO¹¹¹ and of the HM Chief Inspector of Prisons,¹¹² who told us that the guidance and procedures for ACCT were sound, but that implementation was ineffective, with staff not following processes.
- 3.24. These problems are recognised by staff. The Prison Governor's Association said that there is a huge gulf between the relevant PSI and the actual delivery of ACCT. They felt part of this was due to ongoing staff shortages¹¹³. Similarly the Prison Officers' Association told the Review that while PSI 64/2011 tells staff what has to be done to manage safety, "*there is not enough time to do all that is required by the instruction*" (page 3).¹¹⁴

110 Harris Review (2015). Summary of our Examination of the PPO, Rule 43/ Regulation 28 Prevention of Future Death reports on cohort cases. Can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>. See also some material in Harris Review (2015). Examination of PPO Clinical Reviews. Consideration conducted on behalf of the Harris Review by Ambreen Aslam, Sunil Routhu, Matthew Tovey and supervised by Dr Dinesh Maganty.

111 Stakeholder Hearing 3 (22 May 2014) Nigel Newcomen, the Prisons and Probation Ombudsman. Hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/07/Prisons-and-Probation-Ombudsman.pdf>.

112 Stakeholder Hearing 4 (22 May 2014) Her Majesty's Inspectorate of Prisons (HMIP). Hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/07/Her-Majestys-Chief-Inspector-of-Prisons.pdf>.

113 Stakeholder Hearing 16 (6 November 2014), Prison Governors' Association. Hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-Prison-Governors-Association.pdf>.

114 Stakeholder Hearing 17 (6 November 2014), Prison Officers Association. Hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.

- 3.25. We note that HMIP observed in their evidence “*there needs to be a balance between central direction and local autonomy. Governors need to be able to have the autonomy to adjust the regime to meet the needs of their population.*”¹¹⁵ While we agree with this, we are concerned that the feedback to NOMS centrally about local decisions is currently inadequate.
- 3.26. We agree with Jane Mackenzie who undertakes Clinical Reviews for Health in Wales, when she noted in her submission that one of the things that was needed in order to improve safety was “*a serious commitment to the policies and strong leadership to ensure implementation, and integration, regular monitoring to ensure compliance and improvement and mandatory training and awareness for all staff*” (page 10).¹¹⁶
- 3.27. We question how NOMS leaders can effectively assure themselves or ministers that effective policies are being delivered and complied with, without more effective processes in place to govern and monitor the implementation of PSIs, including there being a proper audit trail of decisions and the reasoning behind them where an alternative course of action is taken. This need to provide assurance to Ministers is essential, as we feel that a vital aspect of the approach towards delivering clearer demonstrable leadership will be through the Minister for Prisons contacting direct the families of prisoners following each self-inflicted death.
- 3.28. We consider that data collection, including on safer cells, examples of good practice and what works also needs to be more consistent across the Estate, with NOMS taking a more proactive and effective role in gathering information that, once analysed and reported on, could help save lives.

115 Stakeholder Hearing 4 (22 May 2014) Her Majesty’s Inspectorate of Prisons (HMIP). Hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/07/Her-Majestys-Chief-Inspector-of-Prisons.pdf>.

116 Submission to the Harris Review received from Jane Mackenzie on 9 December 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Leadership in Prisons

“ There is no consistency when speaking to staff, each one gave different information or did not know procedures for how to arrange visits, what we could take in on the first visit etc. After several phone calls on that first day I came to the conclusion that either staff ‘could not care less’ or the organisation of the establishment was a ‘shambles’. I hoped I was wrong but unfortunately time proved me correct on both accounts ”

(Family member on Hearing Day)

- 3.29. A disconnect between what those in charge think should be happening and what is actually happening is also something that the panel observed in individual prisons. During our prison visits, we spoke to many governors who understood that young adults were vulnerable in custody, who had studied the recommendations of PPO and inspectorate reports, and who were very committed to ensuring that learning was applied in the establishment for which they were responsible. They described processes that they had put in place to ensure that this would happen. However, when the panel toured the prison and spoke to staff and young adults, we found that the governor’s vision was not always followed through.
- 3.30. Then there were other prisons where governors seemed to be overwhelmed by the administrative and managerial challenges that they faced and where concern for the welfare of individual prisoners seemed to have been crowded out by dealing with immediate issues arising from staffing pressures and other problems.
- 3.31. By contrast, the Review also visited establishments where the strong leadership of the Governor was reflected across all levels of staff, and indeed in the messages we heard from the young adults to whom we spoke. There was a notable difference between the culture in these establishments and those where the Governor’s vision was not being implemented or was less prisoner-focused.
- 3.32. The messages we heard from the young adults in the prisons we visited were often revealing. In some establishments, the young adults felt that the Governor was detached from what was really happening. At one institution, for example, we were told that the Governor and senior managers “don’t know how things work”, and that officers change their behaviour when the Governor and inspectors come to visit. In another case, young adults told panel members that staff were not being honest with the Governor, and that there needed to be more communication between governors and staff.



- 3.33. We were concerned by the messages we received that suggested that prison staff behaved differently in front of the Governor, and in particular in front of inspectors. A young adult who left an (oral) message in response to our survey said *“inspectors come round. But they know when they’re coming, so they make everyone behave, and they make everyone clean. When the inspectors ain’t [sic] here it’s a shit-hole, like normal. It’s ardently rudeness, ignorance, neglect.”*¹¹⁷ We are clear that strong leadership would ensure that staff are managing in a decent and safe manner as standard, regardless of who is observing them.
- 3.34. Given examples like this, it is not surprising that our stakeholders have strongly expressed their views that leadership by the Governor can have a significant impact on the prison. For example, PRT explained in their submission, *“as Coroners’, prisons inspectorate and prison and probation ombudsman’s reports have indicated, vulnerability can be exacerbated or reduced depending on the culture and leadership of the specific institution in which the young person is placed”* (2014, page 2).¹¹⁸
- 3.35. HMIP told the Review that *“strong governor leadership is critical to manage this range of relationships effectively and productively. HMIP felt that Governors changing and moving on as frequently as they do is not helpful.”*¹¹⁹ It is interesting to note that a similar point was made in the 1999 thematic report *‘Suicide is Everyone’s Concern’*. This also pointed out the importance of leadership of the prison culture and *“continuity in office for senior prison managers, particularly for Governors”* (1999, page 59).¹²⁰
- 3.36. Governors highlighted to us some of the difficulties they experienced in leading their establishment through change and towards more empathetic styles of managing young adults. A frequent issue was one of resources. They explained that delivering a safe and supportive service is increasingly challenging against a backdrop of public service reforms; there is pressure to deliver more with fewer financial resources. This is something that will be discussed again later in the report.
- 3.37. It was also pointed out to us that some older staff were entrenched in dated attitudes and beliefs about their role. One governor commented that *“staff need to be able to show the young men that someone still cares about them...but we still have legacy staff who do not have the (right) motivation and skills.”* Having come across this attitude a few

117 Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

118 Submission to the Harris Review received from Prison Reform Trust on 18 July 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

119 Stakeholder Hearing 4 (22 May 2014) Her Majesty’s Inspectorate of Prisons (HMIP). Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/07/Her-Majestys-Chief-Inspector-of-Prisons.pdf>.

120 HM Chief Inspector of Prisons (1999). *Suicide is Everyone’s Concern*. A thematic review by HM Chief Inspector of Prisons for England and Wales, May 1999. London: HMIP. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/suicide-is-everyones-concern-1999-rps.pdf>. Accessed 9 March 2015.





times, the panel wondered whether middle managers were addressing issues of poor or inappropriate performance sufficiently. Our view was that staff at senior and middle levels of management in prisons need to be proactive about bringing about culture change and ensuring that all staff adapted to a more modern style of relating to prisoners and their families.

- 3.38. We note that the NOMS Business Plan (2014/15) includes as part of its continuous improvement, innovation and partnerships priorities a commitment that “*Governors are supported in performing two centrally important features of their role – providing ‘operational grip’ and moral leadership’. Work on the ‘role of governor’ will also enable and support governors to rise to the challenge of leading and managing partnerships in the complex delivery landscape in which we operate.*”¹²¹
- 3.39. We consider that this and, indeed, considerably more, is needed in order to ensure that NOMS has a consistently effective and skilled team of Governing Governors to provide the necessary leadership to support the delivery of safe and rehabilitative care across our prisons.

“ I find talking to a member of staff is helpful only if you can see they are listening to wot [sic] you say and give you 5 minutes of there [sic] time it goes a long way. ”

(20 year old who responded to our survey)

Leading Rehabilitation

- 3.40. The next level of leadership that we want to discuss in this report is who takes responsibility for leading the young adult through the custodial experience and their rehabilitative process. And it is around this that some of our most important recommendations are based.
- 3.41. The importance of prisoner-staff relationships came up repeatedly throughout this Review. It was stressed repeatedly by stakeholders and emerged as a key factor at the Public Hearing, the Community & Local Groups Seminar, and at the Characteristics of Young Adults Roundtable event.
- 3.42. The literature review we commissioned the University of Greenwich to carry out also noted that one of the recurring themes in the literature was the importance of having skilled and motivated staff who can identify individuals at risk of self-harm or suicide and deliver prison regimes with empathy.¹²²

121 NOMS (2014). *National Offender Management Service: Business Plan 2014 - 2015*. London: NOMS. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/302776/NOMS_Business_Plan_201415.pdf.

122 Ludlow, A., et al (2015). *Self-inflicted Deaths in NOMS' Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*. For further details see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.



- 3.43. The importance of this relationship has been long recognised. In the 1999 report *'Suicide is Everyone's Concern'*, it was noted that *"how prison officers do their job can prevent a prisoner feeling panic stricken and isolated and help him or her to settle into an establishment. Engaging constructively with prisoners is the core job of prison officers... By focusing on the needs of prisoners and understanding the connection between the objectives of reducing suicidal behaviour and reducing reoffending, they will be contributing to the essence of a healthy prison. This vision requires staff to model 'healthy' positive behaviour to prisoners."*¹²³
- 3.44. Our direct engagement with young adults suggested strongly that relationships with staff are currently mixed. In the establishments we visited, young adults were able to identify staff members that they admired and respected, but also staff members who they felt did not understand them, or who, they claimed, bullied them. The panel noted on a number of occasions that several young adults named the same officers as being the ones they wanted to talk to and spend time with.
- 3.45. When we spoke to a group of young adults at one establishment, they explained that they found it easier to show respect to officers who showed respect back. They complained that some officers were rude and clearly didn't want to talk to them.
- 3.46. Accounts such as these were backed up in what young adults who responded to our survey told us. One 21 year old, who was describing why he tried to kill himself with an overdose, explained that it was because *"I was low + depressed + staff treating me like shit on there [sic] shoe pushed me too far."* A 20 year old from a different institution said that what would make him feel better would be *"if the staff did their jobs properly and helped troubled YO's instead of talking to us like shit whenever we approach them."* A 22 year old wrote *"in this prison there are not many members of staff who care for prisoners. Incompitent [sic], dismissive and neglectful are more appropriate ways to describe staff."*¹²⁴
- 3.47. There were, however, also a number of young adults who explained that when staff treated them with respect and dignity, it had a significant and positive impact on them. One 20 year old responded *"overall I don't think the staff are bad when you get to no [sic] them but there are a few I don't like to be honest they talk to us like dirt but I haven't had that 4 a while so things are looking up"* (sic).¹²⁵ Another 20 year old answered that staff helping when they *"speak to lonely prisoners R [sic] help people who are at high risk by constantly checking that they are ok."*

123 HM Chief Inspector of Prisons (1999). *Suicide is Everyone's Concern*. A thematic review by HM Chief Inspector of Prisons for England and Wales, May 1999. London: HMIP. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/suicide-is-everyones-concern-1999-rps.pdf>. Accessed 9 March 2015.

124 Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

125 Ibid

- 3.48. There is some evidence as well that staff relationships are particularly poor in YOIs. The data provided to the Review on the Measure of Prisoner Quality of Life (MQPL) survey indicated Young Offender Institutions were on average showing poorer scores for the quality of relationships with staff when compared with female prisons and male local prisons.¹²⁶
- 3.49. The POA, in their submission to the Review, noted that work in the female estate has helped reduce self-harming rates, and that actions to mirror this across the estate would include effective staff-prisoner relationships.¹²⁷
- 3.50. The Bradley Commission noted the importance of consistent and continuous relationships for young adults in their second report, which focuses on young adults in transition, commenting that “*attachment underpins effective engagement and is particularly significant when working with young adults, especially those with a history of poor attachment relationships and childhood trauma. Initial engagement is key and can be aided by a degree of informality*” (2014, p.15).¹²⁸
- 3.51. The importance of the need of young adults to have strong relationships with an older adult was discussed at length during the Harris Review Young Adult Characteristics Roundtable in December 2014¹²⁹. It was noted that most young adults in the CJS will already have gone through a sequence of distressing life events that they are still developing and acquiring the skills that they need to be a mature adult. It was felt that, like a young person who is under 18, a young adult needs extra support to navigate through this difficult phase of their life. Those attending the roundtable unanimously agreed that **all young adults need a significant adult in their lives** - a view that we endorse.
- 3.52. The concept of a ‘significant adult’ will be discussed again later in the report, in relation to young adults who do not have effective relationships within their own families, or who are Care Leavers. In this section, however, we would like to look at the importance of having someone within the prison who can have a supportive, personal relationship with each young adult.

126 Harris Review (2015) Measuring the Quality of Prisoner Life (MQPL). For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>, page 11, paragraph 12.3

127 Submission to the Harris Review received from Prison Officer’s Association on 28 August 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

128 Saunders, A. (2014). *Young adults (18-24) in transition, mental health and criminal justice. The Bradley Commission, Briefing 2*. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf. Accessed 30 March 2015.

129 Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 3.53. There are some roles within the prison that do provide a more personal relationship with prisoners. The Review has been impressed, on a number of occasions, at the consistent pastoral care that the Chaplaincy offers to prisoners of all faiths. We have seen that the care and compassion that they show to prisoners and their families is an example of good practice that probably goes unacknowledged most of the time. However, we are concerned that the Chaplaincy is being used to plug the gaps in Prison resources and their role has unofficially evolved until it has taken on a greater level of responsibility than was originally envisaged.
- 3.54. A submission from a serving prisoner, said *“I would question whether chaplaincy staff are relied upon too much to identify and support crises in mental health that in many cases would be more appropriately treated by mental health staff. Their expertise is not directly in the field of mental health crisis support. However chaplaincy staff appear to be much more readily available in prison than mental health staff and ...do not ‘cost’ their time to support the subject – as mental health team do.”*¹³⁰
- 3.55. The Personal Officer Scheme should, theoretically also provide a more personal relationship. It was originally set up to do this, and this was described in the Government Response to the Justice Select Committee Report of 2010 on ‘The Role of the Prison Officer’. That stated *“NOMS recognises the value of well-run personal officer schemes but does not currently have the resources to mandate such schemes across the estate.”*¹³¹ In their submission to the Review, NOMS said that personal officers are not a mandatory requirement, and that they are a matter for local management and training.¹³²
- 3.56. We have seen that the scheme is not in use regularly across the estate, and, even when it is in use, it is not used consistently. During our visits to establishments, we heard of a number of examples of where the scheme was either not running any more, or was running on a reduced basis, such as on the First Night wing. In other cases, the scheme is somewhat diluted, with officers sharing duties between them.
- 3.57. A recent report on self-inflicted deaths of prisoners published by the PPO noted that *“in 2013/14, a smaller proportion of prisoners had a named personal officer than the year before (43% compared to 52%). Of those who had one, the proportion of prisoners who were at least ‘quite well’ known by their personal officer was 23% – exactly the same as in 2012/13”* (2015, p.19).¹³³ This finding suggests that the scheme is not thriving.

130 Submission to the Harris Review received from an individual serving Prisoner on 12 August 2014. In respect to their privacy, the details of their submission have not been published on the website.

131 Ministry of Justice (2010). *Government Response to the Justice Select Committee’s Report: “Role of the Prison Officer”*. London: TSO. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228951/7783.pdf. Accessed 30 March 2015.

132 Submission to the Harris Review received from NOMS on 3 February 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

133 Prisons and Probation Ombudsman (2015). *Learning from PPO Investigations: Self-inflicted deaths of prisoners – 2013/14*. <http://www.ppo.gov.uk/wp-content/uploads/2015/03/self-inflicted-deaths-2013-14-Final-for-publication-5.pdf>. Accessed 11 March 2015.

- 3.58. The statistics are backed up with what we heard on the ground. The young adults we spoke to in September who had previously been in custody expressed their reservations about the effectiveness of personal officers. One told us, *“it was two weeks before I met my Personal Officer and then when I approached him he said ‘I’ll tell you when I have time for you’.”* Another explained *“Personal Officers don’t have time to assess all their prisoners. After ‘free flow’ you go back to your cell. At lunchtime they lock you up... they should use that time to speak to their prisoners: they have a duty of care”* (page 4).¹³⁴
- 3.59. The Review concluded that it is necessary that the Personal Officer role is replaced with a new specialist role that should work specifically with all young adults in custody, with a specific remit to build and sustain an effective relationship with the young adult. This role, which we are calling the Custody and Rehabilitation Officer (CARO) will have a key part to play in other recommendations in this report. These functions, together with the processes surrounding the proposed replacement to ACCT, which encompasses the Individual Custody Plan (ICP) and the Safety and Vulnerability, Risk Assessment and Support (SAVRAS), will be described later in Chapter 6. The CARO will be responsible for regular liaison with the young adult’s family (including following visits), social worker, personal advisor and any other relevant people. The CARO roles will include overseeing the delivery of the ICP, co-ordinating the creation of the care plan for the SAVRAS and ensuring that it is updated as necessary. The CARO will also need to liaise with other individuals who are important to the rehabilitation and care of the young adult, including those involved in offender management and resettlement.
- 3.60. Many staff recognise the importance of improved relationships with young adults. Our qualitative study on staff perceptions and experiences found that staff expressed frustration at having too little time for personalised, integrated care. They explained that there were not just too few staff on wings, but that the staff who were present were less effective than they could be. This was said to be due to ‘inconsistent detailing’, which arises from the use of agency and detached duty staff, and this in turn is a consequence of staffing shortages.¹³⁵
- 3.61. In their submission to the Review, the POA pointed out that better relationships were dependent on having *“the right number of staff in place and ensure those staff are given the levels of training needed to deliver the desired outcomes”* (2014, p.3).¹³⁶
- 3.62. These two issues – staff numbers and training – are, both fundamental problems that need to be urgently resolved before NOMS can be confident that it is doing what is necessary to reduce self-inflicted deaths in custody. We will look at them separately here.

134 Stakeholder Hearing 14 (4 September 2014) User Voice. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/User-Voice.pdf>.

135 Ludlow, A., et al (2015). *Self-inflicted Deaths in NOMS’ Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*, <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

136 Submission to the Harris Review received from Prison Officer’s Association on 28 August 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Staff Training

- 3.63. Concern about the effectiveness of current levels of staff training was raised throughout most of the evidence we have reviewed; misgivings were articulated by stakeholders, young adults and by the staff themselves.
- 3.64. Young adults themselves complained about the levels of training that staff received, many of them commenting during prison visits that staff did not have the training to understand their issues. One young adult who responded to our targeted survey left us an oral message saying *“I believe, without a shadow of a doubt that there needs to be more done to educate the staff in order to make them aware of how vulnerable young people are, and even older people, especially the older generation, to get more support.”* Another said *“prison staff are ex Marks and Spencer workers or wherever they’re from. They don’t really have the relevant qualifications to be able [to] say...and when someone’s struggling... I see someone struggling, I go to the officers and sort of let them know, all they’ll do is say, ‘Is he okay?’ and I say ‘No, you need to go and speak to him’ and that’s the end of it”* (pages 65-66).¹³⁷
- 3.65. In their submission to the Review, Women in Prison said *“The recruitment and training of staff is key to running safer prisons. Staff need to have pride in their role, to understand the social care elements of the role not just the security elements”* (page 11).¹³⁸
- 3.66. Some of the submissions pointed out where they felt there are currently particular gaps. For Women in Prison, this was around the particular training needed for *“working with women and (staff) should be trained in gender responsive and trauma informed ways of working”* (page 9).¹³⁹
- 3.67. Others recognised the particular vulnerabilities of young adults and highlighted that training needs to take into account maturity and other issues. In their submission to the Review, the Transition to Adulthood Alliance proposed that *“a training course should be developed for those working with young adults in custody, emphasising that staff should take into account the characteristics of young people’s behaviour and stage of development through appropriate role modelling, promoting and maintaining positive behaviour, and clearly defining behavioural boundaries”* (page 24).¹⁴⁰

137 Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

138 Submission to the Harris Review received from Women in Prison on 1 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

139 Submission to the Harris Review received from Women in Prison on 1 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

140 Submission to the Harris Review received from Transition to Adult Alliance on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 3.68. Another area on which stakeholders felt staff needed further training was mental health. The Royal College of Nurses highlighted this in their submission, saying *“it is not uncommon for criminal justice staff to have limited awareness of mental health and learning disability issues because training is currently only scantily available, the RCN calls for such training to be increased.”* They articulate their reasons for this further by explaining *“(because of) a lack of awareness amongst criminal justice staff, attitudes vary, but distress and vulnerability can often be mistaken for someone simply being ‘difficult’, ‘un-cooperative’ and ‘aggressive’”* (page 2).¹⁴¹
- 3.69. This is a view that is also reflected by prison staff themselves. The qualitative study that we commissioned RAND Europe/University of Cambridge to conduct on the perspectives of staff found that ACCT foundation training¹⁴² was too focused on procedure at the expense of mental health awareness. Some staff felt underprepared for how they should manage Self-inflicted deaths risks and respond to instances of Self-inflicted deaths. The report says that *“prison staff suggested training could be improved by providing more focused mental health training as well as training involving role plays and question and answer sessions”* (2015, p. xi).¹⁴³
- 3.70. Overall, there was a sense that officers needed to be better equipped with the skills to understand and empathise with the young adults in their care. In their submission, the Samaritans noted that *“staff training appears to focus more on systems and processes than it does on the human contact element of the role; training should cover not only the Listener scheme and how it can help staff to support vulnerable prisoners, but on the softer skills of listening, showing empathy and engaging with people who are struggling”* (page 4).¹⁴⁴

141 Submission to the Harris Review received from Royal College of Nurses on 21 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

142 From January 2012 ACCT foundation training was replaced by Introduction to Safer Custody.

143 Ludlow, A., et al (2015). *Self-inflicted Deaths in NOMS' Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*, <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

144 Submission to the Harris Review received from Samaritans on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.



- 3.71. We also examined the recommendations made in the reports completed by the PPO and the coroner for the 83 young adults and 4 children that died through self-inflicted deaths between April 2007 and December 2013. Analysis that we commissioned¹⁴⁵ concluded that recommendations that related to staff training and improving skills or knowledge came up 135 times in these cases (with a further 13 instances of recommendations around training specifically for medical staff). Some example of these include:
- PPO recommendation: *“The Governor should provide ACCT training for all staff who have contact with prisoners;”*
 - PPO recommendation: *“The Governor should ensure that staff understand all information about bullying, threats and potential violence is fully considered and acted on through a robust and responsive violence reduction policy that reflects the tensions in a women’s prison;”*
 - PPO recommendation: *“In accordance with the latest guidance from ‘National Health Service Litigation Authority (NHSLA) advice for Mental Health, May 2009’ it is advised not only for ILS training of appropriate staff in high risk areas but also regular emergency drills to take place to practice scenarios and adequately prepare scenarios and adequately prepare staff for such emergencies.”*¹⁴⁶
- 3.72. Currently, there are no specific requirements necessary to be a prison officer. Applicants that pass initial eligibility requirements (including proof of right to work in the UK and a security check), are given literacy and numeracy tests, and an assessment day looks at how they respond to particular situations. After this, new officers are required to complete the Prison Officer Entry Level Training (POELT) course. This is an eight-week course, aimed at giving the individual the basic knowledge and skills needed to work as a prison officer. During their first year of service they will continue to receive on-the-job training and will be supported and assessed by experienced staff. They will also be expected to complete the Level 3 (NVQ) Diploma in Custodial Care.
- 3.73. In their submission to the Review, Professors Joe Sim (Professor of Criminology, Liverpool John Moores University) and Professor Steve Tombs (Professor of Criminology, The Open University) pointed out the disparity in the length of time officers are trained in England & Wales, as compared to their continental counterparts, quoting from an article published in July 2011 in Inside Times *“...training for prison officers in Norway took two years, while in England and Wales it was eight weeks, which was ‘perhaps the shortest of all staff training in Europe...’”*¹⁴⁷

145 See Appendix 3 – The Approaches and Methods used by the Review - for further information.

146 Harris Review (2015). Summary of our Examination of the PPO, Rule 43/ Regulation 28 Prevention of Future Death reports on cohort cases. Can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

147 Submission to the Harris Review received from Professor Joe Sim and Professor Steve Tombs on 27 October 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.



- 3.74. The question of professionalising the role of Prison Officer has been debated for a number of years. During their 2009 inquiry into the role of Prison Officers, the House of Commons Justice Committee heard from Professor Andrew Coyle, who explained that giving prison officers *“if they are lucky, eight weeks’ training, sometimes within a prison, not in a prison college, and then sending them off to a dispersal prison, or to a local prison, or to a women’s prison, or to a young offenders’ prison and expecting them to know what to do and how to do it is really quite wrong”* (page 19).¹⁴⁸
- 3.75. In their submission to the Review, the Prison Reform Trust (page 19) concluded that *“there is little specialist training available for prison staff working with young adults in custody. We believe that a specialist syllabus should be designed that takes into account the characteristics of young people’s behaviour and stage of development through appropriate role modelling, promoting and maintaining positive behaviours, and clearly defining behavioural boundaries.”*¹⁴⁹
- 3.76. The Review feels that in order effectively to manage, rehabilitate and keep safe vulnerable people in custody, including but not limited to young adults, then, the workforce needs to be trained and developed to a far more professional standard. Training needs to include all staff working in prisons who have contact with prisoners, including prison officers, contracted staff, and in-reach workers. Training should be mandatory and should include regular continued professional development requirements. It should also be quality assured, ideally forming part of an accredited diploma or degree, which would further incentivise staff and also ensure content and quality of material is regularly updated and maintained. Valuing diversity and promoting equality of treatment for prisoners and fellow Prison Service employees should be seen as an essential element of the quality and health of the prison.
- 3.77. In their submission to the Review, the Royal College of Nursing outlined the range of skills that an individual prison officer should have in order to work with young adults, saying that *“Staff working with young people should be particularly aware of mental health issues, learning disabilities, autism, self-harm and CPR. An overall goal of increased knowledge about safeguarding is also necessary”* (page 5).¹⁵⁰

148 House of Commons Justice Committee (2009). Role of the Prison Officer - *Twelfth Report of Session 2008–09*. London: TSO. <http://www.publications.parliament.uk/pa/cm200809/cmselect/cmjust/361/361.pdf>. Accessed 20 March 2015.

149 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

150 Submission to the Harris Review received from Royal College of Nursing on 21 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Staffing levels and Resource Pressures

- 3.78. The second issue that the POA suggested needed to be changed to improve outcomes for prisoners was around levels of staffing. Throughout this Review, the problem of inadequate levels of staffing has been a recurrent theme, although NOMS told us that following the benchmarking and ‘fair and sustainable’ exercises, many prisons are not yet at the levels of staffing that they expect to be at later in 2015.
- 3.79. Benchmarking is the process by which the work of prisons is streamlined while maintaining and, where possible, raising standards, and also allows for activities to be costed.¹⁵¹ NOMS told the Review that it was introduced to implement consistent staffing levels and operating models across each establishment.¹⁵²
- 3.80. ‘Fair and Sustainable’ is the NOMS workforce reform programme that was developed to reduce staffing costs and make public sector prisons competitive in the longer term¹⁵³, NOMS told the Review that it ensures more equal pay for comparable work.¹⁵⁴
- 3.81. There has been much media comment on the resourcing challenges facing the Prison Service¹⁵⁵ together with criticism from the Inspectorate and from Parliamentary Committees. In the recently published report by the Justice Committee (House of Commons Justice Committee: *Prisons: planning and policies, Ninth Report of Session 2014–15*, 4 March 2015), the Committee concluded (page 4) that “*the fall in staffing levels stemming from redundancies and increased turnover, which at their most acute have resulted in severely restricted regimes, are bound to have reduced the consistency of relationships between officers and prisoners, and in turn affected safety*” (page 4).¹⁵⁶ Additionally, the Committee analysed the evidence it had heard on the potential ramifications arising from benchmarking (page 48, paragraph 115) concluding that “... *the key explanatory factor for the obvious deterioration in standards over the last year is that a significant number of prisons have been operating at staffing levels below what is necessary to maintain reasonable, safe and rehabilitative regimes. Having fewer*

151 National Audit Office (2012). *Restructuring the National Offender Management Service. Report by the Comptroller and Auditor General*. London: TSO. <http://www.nao.org.uk/wp-content/uploads/2012/09/1213593.pdf>. Accessed 30 March 2015.

152 Stakeholder Hearing 6, (19 June 2014) NOMS. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/11/National-Offender-Management-Service.pdf>.

153 National Audit Office (2012). *Restructuring the National Offender Management Service. Report by the Comptroller and Auditor General*. London: TSO. <http://www.nao.org.uk/wp-content/uploads/2012/09/1213593.pdf>. Accessed 30 March 2015.

154 Stakeholder Hearing 6, (19 June 2014) NOMS. Summaries of hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/11/National-Offender-Management-Service.pdf>.

155 The Economist (2014, 2 August). *Rough justice: Overcrowded and understaffed, prisons in England and Wales are deteriorating*. The Economist (Online). Retrieved from: <http://www.economist.com/news/britain/21610242-overcrowded-and-understaffed-prisons-england-and-wales-are-deteriorating-rough-justice>. Accessed 30 March 2015.

156 House of Commons Justice Committee (2015). *Prisons: planning and policies – Ninth Report of Session 2014-15*. London: TSO. <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmjust/309/309.pdf> accessed 30 March 2015.

*prison officers can tip the power balance, leading to less safety and more intimidation and violence on wings.”*¹⁵⁷

- 3.82. When representatives for the IMBs gave evidence to the Review they suggested that benchmarking and the ‘Fair and Sustainable’ programme were having an impact on all prisoners. They explained that this is because there are fewer officers on the wings and prisoners are spending more time locked in cells, resulting in heightened stress levels and that it also means that there are not enough staff to support young adults and respond to their issues.¹⁵⁸
- 3.83. The qualitative study that the Harris Review commissioned to get a better understanding of the perspective of staff also reported that staff felt that their capacity to form and sustain high quality staff-prisoner relationships that were needed to support vulnerable young adults had been adversely affected by Benchmarking and the ‘New Ways of Working’. However, it was felt that the problem was not just too few staff on wings but that the staff who were present were less effective than they could be because of inconsistent detailing, the use of agency and detached duty staff coupled with low staff morale. Staff felt that they were managing risk more reactively than proactively as a result.¹⁵⁹
- 3.84. The impact of recent changes have not just been on existing staff. We have been struck by how difficult prisons are finding it to recruit staff into the very many vacancies that currently exist throughout the estate.
- 3.85. The NOMS Workforce Statistics bulletin September 2014¹⁶⁰ recorded that at that time only two of the public service prisons were operating in excess of their agreed benchmark levels, while the remainder were working below those levels; in total the Prison Service was operating with over 3,500 vacancies (or approximately 9%) below their benchmark staffing level.
- 3.86. During our prison visits, we spoke to Governors who were having significant difficulties recruiting staff. Many had tried innovative means to boost applications locally. At one prison, when we arrived, there was a large banner outside saying that they were now recruiting. In addition, this institution had persuaded a local celebrity who was also a former prison officer, to advertise vacancies on the celebrity’s social network pages.

157 House of Commons Justice Committee (2015). *Prisons: planning and policies – Ninth Report of Session 2014-15*. London: TSO. <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmjust/309/309.pdf>. Accessed 30 March 2015.

158 Stakeholder Hearing 7 (26 June 2014) Independent Monitoring Board. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/01/Summary-IMB.pdf>.

159 Ludlow, A, et al (2015). *Self-inflicted Deaths in NOMS’ Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*, <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

160 Ministry of Justice (2014d). National Offender Management Service Workforce Statistics Bulletin, 30th September 2014. *Ministry of Justice Statistics Bulletin*, 27 November, 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379773/noms-workforce-stats-sept-2014.pdf. Accessed 20 March 2015.

- 3.87. We feel, however, that the package available to new recruits, in terms of remuneration and development prospects, is unappealing in the current job market. If prisons are to attract the sort of professional and skilled staff that they need to keep vulnerable prisoners safe, then this needs to change quite radically.
- 3.88. The PGA told the Review that recent problems with the recruitment and retention of staff may have had an effect on the number of self-inflicted deaths. An example was given of the current restricted regime at Swaleside prison, which meant that only half the prison at a time is unlocked. This means less time for prisoners to make calls to family and friends. According to the PGA, this loss of ‘time out of cell’ can increase the spiral of depression for some prisoners.¹⁶¹
- 3.89. As well as training, therefore, NOMS needs to urgently address the issue of staffing. The Review believes that recruitment and retention of prison staff needs to be about more than just ensuring that there are enough staff available to safely and effectively manage the population, but also that the staff in our prisons are motivated, knowledgeable and compassionate.
- 3.90. Associated with the retention of staff is the recognition associated when staff, through their actions or initiatives, prevent a self-inflicted death. The qualitative research on staff perceptions highlights this. A respondent to the survey in this from chaplaincy noted *“literally all the time we are preventing suicide. We actually do it extremely well and I don’t think that’s anywhere near widely enough recognised. You never hear of the success stories. You only ever hear of the failures. Our staff are very good at preventing suicide”* (page 59).¹⁶²
- 3.91. Unlike incidents of self-harm or assaults against officers, there is no record of ‘near misses’, or the times when an officer uses their ‘fish knife’ to cut through a ligature and saves a life. The Review believes that more needs to be done to record and commend staff who have through their actions prevented a self-inflicted death.

161 Stakeholder Hearing 16 (6 November 2014), Prison Governors’ Association. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-Prison-Governors-Association.pdf>.

162 Ludlow, A, et al (2015). *Self-inflicted Deaths in NOMS’ Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*, <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Conclusions and Recommendations on Leadership & Ownership of Prisoner Safety and Rehabilitation

- 3.92. The Review believes that for prisoners to be safer and more effectively engaged in their rehabilitative process, there needs to be stronger leadership and commitment to that purpose shown by Ministers, NOMS senior management, and prison Governors.
- 3.93. The responsibility for ensuring that young adults in custody are rehabilitated and their well-being is delivered ultimately rests with Ministers and with NOMS who need to ensure that this is a priority for all prisons and that prisons are resourced adequately to deliver it. Within an individual establishment the Governor needs to provide effective leadership that prioritises that goal.
- 3.94. For each individual young adult in prison, the responsibility for ensuring that their security and well-being is supported and that their health, education and rehabilitation needs are met should fall to the new role of a Custody and Rehabilitation Officer (CARO).
- 3.95. The CARO needs to be a specialist, suitably trained professional, with a small enough case load so that enough time can be given to each vulnerable adult.
- 3.96. Overall, staff in prisons need to be recruited, trained and remunerated at a level that will motivate and enable them to provide more effective care.

Our recommendations for this chapter are:

Primary Recommendations

15. A new specialist role must be created to work specifically with all young adults in custody. The Custody and Rehabilitation Officer (CARO) will be required to take responsibility for the overall well-being of the young adult and must have a caseload of no more than fifteen or twenty prisoners, so that as a central part of the role it is possible to build and sustain a close and effective relationship with each individual prisoner. This role will be specialist and skilled, understanding developmental and maturity issues that impact on young adults, and will require competencies at least equivalent to a professional youth worker or qualified Social Worker.
16. A senior individual, supported by a dedicated unit within NOMS, must be given clear responsibility for ensuring the particular needs of all young adults are provided for appropriately across the estate.
17. CARO training must begin within 12 months of publication of this report.
18. The role of all operational staff including governors must be further professionalised, with the improvement of skills and knowledge across the workforce, including governors. A process of Continuous Professional Development be introduced so that these skills are kept up to date.
19. MoJ and NOMS must take urgent steps to fill the recruitment gap that is putting undue pressure on an already stretched workforce in prisons.

20. From the evidence given to the panel from many sources, it is apparent that the current operational staffing levels in prisons are not adequate. Following the recruitment that NOMS is currently undertaking, Benchmarking levels should be reviewed immediately to allow for full compliance with Prison Service Instructions that concern the safety and well-being of prisoners and must include implementation of this report.
21. NOMS should ensure that the implementation of Prison Service Instructions is properly resourced in order that the intended benefits can be effectively delivered throughout the prison system. NOMS must have systems in place to ensure that this is happening.
22. Following each self-inflicted death in custody, the Minister for Prisons should personally phone the family of the prisoner who has died to express their condolences on behalf of the State and to promise that a full and thorough investigation will take place, and that any lessons from the death will be studied and acted upon to avoid similar deaths in the future.
23. All staff working in prisons who have contact with prisoners, including prison officers, contracted staff, and in-reach workers must receive regular mandatory training to enable them to recognise and deal with vulnerabilities, particularly mental health needs, and also in relation to the Safety and Vulnerability, Risk Assessment and Support (SAVRAS) (referred to in chapter 6) process. All staff should be subject to regular continuous professional development requirements that are subject to external moderation.
24. Remuneration of prison officers should reflect this professionalization, because it is otherwise unrealistic to expect to recruit and, retain a workforce capable of successfully managing complex vulnerabilities in a custodial environment.
25. Governors must commend every frontline member of staff who have actively implemented measures and made judgments that lead to the prevention of a self-inflicted death and that a record of every commendation and the action taken be shared with the Equality Rights and Decency Group, who must disseminate this across the custodial estate where appropriate.
26. The management of young adults is distinct from the management of the older prison population. The specific skills and personal qualities that are required to work successfully as a prison officer in these situations needs to be assessed and provision made for regular, progressive and monitored training.
27. NOMS must properly assess the impact of each PSI both new and existing with relevant practitioners and experts consulted as appropriate. An impact assessment must also be carried out every time a PSI is changed. If a policy decision has been made that the benefit of a PSI is required then sufficient resources must be provided to ensure its delivery.
28. NOMS must put in place a more effective central system for auditing the implementation of PSIs at individual establishments and to assure NOMS senior management that the Instructions are practical and are being implemented with all anticipated benefits being delivered.

4. The Vulnerability of Young Adults in Custody

“ You don’t become a man overnight. One minute you are under 18 and you are a child and next minute they say that you are a man. ”

(Family hearing day - quote from the parent of a young adult who took his own life)

- 4.1. So far, we have shown that prison can be a very distressing place, particularly if a culture of impoverished regimes, a shortage of motivated and trained staff and disjointed leadership mean that prisoners are not getting the support they need to move safely towards rehabilitation. In the last chapter we introduced the concept of the Custody and Rehabilitation Officer (CARO), whose role is to take ownership of the individual young adult’s needs and journey through the prison system.
- 4.2. This chapter looks more specifically at what these needs are, and explores what particular issues make young adults more vulnerable. It also looks at the origin of some of these vulnerabilities, and explores what might have been done to prevent them being in the situation where they died through self-inflicted death in custody.
- 4.3. The ages 18 to 24 are a complex stage of development that mark the transition between childhood and adulthood. Various social and legal milestones are reached, including the legal status of adulthood, and the rights and responsibilities that this brings with it; for many, it is a time of increasing independence and self-sufficiency.
- 4.4. However, as the quote at the beginning of this chapter suggests, the process is a gradual one, with considerable individual difference in terms of how and when (and even whether) full self-sufficiency is attained. The Bradley Commission’s second report, which focuses on young adults in transition, comments “*the line between childhood and adulthood is often socially constructed and artificially drawn, driven by many factors including legislation. In reality a child’s pathway to physiological, emotional and psychosocial maturity depends on their individual rate of maturation*” (2014, p.2).¹⁶³
- 4.5. Research shows that brain structures continue to mature and develop well into the twenties (e.g. Asato et al 2010).¹⁶⁴ Depending on their neurological stage of development, young adults are likely to have different abilities and perceptions.

163 Saunders, A. (2014). *Young adults (18-24) in transition, mental health and criminal justice. The Bradley Commission, Briefing 2*. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf. Accessed 30 March 2015.

164 Asato, M. R., Terwillinger, R., Woo, J. & Luna, B. (2010). White Matter Development in Adolescence: A DTI Study. *Cerebral Cortex*, 20 (9): 2122-2131.

In addition, as pointed out in the submission by the Prison Reform Trust “*maturity is influenced by life experience and individual characteristics, so a simple test of chronological age provides little insight into the vulnerability of the individual young person*” (2014, p.6).¹⁶⁵

- 4.6. Any inherent difficulties in progressing through this stage of development are compounded, not only by the life experiences of young adults who come into contact with the CJS, but with the processes associated with the CJS itself. This is very effectively summed up in the Transition to Adulthood Alliance (T2A) submission when they explain:
- “The transition to adulthood is a process not an event and does not begin and end on a person’s 18th birthday.19 is the peak age for offending behaviour (for males), but it is also the age at which youth focussed services end. access to supportive services such as mental health, supported living, youth work, education and drug treatment change in nature or cease. Yet with the right intervention, one that takes account of young adults’ distinct needs, this is the most likely age group to desist from crime...”* (2014, p4).¹⁶⁶
- 4.7. Investing in this age group, therefore, offers an excellent opportunity to help young adults develop the skills that will rehabilitate them effectively to reintegrate into society as mature and capable adults. To do this, however, a better understanding is needed about the concept of maturity and the impact it has on young adults.

Development and Maturity

- 4.8. Concern about the relative immaturity of young adults was raised by many of the stakeholders who responded to our *Call for Evidence*, and was also the subject of discussion at a number of our events. The point that the human brain continues to develop into the mid –twenties, and so relative maturity needs to be given more consideration in the CJS was made in multiple submissions (for example, submissions including, but not limited to, those from Catch22, T2A, Frances Done, Prison Reform Trust, Howard League). The issue was summed up by the submission from the Criminal Justice Alliance, when they said “*the evidence points to the assumption of a lack of maturity and the need for a distinct approach to this age group as a whole... individuals mature at different rates, and many young adults in the criminal justice system exhibit development levels more characteristic of a far younger group*” (page 3).¹⁶⁷

165 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

166 Submission to the Harris Review received from Transition to Adulthood Alliance on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

167 Submission to the Harris Review received from Criminal Justice Alliance on 29 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 4.9. These less mature behaviours that we associate with this age group have been described as being attributable to continued brain development. The Barrow Cadbury Trust report on *'Maturity, Young Adults and Criminal Justice'* found that one of the consequences of this prolonged period of development and maturation of the brain is that *"temperance (evaluating consequences of actions, limiting impulsivity and risk-taking is a significant maturity factor that continues to influence antisocial decision-making among young adults"* (Prior et al, 2011).¹⁶⁸
- 4.10. Similarly, T2A's submission to the Review pointed out that young adults' maturity *"will impact on their behaviour as it relates to their cognitive ability, such as their decision-making, empathy and ability to avoid risks"* (page 9).¹⁶⁹
- 4.11. Staff in the establishments that we visited also recognised that young adults were less mature, and some were able to describe behaviour in those terms, referring to acts that were rash or as a front to hide their emotions from their peers. Some of the governors we spoke to said that this sort of behaviour was worse in institutions that did not have older adults, who could have a calming influence. NOMS' submission also pointed out that *"younger adults are more likely to display impulsivity and may pay less heed to potential consequences of their behaviour"* (p.7).¹⁷⁰ Additionally, the submission from Paul Scoular on behalf of the Scottish Prison Service noted that *"young offenders tend to be impulsive in behaviour"* (page 3).¹⁷¹
- 4.12. We came across evidence of some of the characteristic behaviours associated with a lack of maturity when we spoke to young adults in the establishments. One young man told us that he really wanted qualifications, but complained that education services at the establishment (which held 18-24 year olds) was "like a kid's school" and so he quit because he "didn't like school anyhow". There did not seem to be anybody at the prison who could help this young man evaluate the longer term consequences of this behaviour.
- 4.13. A similar issue was raised in terms of budgeting, something with which this age group struggle in prisons. One of the families told us that their son was not mature enough to handle planning his budget, explaining *"all the young people are given a phone card of £7.50 for the week. [He] didn't know how to manage money. He was given the card on*

168 Prior, D., Farrow, K., Hughes, N., Manders, G. & Wilkinson, B. (2011). *Maturity, Young Adults and Criminal Justice: A Literature Review*. University of Birmingham paper commissioned by Barrow Cadbury Trust for T2A. Retrieved from: <http://www.t2a.org.uk/wp-content/uploads/2011/09/Birmingham-University-Maturity-final-literature-review-report.pdf>. Accessed 30 March 2015.

169 Submission to the Harris Review received from Transition to Adulthood Alliance on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

170 Submission to the Harris Review received from NOMS on 3 February 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

171 Submission to the Harris Review received from Paul Scoular on behalf of the Scottish Prison Service on 8 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Friday, by Sunday it was all used up. He then had no way of contacting [me] until his credit was topped up again” (page 18).¹⁷²

- 4.14. Understanding maturity and how it manifests itself is very important because it is simple actions, such as working to keep a young man engaged in purposeful activity and education, or having enough credit to phone his mother when he feels distressed, that will help to save lives. At an establishment level, this means ensuring staff, and particularly those involved in a CARO role, are trained to recognise behaviour that results from a lack of maturity and that they have the skills to support the young adult through this period.
- 4.15. It also means that the CARO needs to have the tools to be able to identify young adults who are less mature, and to assess whether changes in their maturity levels have consequences for planning their rehabilitation and resettlement. The response from HM Chief Inspector of Prisons also recognised that *“assessing maturity is essential to mitigating risks and responding to young adults’ needs. Tools are needed to make this effective”* (paragraph 35).¹⁷³
- 4.16. The panel was impressed with a presentation we received from NOMS (interestingly not referred to in the main NOMS submission) on work being done to develop a tool to measure and assess maturity of young adults and other prisoners, which might potentially use data gathered through the existing OASys process. We appreciate that this work is still in early stages, but we feel that as much support as possible needs to be given to progressing this tool and developing it.
- 4.17. More broadly, the Review has been convinced by the overwhelmingly strong message we have been given that *“maturity’ is a better guide to a young person’s transition to adulthood than their chronological age”* (T2A submission, page 3).¹⁷⁴ Given the current understanding of maturity and human development, and brain development in particular, we feel it no longer makes sense to expect that young adults, especially when they are distinctly vulnerable, should be sentenced as an adult solely on the basis of their age. It is worth looking at other jurisdictions to see how this complicated period is dealt with. T2A have pointed out that in Germany *“the courts choose either juvenile or adult law for young adults on the basis of maturity of the individual and their distinct needs”* (T2A submission, page 5).¹⁷⁵ We consider that these and other practices should be examined, and that it is imperative that the concept of maturity receives statutory recognition.

172 INQUEST (2015). *Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds* Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

173 Submission to the Harris Review received from HM Chief Inspector of Prisons on 24 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

174 Submission to the Harris Review received from Transition to Adulthood Alliance on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

175 Ibid

Vulnerability and Young Adulthood

- 4.18. As has already been set out, maturity is influenced by life events and experiences. Prison Reform Trust pointed out to us that *“this is especially the case for young people who have experienced childhood trauma or who have certain disabilities,”* (Prison Reform Trust submission, page 6)¹⁷⁶ which was echoed by the Howard League who commented *“young people with the most troubled or traumatic children often take longer to mature”* (page 4).¹⁷⁷
- 4.19. The Bradley Commission commented in their briefing note no.2 *‘Young adults (18-24) in transition, mental health and criminal justice’* *“it is the norm, not the exception, that young adults in contact with the CJS have multiple vulnerabilities arising from a variety of social, psychosocial and economic factors”* (page 3).¹⁷⁸
- 4.20. Indeed, these issues were pointed out repeatedly to us in response to the questions we asked about vulnerability in our Call for Submissions. The response from INQUEST explained *“early experience of state care, mental health issue, learning difficulties and disabilities are key factors underpinning vulnerability”* (page 9).¹⁷⁹
- 4.21. This section now looks at some of the specific issues that might increase vulnerability and their particular context in custody. Throughout this section, case studies of the young adults who died between April 2007 and December 2013 are presented in text boxes. These illustrate the range of different vulnerabilities with which these young adults were dealing.

Life Experiences

- 4.22. The Bradley Commission in their report *Young Adults (18-24) in transition, mental health and criminal justice* stated that *“the most vulnerable young adults are those who have experienced a lifetime of social adversity, poor parenting, avoidant attachment relationships stemming from emotional neglect, abuse, domestic and sexual violence, and trauma”* (2014, page 3).¹⁸⁰
- 4.23. The Office of the Children’s Commissioner outlined in their submission that *“there is a wealth of evidence to indicate that the majority of children and young people in the youth*

176 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

177 Submission to the Harris Review received from Howard League for Penal Reform on 28 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

178 Saunders, A. (2014). *Young adults (18-24) in transition, mental health and criminal justice. The Bradley Commission, Briefing 2*. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf. Accessed 30 March 2015.

179 Submission to the Harris Review received from INQUEST on 13 October 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

180 Saunders, A. (2014). *Young adults (18-24) in transition, mental health and criminal justice. The Bradley Commission, Briefing 2*. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf. Accessed 30 March 2015.

*justice system in England and Wales come from the most deprived and disadvantaged families and communities and their lives are characterised by disruption, neglect and impoverished social landscapes. Many have experienced abuse and neglect and those who move through both the welfare and youth justice systems into custodial institutions tend to have particularly complex needs” (page 24).*¹⁸¹

- 4.24. The OCC also pointed out that “traumatic loss and separation figure highly among children and young people who offend” (page 25).¹⁸² They described a 1997 study that reported higher than average levels of loss and bereavement among children and young people in the youth justice system with 57% out of 200 children convicted of ‘grave crimes’ having suffered the loss of a parent, grandparent or other relative or carer through bereavement or separation.¹⁸³ The Prison Reform Trusts submission also refers to “*evidence from studies... that children who take their lives have often experienced the untimely death of close relatives, and that this has a significant impact on them*” (page 8).¹⁸⁴ This is backed up further by the Howard League, who point out that their casework contains “*a surprising number of young adults in custody are grieving the death of loved ones*” (page 4).¹⁸⁵
- 4.25. We received a submission from Keith Ibbetson and Kevin Harrington, Independent Serious Case Review author and Panel Chair respectively about a child that they referred to as Child F, which gave details about years of early abuse and neglect that impacted on his emotional health and behaviour.¹⁸⁶ As he became a teenager he became increasingly preoccupied with his history and his identity, and why he wasn’t living with family members. The submission explains that on the night that he died he mentioned to a prison officer for the first time that he had been sexually abused as a young child.
- 4.26. A number of submissions also described concern about numbers of young adults in custody who have acquired brain injuries and/or neurodisability (e.g. T2A, Prison Reform Trust, NOMS) and histories of substance misuse (e.g. Prison Reform Trust, OHRN).
- 4.27. Unfortunately, as our case studies illustrate, these experiences are not uncommon when there is a self-inflicted death in custody of a young adult.

181 Submission to the Harris Review received from Office of the Children’s Commissioner on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

182 Ibid

183 Berelowitz, S. and Hibbert, P. (2011). *‘I think I must have been born bad’: emotional wellbeing and mental health of children and young people in the youth justice system*. London: Office of the Children’s Commissioner. http://www.childrenscommissioner.gov.uk/force_download.php?fp=%2Fclient_assets%2Fcp%2Fpublication%2F503%2FI_think_I_must_have_been_born_bad_-_full_report.pdf. Accessed 30 March 2015.

184 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

185 Submission to the Harris Review received from Howard League for Penal Reform on 28 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

186 Submission to the Harris Review received from Keith Ibbetson and Kevin Harrington (serious Case Review) on 28 May 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Young Adult Women

The Case of Alison

Alison had a long history of mental health problems and suffered from epilepsy. She had been the victim of domestic violence and rape. Her father had committed suicide 15 years before her death. She started drinking at the age of 12, and had a daily heroin habit since the age of 17. She had overdosed at age 22.

She was remanded in custody 11 months before she died, when she was put on a detoxification programme. After sentencing, she was transferred to another prison. She was accepted on to the Mental Health In-Reach Team caseload, and was prescribed antidepressants, an antipsychotic drug and medication for epilepsy.

She was involved in a number of incidents in the following months, including fights with other prisoners. She complained that she was being bullied and staff suspected that she was being threatened by other prisoners.

She formed a number of close relationships with other female prisoners, including one with a woman with whom she wanted to live after release. Shortly after this woman was released, Alison became depressed again.

A month later she resumed a relationship with a previous girlfriend. When the released woman was murdered, Alison became upset and was put on an ACCT. She was observed, and checked on several times the day she died because her friend asked staff to check on Alison. She was found by her friend after the cells were unlocked for the afternoon, hanging from a ligature point on the window. She was 24 years old.

- 4.28. Young adult women face a number of particular needs in prison. INQUEST's submission to the Review noted that "*many young women enter the criminal justice system as a result of unmet welfare needs including neglect, abuse and poverty*" (page 23).¹⁸⁷ Additionally, the submission from Women in Prison suggests that women have higher rates of trauma, victimisation, substance misuse and mental health issues.¹⁸⁸
- 4.29. It has also been pointed out, however, that their experience of custody will be different because, on top of their previous experiences, they have additional pressures such as separation from children (e.g. submissions from Scottish Prison Service and Action for

187 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

188 Submission to the Harris Review received from Women in Prison on 1 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Prisoners Families)¹⁸⁹ and discrimination “*caused by a criminal justice system designed for its majority male population*” (Women in Prison submission, page 6).¹⁹⁰

- 4.30. MoJ (2013) analysis of the Surveying Prisoner Crime Reduction (SPCR) on gender difference in substance misuse and mental health among prisoners, found that female prisoners reported poorer mental health than both women in the general population and male prisoners. This was true in relation to self-harm, suicide attempts, psychosis, anxiety and depression.¹⁹¹
- 4.31. Only 2 of the 87 cases in our cohort were female, aged respectively 19 and 24, which means it is not possible for us to identify specific trends or themes. Looking at our analysis of the longer term data, however, we can see that between 2002 and 2013, the average rate of self-inflicted deaths per 1,000 was much higher for female 18-24 year old prisoners than for male, with an average of 0.67 incidents per 1,000 male prisoners and 1.51 incidents per 1,000 female prisoners.
- 4.32. While this pattern has changed recently, with a higher rate of self-inflicted deaths among male prisoners compared to female prisoners in the last five years, the pattern is still different between young adult males and young adult females. Analysis of data between 2002 and 2013 (which is the only period during which this data is available) shows that the average rate of self-inflicted deaths generally decreased with age for female prisoners (with the exception of 15-17 year olds), which is the inverse of what happens with males. This meant that a higher proportion of young adult women who were 18-24 took their own lives than older females from 2002 to 2013.
- 4.33. We are clear that young adult women can be a particularly vulnerable group, and this was confirmed by the young adult women who came to speak to us in September 2014 with *User Voice*. One of them said to us, when describing why she self-harmed, “*at sixteen years old I already felt very alone and then I went to [YOI/prison’s name]. There was no one to talk to. I put on a brave front and went back to my cell and cut up. I was full of fear; that is why I put on a brave front particularly to people older than me*” (User Voice Hearing).¹⁹² It is evident that those working with these very vulnerable young people need to have the necessary skills to support them through the custody process.

189 Submission to the Harris Review received from Action for Prisoners Families on 4 August 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

190 Ibid, submission received from Women in prisons (2014).

191 Ministry of Justice (2013a). *Gender differences in substance misuse and mental health amongst prisoners – Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners*. Ministry of Justice Analytical Series, Ministry of Justice. Retrieved at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf. Accessed 10 March 2015.

192 Stakeholder Hearing 14 (4 September 2014) User Voice. Summaries of hearings can be accessed at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/User-Voice.pdf>.

Black, Asian and Minority Ethnic Groups

- 4.34. A number of submissions expressed concern about the overrepresentation of young adults from BAME groups in custody (e.g. submissions from YJB and HMIP). T2A noted that *“Black, Asian and Minority Ethnic (BAME) people are over-represented at every stage of the criminal justice process with seven times the rate of stop and search of this group than white people, and a between three and four times over-representation in custody”* (page 17).¹⁹³ The submission from the Criminal Justice Alliance reported that *“26%... of the prison population [have] a BAME background compared to about 10% of the general population”* (page 6).¹⁹⁴ Analysis of the 87 cases within our cohort, showed that 15 (17%) declared themselves to be from a BAME ethnic background.¹⁹⁵

Case Study - Olewale

Olewale was a 21 year old black male who died by hanging himself from a bed sheet to a ligature point on the window.

He was a Nigerian national who said he had been sexually abused before arriving in the UK. He did not know how to grieve his mother’s death and had been physically abused as a child in foster care. He remained in custody after his expected release date as he was being deported to Nigeria. He developed an infatuation with a female prison officer during the period he was awaiting deportation and was referred to the mental health in-reach team. After being put on an ACCT, he set fire to a bin and tried to hang himself while the fire was being extinguished. Olewale began to express concerns about having to return to Nigeria. He was transferred to another YOI due to his infatuation. At this institution it was noted that his mood fluctuated and he would have periods of sadness and grief. A few days before he died, he was put on an ACCT because of an incident of self-harm.

¹⁹³ Submission to the Harris Review received from Transition to Adulthood Alliance on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

¹⁹⁴ Submission to the Harris Review received from Criminal Justice Alliance on 29 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

¹⁹⁵ Harris Review (2015) Examination of the specific circumstances associated with the Review cohort cases, <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 4.35. A teacher and community worker at a music academy speaking at the BMH UK Roundtable event about the disproportionate number of African Caribbean people in the CJS said, *“The ease of access into this criminal justice system leads straight to a trajectory that can destroy a life, it is the equally opposite path to accessing education and training for the young people from our communities.”* He continues, emphasising the need for professionals who work diverting people from custody or supporting their rehabilitation to be representative of that group and have personal experience of the CJS, *“Why is it that experts whose opinions are taken on board when it comes to important issues like these are not those who have lived it and really understand the issue, but rather information is always taken second hand from someone who has studied it.”*¹⁹⁶
- 4.36. One of the particular issues about young BAME adults that has been repeatedly raised is that they feel less safe in prison. In their Thematic Report of the Review of the Implementation of the Zahid Mubarek Inquiry recommendations HMIP state that in their analysis of 2012/2013 survey data, *“...prisoners from black and minority ethnic groups were generally more likely to report feeling unsafe than their white counterparts”* (2014).¹⁹⁷
- 4.37. The submission from Baroness Lola Young gave several examples of the difficulties that in particular Black and Muslim young men experience in custody. Many of the men that the Young Review spoke to said they experienced differential treatment because of their race, ethnicity or faith. The submission explained that *“Black prisoners felt they were stereotyped as drug dealers and Muslim prisoners as terrorists”* (page 3). Furthermore, *it was pointed out that these young adults were “being perceived as a risk rather than in need”* (page 2).¹⁹⁸
- 4.38. A potentially contributory factor to this is that BAME prison officers are underrepresented in the workforce. This means, as PRT point out *“young people from black and other minority ethnic groups are imprisoned in places where the prison workforce is much more likely to be predominantly white”* (page 7).¹⁹⁹ T2A expand on this by saying *“concerns have been raised that the prison service at both operational and management level does not have sufficient culturally competency to effectively deliver its service to the population in custody”* (page 17).²⁰⁰

196 Submission to the Harris Review received from BMHUK on 19 March 2015 (OOC 83). Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

197 HM Inspectorate of Prisons (2014). *Report of a review of the implementation of the Zahid Mubarek Inquiry recommendations: A thematic Review*. London: HMIP. <https://www.justiceinspectors.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/07/Mubarek-final-published.pdf>. Accessed 30 March 2015.

198 Submission to the Harris Review received from Baroness Young in September 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

199 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

200 Submission to the Harris Review received from Transition to Adulthood Alliance on 18 July 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 4.39. The disproportionate mix of BAME young adult prisoners and white staff was also raised at some of the events we held, and was discussed in particular at the Local & Communities Groups Seminar.
- 4.40. The Review is concerned by these issues and feels that more needs to be done to ensure that the ethnic mix of the staff in a particular prison more closely matches those of the prisoners in that prison. This is important in helping ensure that more staff have an empathic understanding of the prisoners for whom they are responsible and that prisoners have more role models within the prison to whom they can relate.
- 4.41. However, in our sample, those who died were far more likely to be white, with only 17% of our cohort declaring that they were from a BAME background (see paragraph 4.33 above). The findings from the commissioned Ministry of Justice analysis of self-inflicted deaths in custody between 1978 and 2014,²⁰¹ showed that amongst 18-24 year old prisoners there were more incidents amongst white prisoners than other ethnic groups, with a total of 358 incidents across the available time series. There were 42 incidents amongst black 18-24 year old prisoners, 15 incidents amongst Asian prisoners, and three incidents amongst prisoners of mixed ethnicity.
- 4.42. Amongst 18-24 year olds the rate of self-inflicted deaths per 1,000 prisoners by age and ethnic group was more variable, owing to smaller numbers within each group. White 18-24 year olds had a higher rate of self-inflicted deaths (with an average of 0.69 incidents per 1,000 prisoners for the period 2004 to 2013) compared to other ethnic groups.
- 4.43. The Review thought that it was important that more research should be done on this. If there are protective factors that support young BAME adults in custody from Self-inflicted deaths, as opposed to young white adults, it is important that these are understood and any lessons learned. If, however, this differential in the rate of Self-inflicted deaths is a function of more BAME young adults entering the CJS and prison with a lower threshold of offending behaviour than their white counterparts and that perhaps because as a cohort their offending has been less violent and this is leading to a lower rate, then that would suggest some much more fundamental issues for the operation of the CJS. Either way, more research would clearly be helpful.
- 4.44. A related issue, in terms of the perception of BAME prisoners, is that of gangs. This has already been discussed in this report in relation to the impact it can have on regimes, but it also impacts on how BAME young adults experience custody. The Young Report suggested that the gang agenda focuses disproportionately on BAME young people, and raised concerns that “*more young BAME people were entering the CJS, including those who are only on the periphery of gang activity*” (page 71).²⁰² The Review has already earlier in this report expressed its concerns about the inadequacy of NOMS policy on gangs.

201 Ministry of Justice (2015). *Self-inflicted Deaths in Prison Custody in England and Wales between January 1978 and March 2014*. London: Ministry of Justice. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

202 Young, L. (2014). *The Young Review: Improving outcomes for young black and/or Muslim men in the Criminal Justice System*. London: Barrow Cadbury Trust. Retrieved from: http://www.youngreview.org.uk/sites/default/files/clinks_young-review_report_dec2014.pdf. Accessed 30 March 2015.

Care Leavers

- 4.45. The Who Cares? Trust, in their submission to the Review, commented that “*care leavers are a particularly vulnerable group of young people due to their own prior experiences; their life in care and also their care leaver status. Their situation as care leavers can often compound existing vulnerabilities and put them at risk of developing further vulnerabilities, which can in turn put them at risk of harm*” (2014, page 1).²⁰³
- 4.46. In their submission, Prison Reform Trust pointed out that there was a “*paucity of data allowing identification of care leavers. The most reliable data on this is found in prison inspectorate reports, though the lack of formal recording mechanisms for this information, particularly for young adults, means reports are likely to underestimate the number of care experienced children and young people in custody*” (page 13).²⁰⁴
- 4.47. NOMS states that care leavers “*have been estimated to make up 27% of the adult prison population, despite the fact that less than 1% of under 18s enter local authority care annually*” (2013, page 3).²⁰⁵ Darren Coyne, of the Care Leavers Association, told the Harris Review Young Adult Characteristics Roundtable Event that between 25-50% of the prison population have experience of the care system, while in the population as a whole it is only 1%²⁰⁶. These statistics, however, are difficult to substantiate because of inconsistent data collection and also because some young adults do not want to report their care status.

Case Study Brian

Brian was an 18 year old white male who died in custody when he hung himself from a ligature point on the window.

As a teenager, he had spent 2.5 years in care due to his learning needs and social conduct disorder. He was subject to a number of supervision orders over the years, and was a persistent offender who had committed a number of offences since he was 10. Over several periods in custody as a 16 and 17 year old, he was in several fights and altercations and was often disruptive. He was the subject of security reports, adjudications, etc. The YOT officers who prepared his pre-sentence report noted Brian had issues with alcohol, learning difficulties and managing his anger.

²⁰³ Submission to the Harris Review received from the Who Cares Trust on 18 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²⁰⁴ Submission to the Harris Review received from Prison Reform Trust on 18 July 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²⁰⁵ NOMS (2013). *Practice Guidance: Working with Care Leavers (18-25), in custody and the community, to reduce reoffending and promote effective transition to adulthood*. London: NOMS. http://www.careleavers.com/component/docman/doc_download/189-noms-guidance-care-leavers. Accessed 31 March 2015.

²⁰⁶ Harris Review (2015), Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 4.48. Our roundtable event to look at characteristics of young adults was attended both by the MoJ policy lead on young adults and by the NOMS Care Leavers Champion. They were able to confirm that mechanisms are now in place to record information on care status of young adults in custody and offenders on community sentences, but it will still be some time before substantial data will be available for further analysis.
- 4.49. The Review also heard that since 2013, NOMS has focused more purposively on the issues of Care Leavers, issuing guidance to staff and also appointing a Governing Governor to the position of Care Leavers Champion (mentioned in paragraph 4.46 above). MoJ delivered these as part of its commitments to the 2013 Cross Government Care Leavers Strategy.²⁰⁷ We feel more needs to be done to take this work forward and the proposed new CAROs will need to be aware of and trained to deal with the particular issues of care leavers.
- 4.50. However, we are particularly concerned with the lack of support that care leavers have from family and responsible adults outside of the prison environment.
- 4.51. At the roundtable, Darren Coyne provided us with quotes from care leavers with whom he works. One young man, who had been very vulnerable in custody due to his lack of external support and low self-confidence told Darren *“they think once you’re a criminal you’re always a criminal but that’s not the way ... just certain things go on in your life and you think f**k it, what have I got to live for ... I was homeless at the time ... I had nowhere to live. I thought you know what, what have I got to live for”*. This young man explained that nobody understood how he was feeling until he spoke to an ex-offender who had been through a similar experience. He said *“I’m used to just getting NOPE so I don’t bother. He [the worker who is an ex offender] asked questions and my heart was buzzing”* (see summary of event).²⁰⁸
- 4.52. In the last chapter we referred to the concept of a ‘significant adult’, and we explained that we felt every young adult needs to have someone like this in their lives. When we consider the particular situation of young adults in custody who are care leavers, we feel that more needs to be done to ensure that they have someone – outside of the CJS and not including their lawyers – whom they can speak to and from whom they should receive support. In his introduction to the 2013 cross-government care leavers strategy, by the then Children’s Minister Edward Timpson MP said *“central and local government have a unique relationship with children in care and care leavers as we are their ‘corporate parents’”* (2013, page 3).²⁰⁹ At present this corporate parenting role is rarely evident for young adult care leavers who are in custody.

207 HM Government (2013). *Care Leavers Strategy: A cross departmental strategy for young people leaving care*. London: Department for Education. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266484/Care_Leaver_Strategy.pdf. Accessed 30 March 2015.

208 Harris Review (2015), Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

209 HM Government (2013). *Care Leavers Strategy: A cross departmental strategy for young people leaving care*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266484/Care_Leaver_Strategy.pdf. Accessed 30 March 2015.

- 4.53. Under existing legislation, the Children (Leaving Care) Act 2000, which came into effect on the 1st October 2001, provides that local authorities have a duty to maintain contact and to provide support to the Care Leaver through a Personal Adviser and also requires local authorities to assist those who are 18-21 years of age with the costs of education, employment and training. The Act (section 4) also makes clear that the duty to support 18-21 year olds continues while a young adult is under 24 years old if they are still in education or training, and there is also a duty to ensure vacation accommodation for higher education. The local authority with the responsibility for meeting the duties under the Leaving Care Act is the last local authority which had the responsibility of looking after the young person and it applies wherever the young person is currently living.
- 4.54. Statutory guidance has now been issued for the Care Act 2014 (due to come into force April 2015). Social Services of the young adult's Local Authority are responsible under the Care Act (2014) for preparing a pathway plan for care leavers, which should consider the young person's need for support and assistance and how these needs will be met until they reach 21 (or later if the young adult is in education or training).
- 4.55. Despite these statutory obligations, the Review has struggled to find out – notwithstanding numerous queries made to both the Local Government Association and Welsh Local Government Association - what support the young adults in custody should be and are getting from local authorities, particularly in terms of 'corporate parenting'. It is clear from discussions we have had with the Care Leavers Association and with prison staff, that many young adult care leavers who are in custody are not receiving support. We understand that the NOMS' Care Leavers Champion has been having discussions with local authorities about how to improve the situation, and while this is commendable, we feel that the burden of responsibility for ensuring the statutory duties of local authorities are discharged should not lie solely with NOMS. Further work needs to be done to fix this disconnect between the CJS and the social care system.
- 4.56. We think that the personal advisor scheme should be reviewed to see how it could be improved for young adult care leavers who are in custody. Furthermore, we feel that an obligation needs to be placed on local authorities to ensure that care leavers receive pastoral support from a 'significant adult'.
- 4.57. We are also concerned care leavers may not have a home address and so are more at risk of being denied bail and remanded into custody. At the Characteristics of Young Adults round table event, the Deputy Children's Commissioner suggested exploring the possibility of an extension of section 20 of the Children Act 1989 to require local authorities to pay for the costs of accommodation of young adult care leavers who would otherwise be remanded in custody. We acknowledge that this would be complicated and may place unfeasible financial burden on local authorities, but we strongly believe that more needs to be done to ensure that young adults are not being placed in custody because they have had the misfortune to have had a history of being placed in care.

Mental Health

- 4.58. There is substantial evidence of the high prevalence of mental health problems amongst young adults in custody. In 2005 the Barrow Cadbury Commission published its report *Lost in Transition*,²¹⁰ which highlighted that many young adults had an existing history of mental illness at the point of their entry into the CJS. Their findings included that nearly 90% of 18-21 year olds in custody had at least one form of mental illness, ranging from severe psychosis to depression.
- 4.59. The submission from PRT refers to the 2012 study by PRT and INQUEST that found “that nearly half (48%) had a history of mental health problems (page 8).²¹¹ Research has shown that 95% of 15-21 year olds in custody have been found to suffer from one mental health disorder and 80% from at least two (Singleton et al, 1998).²¹²
- 4.60. Prisoners’ mental health tends to be worse than the general population. This was established by the 1997 Office of National Statistics’ *Psychiatric Morbidity Survey* (Singleton et al, 1997)²¹³, which demonstrated that the prisoner population suffered from higher rates of mental illness than the general population. It also showed that there were higher rates of self-harm, alcohol misuse, drug dependence and low intellectual functioning amongst prisoners compared with the rest of the population.
- 4.61. More recent studies, such as the Surveying Prisoner Crime Reduction (SPCR) study²¹⁴, have demonstrated similar findings, with between a quarter and half of prisoners likely to suffer from mental illness – this proportion rises to between 70 and 90 per cent if substance misuse issues are included.
- 4.62. Mental health issues are so fundamental that we will discuss them in more detail in the next chapter. At present, it is sufficient to say that they are an additional contributory factor to vulnerability.

210 Barrow Cadbury Trust (2011). *A Report of the Barrow Cadbury Commission on Young Adults and the Criminal Justice System*. London: Barrow Cadbury Trust. <http://www.barrowcadbury.org.uk/wp-content/uploads/2011/09/Lost-in-Transition.pdf>. Accessed 11 March 2015.

211 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

212 Singleton, N., Meltzer, H., Gatward, R., Coid, J., & Deasy, D. (1998). *Psychiatric Morbidity among prisoners. A survey carried out in 1997 by the Social Survey Division of ONS on behalf of the Department of Health*. London: TSO. <http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-prisoners/psychiatric-morbidity-among-prisoners--summary-report/psychiatric-morbidity---among-prisoners--summary-report.pdf> Accessed 15 March 2015 .

213 Ibid

214 Ministry of Justice (2013a). *Gender differences in substance misuse and mental health amongst prisoners – Results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners*. Ministry of Justice Analytical Series, Ministry of Justice. Retrieved at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf. Accessed 10 March 2015.

Foreign National Offenders

- 4.63. Foreign National Offenders (FNOs) will have unique vulnerabilities which may reflect their past history and be compounded by possible problems with communication and uncertainty about their future. The PPO in his submission²¹⁵ to the Review talked about fear of deportation to a country left in childhood that the young adults have very little knowledge of or connection with and how this will lead to separation from their families in the UK. The PPO suggested that the bureaucratic language of the deportation documentation is such that even with reasonable English FNOs may not realise that they have an opportunity to appeal and the PPO provides two case studies where a 19 and 24 year old took their own lives in despair at the prospect of deportation.

What is a ‘vulnerable’ young adult in custody?

- 4.64. The last few pages have demonstrated that young adults can come into custody with a multitude of different issues that might increase their vulnerability and their ability to cope with the custodial environment, and as noted in INQUEST’s submission, “*custodial experience exacerbates and compounds these early life disadvantages*” (page 9).²¹⁶
- 4.65. When we considered the answers to the questions we asked about vulnerability, we were struck by how many people suggested that all young adults in custody were inherently vulnerable. The submission from Bindmans noted “*in acting for bereaved families of 18-24 year olds who have died in prison as well as prisoners themselves under 24, it is our experience that this age group is inherently vulnerable due to their age and common experiences outside custody*” (page 2).²¹⁷
- 4.66. In preparing their submission to the Review, *User Voice* held focus groups with young adults currently in custody to discuss some of the questions we asked in our *Call for Submissions*. They explained that the young adults felt that there were difficulties in defining vulnerability among prisoners. The submission points out that “*whilst it may be in the prison’s interest to focus resources on particularly vulnerable individuals, this could take help away from other prisoners who also need the prison’s attention.*” They added that one of the young adults they spoke to said “*I think everyone should be seen as vulnerable when they come into prison regardless of whether they seem it or not – doesn’t matter what they are pretending to be like when they come in. Usually loud ones are putting on a front and are more vulnerable than us*” (Quote from *User Voice* submission, 2014, page 2).²¹⁸

215 Submission to the Harris Review received from Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

216 Submission to the Harris Review received from INQUEST on 13 October 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

217 Submission to the Harris Review received from Bindmans (Solicitors) on 1 August 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

218 Submission to the Harris Review received from *User Voice* on 15 September 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 4.67. Similarly, the submission from Dr David Scott noted *“the ACCT fails to acknowledge that the key problem is the potential vulnerability of every prisoner and as such its practices simply reinforce the labelling of certain prisoners as ‘vulnerable’, thus implying that the rest are invulnerable”* (page 6).²¹⁹
- 4.68. Having considered the range of evidence we have been given, and in particular having considered the 87 cases in detail, the Review agrees that **all young adults in custody are potentially vulnerable**, and all need to be given particular care.
- 4.69. As well as the processes that we are proposing in the next chapter to help to better manage this, it is clear that the CARO will need specialised skills in their role supporting these young adults. They will need to have a wider understanding of a range of issues that might make the a young adult vulnerable, and be able to recognise when behaviour that might seem to be disruptive, or that might come across as bravado, or behaviour that is more reticent, may all be manifestations of feelings of vulnerability.
- 4.70. The submission from Catch22 gives an example of the work in HMP Doncaster, where the levels of need of each individual is assessed by their caseworker on arrival at the prison. This takes into account individual circumstances and risks, and is mindful of levels of maturity for young adults. The model described is based on building strong relationships with the young adult, so that trust is built up between each vulnerable person and their caseworker. Catch22 explain *“this model enables caseworkers to make informed decisions regarding the level of personal interaction required, taking into account the risk and individual needs, and to begin the process of involving other internal services and disciplines. Importantly, these strong relationships also mean that prisoners feel able to tell us if they are having a difficult period or if they are struggling, which means we can identify likely self-harm as well as potential harm to others”* (page 2).²²⁰
- 4.71. We envisage that this will be a core function of the role of the CARO that this Review is proposing.

219 Submission to the Harris Review received from Dr David Scott on 29 October 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

220 Submission to the Harris Review received from Catch22 on 2 October 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Experience in Custody

- 4.72. We have established that young adults face significant issues in their journey into custody. However, the experience of prison itself is likely to increase vulnerability significantly, and this section of the report examines some of the elements of the custody experience that are particularly likely to adversely affect young adults.
- 4.73. In their submission, the Samaritans pointed out that young adults feel particularly vulnerable during key points in their experience, such as transfers, adapting to a new environment and fear of what will happen next (page 3),²²¹ and indeed this was supported by a number of other submissions.

Transitions

- 4.74. Transfers between establishments are quite common during the custodial experience, and can happen for a range of reasons. The submission to the Review from the PPO points out “*moves between prisons can be unavoidable and even desirable, but there are a number of occasions when the investigation raised concerns about the way moves were handled*” (page 8).²²²
- 4.75. An example is given by Harrison Bunday Solicitors in their submission to the Review, where they describe a case of a young man who self-harmed “*through fear and uncertainty as to what would happen to him*” (page 1). They felt this fear and uncertainty remained up to his death at age 24.²²³
- 4.76. Another disturbing example was given by the PPO, who described the case of a young man who was told at short notice that he was to be transferred. The move took him far from his home and from the support of two prisoners who had helped him with his disabilities. He was eventually tricked into leaving his cell by staff, who restrained him when he tried to return. The receiving prison was not told of this background and he hanged himself a week later (page 8).²²⁴
- 4.77. One of the most stressful transfers can be the move from the youth estate to an adult prison.

221 Submission to the Harris Review received from Samaritans on 17 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

222 Submission to the Harris Review received from Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

223 Submission to the Harris Review received from Harrison Bunday (Solicitors) on 08 August 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

224 Submission to the Harris Review received from Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 4.78. This chapter started with the quote from a parent of a young man who died: *“You don’t become a man overnight. One minute you are under 18 and you are a child and next minute they say that you are a man”* (Family Hearing Day).²²⁵ It is worth reiterating this, because despite the fact that maturity is a gradual process, the support that is offered young people who are under 18 virtually disappears overnight once they turn 18.
- 4.79. The YJB pointed out in their submission that *“those young adults who have transitioned from the youth secure estate are often particularly vulnerable individuals”* (page 2) and also that *“... the impact of moving from a better resourced and more supportive environment may be stark”* (page 2).²²⁶ Similarly HMIP warned that *“transitions, such as those from youth to adult custody, can be extremely unsettling and lead to risk”* (paragraph 36).²²⁷
- 4.80. The transition from the youth to the adult estates is made particularly difficult because provision of many services also changes at that point. T2A point out *“young adults with complex problems often face the additional challenge of multiple transitions between services and systems. Often these young people fall between the gaps, when they lose the very support or intervention that might help them make a smooth transition to adulthood”* (T2A submission, page 6).²²⁸
- 4.81. A teenager at 17 years of age might be receiving support from CAMHS and from various members of the YOT team during the first part of his sentence in a more supportive STC environment, and on turning 18 he might find himself being transferred to a harsher adult YOI, where he no longer has access to the YOT and is no longer eligible for CAMHS support. As pointed out by the Bradley Commission, *“transitioning from one service or system to another inevitably entails a change of professionals, disrupting relationships which have been built over time”* (2014, page 5).²²⁹
- 4.82. Recognising the difficulties of this time, NOMS and YJB have worked to improve the experience for those transitioning from the youth estate by developing guidance for staff who work in institutions where the young person leaves from and is received into. However, our submission from HMIP suggests *“there is inconsistent application of the framework and that young adults are not getting the support they should once transferred”* (paragraph 37).²³⁰

225 INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

226 Submission to the Harris Review received from the Youth Justice Board on 17 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

227 Submission to the Harris Review received from HM Chief Inspector of Prisons on 24 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

228 Submission to the Harris Review received from Transition to Adulthood Alliance on 18 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

229 Saunders, A. (2014). *Young adults (18-24) in transition, mental health and criminal justice. The Bradley Commission, Briefing 2*. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf. Accessed 30 March 2015.

230 Submission to the Harris Review received from HM Chief Inspector of Prisons on 24 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 4.83. Additional work needs to be done to ensure that young adults are properly supported during this and other transitions (not just those from the youth estate), and in particular that processes that are supposed to take place are properly implemented.
- 4.84. An area of repeated failure relates to the transfer of information. The Review frequently heard evidence to suggest that information does not follow prisoners in a consistent and timely manner. The submission from HM Chief Inspector of Prisons, for example, noticed two significant problems with transitions from youth to adult custody. These were *“insufficient timely sharing of information and forward planning between the youth based and adult-based services”* and *“lack of advance notice and information on adult establishments to which the young adult was being transferred”* (paragraph 36).²³¹
- 4.85. The same issues were raised in a number of the PPO investigations that followed the self-inflicted deaths in the 87 cases we reviewed. In one case, for example, the PPO report said *“the Governor and Head of Healthcare at [prison] should ensure that potentially important health information is transferred with prisoners when they move establishments”* (case information). NOMS accepted the recommendation and acknowledged that transfer of information was essential to maintain the safety of prisoners. They said that *“staff will be reminded through clinical supervision and staff briefings of the importance and all information must be transferred”* (case information). This recommendation is typical following a self-inflicted death (e.g. 33 on information transfer and 30 on internal communication). We also noted that the same sort of recommendations were made over the years. For example:
- PPO recommendation 2007: *“The Governor should review the procedures for transfers to ensure that medical considerations are given full weight, and that all relevant information is made available to the receiving establishment”*.
 - PPO recommendation 2008: *“The Head of Healthcare at [prison] should ensure that proper written handovers are given to any receiving prison, especially when a prisoner has ongoing medical issues.”*
 - PPO recommendation 2012: *“The Governor and Head of Healthcare at [prison] should ensure that potentially important health information is transferred with prisoners when they move establishments.”*
 - PPO recommendation 2012: *“The Governor of [prison] should ensure that ACCT documents accompany all transferring prisoners.”*
- 4.86. Information sharing will be discussed again in a later chapter in this report. There is no doubt, however, that there are inherent weaknesses in prisoner information management and that particular attention needs to be given to transferring information on vulnerable young adults who are transferring from the youth estate.

²³¹ Submission to the Harris Review received from HM Chief Inspector of Prisons on 24 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Accommodation & Management of Young Adults

- 4.87. The Review is aware that the Government's response to the consultation Transforming Management of Young Adults in Custody has been deferred pending the findings of this Review. How young adults should be accommodated is a complex question.
- 4.88. On the one hand, the violence noted in recent inspection reports relating to YOIs that only hold young adults demonstrate that holding so many vulnerable young adults in one place can be risky. In addition, enabling young adults to be held in a wider range of institutions means that they are more likely to be held closer to home. Distance from home is important to young adults (as discussed in paragraph 5.74), and has been mentioned several times by the young adults to whom we have spoken.
- 4.89. The submission from HM Chief Inspector of Prisons stated that "*currently, outcomes for young adults are broadly inadequate, whatever type of establishment they are held in*" (paragraph 12).²³² In particular, he cited the following:
- HMI Prisons survey data shows that young adults felt least safe when integrated with adults and most safe in dedicated YOIs;
 - NOMS Safety data analysed by HMI Prisons suggests that the incidents of assault per 100 prison population are almost three times higher in young adult YOIs than in male prisons.
- 4.90. These points suggest that while young adults feel safer, this is not matched by the safety data.
- 4.91. The HMIP submission also said that integrating young adults within adult populations "*can have a 'calming effect', but we have also seen integrated establishments where young adults were at risk from adult prisoners*" (paragraph 41).²³³
- 4.92. The dilemma was discussed with a number of governors at the establishments we visited, and it was clear that they realised the difficulties. One governor of a YOI was clear that mixing would make management of the regime easier, but others, while acknowledging that this was an advantage, felt that some young adults were too vulnerable to be in adult establishments.

²³² Submission to the Harris Review received from HM Chief Inspector of Prisons on 24 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²³³ Ibid

- 4.93. We also note that the detailed analysis of data provided by MoJ analysts' shows that the highest proportion of self-inflicted deaths amongst 18-20 year olds in the years for which data was available (1993-2013) occurred in single use YOIs²³⁴. While the population of young adults (18-20 years) fluctuates in terms of the proportion held in YOIs and in mixed establishments (and so over such a long period it may reflect that more young adults were held in YOIs), this is clearly a concern. By the time the Ministry of Justice published its consultation paper *Transforming Management of Young Adults in custody* in 2013, less than half of the 18-20 year old population was held in dedicated YOIs (page 4).²³⁵
- 4.94. We are inclined to agree with the HM Chief Inspector's conclusions that "*there are no simple answers to whether young adults are safer when integrated or in dedicated establishments and evidence often appears contradictory*" (paragraph 41). This is a complex issue, and as such it needs a varied and nuanced solution, such that the relative maturity of the individual should be taken into account more than their chronological age.
- 4.95. We consider that better assessment of maturity and ability to cope with the challenges of a mixed environment is needed. A new assessment tool might involve more strategic use of data already gathered through instruments such as OASys. In addition, we feel that there is a strong argument that some particularly immature or vulnerable 18 year olds need to be retained for longer in the youth estate.

²³⁴ Ministry of Justice (2015). *Self-inflicted Deaths in Prison Custody in England and Wales between January 1978 and March 2014*. London: Ministry of Justice. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²³⁵ Ministry of Justice (2013b). *Transforming Management of Young Adults in Custody Consultation*. London: TSO. https://consult.justice.gov.uk/digital-communications/young-adults/user_uploads/transforming-management-of-young-adults-in-custody.pdf. Accessed 27 February 2015.

Early Days in Custody

- 4.96. Many stakeholders have highlighted for us how crucial the earlier stage of custody can be, both in terms of initial experience of custody, and also in terms of the time immediately following a move to another prison. In chapter 1 of this report, we explained that almost a half (48%) of the deaths on which data is available happened before three months in custody.²³⁶
- 4.97. The detailed analysis of data conducted by Ministry of Justice Analytical Services on data between 1978 and March 2014²³⁷ also showed that many deaths of 18-24 year olds happened in the early days. Almost 70% (68.6%) happened in the first 6 months of being in custody, and as many as 20.7% happened as early as within the first week.
- 4.98. Furthermore, this analysis also showed that over a quarter (26%) of the self-inflicted deaths of 18-24 year olds died within a week of their arrival at the custodial establishment in which they took their own life, and also that the vast majority (86%) of incidents occurred within the first six months at the prison or YOI.²³⁸
- 4.99. This is reinforced by many of the submissions that we have received. They have highlighted that key moments of vulnerability happened in the first few days and weeks of being in custody.
- 4.100. The submission from Bindmans says *“the first days in prison... are an extremely vulnerable time for young people. They are often unknown to staff; there is usually a lack of information available about that person...young people will often be worried about the unknown social dynamics within a prison”* (page 3).²³⁹
- 4.101. User Voice reported that *“the most frequently identified time within the focus groups that prisoners are likely to be vulnerable is at the start of their first sentence. This is due to the state of confusion of those starting their first custodial experience”* (page 3).²⁴⁰
- 4.102. NOMS in their submission recognises the importance of assessing vulnerability at this early stage. PSI 74/2011 (Early Days in Custody) states the mandatory requirement for all prisoners to be *“assessed for potential harm to themselves, to others and from others”* on reception into custody, and explains that this must be done using all available information, as well as by interviewing the prisoner (page 7).²⁴¹

236 Harris Review (2015). Examination of PPO Clinical Reviews. Consideration conducted on behalf of the Harris Review by Ambreen Aslam, Sunil Routhu, Matthew Tovey and supervised by Dr Dinesh Maganty. <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

237 Ibid

238 Submission to the Harris Review received from HM Chief Inspector of Prisons on 24 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

239 Submission to the Harris Review received from Bindmans (Solicitors) on 1 August 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

240 Submission to the Harris Review received from User Voice on 15 September 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

241 Submission to the Harris Review received from NOMS on 3 February 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 4.103. However, one of the key things that does not seem to be happening, is enabling more contact with the family during these early days. Many of the young adults we spoke to when we visited prisons and YOIs talked at length about how hard it was during the first few days, when contact with the outside was particularly limited, and yet their feelings of fear and vulnerability were at their strongest.
- 4.104. The Prison Reform Trust told us that “*early contact between young people and their families on arrival in prison (or following transfer to a new prison) is important in addressing one area that young prisoners regularly describe as a major source of anxiety*” (Prison Reform Trust, page 21).²⁴²
- 4.105. In one institution we visited, we spoke to a number of young adults on a wing dedicated to the first few nights in prison. These young adults described their frustration that they could not contact their families. Prisoners were due to be supplied with PIN numbers to allow them to use the prison phones, but because of the security clearance process for their chosen numbers, the PIN numbers were not going to be available for a period of weeks.
- 4.106. While we accept that prisoners’ chosen phone numbers will need to be security checked, this process at present seems to take far too long and needs to be speeded up significantly. In addition, a mechanism should be in place to provide for some contact telephone numbers to be cleared, so as to enable the young adults to speak to a family member or friend within 24 hours of their completing the reception process. This is also especially important for young adults who are transferring between custodial establishments, regardless of the reason for the transfer. We were told that the PIN process and the security clearance process had to be repeated with each transfer, we cannot understand why this should be necessary – once numbers have been cleared that clearance should travel with the prisoner.
- 4.107. It is also disturbing that worried family members were not able to make contact with their vulnerable family member during these early days. At the family listening day, we were told “*no information was given at the court, no contact details or procedures etc. We had to find out contact information for the prison, which invariably led to being passed from pillar to post as every telephone number we tried, gave us a new one to ring*” (Family Hearing, page 16).²⁴³

²⁴² Submission to the Harris Review received from Prison Reform Trust on 18 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²⁴³ INQUEST (2015). *Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds* Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Staff-Prisoner Relationships

- 4.108. The research commissioned by the Review from RAND Europe/University of Cambridge found that, “*prison staff universally identified staff-prisoner relationships as the key to identifying and managing risk. There was strong agreement that staff capacity to form and sustain high-quality staff–prisoner relationships supported SID prevention*” (page ix).
- 4.109. In the research, staff emphasised the potential of the prison environment, and relationships between staff and prisoners, to induce or alleviate stress. One of the managers interviewed said that, “*If we get the prison right – if we provide opportunities for numeracy, training, qualifications, we offer them hope, and we have good relationships that demonstrate care and that we’re not giving up on them then we can massively reduce deaths in custody.*”²⁴⁴
- 4.110. However, some staff are much less positive and supportive. A couple of examples have already been given in this chapter. One was the example raised by the PPO, of the young man who did not want to be transferred from his friends who helped him with his disability (PPO submission, page 8).²⁴⁵ This was not handled sensitively by staff, and may have contributed to the distress that caused his death.

244 Ludlow, A, et al. (2015). *Self-inflicted Deaths in NOMS’ Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*, <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

245 Submission to the Harris Review received from the Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Bullying

- 4.111. The Review, however, has been particularly concerned by what it has heard about bullying (both by staff and between prisoners); in the submissions to the Review bullying was one of the most frequently identified causes of vulnerability.
- 4.112. In their submission the PPO highlighted a sample of 89 investigations into Self-inflicted deaths of young adults between April 2007 and March 2014, of whom 20% had experienced bullying in the month before their death. The submission states *“given the vulnerabilities of many of the young adults in our sample it is surprising how rarely bullying was considered as increasing the risk of self-harm”* (page 2).²⁴⁶
- 4.113. Our separate research into the clinical reviews, associated with the cases contained within our cohort, identified that of those 87 cases, 31 (35.6%) included references to the individual being bullied (actual or perceived) by other prisoners.
- 4.114. The PPO submission proposes that greater recording and data on the instances of bullying should be undertaken, proposing that *“indications and allegations of bullying should be recorded, investigated and acted upon to protect the apparent victim and address the behaviour of the alleged bully or bullies. The impact on the risk of suicide and self-harm for victims should always be considered”* (page 14).²⁴⁷
- 4.115. In their submission to the Review, NOMS outlined their proposals relating to ‘Violence Reduction’ of which the issue of bullying was an aspect. They explained: *“Violence and drug use cause a large number of problems across prisons, giving rise to health and physical safety concerns, as well as the bullying, debt and isolation that can be associated with them. We are conscious of the potential impact on individuals caught up in such activity which may increase their vulnerability to self-harm or self-inflicted death. We have commissioned research into ‘illicit economies’ in prison to help us understand these dynamics and address them”* (page 17).²⁴⁸

²⁴⁶ Submission to the Harris Review received from the Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²⁴⁷ Ibid

²⁴⁸ Submission to the Harris Review received from NOMS on 3 February 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 4.116. Some examples of bullying were given to us when we visited prisons. It was explained that owing money to other prisoners can cause a lot of bullying, with some young adults even being harassed for debt that was built up not by them, but by the last person in their cell. Access to phones also caused bullying, with some young adults trying to get access to phones on the wing at the expense of other prisoners. A young adult who spoke to the Review in September at the Hearing from *User Voice* explained “*phones in cell is a good thing... there is no queue, no bullying...*” The young adults at the *User Voice* hearing in September also explained that being on ACCT could lead to bullying. The ACCT form, which is bright orange, was considered so embarrassing that one young adult said “*I’d lie to get off an ACCT*” (Stakeholder Hearing 14).²⁴⁹ This is particularly concerning to the Review, given the vulnerability of these young adults.
- 4.117. Bullying was also raised by the young adults who responded to our targeted survey. When describing his reasons for feeling suicidal, one 20 year old young adult wrote “*the most common reason for me is guilt about my offence but I have been suicidal for other reasons too such as bullying.*” Others noted that being bullied and owing money were things that made them feel vulnerable in prison.
- 4.118. There were mixed views from young adults about whether staff helped with these issues, with some indicating that staff helped if they could (e.g. “*if they can help they will*”). Having said this, other young adults felt that more needed to be done by staff to deal with the issue. One young adult who spoke to us in September 2014 said “*there’s containment around bullying rather than pro-active management – no group work to tackle the issue.*”
- 4.119. MQPL data suggests that on average YOIs have particularly negative scores regarding the prison being well controlled, weak prisoners getting badly exploited and victimised, and having to be in a group in order to get by. We noted that the data also showed that prisons tended to have a positive score for not tolerating bullying but, regardless of the type of prison, the tended to have a negative score in regard to victims of bullying being given the help they need to cope. On average, YOIs had the lowest score in regard to the toleration of bullying (pp 10-12).²⁵⁰

249 Stakeholder Hearing 14 (4 September 2014) *User Voice*. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/User-Voice.pdf>.

250 Harris Review (2015) Measuring the Quality of Prisoner Life (MQPL). For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.



- 4.120. Young adults also explained that there were times when they felt that they were being bullied by staff. When we visited prisons, some young adults had very negative attitudes towards particular members of staff, and some clearly felt a bit persecuted by them. In response to our targeted questionnaires, one young adult said *“the [staff] sometimes give us a hard time because we’re [young offenders]... I feel like the [staff] target me because I’m young.”*
- 4.121. The Review considers that the issue of bullying requires distinct and separate Prison Service Instruction, and that it should not be submerged in an all-encompassing instruction.
- 4.122. As part of this approach, there needs to be a strategy developed which enables both Prisoners and their families to report incidents in confidence to a dedicated point of contact. The Review believes that this could be best facilitated through a dedicated 24 hour telephone helpline that is communicated to both Prisoners and their families, with records kept of every call received and action taken, including details of who the information was forwarded to.



Conclusions and Recommendations on Vulnerability of Young Adults in Custody

- 4.123. The Review concludes that, given the overwhelming evidence, it is wrong to assume that maturity will necessarily have been reached by the age of 18. The Criminal Justice System needs to recognise that young adults who are 18-24 years are still developing, and their behaviour and ability to cope with custody will depend on the level of maturity they have attained.
- 4.124. Given the wide range of vulnerabilities that young adults, and children, arrive with into custody, it is not surprising that they find the harshness of the environment difficult to cope with. This can be particularly true of young adults who have had to face multiple distressing early experiences, and who may not have the support of a 'significant adult'. We are particularly concerned about care leavers in custody. In addition, more needs to be done to address stereotypes within the system, particularly relating to young adults from a BAME background.
- 4.125. Within the custodial experience there are other factors, such as moving to a new environment, the first experiences of custody, and bullying that can make the experience even more difficult. Although some work has begun to address vulnerabilities and provide guidance to staff, this needs to be developed further.

Our recommendations for this chapter are:

Primary Recommendations

29. There must be a legal recognition of the concept of 'maturity'. As well as chronological age, maturity should be a primary consideration in making decisions relating to diversion, sentencing and, where a custodial sentence must be given, how and where a young adult (18-24) should be accommodated. The work to achieve this should be the responsibility of the Ministry of Justice, who should report on progress within 1 year of the publication of this review.
30. A multidisciplinary and cross-departmental approach must be adopted to support young adults who have entered or are at risk of entering the Criminal Justice System. The Government Departments involved should be the Ministry of Justice, the Home Office, the Department of Health, Department for Business, Innovation and Skills (BIS), Department for Work and Pensions, and Department for Communities and Local Government. The initiative should be coordinated by the Cabinet Office, with input from the Government Equalities Office. Similar arrangements should be developed in Wales under the auspices or working with the Welsh Government.
31. NOMS must accept that bullying wherever it occurs is a specific problem that requires specific, focussed responses. We recommend that NOMS must publish a specific Prison Service Instruction to cover the issue of bullying both from other prisoners and from staff and how custodial establishments can tackle and aim to reduce numbers of incidents. Bullying should not be subsumed into the policies that cover Violence Reduction.
32. Local authorities must have an explicit statutory duty to provide a corporate parenting and support role to all young people who are in NOMS custody, in addition to their existing statutory duties towards care leavers in custody. This should include providing a

'Significant Adult' who would be able to visit during normal visiting hours and to act as a mentor and personal advisor to these young adults.

Secondary recommendations:

33. The Review recognises that there is no simple answer as to whether young adults should be accommodated in separate institutions or mixed with older adults. All young adults (18-24 years), however, must be accommodated in small units that have the specialist staff and regime to meet their needs and that, when their maturity or vulnerability mean it is in their best interests, they should have the facilities to accommodate them in specialised wings or blocks.
34. All custodial establishments should have in place a process whereby a prisoner can arrange for a visit from family within three days of their arrival at the prison for the first time.
35. NOMS should continue its useful work on developing a tool to measure maturity effectively, the aim of which should be to better identify and support those in custody who are vulnerable because of a relative lack of maturity. This tool should be appropriately tested and made operational as soon as possible. Progress on this tool should be reported within one year of the publication of this Review.
36. If the YOT and other key organisations believe that due to an individual's lack of maturity, it would be in the best interest of a vulnerable young adult to remain in the under-18 estate after they reach 18, suitable accommodation should be found for that person within the juvenile estate, recognising safeguarding issues.
37. YOTs and other relevant agencies should be required to remain in contact with a young adult who transfers from the youth estate to an adult or young adult establishment for at least 6 months after they reach 18, and longer if particular vulnerabilities are identified. This may extend to 21 or 24 (if they are in full-time education), comparable with the local authority duty for young adults who were 'looked after' before they reached 18.
38. NOMS should further develop its work on care leavers, in order to ensure that care leavers can be accurately and reliably identified upon arrival in Prison and that data is collected to ensure that progress through custody for care leavers is properly recorded, researched and improved.
39. NOMS should introduce a robust assurance process for the safe transfer of every prisoner. As part of the preparations for transfer and on completion of transfer there must be a mandatory obligation on both the sending and the receiving establishments to ensure that the full details of a prisoner's record, including any current or former SAVRAS, is transferred. There must also be a positive duty on the receiving establishment to review and, if necessary, to act on the information provided, and also to follow up, in a timely manner, when information is thought to be missing.
40. As part of their response to bullying NOMS must provide (for example through an external contractor or NGO, if appropriate) a 24 hour anti-bullying helpline. This service should be provided through a free telephone hotline, so that prisoners or their families could report problems. All calls would be logged and passed to the relevant prison which would be expected to record the action taken, including consideration of urgency and appropriate management of the issues raised.

5. Diverting the Vulnerable from Prison and Moderating the Risk of Vulnerability in Prison

- 5.1. The last chapter explored the different ways in which young adults in custody are vulnerable. There is much that should be done to better manage the vulnerability of young adults in custody, and indeed support them through the rehabilitative process. This chapter explores some of this, but starts by looking at what can be done to address the issues of vulnerability before the young adult enters custody or even before they encounter the criminal justice system. We will also explore the importance of family contact and peer support within the prison.

Diversion from Custody

“ Police, doctors and psychiatrists all knew about these day to day incidents, but still the help was not there. On many occasions he used to hold his head and cry for help because he knew he could not control what he would do to himself ”

(Family of a young man who died).

- 5.2. In the 87 cases we examined in detail, we found that in many cases a substantial range of vulnerabilities, including mental health issues, had been evident from an early age. We had to ask the question, *why were so many of these young adults in custody in the first place?*
- 5.3. We are not advocating that the crimes committed did not warrant a custodial sentence. However, our terms of reference specifically ask us to identify what lessons should be learned and what actions should be taken to prevent future deaths. Given that so many of these young adults, and the four children’s cases we also examined, had histories that would have included contact with social services, mental health services and other services, we felt it would be remiss not to explore what actions might have been taken to prevent these vulnerable people coming into custody in the first place, or whether different sentencing decisions might have been made to reduce the risk.
- 5.4. This was reinforced by many of the submissions we received that urged us to look further into the issues that lead to a child or young adult coming into custody. For example, the Prison Reform Trust urged the Review to consider *“the journey into custody taken by children and young people who have died”* (page 1).²⁵¹

²⁵¹ Submission to the Harris Review received from Prison Reform Trust on 18 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Case of Liam

Liam was 17 years old when he hanged himself. He had been in prison on remand for just 19 days. Liam had been taken into care at 18 months old because of his mother's bi-polar disorder. His foster placement broke down because of his behaviour. He was first convicted of an offence at 13, after which he lived part in foster care and part in a hostel. It was noted by his social worker and in his pre-sentencing report that he had a tendency to hide his emotions. When he was later arrested and charged with two counts of robbery with an offensive weapon, the Prison Escort Record (PER) noted that he had self-harmed by banging his head against a wall but no "Self-Harming Warning Form" was opened. Liam was checked about every 15 minutes as his age required. When he arrived at the YOI, the PER was not acted upon, no concerns were identified and he was placed in a single cell. Around the time of Liam's subsequent court appearance his behaviour had deteriorated and it appeared later that he was being bullied. On the morning of Liam's death staff failed to carry out the normal roll checks and so Liam was not being checked on. He was not found until he was being unlocked for exercise at which time resuscitation was attempted.

- 5.5. A number of stakeholders suggested that there could be long term financial benefits to diverting children and young adults out of the CJS and out of custody. The All Party Parliamentary Group for Children said "*prison is poor value for money; community sentences with early intervention, family therapy and multi-focused therapy are best value.*"²⁵²
- 5.6. The submission from the Howard League pressed the matter further, saying that "*inquests and inquiries have hitherto only considered their treatment in prison that immediately led to death but no one has asked the critical question about whether they should have been in prison in the first place. From the inquest and inquiry into the murder of Zahid Mubarek to the death of Greg Revell a couple of weeks ago, the question about the remand and sentencing decisions and practices of the courts need to be questioned as a contributory factor that led directly murder and suicide*" (2014, page 1).²⁵³

²⁵² All Party Parliamentary Group for Children (2010). *Children and Young People in the Youth Justice System: Report of seminars organised by the All Party Parliamentary Group for Children 2009/10*. London: National Children's Bureau. http://www.ncb.org.uk/media/153014/youth_justice.pdf. Accessed 1 April 2015.

²⁵³ Submission to the Harris Review received from Howard League for Penal Reform on 28 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 5.7. These views reflect concerns that have been around for some years now. The Bradley report commented “*while public protection remains the priority, there is a growing consensus that prison may not always be an appropriate environment for those with severe mental illness and that custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide*” (2009, page 7).²⁵⁴
- 5.8. The accounts given to us by the families of those who died about the support they did not get, despite very often trying very hard to access it, during their child’s early years, were very powerful. One family said:
- “There was nothing, no help for [him]. The only help we received was from an Educational Psychologist. He tried to get him moved from the school. He tried to get him help. He couldn’t get anything. Nobody else did anything. I contacted the social services. I knew he had problems from the word go. When he left school there was nothing. Social services were rubbish. They said ‘watch your back’. I was working so many hours every day. I had 3 or 4 jobs on the go. I also stayed at home with him and looked after him full-time. I was looking after him on my own with no help. I am just so angry. How could social services tell me to ‘watch my back’?”* (INQUEST, 2015, page 10).²⁵⁵
- 5.9. This example suggests that effective interventions at an early stage in the young person’s life might have prevented him from coming into contact with the criminal justice system in the first place.
- 5.10. The submission from Women in Prison said that “*we believe it is vital that there is a recognition that solutions are often outside the criminal justice system and that criminalising young women exacerbates their problems without offering much in the way of ‘rehabilitation’ or even being effective in terms of likelihood of reducing further offending*” (Women in Prison pp 6-7).²⁵⁶
- 5.11. When BTEG spoke to the panel, they pointed out that more young adults could be diverted from the CJS if there was more investment in them, particularly through schools and local communities. They argued that more positive models of good practice were needed, avoiding a retributive response to young adults, particularly those from a BAME background.²⁵⁷

254 Bradley, K. (2009). *The Bradley Report: Lord Bradley’s review of people with mental health problems or learning disability in the criminal justice system*. London: Department of Health. http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_2009.pdf. Accessed 30 March 2015.

255 INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

256 Submission to the Harris Review received from Women in Prison on 1 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

257 Stakeholder Hearing 18 (6 November 2014) The Black Training and Enterprise Group (BTEG). Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-BTEG.pdf>.

- 5.12. At the Review's roundtable on Characteristics of Young Adults, it was recognised that more should be done to engage with young adults, listen to them and develop their emotional resilience earlier in their lives, including whilst they were at school. It was also noted that specialist help is often required in schools. The nature of this age group can be challenging, especially when trying to identify whether they might be vulnerable, as many are reluctant to be open²⁵⁸ or may not respond well to middle-class professionals whom they may perceive as not understanding them or their culture.
- 5.13. The roundtable participants told us that there are longer term benefits from investing in mental health services at an early stage, and drew attention to the need for increased co-ordination and communication between relevant organisations, so that a holistic approach should be considered and applied. Relatively small investment at an early stage can have significant benefits later on.
- 5.14. One of the participants at the *User Voice* facilitated event in September 2014, spoke of their own experience, advocating that vulnerable young adults should be referred to other agencies and receive more help for the underlying causes of their offence before receiving a custodial sentence *"I think there should be more options [to custody] as most of those will have drink and drug issues as well. Maybe help them with their issues, help with their stability in the community because let's be honest most people who go into prison their life is more f***** when they come out"* (page 6).²⁵⁹
- 5.15. The overuse of custody for vulnerable people has recently been the subject of recent reports. The recently published EHRC Report (*Preventing Deaths in Detention of Adults with Mental Health Conditions: An Inquiry by the Equality and Human Rights Commission*) concluded that *"it is impossible to talk about the high levels of people with mental health conditions in prisons without questioning whether imprisonment is the appropriate place. For some people the need for tailored rehabilitation that meets their particular needs might be served within the community or psychiatric hospitals."*²⁶⁰
- 5.16. Further involvement of Child and Adolescent Mental Health Services (CAMHS) within schools could help to develop a young person's emotional resilience, provide immediate support and potentially also de-stigmatise the issue of mental health. The charity Place2Be currently provides mental health services to children in schools, with the aim of enhancing the wellbeing of children and their families by providing access to therapeutic and emotional support.²⁶¹

²⁵⁸ Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²⁵⁹ Stakeholder Hearing 14 (4 September 2014) User Voice. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/User-Voice.pdf>.

²⁶⁰ Equality and Human Rights Commission (2015). *Preventing Deaths in Detention of Adults with Mental Health Conditions: An Inquiry by the Equality and Human Rights Commission*. London: EHRC. http://www.equalityhumanrights.com/sites/default/files/publication_pdf/Adult%20Deaths%20in%20Detention%20Inquiry%20Report.pdf. Accessed 31 March 2015.

²⁶¹ For further information on the work of Place2be, please see <http://www.place2be.org.uk>.

- 5.17. A recent report published by the Centre for Mental Health concluded that focussed investment in treatment and interventions for adolescents with mental health issues at an early stage would have long term economic benefits.²⁶² The report argued that there was good evidence that, if well implemented, a number of interventions could improve the outcomes for children with early behavioural problems. The report estimated that children with early conduct disorder were ten times more costly to the public sector by the age of 28 than other children and would impose lifetime costs on society as a whole of around £260,000 per child. Therefore, as the long-term costs of early conduct disorder were high, only a small improvement in outcomes would be needed to support a ‘value-for-money case’ for intervention.
- 5.18. Similarly, a number of the participants at the Review roundtable were of the view that greater investment in early interventions would not only improve an individual’s life and reduce the impact on the criminal justice system, but would also deliver longer term economic benefits to the public spending purse.
- 5.19. This view was supported by some of the submissions received. For example, Marny Zimmer described the analyses conducted by the Washington State Institute for Public Policy looking at material gathered over the last forty years which using a rigorous process of cost benefit analysis looked at the impact of various interventions and found that some, like Functional Family Therapy, Nurse Family Partnerships and Parent Child Interaction Therapy, have provided significant benefits which would “*reduce crime rates and save taxpayers’ money.*” As the submission concludes: “*The state of Washington made a long-term commitment to evidence-based, cost-effective programs and invested substantial funds in proven programs. Today Washington is reaping the benefits of those programs with lower crime and more effective use of taxpayer money.*”²⁶³
- 5.20. Even when a young person has not been identified by educational, social or mental health services, diversionary schemes can help keep children and young adults out of custody. The Bradley Report (2009) advocated the early identification and assessment of offenders’ problems, leading to better informed charging, prosecution and sentencing decisions. The report states “*in the longer term, the impact may be that more offenders can be treated in the community, ensuring that those individuals who must be in prison can receive targeted, effective care while they are there*” (page 149).²⁶⁴ The report concluded that although existing liaison and diversion services demonstrated the potential to realise significant benefits, their provision was inconsistent and patchy.

262 Centre for Mental Health (2015). *Investing in Children’s Mental Health – a review of evidence on the costs and benefits of increased service provision*. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/investing_in_childrens_mental_health.pdf. Accessed 30 March 2015.

263 Submission to the Harris Review received from Marny Zimmer on 12 December 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

264 Bradley, K. (2009). *The Bradley Report: Lord Bradley’s review of people with mental health problems or learning disability in the criminal justice system* London: Department of Health.. http://www.centreformentalhealth.org.uk/pdfs/Bradley_report_2009.pdf. Accessed 30 March 2015.

Case of Darren

Darren was a vulnerable young man, who had struggled with acute mental health problems throughout his life. He was diagnosed with a personality disorder, and had attempted suicide a number of times, including jumping from windows and overdosing. His family urged local authorities to provide mental health services, and Darren received some psychiatric care. At his inquest, Darren's mother said she felt that he was sent to prison because there was no capacity to keep him at the local hospital.

While in prison, there was a continued failure to take into account his mental health needs and other difficulties. By the time of his self-inflicted death at 21 years, various distressing life events had not been considered by staff. At his inquest, the jury was critical of the lack of continuity in Darren's care, and that information was not passed on to the appropriate individuals.

- 5.21. Six years after the Bradley report was published, these problems continue. Professor Louis Appleby told the Review at a hearing²⁶⁵ that high risk individuals should be kept out of custody where possible. He suggested that liaison and diversion schemes were not being implemented as intensively as he felt was necessary in order to support vulnerable individuals and that they are often only used for low level offenders.
- 5.22. Examples of good practice in terms of liaison and diversion schemes were given to us by a number of stakeholders. The submission from T2A, for example, highlights two community based projects that aim to divert young adults into treatment rather than a community sentence. One of these was focused on mental health, and the other on drugs and alcohol.²⁶⁶
- 5.23. We also heard from a number of stakeholders who highlighted the important role that YOTs played for young people who are under 18. Many of the families we spoke to at the Family Hearing days praised the YOT team and the work they did to try and keep the young person out of trouble. One family member said *"I had a good experience with the Youth Offending Team also. There was an excellent support worker... she pushed for him to get support and said she was worried about him."* Another explained *"the difference is that Youth Offending Team workers are trained to work with young people. They care about young people and get on their level"* (INQUEST, 2015, page 12).²⁶⁷

²⁶⁵ Stakeholder Hearing 9 (3 July 2014) Prof Louis Appleby. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/12/Stakeholder-Hearing-9-Professor-Louis-Appleby.pdf>.

²⁶⁶ Submission to the Harris Review received from Transition to Adulthood Alliance on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²⁶⁷ INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>

- 5.24. Professor Appleby noted that Youth Offending Teams (YOTs) divert under 18 year old offenders away from the criminal justice system on mental health grounds, and suggested that the same criteria could also be applied to 18-24 year olds.²⁶⁸ Our consideration of the cases of the 83 young adults and 4 children we reviewed has suggested to us that there are few differences between the groups, particularly in terms of their pathways into custody. However, YOT workers have notably more experience and success than probation workers do with young adults.
- 5.25. The Home Affairs Committee's recent report on *Policing and Mental Health* referred to the early indications of the effectiveness of 'street triage' schemes, where mental health nurses accompany police officers to incidents where the police believe that a person might need mental health support. This approach was raised as well at one of our roundtable events on Liaison and Diversion. The street triage pilot currently underway within the West Midlands (Birmingham and Solihull) was described, which has seen a 50% reduction in the number of detentions made under section 136 of the Mental Health Act 1983, over a 20 week period and an 80% reduction in the first six months of the scheme in Cheshire.²⁶⁹
- 5.26. Just a few weeks ago, the House of Commons Justice Committee in its report on *Prisons: planning and policies* concluded that: "*The size of the prison budget, the fact that it completely dominates expenditure on crime, the importance of reducing crime, and other problems identified in this report all indicate that we need to re-evaluate how we use custody and alternatives to custody in a cost-effective way which best promotes the safety of the public and reduces future crime.*"²⁷⁰
- 5.27. Indeed, prison is a hugely expensive intervention. The prison system costs in excess of £3 billion per annum (MoJ Statistics, 2013/14).²⁷¹ The cost per place per year in a male closed YOI (ages 15 – 21) is £39,224 per year, and the cost of a child's place in a male YOI (age 15 – 17) is £49,354²⁷² and significantly higher for secure children's homes, Secure Training Centres and the proposed Secure College. The benefits of this spend are questionable, with a relatively low impact on crime. Rates of re-offending are high, young

268 Stakeholder Hearing 9 (3 July 2014) Prof Louis Appleby. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/12/Stakeholder-Hearing-9-Professor-Louis-Appleby.pdf>.

269 Summary of Liaison & Diversion roundtable stakeholder events (2014/15), accessible from <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

270 House of Commons Justice Committee (2015). *Prisons: planning and policies – Ninth Report of Session 2014-15*. London: TSO. <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmjust/309/309.pdf> accessed 30 March 2015.

271 Ministry of Justice (2014, 28 October). *Costs per place and costs per prisoner*. National Offender Management Service Annual Report and Accounts 2013-14. Ministry of Justice Information Release. Retrieved at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367551/cost-per-place-and-prisoner-2013-14-summary.pdf. Accessed 1 April 2015.

272 Ministry of Justice (2015b). Proven Re-offending Statistics Quarterly Bulletin, April 2012 to March 2013, England and Wales. *Ministry of Justice Statistics Bulletin*, 29 January 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399300/proven-reoffending-apr12-mar13.pdf. Accessed 31 March 2015.

adults have a higher reoffending rate than older adults. Based on proven reoffending data for prisoners released in the 12 months ending March 2013, the proportion of 18–20 year olds who reoffend is 30% and 27.1% for prisoners aged 21-24.²⁷³

- 5.28. Reinvestment and redirection of resources to the health and welfare system and community alternatives to custody will better provide the specialist help tailored to the individual's needs.
- 5.29. On a national basis, the cross-departmental Health and Criminal Justice Programme, includes a work stream to roll out the police and court liaison services that were piloted in response to the Bradley report, and also proposes to invest more in diversion services at police stations and courts to intervene at an early stage.²⁷⁴ The Liaison and Diversion Scheme means that NHS England becomes the single commissioner for liaison and diversion services.
- 5.30. The NHS England Standard Specification 2013/14 describes 'Liaison and Diversion' as a process where "people of all ages who pass through the criminal justice system are assessed and those with mental health, learning disability, substance misuse and other vulnerabilities are identified as soon as possible in the justice pathway" (Liaison and Diversion Standard Specification 2013/14).²⁷⁵ It explains that individuals are supported to access appropriate services.
- 5.31. As the Home Affairs Committee reports (para 40) "*NHS England plans for L&D services to be available in all police custody suites and all courts by April 2017*" (page 20).²⁷⁶
- 5.32. The Review supports the further rolling out and development of the Liaison and Diversion Scheme, and in particular the undertaking to have them rolled out to all police custody suites and all courts by April 2017, but feels this does not yet go far enough to ensure more children and young adults are diverted from custody.

273 Ibid

274 NHS England Liaison and Diversion Programme (2014). *Liaison and Diversion Standard Service Specification 2013/14*. London: NHSE. Retrieved from: <http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/04/ld-ser-spec-1314.pdf>. Accessed 30 March 2015.

275 Ibid

276 House of Commons Home Affairs Committee (2015) Policing and mental health Eleventh Report of Session 2014-15, London, TSO <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/202.pdf> Ref on Home Affairs Committee. Accessed 30 March 2015.

- 5.33. Stakeholders highlighted to us that prison was not the most cost effective means of dealing with many of the young adults who were in custody. As was pointed out by the All Party Parliamentary Group for children “*prison is poor value for money; community sentences with early intervention, family therapy and multi-focused therapy are best value.*”²⁷⁷ The Review considered, as part of their Out of Committee evidence, supporting documentation relating to the *Troubled Families Programme*. The DCLG report ‘*The Cost of Troubled Families*’ (2013, page 5)²⁷⁸ recognizes the benefits of early investment and diversion, when it says “*the projected financial benefits of investing a comparably small amount in family intervention services are compelling.*”
- 5.34. The Review also heard from officials working on the *Troubled Families Programme*²⁷⁹, who outlined the scope of the Programme and also the overall objectives and progress to date. The Programme aims to work alongside local authorities to help turn around the lives of families identified as ‘troubled’. Some of the specific objectives include reducing crime and anti-social behaviour, getting adults on the path to work, and getting children back into school.
- 5.35. The Review heard that young adults on the programme might be eligible because of the family they were born into, or because they are parents themselves. Even if they are sent to custody, the intense support they receive from the programme remains.²⁸⁰
- 5.36. There are many aspects of this programme that appear to resonate with the gaps that we have found around support for young adults. The Review feels that a similar programme that focuses on troubled teenagers and young adults could help to divert many vulnerable individuals out of custody and that the main families-focused programme should look at earlier interventions to support the families concerned.
- 5.37. Overall, we are concerned about how often young, vulnerable adults are sentenced to custody. When we heard from Mr Justice Holroyde²⁸¹ (senior judiciary), in December 2014, he said that he accepts that some people shouldn’t be in prison. At present, prison officers don’t have the skills to look after them when they are mentally ill, and the fact that prisons are dealing with strained resources and are overcrowded is well known. He maintained that prison should be used as a last resort. By the time a young adult gets to the Crown Court, however, the matter is too serious to divert them.

277 All Party Parliamentary Group for Children (2010). *Children and Young People in the Youth Justice System: Report of seminars organised by the All Party Parliamentary Group for Children 2009/10*. London: National Children’s Bureau. http://www.ncb.org.uk/media/153014/youth_justice.pdf. Accessed 1 April 2015.

278 Department for Communities and Local Government (2013). *The Cost of Troubled Families*. London: DCLG. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/68744/The_Cost_of_Troubled_Families_v1.pdf. Accessed 1 April 2015.

279 Stakeholder Hearing 26 (12 February 2015). *Troubled Families Programme*. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.

280 Stakeholder Hearing 26 (12 February 2015) *Troubled Families Programme*. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.

281 Stakeholder Hearing 20 (4 December 2014) *Senior Judiciary*. Summaries of hearings can be accessed at, <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.

- 5.38. The Review strongly agrees that prison should be used as a last resort and that more needs to be done to divert young adults at earlier stages. A reduction in prison population would make it easier for prisons to provide an environment that meets appropriate standards of decency, safety and respect.

Managing Vulnerability at Sentencing Stage

- 5.39. Once a young adult arrives at court, there are still opportunities to at least ensure that their vulnerabilities are met and taken into account.
- 5.40. A key document at this point is the pre-sentence report. This can help identify potential vulnerabilities and concerns, and can also suggest appropriate local diversion or alternatives to the Sentencers. The Magistrates' Court Sentencing Guidelines²⁸² outline the factors that need to be taken into account by Sentencers before passing an appropriate sentence which is commensurate to the offence and the circumstances of the individual. These factors include the consideration of any pre-sentence report, as well as any mental disorder or learning disability, when determining lower culpability. The Review received a presentation from the Magistrates Association concerning the ongoing Milton Keynes Mental Health Treatment Requirement (MHRT) Demonstrator, which was set up in the light of concerns about the availability of effective support and interventions for individuals in the criminal justice system who have mental health problems. The Liaison and Diversion programme full business case includes the proposal that the MHRT programme be expanded and rolled out nationally.
- 5.41. We were concerned to hear from family members who did not feel that their child's vulnerabilities were taken into account by the courts or the Sentencers. One parent said *"the judges shouldn't be judging these people as they judge others, because of their particular vulnerabilities."* Another explained *"the night before [he] was taken to the magistrates court the police who knew him well were so concerned about this unusual behaviour they took him overnight to the Accident and Emergency Unit. I don't believe any of this was taken into consideration by the court or passed on to the prison staff"* (INQUEST, 2015, page 13).²⁸³

282 Sentencing Guidelines Council (2008). *Magistrates' Court Sentencing Guidelines: Definitive Guideline*. London: Sentencing Guidelines Council. http://www.sentencingcouncil.org.uk/wp-content/uploads/MCSG_web_-_October_2014.pdf. Accessed 30 March 2015.

283 INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 5.42. Families were able to differentiate between the support given to their family member as a young adult and the support given to them when they were under 18. One family explained “his YOT worker did a pre-sentence report and contacted CAMHS. They said that he would not be able to answer questions and would not be able to understand the court process. His YOT worker also noticed that he was very vulnerable” (page 14).²⁸⁴
- 5.43. HM Inspectorate of Probation’s recent report *Transforming Rehabilitation – Early Implementation*²⁸⁵ explained that an increased proportion of sentences are imposed following pre-sentence reports which are completed on the day of conviction, either by way of an oral report or a short written report, both of which are sometimes produced within one hour. Their analysis found that in 14% of cases no report was provided to the court. This was also raised by stakeholders who attended our roundtable event on liaison and diversion.²⁸⁶
- 5.44. The London Bench Guide to Community Sentences²⁸⁷ advises magistrates that a 15 day written report is normally necessary for high seriousness cases and some medium seriousness cases with complex issues to address, including serious mental health issues.
- 5.45. Given that we have established that we consider all young adults in custody to be vulnerable and that prison or YOI custody should be a last resort, any consideration of a custodial sentence for a young adult (18-24) should be serious enough for a full and comprehensive 15-day written report to be prepared for the court.
- 5.46. Section 125(1) of the Coroners and Justice Act 2009 provides that when sentencing offenders every court must follow any sentencing guideline which is relevant to the offender’s case, unless the court is satisfied that it would be contrary to the interests of justice to do so.

284 INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

285 HM Inspectorate of Probation, (2014c). *Transforming Rehabilitation – Early Implementation: An independent inspection setting out the operational impacts, challenges and necessary actions*. London: HMIP. https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2014/12/Transforming_Rehabilitation-Early_Implementation1.pdf. Accessed 30 March 2015.

286 Summary of Liaison & Diversion roundtable stakeholder events (2014/15, accessible from <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>).

287 London Probation Trust (2013). *Bench Guide to Community Sentences*. Retrieved from: http://www.londoncrc.org.uk/wp-content/uploads/Bench-Guide-to-Community-Sentences_June-2013.pdf. Accessed 30 March 2015.

- 5.47. Guidelines set out where an offence would normally attract a custodial sentence, and, where a fixed sentence would be appropriate, then provide a “bracket” of possible sentences that a judge would be expected to consider, depending on the seriousness of the offence. A judge will be expected to consider the personal circumstances of the offender including the “age and/or lack of maturity where it affects the responsibility of the offender and any mental disorder or learning disability. Although judges are also advised that in some cases, having considered these factors, it may be appropriate to move outside the identified category range”²⁸⁸ the tightness of the guidelines means that this rarely happens.
- 5.48. The courts also need to consider the problem of remanding young adults to custody. The submission from the Howard League said that “far too many teenagers and young adults are remanded to custody by the courts but do not subsequently get a prison sentence and far too many are sentenced to prison for short periods of time” (page 1). The submission also explains that they are shortly to publish research that will show that 70 per cent of people remanded to prison by magistrates do not get a prison sentence (page 6).²⁸⁹
- 5.49. Twenty-nine of the young adults in our cohort were on remand, including three who were convicted but waiting to be sentenced (this represents 36% of those for whom data was available, as we do not have sentence status for 2 of the 83 young adults). This is similar to the figure obtained from the detailed analysis of self-inflicted deaths between 1978 and 2014, which showed that around 40% of prisoners were on remand at the time of their death (for all prisoners and those aged 18-24).²⁹⁰
- 5.50. It is disturbing that so many young adults on remand are vulnerable to self-inflicted death, in particular if they should not be in custody at all. We are concerned that Sentencers might feel obliged to remand in custody young adults who do not have an address to which they can be bailed. At the Characteristics of Young Adults roundtable, we heard how this might sometimes be the case, especially for Care Leavers.²⁹¹ It is imperative that these vulnerable young adults are not remanded to custody in these circumstances, and instead a joined up effort is made across agencies to ensure suitable accommodation is found.

²⁸⁸ Sentencing Council (2011). *Assault: Definitive Guideline*. London: Sentencing Council. www.sentencingcouncil.org.uk/wp-content/uploads/Assault_definitive_guideline_-_Crown_Court.pdf. Accessed 30 March 2015.

²⁸⁹ Submission to the Harris Review received from Howard League for Penal Reform on 28 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²⁹⁰ Ministry of Justice (2015). *Self-inflicted Deaths in Prison Custody in England and Wales between January 1978 and March 2014*. London: Ministry of Justice. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

²⁹¹ Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

The Importance of Family Contact & Liaison

“ As a young offender, I felt really vulnerable and scared coming in to prison. The main issue is loneliness. Prison breaks you away from your family ”

(21 year old man who responded to the targeted survey).

- 5.51. One of the most important areas where actions can be taken to moderate vulnerability and help manage the risk of self-inflicted death is by maintaining a young adult's relationship with his or her family. This can be achieved both by strengthening contact between the young adult and their family, and also in strengthening the contacts between the prison and the family.
- 5.52. Indeed, family contact was one of the key themes that the Review was expressly asked to focus on and it has repeatedly been raised with us as a critical issue during the course of the Review. While the Panel was never in any doubt as to the importance of family contact, the evidence that we have considered has reinforced for us the central role that families must be allowed to have in the care and support of vulnerable young adults in prison. And, whilst it is acknowledged that there will be some instances where such contacts are inappropriate or counter-productive, such cases will be in the minority, and far more often it will be important for these contacts to be strengthened.
- 5.53. The Youth Justice Board (YJB) puts a good deal of emphasis on contact between young people under 18 and their families and recognises that this can have a beneficial effect on risks in custody and can aid successful resettlement. The YJB expect that young people in custody will be supported to maintain contact with their families and support networks as these have a positive effect on their well-being and families should be able to share their insights and raise concerns (pp 19-20).²⁹² One of the 'cliff-edge' changes that happen to a young person who turns 18 in the criminal justice system is that family contact is no longer considered a necessary part of the management of the offender. As an adult, there is no longer an expectation that families will be involved in care and decision-making processes. However, in the same way that we established that a young adult does not become an adult overnight in Chapter 4, in this section it will be clear that they also don't stop needing their families.

²⁹² Submission to the Harris Review received from the Youth Justice Board on 17 July 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 5.54. As well as still being dependent on their own families, some young adults are also beginning to form close relationships with their own partners, and indeed many are already parents. The Prison and Probation Ombudsman has emphasised the significance of family connections for young adults:

“Young adults often have strong attachments to their families and partners and their lack of life experience can mean they are more emotionally affected by the break of relationships and family bereavements. Prisons need to take this into account when addressing their risk” (PPO, 2014a, page 14).²⁹³

- 5.55. This point was backed up by other evidence we reviewed. For example, when asked about the potential causes of suicidal feelings in our targeted survey, one young man answered “family issues”, another said “*I don’t get visits and don’t see my family*” and another, at only 19 years, said “*worrying about my girl and family*”. Another young man (20 years old) was asked what are the sorts of things about being in prison that make someone feel most vulnerable, unsafe, sad or lonely. He answered:

“the hardest thing I think is being away from family and I feel sad and lonely because I didn’t realise how good my life was until I got put in here. But now I have grown up a lot and have got closer to family and that’s wot [sic] keeps me going I feel like a better person.”²⁹⁴

- 5.56. Action for Prisoner’s Families told the Review that “*many young offenders are parents and imprisonment separates them from their children. Mothers in prison have reported feeling anger, anxiety, sadness, depression, shame, guilt, decreased self-esteem and a sense of loss when separated from their children*”. They said that separation from their children in prison damages mothers’ mental health and suggested that fathers also suffer (page 1).²⁹⁵

- 5.57. The importance of early contact and of access to phones has already been set out in Chapter 4, but we feel that one thing that stands out from the evidence, and in particular when we spoke to young adults themselves, was the importance of continued family contact throughout the custodial experience. We heard repeatedly how young adults missed their families and wanted to see them.

293 Prisons and Probation Ombudsman (2014). *Young Adult Prisoners. Learning Lesson Bulletin, Fatal Incident Investigations Issue 6*. London: PPO. http://www.ppo.gov.uk/wp-content/uploads/2014/08/LLB-FII-o6_Young-adults-.pdf. Accessed 11 March 2015.

294 Harris Review (2015). *Young Adult Engagement with the Harris Review*. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

295 Submission to the Harris Review received from Action for Prisoner’s Families on 4 August 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

“ Once you land in prison, that’s the end of it, nobody listens to the families... ”

(Family member at the Family Hearing Day)

- 5.58. A prisoner who wrote to the Review explained “*the current induction process is inadequate - I speak to many people who have been unable to talk to anyone on the outside even after a week unless they can remember parents/friends addresses and phone numbers..... They cannot write to or phone loved ones for support at their most vulnerable hopeless moment*” (page 1).²⁹⁶
- 5.59. One young adult (who responded to the survey of young adults) said “...visits 2 a month ant the best - we should have overnight visits [with] friends family that wood be good” (sic, 20 year old young man). He went on to say that what would make him feel better is “talking to someone that knows how your felling” (sic).²⁹⁷
- 5.60. This latter point is particularly significant: when feeling distressed, many young adults still want to speak to their mothers, or to other family members. The Prisons and Probation Ombudsman has underlined that “*prisoners often withhold their distress from staff and other prisoners*”. As a result, the PPO argues, “*processes must be in place to respond effectively when family or friends raise concerns*” (2014, page 6).²⁹⁸
- 5.61. A number of the prisons and YOIs that we visited described phone lines that the prison maintained so that families could contact the prison. The reality was, however, that practice appears inconsistent and inadequate, particularly if the family has to leave a message or tries to get through to an office that is closed for the evening. Families complained about phones not being answered, or that they could not get put through to someone who could listen. Even when they did they did not feel they were listened to. One family said “*when you ring them up with concerns they don’t care. Prison officers talk to you like you’re rubbish, say ‘OK, we’ll write this down’, but they don’t*” (INQUEST Family Hearing; Report, page 18).²⁹⁹

296 Submission to the Harris Review received from an individual serving Prisoner on 12 August 2014. In respect to their privacy, the details of this submission has not been published on the website.

297 Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

298 Submission to the Harris Review received from the Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

299 NQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 5.62. Another family said *“there’s no consistency when speaking to staff, each one gave different information or did not know procedures for how to arrange visits, what we could take in on the first visit etc. After several phone calls on that first day I came to the conclusion that either staff ‘could not care less’ or the organisation of the establishment was a shambles’. I hoped I was wrong but unfortunately time proved me correct on both accounts.”*
- 5.63. The Criminal Justice Alliance told the Review that *‘where possible the maintenance of family ties is crucial to the well-being of young adults in custody...given the importance of parents in the transition to adulthood, emphasis should be placed on supporting these relationships. Mothers are a key resource...because they have very detailed knowledge of the young person’s mental health...and state of mind’* (page 4).³⁰⁰
- 5.64. Another family member gave a very poignant example of how their insight into a change of behaviour may have alerted them to a problem if they had known about it.
- “My son was fine when he got there but then he had problems with his girlfriend etc. and he became really depressed but no one noticed. If someone just phoned me and told me that they were concerned as he was giving all his clothes away, I would have gone there; I would have told them to watch him carefully. I knew how important his clothes were for him. There was no communication between us and the prison”* (quote from family member).³⁰¹
- 5.65. The Review is strongly of the view that the family needs to continue to be an important part of the caring and support for their young adults. They often have important information about distress or risk that could impact on how a young adult is coping. It is important that the CARO nurtures close relationships with the family and involves them in the custody planning process (discussed in the next chapter).
- 5.66. In theory, NOMS recognises the importance of engaging with families, which is reflected in the Safer Custody prison service instruction (PSI 64/2011).³⁰² This requires staff who receive information from concerned family members, which indicates a change in the risk that prisoners pose to themselves, to communicate those concerns to the Residential, Daily or Night Operational manager (and consider opening an ACCT).

300 Submission to the Harris Review received from Criminal Justice Alliance on 29 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

301 INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>

302 NOMS (2011b). *Prison Service Instruction 64/2011 (Safer Custody)*. London: NOMS. <http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc>. Accessed 18 March 2015.

- 5.67. Indeed, there is some evidence that some institutions are already more proactive than others at encouraging family contact. MQPL data, for example, suggests that YOIs that hold 18-20 year olds tended to have a less negative score than their adult counterparts regarding help from the staff to maintain family contact. This may reflect a recognition of the importance of family contact for younger adults. YOIs, however, were less positive than male training prisoners in terms of being able to maintain meaningful family contact.³⁰³
- 5.68. When the processes were acted on, family members told us that it made it easier for them to deal with the situation. One family said of an example of good practice, *“I met with the safer custody officer that day... the conversation took place at the end of visiting time face to face. This was a good thing and assured us that someone realised the extent of [his] difficult feelings.”*
- 5.69. Much of the time, however, the evidence we have considered has led us to conclude that families are not sufficiently involved or considered in the processes.
- 5.70. One family complained to us that they were not even given information about how to contact the prison to arrange a visit. We were told *“I found a number on the internet but was told by the ‘stropky’ woman that I had to call back later because they were only open for one hour to book visits. No-one said anything about arranging visits.”*
- 5.71. Visits are particularly important to young adults and children, many of whom are very lonely in prison. When we spoke to young adults at the prison, many of them stressed to us how important visits were.
- 5.72. One young man gave a very heartfelt account of how his family had to travel such a long way to visit him that he did not see them as often as he would have liked. He was very grateful for the efforts his family made to visit him, despite the hardships it caused them. He complained that after all that effort they made, visits were short and limited, often unnecessarily shortened by the process of unlocking and escorting the prisoner to the visiting room. He also spoke with feeling about the distress that he felt at his grandmother seeing him in prison clothes and in the sterile and uncomfortable prison visiting room. He, and his colleagues, told us how a more relaxed environment would improve these contact experiences. Another young man told us that he was at his lowest during that walk back to his cell after family visits, because it would be so long until he saw his family again.
- 5.73. When we looked at the responses to the targeted survey we distributed in a number of establishments, we noticed that ‘more family visits’ came up very often as something that would help the individual feel better, and also that having too little contact contributed to distress. One young man (21 years old) said *“I keep going on ACCT plans because I don’t get visits and don’t see my family I just feel lonely so I get depressed and self-harm and then feel suicidal”*.³⁰⁴

303 Harris Review (2015) Measuring the Quality of Prisoner Life (MQPL). For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

304 Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 5.74. Distance from home can obviously be a barrier to family contact, which has been widely recognised by stakeholders. In his submission to the Review, Paul Scoular on behalf of the Scottish Prison Service acknowledged that a “*significant distance from home can lead to isolation*” (Scottish Prison Service page 3).³⁰⁵ This was something that the panel heard from young adults whom we met during prison visits, and from a group of young ex-offenders, and through the young adult survey. One young adult, who had been transferred away from his local prison to one that was over 100 miles away from his family described to us the high costs of public transport and the logistics around trying to keep to visiting hours. The stress it caused often meant that visits were cancelled at the last minute.
- 5.75. The issue of transfers is a very difficult one for family contact. Already a distressing time for young adults (as set out in Chapter 4), transferring from one institution to another might mean that these vital visits from families either stop or change in frequency. The Review strongly feels that families need to be included in decisions about transferring young adults who are 18-24 years, and that ease of maintaining family contact needs to be included as a priority factor in the decision-making process.
- 5.76. There are other ways in which contact with a family could be improved when the family is living at a distance. These include more innovative use of telephone and other IT. In their submission to the Review,³⁰⁶ NOMS pointed out that telephones are available for prisoners on landings and communal areas, and also that in-cell telephones are available in some privately contracted prisons, and in two public sector prisons. However, we have heard about a number of problems with using the phones, including that the process for using phone ‘cards’ (see paragraph 4.13 for an example) and Personal Identification Numbers was not always explained to prisoners or their families. This caused a great deal of distress to both the young person and their family.
- 5.77. A young man who left a message for us following our announcements on prison radio campaign said:

“...since I’ve been in prison I’ve not been allowed to ring any of my family, so I’ve had no family contact since I’ve been in here now... because none of my phone numbers seem to be on my PIN saying... I just can’t... like I say, I’ve been here five weeks and none of my phone numbers... other than a visit from my brother, which I received today... So I’ve had no contact with the outside.”³⁰⁷

³⁰⁵ Submission to the Harris Review received from Paul Scoular on behalf of the Scottish Prison Service on 8 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁰⁶ Submission to the Harris Review received from NOMS on 3 February 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁰⁷ Harris Review (2015). Young Adult Engagement with the Harris Review. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 5.78. We have already stressed the importance of investing in new information technologies in order to help young adults maintain contact with their families in Chapter 4. However, further work is needed to facilitate better and more frequent contact.
- 5.79. There are a number of good practice models that should be examined in terms of improving family contact. The submission from Catch22 described the model they use at HMP Doncaster that recognises the importance of family relationships. *They explained that “Doncaster has developed imaginative and sensitive approaches to helping men re-establish links, maintain relationships and drawing in the support of their families. Catch22 agrees with the findings of the recent Joint Inspectorate Report regarding the importance of family engagement as a key element of rehabilitation. Catch22’s delivery models, including our approach in Doncaster include a focus on family engagement, and working with Safeguarding and Troubled Families teams as appropriate”* (page 3).³⁰⁸
- 5.80. Other examples of good practice include the Family Engagement Workers that are in place in public sector female prisons. In their Review of the Women’s Estate (2013), NOMS described a pilot that used an integrated approach to family support including the use of Family Engagement Workers. The approach appeared to result in improved custodial behaviour and reduced self-harm and, demonstrating the potential for engaging the family to support desistance (page 24).³⁰⁹
- 5.81. In their submission to the Review, Action for Prisoners’ Families explained that where family relationships are fragile or have broken down, prisons should make efforts to repair and support them where possible as helpful relationships with family can lead to more sustainable outcomes for offenders. Family Engagement Workers can play a key role in this.³¹⁰
- 5.82. It is also worth noting at this point that when a young adult does not have a family, or at least a family with whom they have contact, the Review believes they should still have a ‘significant adult’ in their lives. Prisoners for whom this might be particularly important might include care leavers and foreign nationals. In chapter 4 we highlighted how such isolation increases vulnerability. An important action, therefore, that should be taken to reduce self-inflicted deaths in young adults, is to make sure that they receive visits from someone who can take on this role, even if it is someone employed by the local authority. We believe that there is also scope for more in-reach and NGO involvement in supporting these young adults.

308 Submission to the Harris Review received from Catch 22 on 2 October 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

309 Robinson, C. (2013). *Women’s Custodial Estate Review*. London: NOMS. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252851/womens-custodial-estate-review.pdf. Accessed 31 March 2015.

310 Submission to the Harris Review received from Action for Prisoners Families on 4 August 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 5.83. In their submission to the Review, NOMS acknowledged that *“at present prisons are not primarily public-facing organisations, and we recognise this as an area where our current structures perhaps do not harness the full benefits of the support that family and friends can provide to individuals at risk of self-harm or suicide. We hope to achieve greater consistency in the provision prisons make in terms of providing contact points for families and friends, and initiatives such as digital visits booking form part of this work”* (page 22).³¹¹
- 5.84. The Review welcomes this commitment to better and more effective family engagement. A culture that acknowledges the important place of families and/or significant adults in the support of vulnerable young adults needs to be nurtured. Families need to be included in the SAVRAS process (to be described in more detail in the next chapter) and information from them needs to be logged as part of this process.

³¹¹ Submission to the Harris Review received from NOMS on 3 February 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

The Importance of Peer Support

- 5.85. Clearly there is also a great deal that can be done inside the prison to moderate the risk of vulnerability. One important area, where more also needs to be done, is peer support and mentoring inside the prison itself.
- 5.86. In this context the Listener Scheme, run in conjunction with the Samaritans, where prisoners are trained to act as ‘listeners’ when one of their peers are in distress, can be very effective. However, there appears to be mixed support for the scheme across prisons. In establishments where it was supported by staff, it appeared to work well. In others, however, young adult listeners complained to us that staff did not take it seriously and did not support them in fulfilling this role properly.
- 5.87. In their submission to the Review the Samaritans told the panel that, *“Listeners are trained to identify and support (rather than manage) individuals at risk. Volunteers are not professionals but have a unique role to play in reducing risk. As peer supporters, Listeners are well placed to identify and ‘help’ fellow offenders. There may be less stigma for prisoners to speak to their peers rather than to prison staff, although having spoken to a Listener, a prisoner may then feel more comfortable about speaking to a member of staff. Research has shown that having support from peers is valuable to prisoners, since they are able to fully understand problems that staff or other professionals may not”* (page 13).³¹²
- 5.88. The Review met with a number of young adults who were on the Listener Scheme at most of the prison visits. The Listeners had mixed feelings about their role. While most of them told us how valuable peer listening schemes could be, many were sceptical about how much the prison really encouraged it to be effective.
- 5.89. At their oral hearing, the Samaritans told the panel about how important management support was to making the scheme work well and that there is a variation in whether Listeners have access to prisoners during ‘Early Days’. When management are more engaged, then the scheme works better. The Samaritans would like the opportunity for Listeners to engage more with prisoners during the early days of custody (Stakeholder Hearing 11, 3 July 2014, Samaritans).³¹³
- 5.90. NOMS recognised the value of peer support schemes in PSI 64/2011 and in their submission. They described the value of the ‘Insiders’ scheme. NOMS explained that *“some prisons also operate an ‘Insiders’ scheme through which selected prisoners who provide basic information and reassurance to others who are new to prison. Where they exist, the Insiders scheme aims to improve the quality of life for prisoners by promoting community responsibility, supportive relationships and a caring environment. The first days in custody are particularly distressing for many prisoners, especially those new to the prison system, and the Insiders scheme helps to reduce anxiety experienced by*

312 Submission to the Harris Review received from Samaritans on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

313 Stakeholder Hearing 11 (3 July 2014) Samaritans. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-Samaritans.pdf>.

*prisoners and contribute to the wider suicide prevention strategy by establishing the supportive relationships, and by disseminating relevant and accurate information about the prison regime.”*³¹⁴

- 5.91. In the direct communications that the Review had with young adult prisoners they told us that they valued peer support, both providing it and receiving it.
- 5.92. In a submission from a serving prisoner, he gives an example of how he helped a vulnerable young man who had wanted to talk to a staff member, but who felt unable to do so. He did not think they were taking his issues seriously, and so he had self-harmed as a way to cope with the situation. The submission explained that, *“while he was sharing with me I am delighted to report he did not self-harm once and he said I was the first inmate to both listen and understand his issues or show interest in him.”*³¹⁵
- 5.93. When the young adults from User Voice spoke to the panel, they also raised the value of having someone to talk to them who they could understand. Similarly, the focus groups that User Voice held to inform their submission to the Review raised the same issues. The submission notes that *“service users indicated the importance of being able to communicate with fellow inmates. One focus group was particularly interested in how the ‘buddy system’ in their prison could be extended to provide more support to vulnerable young people in custody.”*³¹⁶
- 5.94. In our visit to Holloway young women described how helpful it was, particularly in the early days of custody to have someone that you could trust and who could help you. *The Systematic Review of the Effectiveness and Cost-effectiveness of Peer Based Interventions to Maintain and Improve Offender Health in Prison Settings found that, “there is consistent evidence from a large number of sources that being a peer worker is associated with positive health. Peer support services can also provide an acceptable source of help within the prison environment and can have a positive effect on recipients.”*³¹⁷

314 Submission to the Harris Review received from NOMS on 3 February 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

315 Submission to the Harris Review received from an individual serving Prisoner on 12 August 2014. In respect to the privacy of the individual, the submission has not been published on the website.

316 Submission to the Harris Review received from User Voice on 15 September 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

317 South, J., Bagnall, A., Hulme, C., Woodall, J., Longo, R., Dixey, R., Kinsella, K., Raine, G., Vinnall-Collier, K. & Wright, J. (2014). A systematic review of the effectiveness and cost-effectiveness of peer-based interventions to maintain and improve offender health in prison settings. Health Services and Delivery Research, 2(35). http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0006/131469/FullReport-hsdro2350.pdf. Accessed 11 March 2015.

Conclusions and Recommendations on Moderating Risk of Vulnerability

- 5.95. This chapter has demonstrated that further action needs to be taken to divert more young adults out of custody and out of the criminal justice system in general. More cross-governmental input is needed to address the needs of troubled children and young adults and to ensure that problems are identified and effectively addressed at an early age. Custody should be used as a last resort, and Sentencers need to have the right information available to them, particularly given the vulnerabilities of this age group.
- 5.96. Families are integral to managing risk of vulnerability in prison and strong relationships with them are a protective factor. More needs to be done to build effective relationships, both between young adults and their families, and between key individuals in the prison, particularly the CARO, and the families.
- 5.97. Within the prison, vulnerability can be further mediated by ensuring young adults, for whom peer relationships are key, are engaged with positive peer mentoring schemes. The Listener scheme needs to be proactively supported and encouraged across the estate.

Our recommendations for this section include:

On Diversion

Primary Recommendations

41. The Review strongly supports the view expressed to us by our judicial representative that prison should be a last resort, it should not be used as the default solution when other alternatives are appropriate and available. A reduction in the prison population will enable prisons to provide an environment which meets appropriate standards of decency, safety and respect, and will assist prison authorities to comply with their human rights obligations, including the obligation to protect life. Diversion to healthcare, social care and other alternatives to custody can be a better means of addressing the complex needs of young people, and, in turn, better serve the victims of crime and society in general. It is essential that all magistrates and judges involved in sentencing decisions must be adequately trained on the vulnerabilities of young people, and the range of diversion schemes and alternatives to custody available within the local area.
42. Where a young adult is at risk of being placed in custodial remand for reasons that include concern that they do not have suitable alternative accommodation to which they can be remanded, the relevant local authority should either have to provide it, in something similar to the 'Bail Hostel' provision, or pay the costs of the custody provided through NOMS.

Secondary Recommendations:

43. The scope of the Troubled Families Programme should be expanded to address early family intervention. The Welsh Government should be invited to expand their own programmes to address the same issue.
44. There should be a parallel Programme focussing on the needs of vulnerable young people who are at risk of entering or already have had a number of encounters with the criminal justice system.
45. Further funding should be made available by the Department of Health to CAMHS services (and Welsh Government equivalent) to ensure early identification of mental health issues that, if properly supported, can be dealt with more effectively at an early age. CAMHS services need to be more closely linked to educational facilities, including custodial ones, to children up to the age of 18.
 - 45.1 Further investment is needed by the Department of Health (and Welsh Government equivalent) in Liaison & Diversion schemes, with a view to providing more appropriate services to vulnerable young people. Equal commitment should be provided to supporting Alcohol and Drug use and addiction services and services relating to the meeting of housing needs of individuals.
 - 45.2 CCGs should consider ways to prioritise access to NHS treatment services for those diverted from custody via the liaison and diversion process.
 - 45.3 Mental Health Treatment Programmes must be expanded to cover all custody suites and criminal courts in England & Wales.
46. When a court is considering passing any form of custodial sentence upon a young adult (18 to 24) then a full written pre-sentence report must be commissioned.
47. It is the collective responsibility of all relevant public agencies to ensure that no young adult who is identified as requiring detention and treatment/assessment in hospital under the Mental Health Act 1983 should be detained in police or prison custody. This should be a 'Never Event'.

On Family Support

48. Families are integral to supporting young people in custody and can help to keep them safe from harm. They must be included, where appropriate, as a central component of the management and care of young people in custody.

Secondary recommendations

49. Assistance should be given to families/principal carers to become more involved with their relative in custody where appropriate, including providing relevant information to help them understand the CJS, how to contact the prison, how to contact the CARO, and how to contact the Visitor Centre.
50. Visits and contact with family are usually a protective factor against harm and should not be withdrawn as part of punishment, IEP or because of restricted regimes.
51. All custodial establishments should have in place a process that will ensure that all prisoners will be able to contact a family member or a friend within 2 hours of their arrival in Prison, including following a transfer.
52. All custodial establishments must produce and publish information for families and prisoners on the arrangements for contacting their relatives in properly appropriate and accessible form. Arrangements should be made for this information to be widely available, for example at Magistrates' Courts and online.
53. Prisons must improve their processes for receiving information direct from the families of prisoners, particularly young adults. We recommend there should be a dedicated telephone line for families/friends and others to pass on concerns about prisoners, which should be continuously available over a 24 hour period. Information received should be logged and passed on appropriately to be recorded as part of the SAVRAS. This process should be audited.
54. A young adult should be given the opportunity to include on the PER two personal phone numbers for friends and family, before a mobile telephone is retained by the police/ prison authorities.
55. NOMS should invest in new technology, such as in-cell telephony and video call facilities, (for example Skype), similar to those used successfully in other jurisdictions in order to facilitate better contact with family. If necessary, to support this, families should be assisted through provision of access to facilities at an appropriate place close to where they live.
56. Whenever an 18 – 24 year old is being considered for a prison transfer, the distance from the address of the family/primary carer must be considered and the transfer needs to be agreed with the recommended new dedicated young adult unit in NOMS.

On Peer Support

Secondary Recommendations:

57. Governors should place high priority on peer support systems, such as Buddy schemes, Peer Mentors and Prisoner Councils and should ensure that there is a guaranteed commitment from their staff towards these schemes.
58. Prison Governors should assure themselves that there is guaranteed commitment from all staff to the operation of the Listener scheme, and that Listeners feel supported and enabled.
59. Governors should ensure that Listener Suites are provided within their establishments and that they are a safe and supportive environment.

6. Managing Vulnerability, Health and Mental Health

- 6.1. A key element of our recommendations is the role of the CARO, and some of the more important tasks that this role should undertake will be developed further in this chapter, where we examine formal processes for managing vulnerability and health, including mental health, in prisons. This chapter will also explore concerns that have been raised about the sharing of medical and other information between establishments and between organisations.

Provision of Health Care in Prisons

- 6.2. Since April 2013, NHS England has had responsibility for commissioning health care services and facilities for adult prisoners (over 18 years of age) in prison (including both public and private prisons) in England. This arrangement is supported by a co-commissioning partnership agreement between NHS England, NOMS and Public Health England (PHE) which sets out the respective responsibilities of the partners and their joint development priorities.³¹⁸
- 6.3. The Agreement explains that the range of healthcare services which are commissioned for prisons include “*primary care incorporating dentistry and optometry services, preventative and public health services, secondary care, community services, mental health services and substance misuse services*” (2015, page 3).³¹⁹
- 6.4. There is a separate partnership arrangement in place between NHS England, Public Health England and the YJB for delivery of services in the youth estate.³²⁰
- 6.5. In Wales, responsibility for all health services in public sector prisons has been devolved from the National Assembly for Wales to Local Health Boards (LHBs) since April 2006. NOMS has commissioning responsibility for the only private sector prison in Wales, HMP/ YOI Parc, and health care is delivered through the terms of the contract with the private sector provider.

318 NOMS and Public Health England and NHS England (2014). *National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the Co-commissioning and Delivery of Healthcare Services in Prisons in England 2015-2016* Retrieved from: https://www.justice.gov.uk/downloads/about/noms/work-with-partners/national_partnership_agreement_commissioning-delivery-healthcare-prisons2015.pdf. Accessed 28th March 2015.

319 NOMS/NHSE/PHE (2014) *National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the Co-commissioning and Delivery of Healthcare Services in Prisons in England 2015-2016*, London, TSO. https://www.justice.gov.uk/downloads/about/noms/work-with-partners/national_partnership_agreement_commissioning-delivery-healthcare-prisons2015.pdf. Accessed 28th March 2015.

320 NHS England (Online, no date). *NHS Commissioning - Health and Justice*. Retrieved from: <http://www.england.nhs.uk/commissioning/health-just>. Accessed 30 March 2015.

- 6.6. Health services are regulated in England by the Care Quality Commission (CQC), and this also covers the provision of healthcare services in prisons and YOIs. As will be described in Chapter 8, CQC inspectors usually accompany HMIP inspectors and provide a joint inspection report on services.
- 6.7. In Wales, the Healthcare Inspectorate Wales' (HIW) has the role of reviewing and inspecting NHS and independent healthcare organisations – again, this includes services provided in prisons and YOIs. Services are reviewed against a range of published standards, policies, guidance and regulations.
- 6.8. According to the commissioning documents or the policies governing these services, in theory at least, high quality care should be being provided. There is, for example, a mandate between the Department of Health and NHS England setting out the key expectations on “*developing better healthcare services for offenders and people in the criminal justice system which are integrated between custody and the community, including through development of liaison and diversion services*” (page 26).³²¹
- 6.9. However, our visits to prisons have suggested that these high aspirations are not always been delivered. There are, of course, very different cultures amongst healthcare staff and prison staff and there does not always seem to be a joined up approach.
- 6.10. For example, in one YOI we visited healthcare staff complained about the number of occasions in which prisoners did not turn up for appointments. They attributed this to prison officers who “couldn’t be bothered” to find the young adults concerned and escort them to their appointments. Prison officers, however, said either that the young adults did not wish to attend the appointments or that staffing resources meant that it was difficult to fit in escorting a prisoner to an appointment given other regime demands.
- 6.11. This pattern was reflected in other prisons and YOIs with health appointments often not being met, either because of a lack of staff to escort the young adult, or because of what appeared to be a lack of personal engagement with the young adult in order to convince them of the importance of the appointment.
- 6.12. However, young adults in custody do have many health and mental health needs. In their submission to the Review, the Offender Health Research Network (OHRN) reported on a number of studies that have found a substantial range of physical ailments in young people in contact with the CJS, including migraines, respiratory and musculoskeletal problems, and in particular there tends to be a high prevalence of substance use disorder (pp 7-8).³²²

321 Department of Health (2014). *A mandate from the Government to NHS England, April 2015 to March 2015*. London: Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/383495/2902896_DoH_Mandate_Accessible_vo.2.pdf. Accessed 30 March 2015.

322 Submission to the Harris Review received from Offender Health Research Network on 12 December 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 6.13. Indeed, this is reflected in the National Partnership Agreement between NOMS, NHS England and PHE, which explains “*offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely than the general population*” (page 1).³²³
- 6.14. Unfortunately, our visits to prisons and the other evidence we have received suggest that these needs are not always being met. This is not to say that there is no good practice to be found. On the contrary, some of what we saw was very good. We believe that it is important as part of the co-commissioning approach for both NOMS and NHS England Commissioners to identify examples of good practice in health care and ensure that these are promoted and encouraged throughout the estate.
- 6.15. A significant number of the 87 individual cases that we considered in detail had PPO or Rule 43 report recommendations relating to health care in the prison. Some of the issues highlighted by these reports will be considered later in this chapter. We will look at mental health and mental well-being, and then consider the arrangements for the management and assessment of vulnerability and how there should be a radically different approach to this in future. We will also look at the arrangements for dealing with medical emergencies, before looking at the sharing of medical information.

Mental Health and Mental Well-Being

- 6.16. In chapter 4 of this report we identified mental health issues as a key vulnerability for young adults in custody. Concern about mental health issues pervades all of the evidence considered, and was raised repeatedly at the hearings and at the events we have held.
- 6.17. In their 2013 report ‘*Same old... the experiences of young offenders with mental health needs*’, Young Minds refer to various studies that demonstrate high levels of mental health and other vulnerabilities among young offenders between 16 and 24. They pointed out “*it is well known that many young people who are involved in the criminal justice system have mental health problems, some have a diagnosis, others don’t, some have accessed CAMHS services, many haven’t but need support, some are referred to adult services but many are not accepted... Sadly the prison system has a high proportion of young people with these disorders*” (page 8).³²⁴

323 NOMS and Public Health England and NHS England (2014). *National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the Co-commissioning and Delivery of Healthcare Services in Prisons in England 2015-2016*. Retrieved from: https://www.justice.gov.uk/downloads/about/noms/work-with-partners/national_partnership_agreement_commissioning-delivery-healthcare-prisons2015.pdf. Accessed 28th March 2015.

324 Young Minds (2013). *Same old... the experiences of young offenders with mental health needs*. London: Published jointly by Young minds, T2A, Barrow Cadbury Trust and London City University. http://www.youngminds.org.uk/assets/0000/9472/Barrow_Cadbury_Report.pdf. Accessed 30 March 2015.

Case Study Jordon

Jordon was a 20 year old white male, who died in custody following an upsetting break-up with his girlfriend over the phone. He hung himself from a light fitting, leaving notes for his mother and his former partner.

Jordon first tried to take his own life at the age of 10 and first appeared before a court aged 12, before becoming a prolific offender in the following years. He had mental health problems and was diagnosed with an anti-social personality at 16 years. Just before he was arrested for the index offence, he attempted suicide again. Responding to an earlier indication from his girlfriend that she wanted to end the relationship, he attempted suicide in prison a year before he died by hanging himself and cutting his wrists.

- 6.18. Most prisoners with mental health problems have common conditions such as anxiety and depression, with a smaller number experiencing more severe conditions such as psychosis (Sainsbury Centre, 2009).³²⁵
- 6.19. Part of our analysis of the cases included a detailed study by psychiatrists whom we commissioned to look at all the material, including the Clinical Reviews prepared for the PPO investigations, Their assessment suggests that 38 (44%) of the 87 cases had evidence of a mental health diagnosis. In 12 of the 87 cases, there was evidence of overt symptoms of mental illness in the immediate period prior to death. Of the 38 cases identified who suffered with diagnosed mental health conditions, the psychiatrists identified 55 separate mental health diagnoses (some cases had multiple diagnoses). The most frequently occurring of these was major depressive disorder (diagnosed in 12 of the 87 cases in our cohort).³²⁶
- 6.20. For young adults in custody, living with mental health problems compounds other vulnerabilities. For example, the Centre for Mental Health reported that many of the co-morbidities reported by young people in the CJS can be compounded by cultural differences and inequalities (2013).³²⁷

³²⁵ Centre for Mental Health (2011, revised). *Briefing 39: Mental health care and the criminal justice System (Revised and updated)*. London: Centre for Mental Health. <http://www.openeyecomunications.com/wp-content/uploads/2011/10/mentalheathcareandtheCJS.pdf>. Accessed 30 March 2015.

³²⁶ Harris Review (2015). Examination of PPO Clinical Reviews. Consideration conducted on behalf of the Harris Review by Ambreen Aslam, Sunil Routhu, Matthew Tovey and supervised by Dr Dinesh Maganty. <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³²⁷ Centre for Mental Health (2013). *Black and Minority Ethnic communities, mental health and criminal justice*. London: Centre for Mental Health http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing1_BME.pdf. Accessed 30 March 2015.

- 6.21. Research shows that mental illness is associated with self-harm. In a case control study of prisoners making near-lethal suicide attempts, Rivlan, Hawton, Marzano & Fazel (2010)³²⁸ showed that all the cases met the criteria for a psychiatric diagnosis, and that a lifetime diagnosis of recurrent depression and psychosis were strongly associated with suicide attempts.
- 6.22. Despite the prevalence of mental health issues in custody, we have seen stark evidence that vulnerable young adults are not getting access to the support and treatment they need. When we spoke to a group of young adult ex-offenders in September 2014, they were overwhelming in their negative response to our questions ‘are mental health issues well recognised and managed?’ The immediate response from one young adult was “*No! Not by prison staff or healthcare.*” Another said “*Healthcare screening doesn’t pick up issues; it’s too short. Also, prisoners may not know what all their problems are.*” Another noted of staff “*they put a lot of pressure on Listeners. They’re used as a substitute for healthcare.*”³²⁹
- 6.23. In reviewing the case histories of our cohort, there are many cases where staff did not demonstrate appropriate awareness of the mental health needs of the young person, or that the prison did not appropriately follow through with ensuring the needs of the young person were met. Examples of this include one case where the PPO recommended: “*the Governor should ensure that officers receive regular mental health awareness training appropriate to their role, to educate them about some of the more common mental health problems affecting the prisoner.*” In another the PPO report recommended that “*consideration should be given to putting systems in place for referral to the prisons in reach mental health team,*” while in a third, the PPO report stated “*the healthcare manager should review the arrangements for following up prisoners who do not collect their medication. This is particularly important for prisoners who are vulnerable due to mental health symptoms.*”
- 6.24. Some of the families we spoke to also felt that health care staff did not fully respond to their child’s or young adult’s needs. One family member told us:
- “The Prison and NHS Mental Health team do not understand the behaviours of ADHD. [He] would constantly tell them that he was OK and he was not thinking of self-harming. How many prisoners actually give notice that they will self-harm? He would give the appearance that he was happy when he was on a high and then write a desperate statement on a complaints form when he was on a low.”*³³⁰

328 Rivlin, A., Hawton, K., Marzano, L., & Fazel, S. (2010). Psychiatric disorders in male prisoners who made near-lethal suicide attempts: case-control study. *British Journal of Psychiatry*, 197, 313–319. <http://bjprcpsych.org/content/bjprcpsych/197/4/313.full.pdf>. Accessed 30 March 2015.

329 Stakeholder Hearing 14 (4 September 2014) *User Voice*. Summaries of hearings can be accessed at <http://iapdeathscustody.independent.gov.uk/wp-content/uploads/2015/02/User-Voice.pdf>.

330 INQUEST (2015). *Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds*. Full report is available at: <http://iapdeathscustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 6.25. Given the prevalence of mental illness in the cohort and its association with self-harm, is probably not surprising that many of the children and young adults who died through Self-inflicted deaths since 2007 had a history of previous self-harm. Forty of the 87 cases (46%) had a history of verbal or written communication about their intention to self-harm or end their life. Of these, only three had never been known to actively engage in self-harm or suicide attempts.³³¹
- 6.26. Research shows that prisoners with a history of self-harm are over eight times more likely to die from a self-inflicted death than those with no history of it (Fazel, Cartwright, Norman-Nott, & Hawton, 2008).³³²
- 6.27. Provision of mental health support is particularly important for vulnerable young adults, who are less likely to have the maturity to cope with their mental health needs alongside the other vulnerabilities of their situation. The submission from the Office of the Children’s Commissioner pointed out that “*that behaviours arising from mental health problems, neurodisability and prior trauma may be responded to merely as behavioural infractions and that isolation practices – loss of association, reduction of IEP levels, and segregation – may result*” (page 2).³³³ In addition, the *Young Minds Report*³³⁴ describes how 18 – 25 year olds, when asked what experiences had led to their offending, indicated that while waiting for support from mental health services they had ‘self-medicated’ with drugs and alcohol.
- 6.28. In her submission, Jane Mackenzie, from NHS Wales, highlighted the importance of the initial assessment, saying that “*Initial mental health and suicide risk assessments on a prisoners admission to prison are not robust, or evidence based and are mainly a tick box assessment requiring a yes/no response*”.³³⁵ This was an observation that the Prison Reform Trust echoed, saying “*one step that would lead to significant improvement would be the adoption of an approach that sought to engage young people in deciding in support options. Real engagement would move practice away from a tick box approach.*”³³⁶

331 Harris Review (2015). Examination of PPO Clinical Reviews. Consideration conducted on behalf of the Harris Review by Ambreen Aslam, Sunil Routhu, Matthew Tovey and supervised by Dr Dinesh Maganty. Paper can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

332 Fazel, S., Cartwright, J., Norman-Nutt, A. & Hawton, K. (2008). Suicide in prisoners: a systematic review of risk factors. *Journal of Clinical Psychiatry*, 69(11), 1721-1731. http://www.researchgate.net/profile/Seena_Fazel/publication/23490177_Suicide_in_prisoners_a_systematic_review_of_risk_factors/links/0046351ffdoaea53bc000000.pdf. Accessed 30 March 2015.

333 Submission to the Harris Review received from Office of the Children’s Commissioner on 18 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

334 Young Minds (2013). *Same old... the experiences of young offenders with mental health needs*. London: Published jointly by Young minds, T2A, Barrow Cadbury Trust and London City University. http://www.youngminds.org.uk/assets/0000/9472/Barrow_Cadbury_Report.pdf. Accessed 30 March 2015.

335 Submission to the Harris Review received from Jane Mackenzie on 9 December 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

336 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 6.29. In October 2007 the UK government announced a large-scale initiative for Improving Access to Psychological Therapies (IAPT)³³⁷ for depression and anxiety-based disorders within the NHS. IAPT services have now become an integral part of wider health and care systems and therefore, should be as readily available to those in prison. In January 2009 the first IAPT: Offenders Positive Practice Guide³³⁸ was published, which acknowledged that providing IAPT services that meet the needs of offenders is a significant challenge, but has the potential for considerable rewards.
- 6.30. Ensuring that young adults receive the mental health support they need while in custody is vitally important, both in terms of reducing the numbers of self-inflicted deaths in this age group, and in enabling more effective rehabilitation and resettlement.
- 6.31. It is also important to remember that not all mental health and mental well-being issues relate to a diagnosis of mental illness. In his submission to the Review, Dr David Scott pointed out that it was not always helpful to view risk of self-harm and suicide from the perspective of mental health. Dr Scott explains that *“even if a person who takes their life has mental health problems this cannot tell us why they took their life at that specific time or provide any insight into the distinct set of interpersonal dynamics leading up to the act”* (page 2). He cites statistics that demonstrate that 40% of male and 55% of female prisoners experience suicidal thoughts in their lifetime, compared respectively with 14% and 4% of men and women in the wider community. He also points out that *“whilst many people in prison do have mental health problems, those who commit ‘suicide’ are less likely to have a psychiatric history than those on the outside who take their own lives.”* Dr Scott explains *“a suicide may be a frantic and desperate attempt to ‘solve the problem of living’”* (page 2).³³⁹
- 6.32. This focus on the overt or diagnosed signs of mental distress may be why so many young adults who took their lives were not on ACCT (as discussed in the next section). One family told us *“His letters home were very turbulent with various statements of his thoughts. But because he was not at risk, nor was an ACCT ever raised, nobody was alerted to his tormented state of mind”* (Family member, at Family Hearing Day).³⁴⁰

337 For further information see NHS/ IAPT website on <http://www.iapt.nhs.uk/about-iapt>.

338 Improving Access to Psychological Therapies (2013). Offenders - Positive Practice Guide London: NHS. <http://www.iapt.nhs.uk/silo/files/offenders-positive-practice-guide.pdf>. Accessed 30 March 2015.

339 Submission to the Harris Review received from Dr David Scott on 29 October 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

340 INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 6.33. This is consistent with the view that, alongside the vulnerabilities people bring into prison with them, the experience of being in prison is so difficult that it can have a profound impact on mental well-being (e.g. see papers by Alison Liebling³⁴¹ and by Diane Medicott, 2012).³⁴² The impact of the custodial experience upon the mental wellbeing of a vulnerable young adult is considered in additional detail within earlier chapters two and four.
- 6.34. Before we look more at the importance of a holistic approach that looks at being able to identify individual needs and the individual's experience of the prison environment, this report will first examine how vulnerability is currently managed.

Management and Assessment of Vulnerability

- 6.35. A thematic review of suicide in prisons by HMIP in 1999³⁴³ looked at the Prison Service Strategy 'Caring for the Suicidal in Prison', which was the process by which incidents of self-harm and self-inflicted deaths were managed at that time. The review found that while the policy was "*fundamentally sound, it had only been partially implemented and there were serious deficiencies in its application, including ignoring the need for case reviews, the absence of quality checks on documentation and inadequate staff training*". It also found that "*there was too much emphasis on filling in form F2052SH rather than ensuring the proper care of the suicidal*" (1999, page 37).
- 6.36. Following this report, the Prison Service commissioned an evaluation of the F2052SH³⁴⁴ process, which led to its eventual replacement by the Assessment, Care in Custody and Teamwork (ACCT), the rollout of which was completed in April 2007. After reviewing the evidence we have received, this current Review is very disappointed to say that we could almost repeat the HMIP conclusions of 1999 word for word.

341 Liebling, A. (2012). *Can human beings flourish in prisons?* PPT Lecture, May 2012. Retrieved from: <http://www.theppt.org.uk/documents/Can%20Human%20Beings%20Flourish%20in%20Prison%20-%20Alison%20Liebling%20-%20May%202012.pdf>. Accessed 29th March 2015.

342 Medicott, D. (2012). *Suicide and the Agonies of Prison Time: How Prisoner Narratives Can Help to Make Prison More 'Successful.'* Retrieved from: <https://www.inter-disciplinary.net/probing-the-boundaries/wp-content/uploads/2012/04/Suicide-and-the-Agonies-of-Prison-Time-How-Prisoner-Narratives-Can-Help-to-Make-Prison-More-Successful.pdf>. Accessed 29th March 2015.

343 HM Chief Inspector of Prisons (1999). *Suicide is Everyone's Concern. A thematic review by HM Chief Inspector of Prisons for England and Wales, May 1999.* London: HMIP. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/suicide-is-everyones-concern-1999-rps.pdf>. Accessed 9 March 2015.

344 The F2052SH process was the predecessor to ACCT and operated in the Prison Service between 1992 and 1994. It was designed to address the issue of self-harm and suicide through the use of a multi-disciplinary prison wide approach. The thematic review by HM Chief Inspector of Prisons for England and Wales, May 1999, '*Suicide is everyone's concern*' focussed on this process.

6.37. In their response to the Review, NOMS describe ACCT:

“The Assessment, Care in Custody and Teamwork process (ACCT), mandated in PSI 64/2011, provides a case management system that is designed to be flexible and responsive to individual need.

All prisoners who are identified as being at risk of self-harm or suicide are subject to the ACCT process and receive a detailed assessment by a trained ACCT assessor within 24 hours of the ACCT Plan being opened...any triggers and warning signs are identified at the first case review and noted in the relevant section. A CAREMAP is devised at the first review, and the ACCT process is then followed until the risk has been reduced. The process includes a post closure phase to make sure that the progress made by the prisoner has been maintained and that there are no risks that require the ACCT to be re-opened” (page 12).³⁴⁵

6.38. The Safer Custody Prison Service Instruction (PSI 64/2011)³⁴⁶ outlines the process that must be followed by custodial establishments when opening, managing and maintaining, and closing an ACCT form. It includes some mandatory actions that must be implemented locally. The Review found that the instruction was thorough and comprehensive, and took into account many of the themes that the Review has considered, including, for example, family contact. However, as with other PSIs we have looked at, there is a disconnect between what is supposed to happen in theory and what actually happens in practice. There do not seem to be sufficient or effective auditing and governance processes in place to ensure that senior management in NOMS can be assured that what they have declared to be mandatory is being delivered locally.

6.39. We received a lot of evidence to suggest that the ACCT process is not always fully complied with, but also that it relies on a limited interpretation of risk and harm. In addition, there are questions about whether the right people are always involved in the process.

6.40. The submission to the Review from the PPO noted *“When implemented properly, ACCT provides a comprehensive, multidisciplinary framework to address the underlying cause of a prisoner’s distress. However, to be effective, ACCT requires a concerted, joined-up and holistic approach”* (page 6).³⁴⁷

345 Submission to the Harris Review received from NOMS on 3 February 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

346 NOMS (2011b). *Prison Service Instruction 64/2011 (Safer Custody)*. London: NOMS. <http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc>. Accessed 18 March 2015.

347 Submission to the Harris Review received from the Prison and Probation Ombudsman on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 6.41. The submission to the Review from HM Chief inspector of Prisons noted that there have been significant failures in the ACCT process in prisons where young adults have died. In addition, the submission says *“too many people on ACCTs were being held in segregation”* (paragraph 31).³⁴⁸
- 6.42. We have also heard evidence that young adults have found the ACCT form itself, which is a very distinctive visible document, to be a problem that draws attention to their vulnerability. Signs of vulnerability are not usually treated with sympathy by other prisoners, particularly in male establishments. One young adult who we spoke to at the Hearing with User Voice in September said *“ACCT is bright orange so everyone knows. It’s embarrassing.”* This was reinforced by the findings of the April 2014 unannounced inspection of HMYOI Brinsford. Among other things, HMIP found that *“some prisoners subject to ACCT had been threatened or bullied and levels of self-harm were higher among this group, and yet the prison appeared unsighted to their needs”* (page 12).³⁴⁹
- 6.43. The submission from Jane MacKenzie noted a problem that staff in prisons had also mentioned during our visits. She said that *“because of the limited number of trained and qualified healthcare staff and poor communication processes, there is not always a multi-disciplinary/agency, or clinical presence at ACCT or other meetings where prison staff have to determine crucial decisions in further care or risk management”* (page 3).³⁵⁰ This was backed up in the cases we reviewed; for example, in one the PPO recommended: *“The Governor should ensure that ACCT reviews are attended by a multi-disciplinary team.”*
- 6.44. Some submissions particularly identified families as being left out of important ACCT processes and decisions. Families themselves expressed a great deal of frustration over the process when they spoke to us. One family member told us *“an ACCT needs to be opened for all prisoners and needs family involvement; but an ACCT also relies on well trained officers who care about the welfare of young prisoners”* (page 21). Another complained to us that *“we weren’t given information about how we can raise any concerns we might have. His file went into the prison with him. Despite this, the prison still said he didn’t need to be put on ACCT or go into a safe cell.³⁵¹ [He] wasn’t on an ACCT at any point in the prison”* (page 20).³⁵²

³⁴⁸ Submission to the Harris Review received from HM Chief Inspector of Prisons on 24 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁴⁹ HM Chief Inspector of Prisons (2014). *Report on the unannounced inspection of HM YOI Brinsford, 4-15 November 2013*. London: HMIP. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/04/Brinsford-2013.pdf>. Accessed on 27th February 2015.

³⁵⁰ Submission to the Harris Review received from Jane Mackenzie on 9 December 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁵¹ See The Purpose of Prison, page 44, paragraph 2.68 for a description of what is meant by ‘Safer Cells.’

³⁵² INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

6.45. The PPO Thematic *‘Learning from PPO Investigations: Self-inflicted deaths of prisoners – 2013/14’*³⁵³ that was published in March 2015 concluded that “Weaknesses in the implementation of ACCT continued to be a problem. Too often the individual’s triggers were not recorded, there were failures to identify appropriate actions to minimise or resolve the reasons for distress, safety checks were not at the required intervals (or else were too predictable) and too often the case reviews did not include input from a multi-disciplinary team.”

6.46. In support of this, the cases of the children and young adults that we examined are cluttered with PPO and Rule 43 recommendations on the proper implementation of the ACCT process. In the 87 cases, there were 145 different recommendations made about ACCT, and a further 13 that specifically related to training on ACCT. In total, these 158 recommendations came up in 43 out of the 87 cases. Some examples from individual investigation reports that indicate that fundamental processes are not being followed include:

- PPO report: “The Governor and Head of Healthcare should ensure that all members of staff update ACCT documents after interacting with prisoners.”
- PPO report: “The Governor should ensure that ACCT reviews take place following an incident of self-harm” (this particular recommendation came up multiple times).
- PPO report: “The Governor should ensure that managers at all levels, including those on temporary promotion, have completed the necessary ACCT training before fulfilling the role of case manager.”
- PPO report: “The Governor should ensure that staff clearly record all decisions about ACCT monitoring and reviews in the ACCT document, and that case managers plan and take account of the availability of all attendees when scheduling reviews.”
- PPO report: “The Governor should satisfy himself that there is no impediment to opening ACCT forms, such as the perception by staff that forms will be closed at such a speed as to render their use pointless. ACCT forms should remain open until staff are satisfied that all issues have been identified and effectively managed through appropriate case reviews. Relevant training should be offered to staff in this regard.”

353 Prisons and Probation Ombudsman (2015b). *Learning from PPO Investigations: Self-inflicted deaths of prisoners – 2013/14*. London: PPO. <http://www.ppo.gov.uk/wp-content/uploads/2015/03/self-inflicted-deaths-2013-14-Final-for-publication-5.pdf>. Accessed 11 March 2015.

- 6.47. The psychiatrists who assessed the Clinical Reviews and other medical information relating to our cohort found that in 54 of the 87 cases (62%), the individual had been known³⁵⁴ to have been managed under the ACCT process at some time during their history of custody (although this could have related to a previous period in custody). Of these 54 cases, 31 were not on ACCT at the time of their death.³⁵⁵
- 6.48. At the time of their death³⁵⁶, 23 of the 87 cases were being managed under the ACCT process, while 63 of the 87 were not. Of those 63 individuals not being managed under ACCT at the time of their death, 31 of those 63 had a history of self-harm or suicide, while 14 of the 63 were identified as having vulnerabilities.
- 6.49. The psychiatrist who considered the clinical reviews and other information judged that 36 of those 63 cases not being managed under ACCT at the time of death should have been managed under this process. Of the remainder, in 12 of the 63 cases there was insufficient information available to enable a judgement to be made. This left only 15 of the 63 cases where there was no evidence to suggest that management under an ACCT would have been appropriate and that it appeared to be correct that no ACCT had been opened.
- 6.50. These findings are reflected in the review of data on deaths since 1978 that was carried out by MoJ analysts, which also demonstrated that the majority of prisoners were not on ACCT at the time of their deaths, and that a similar majority had a history of previous incidents of self-harm. All of this leads the Review to conclude that ACCT as a process for managing risk of self-inflicted deaths is failing. This analysis also showed that a slightly higher proportion of black 18-24 year olds were on an open risk assessment in comparison to other ethnicities with this age group (though this difference was not statistically significant). This is not translated into increased self-inflicted deaths in Black young adults which could suggest that the ACCT process is at least working as well for Black young adults as others.
- 6.51. As well as this, the analysis of the Clinical Reviews gave information on when the ACCT documents were closed for the 31 young adults for whom the ACCT had been opened and then closed before they died. Although data was unavailable for 10 cases, 13 had their ACCT closed within 2 months of their deaths, and 2 of these were within 7 days of death. This indicates the high risk that was still present when the ACCTs were closed.

³⁵⁴ There was no information on ACCT status in one case.

³⁵⁵ Harris Review (2015). Examination of PPO Clinical Reviews. Consideration conducted on behalf of the Harris Review by Ambreen Aslam, Sunil Routhu, Matthew Tovey and supervised by Dr Dinesh Maganty. <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁵⁶ The ACCT status at the time of death in one of the 87 cases was not known.

- 6.52. Interestingly, staff themselves were also able to identify some problems with the ACCT process. The qualitative study that explored their perceptions found that staff felt that ACCT was best used with professional discretion and the process should be tailored individual needs. Staff also felt that there were currently more open ACCTs than they could manage, and that the process does not provide enough support for prisoners with greatest need. The study suggests that where staff fear of blame for self-inflicted deaths was high, there was limited use of discretion by prison staff and a mechanistic dependency on ACCT developed.³⁵⁷ One contributor to the study said that for many it was the ‘fear of having to give evidence before an inquest that determined their decisions relating to whether to open or close an ACCT (page 41) *‘[you] do everything you can not to get in the Coroner’s box. For some of us that means good practice, humane care and using best judgement. For some officers, they think that means ticking the ACCT boxes and that’s it’*.³⁵⁸
- 6.53. After considering the range of evidence available to us on ACCT, and after hearing from the psychiatrist who completed the analysis of the clinical reviews, the Review is concerned that there is too much focus on the process of ACCT, and not enough on producing the CAREMAP, which is fundamental to addressing the underlying issues. An effective quality CAREMAP should engage the individual who is at risk and identify the most urgent issues, including immediate problems that the person is facing. It is interesting to note that the MQPL data that we have been given suggests that on the whole, prisoners felt that prisons were less good at the prevention of self-harm and suicide than they were at providing care to those who were subject to ACCT.³⁵⁹
- 6.54. We conclude from the analysis of the cases within the cohort that some of the fundamental problems with the current ACCT process are:
- It has not been activated in a number of cases where it should have been;
 - When it was activated it was failing to provide the protection that it was designed to;
 - It was being closed prematurely without the factors driving the risk of suicide being addressed;
 - The right people are not always involved in the process, including families;
 - The holistic needs associated with the CAREMAP are not given precedence over the focus on process and ‘box-ticking’ of the ACCT plan.

357 Ludlow, A. et al (2015). *Self-inflicted Deaths in NOMS’ Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*. Further information can be found at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

358 Ibid, page 41.

359 Harris Review (2015) *Measuring the Quality of Prisoner Life (MQPL)*. For further details see <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

A New Approach to Vulnerability and Risk Assessment

- 6.55. We have already set out in this report why we think all young adults are vulnerable. For that reason, we are recommending that all young adults should have an Individual Custody Plan (ICP) developed for them by their CARO. In order to facilitate this, they will need to undergo a full multi-disciplinary holistic needs assessment within 48 hours of their arrival in custody.
- 6.56. This process, which we are calling Safety and Vulnerability Risk Assessment and Support (SAVRAS), would not replace initial Reception screening and would be in addition to any urgent risk assessments which need to be put in place as soon as a young person arrives in prison (the SAVRAS will be opened from the first instance to manage this information), including OASys. The SAVRAS process should be integral to how the needs of a young adult are assessed and acted upon.
- 6.57. The SAVRAS process should be co-ordinated by the CARO. We have already made clear in Chapter 3 that the CARO should have responsibility for the young adult's needs. The CARO will also develop and maintain key links with family and mental health in-reach staff or other key individuals who need to be part of the process.
- 6.58. The CARO will ensure that appropriate assessments of the prisoner's needs are made by suitably qualified practitioners, and these needs will include all of those currently covered by the ACCT process.
- 6.59. The SAVRAS process should feed into the ICP, which would provide a holistic rehabilitation programme and a custody plan based on the assessed individual needs and vulnerabilities of the young adult. The elements of the current ACCT procedures designed to protect and safeguard someone at risk of self-harm or suicide would be incorporated into the SAVRAS process.
- 6.60. The role of the CARO will be to co-ordinate the initial SAVRAS process and the development of the ICP.
- 6.61. A prisoner's CARO will also be responsible for the delivery of the agreed elements of the ICP, and its regular review by a multi-disciplinary team. This will necessarily involve regular contact by the CARO with each of the prisoners for whom they are responsible and a prisoner's CARO will be the first port of call if other staff have concerns about a prisoner's increased risk or increased needs. The CARO will have primary responsibility for acting on these concerns and ensuring an appropriate response.
- 6.62. Identification of mental health needs is an important part of the process, and so the health teams will need to input to the SAVRAS process of all young adults. If issues such as mental health needs, learning difficulties or social or maturity issues are identified, a full age-appropriate psychosocial assessment will be carried out by a suitably qualified health care professional, the results of which will inform the contents of the ICP.

- 6.63. In cases where risk or history of self-harm has been identified, the ICP would include a crisis plan. This would include observations and multi-agency reviews in line with the current ACCT process.
- 6.64. Case reviews of the SAVRAS and ICP will be led by the CARO and must be multi-disciplinary and where necessary would include representatives from healthcare. It is our view that the widest information should be garnered during reviews and assessments. Where appropriate, the CARO should consider including chaplaincy, education, and relevant in-reach staff, any local NGO and prisoners' families/friends. When the individual is being prepared for transfer to another establishment, then the new CARO will need to be involved. When the young adult is being prepared for resettlement, then CRC/NPS probation and TTG workers should also be involved.

Case study

Robert had previously spent time in custody in three other establishments, the longest of which was 10 weeks. On his arrival at the third prison, it was noted that he had a history of violent self-harm and was experiencing suicidal thoughts. A psychologist assessed him and diagnosed him with depression and anxiety but could not find clear evidence of psychosis. An ACCT document was opened.

A year later, Robert was back in custody at a different institution. A preliminary assessment and nurse's examination noted that he was at risk of self-harm, having self-harmed very recently and had a history of overdosing. His behaviour was isolative. As a result the nurse opened an ACCT document and he was transferred to the healthcare unit.

Over the following 2 months, Robert was subject to a number of assessments from psychiatrists and the Senior Officer, at which he continued to express intentions of self-harm and that he wanted to commit suicide.

On the day he died, Robert was checked at 04:15 am by an Officer Support Grade (OSG), one hour and 20 minutes after the previous check. The OSG's torch battery had died so he turned on the cell light to find the man hanging from his wardrobe. He raised the alarm and an ambulance was called, but he did not enter the cell as he thought he should not do so without another officer. He was untrained in first aid and ACCT procedures. Staff arrived and one nurse began CPR whilst another deployed oxygen. At 4.43am an ambulance crew with two paramedics arrived. Due to staff shortage, one officer had to deliver the fast response paramedic before doubling back to collect the ambulance crew. She experienced difficulties unlocking outside gate locks because of the freezing temperatures. Robert was moved to the local hospital whilst attempts at resuscitation were made. He was pronounced dead at 5.42 am.

- 6.65. Where an ICP contains a crisis plan designed to avert risk of self-harm or suicide, then it is important that such a crisis plan is not terminated unless this has been specifically agreed by a suitably qualified health care professional, in conjunction with the CARO. Given so many of our cohort were not on an ACCT, or had an ACCT closed down shortly before they died, we think it is important that steps are taken to ensure that this is not repeated in a new process.
- 6.66. While the processes we have described here should be used for every young adult in custody, we would like NOMS to consider implementing this system more widely across the prison population, especially for more vulnerable people.
- 6.67. To ensure that appropriate healthcare is available to support these processes, it is important that NHS England and Local Health Boards in Wales commission the necessary services for prisons and YOIs. This should include:
- IAPT services that will be for all young adults (or indeed any prisoner where the SAVRAS process recommends it) on a self-referral basis with short waiting times. These should target depression, anxiety and other common mental disorders.
 - Screening for every young adult for ADHD with the provision, where necessary, of appropriate treatment in line with NICE guidelines for ADHD within mainstream prison health care services.
 - Assessment by a Band 7 (or above) mental health nurse of all young adults on an initial basis within 24 hours of arrival in Reception with a more detailed assessment, where necessary, taking place. Every prisoner must be assessed by a Band 7, or above, Mental health nurse firstly for an initial assessment on the day of arrival in Reception and with a more detailed assessment, where appropriate, following within 7 days of arrival.
 - An age appropriate psychosocial assessment for all young adults that includes maturity and mental health issues.
 - Consultant psychiatrist / forensic psychiatrist / lead mental health services in a prison setting which are available 24/7, with services equivalent to the home treatment and crisis intervention services that are supposed to be available in the community.
 - In addition, self-harm reduction should be a key outcome indicator for prison mental health services and, as emotional instability is a key driver for Self-inflicted deaths, the treatment of young adults with such issues should be a key focus of the NOMS/DH/NHS England (Specialised Commissioning) personality disorder treatment strategy.

Dealing with Medical Emergencies

- 6.68. NOMS policy for managing medical emergencies, including the development of local protocols between each custodial establishment and the local Ambulance Service (which is not included in the services commissioned directly by NHS England) are set out in PSI 03/2013. The PSI directs that medical emergency response protocols must be written and agreed locally in conjunction with the healthcare commissioner at the prison and the ambulance trust. The minimum the protocol must cover includes arrangements to “prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison (with or without the patient). This must include procedures for admitting and discharging ambulances during the night state.”
- 6.69. The NOMS submissions highlights that “PSI 03/2013 sets out the framework for calling a medical emergency consistently over the establishment radio network. Each prison is required to put in place a medical emergency response code protocol to ensure timely, appropriate and effective response to emergencies and thereby to maximise the likelihood of a positive outcome for the patient.”
- 6.70. As we have already demonstrated, there is a disconnect with the standards set out in PSIs and what happens in practice. The PPO’s investigations into the cases that we have considered have frequently identified significant delays in providing access to Emergency Services and this has impacted upon the ability to resuscitate the young adult.
- 6.71. Bindmans pointed out to us that “in the large majority of cases in which we have acted, there have been concerns regarding the emergency procedures when a prisoner is found. This includes a lack of available emergency equipment; a lack of first aid training, which is particularly important now that some prisons... do not have 24 hour healthcare ... a lack of training and understanding by discipline staff of when a member of staff can enter a prisoner’s cell without another officer being present; the inappropriate use of emergency codes leading to delays in response and in an ambulance being called; and delays in ambulance staff being allowed access to the prison” (Bindmans submission, p10).³⁶⁰
- 6.72. In 2010, a PPO report was published looking at learning from deaths from circulatory diseases³⁶¹, and as a follow up in 2011, the Chief Executive of NOMS issued a letter³⁶² to all Governors concerning the local arrangements for providing emergency access to custodial establishments for ambulance services, with a view to minimising delays. This clearly placed a responsibility locally on the Governor to agree arrangements

³⁶⁰ Submission to the Harris Review received from Bindmans (Solicitors) on 1 August 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁶¹ Prisons and Probation Ombudsman (2010). *Learning from PPO investigations: Deaths from circulatory diseases*. London: PPO. <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2011/07/PPO-Deaths-from-Circulatory-Diseases-Nov-2010.pdf>. Accessed 20 March 2015.

³⁶² NOMS & Department of Health (2011). Emergency access to establishments for ambulance services. Letter from Michael Spurr and Richard Bradshaw. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215755/dh_124566.pdf Accessed 11 March 2015.

with the local emergency services. However, NOMS needs to be able to provide full assurance to its own senior management and ultimately to ministers that these arrangements are adequate. As with other so-called “mandatory” requirements, we do not believe that at present sufficient auditing and governance arrangements are in place to ensure local protocols are adequate.

- 6.73. There were many cases in our cohort that highlighted concerns about delays in access to medical emergency services, as a result of deficiencies in local arrangements. In the case of ‘Philip’, the PPO found that *“the ambulance was called at 05:25 and arrived at 05:35 but at the wrong gate. A second ambulance arrived at 05:38 and at 05:40 the paramedics arrived at the cell. The Governor should review the procedure for the attendance of ambulances at the prison”*. In the case of ‘Michael’, the PPO found *“although an ambulance was requested promptly, the paramedic crew were unaware of the nature of the emergency until they arrived at the prison. The Governor should review his contingency plans for the management of life-threatening emergencies so as to ensure that proper information is passed to the emergency services as to the nature of the emergency. If necessary, appropriate staff training should be offered.”*
- 6.74. The case of ‘Robert’ that is highlighted in the textbox gives an example of a self-inflicted death where, as a result of ineffective processes there were clearly significant delays to attempts at emergency resuscitation. In Robert’s case, the PPO report concluded that *“the Governor should review the level of first aid training amongst night duty staff and where necessary ensure such staff receive additional training.”*
- 6.75. Another case is ‘Dan’, who was 18 when he died. Following the inquest, the Coroner highlighted concerns over training in medical treatment and resuscitation in a Rule 43 report. The PPO said *“[Dan] hung himself by a sheet within his cell on the [prison unit] and was discovered by the Operational Support Grade whilst she was doing her 6.30 am roll call. A fellow OSG attended rapidly and they both entered the cell and attempted to cut [Dan] down using the standard issue fish knife. Neither of these OSG’s had any training in suicide prevention or resuscitation techniques. Other prison officers attended and assisted. My concern is that OSG’s are locked into the units and will invariably be first responders. Help may not be immediately available and they may therefore miss the opportunity to prevent a suicide or revive a suspended inmate.”*³⁶³
- 6.76. Addressing the issues raised by the coroner in Dan’s case, NOMS set out the actions that the Governor of that establishment had taken to address the issue of insufficient training. Training on suicide prevention and resuscitation techniques was made mandatory for all OSGs. In addition, NOMS noted that the establishment concerned was *“also looking to obtain ‘everyday life support’ training from the Red Cross over the coming months, targeting OSG staff where ever possible.”*³⁶⁴

³⁶³ Information is from the case material considered by the Review. Further information is provided in Appendix 3.

³⁶⁴ Harris Review (2015). Summary of our Examination of the PPO, Rule 43/ Regulation 28 Prevention of Future Death reports on cohort cases. Can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 6.77. The Review considers that training such as this is very important in all prisons and YOIs. It is often difficult for ambulance services to access all areas of the prison quickly, and it is important that staff are trained to be able to save lives where possible.
- 6.78. The Resuscitation Council UK (RCUK) states that *“All providers of primary care must ensure that their staff have immediate access to appropriate resuscitation equipment and drugs when needed”*³⁶⁵
- 6.79. The submission from the Royal College of Nurses (RCN) also noted the importance of resuscitation training. They said that they would *“like to see greater attention paid to Cardiopulmonary resuscitation (CPR), including the training of all criminal justice staff, not solely health professionals, in CPR. This currently is severely lacking in criminal justice settings and could be pivotal in saving lives. Annual training reviews of all staff would likely improve the outcomes for those who have inflicted self-harm”* (page 4).³⁶⁶
- 6.80. In the case of ‘Paul’, the PPO highlighted the lack of resuscitation training and the priority need to address it, saying *“the Governor should ensure staff undertake update training in CPR as a matter of priority to ensure compliance with the Resuscitation Council (UK) Resuscitation Guidelines 2005.”*³⁶⁷ The clinical review also suggested that the governor should ensure that a defibrillator is taken to all identified or possible cardiac arrests, and that staff are trained in its use.
- 6.81. First aid equipment being present during a ‘code blue’ alarm was also raised by the PPO in response to another case, where the recommendation was *“Healthcare staff should take an emergency ‘grab bag’ and a defibrillator to serious situations, particularly those of a ‘code blue’ nature.”*³⁶⁸
- 6.82. Given the repeated examples of inadequate emergency response when a young adult tried to take their own lives, the Review feels that it is imperative that each establishment should have emergency medical response plans in place that include emergency response exercises so that staff are familiar with processes, and mechanisms for ensuring that equipment is maintained in good condition.
- 6.83. While ideally all staff working with vulnerable young adults that might be at risk of self-harm should have comprehensive training, we feel that a more practical solution would be that all Healthcare professionals (HCPS) working in prison should be trained to the Resuscitation Council ‘Immediate Life Support’ (ILS) level. Prison staff should have sufficient levels of first aid training, to a minimum of basic life support level.

365 Resuscitation Council UK (2013). *Quality standards for cardiopulmonary resuscitation practice and training. Primary Care – Quality Standards for CPR and training*. Retrieved from RCUK website: <https://www.resus.org.uk/quality-standards/primary-care-equipment-and-drug-lists>. Accessed 11 March 2015.

366 Submission to the Harris Review received from Royal College of Nurses on 21 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

367 Harris Review (2015). Summary of our Examination of the PPO, Rule 43/ Regulation 28 Prevention of Future Death reports on cohort cases. Can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

368 Ibid

Sharing Medical Information

- 6.84. Throughout this Review, we have been struck by how poor information exchange appears to be. Whether it is between Departments, between prison and YOI establishments, or between individuals within an establishment, information is falling through gaps and lives are being put at risk as a result. While other examples of this are given elsewhere in this report, this section focuses on the complicated issue of medical information, including about mental health and that currently contained in the ACCT process.
- 6.85. Drawing from their own casework data on children and young adults who were victims of Self-inflicted deaths in custody between April 2007 and September 2014, INQUEST calculated that 68% of the 96 deaths that they looked at “*had not been identified as being at risk of harm and were not on an open ACCT, despite many having self-harming histories and mental health issues*” (page 11).³⁶⁹ The previous history had not been passed on or was not acted upon.
- 6.86. NOMS has acknowledged in its submission to the Review that “*getting information-sharing and communication right is an ongoing challenge*” and also recognised “*from reports from the PPO and from inquests that poor information exchange does still occur*” (page 10).³⁷⁰ Indeed, the problem is acknowledged by the Safer Custody Prison Service Instruction (PSI 64/2011): “*the failure to transfer information within and between services is a perennial issue and one that receives significant attention from the Prisons and Probation Ombudsman (PPO) in investigation reports and at inquests.*”³⁷¹
- 6.87. The Review’s analysis of the PPO clinical reviews found that in 16 cases (18% of those for which information was available) there were clear inadequacies in the sharing or communication of existing medical information. Some cases showed multiple failings.

³⁶⁹ Submission to the Harris Review received from INQUEST on 13 October 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁷⁰ Submission to the Harris Review received from NOMS on 3 February 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁷¹ NOMS (2011b). *Prison Service Instruction 64/2011 (Safer Custody)*. London: NOMS. <http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc>. Accessed 18 March 2015.

6.88. Repeatedly, the PPO or coroners have identified these problems. For example:

- Coroner Rule 43 report: *“my concern here is that there should be a system to ensure that key members of staff have all of the relevant information available to them to make adequate risk assessments in the future to ensure inmates at risk of self-harm and suicide are quickly identified”*;
- PPO report: *“The Governor and Head of Healthcare at [prison’s name] should ensure that potentially important health information is transferred with prisoners when they move establishment”*;
- PPO report: *“The Governor and Head of Healthcare should ensure that members of staff working in reception thoroughly check the person escort record for all relevant information about prisoners being received”*.³⁷²

6.89. These problems need to be resolved with more effective procedures, including better information technology, clear governance processes for ensuring the relevant PSI is effectively implemented locally, and with a change in culture so that successful information exchange becomes entrenched. Of equal importance is the need to ensure that all staff are trained and skilled in how to discuss the issue of consent with vulnerable young adults in order to understand how it will benefit in caring for them.

6.90. However, it is recognised that better exchange of medical information may bring other complications. This may include a reluctance on the part of the prisoner to consent to disclose information, and a reluctance of other bodies to disclose information when they are not sure whether consent is needed or where they are not confident that the information they disclose will only be passed on to those who need to use it.

6.91. The Department of Health Mental Health Equality & Disability Division’s Information sharing and suicide prevention Consensus statement (DH, Jan 2014)³⁷³ stated that *“confidentiality, consent and capacity are all issues which have rightly received a great deal of careful attention over the years. It is clear that, where the common law duty of confidentiality applies, practitioners will be under a duty to respect a person’s refusal to consent to disclosure of their suicide risk, if the person has capacity and they do not pose a risk to anyone but themselves.”*

372 Harris Review (2015). Summary of our Examination of the PPO, Rule 43/ Regulation 28 Prevention of Future Death reports on cohort cases. Can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

373 Department of Health (2014). *Review of the operation of Sections 135 and 136 of the Mental Health Act*. London: Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389202/S135_and_S136_of_the_Mental_Health_Act_-_full_outcome.pdf. Accessed 13 March 2015.

- 6.92. Paragraph 27 of the GMC guidance³⁷⁴ to doctors states “*you must respect the patient’s wishes who objects to particular personal information being shared with the team or to others providing care unless justified in the public interest.*” These guidelines are similar to those of the Nursing Midwifery Council and the Health and Care Professional Council. The guidance from the GMC discourages sharing information between healthcare professionals without the consent of the patient.
- 6.93. However, GMC guidance is written, for the most part, without giving due regard to the very particular situation of those who are in custody. The young adults considered as part of this Review, and indeed everyone in custody, are under the care of the state and the Review considered how the obligations to safeguard those in custody fit with medical guidance and also human rights legislation.
- 6.94. Article 2 of the European Court of Human Rights³⁷⁵ lays down a positive obligation to protect the right to life. This means that authorities would be expected to avert the risk of loss of life where they knew or ought to have known of a real and immediate risk and fail to take measures within their powers to avert the risk. In the custodial environment the state has duty of care and an overriding obligation to Article 2, which places a different degree of responsibility on healthcare professionals that does not exist in the more usual and open access healthcare arena. This means that regulatory bodies should review their guidance in terms of consent and confidentiality to avoid placing healthcare professionals at risk of a conflict between the medical regulator and the state’s duty of care.
- 6.95. Under Article 3 of the ECHR, prisoner’s health and well-being must be adequately met. Where medical staff only have partial and self-reported information there is a risk that they will not meet the patient’s health needs adequately.
- 6.96. However, under Article 8 of the ECHR, the prisoner has a right to respect for private life, and could object to their medical history being shared outside of the immediate treating team. This has resulted in the situation where any medical history, including being treated or detained for mental illness, would not be routinely shared without positive consent.
- 6.97. Article 8, however, is a qualified right, and there are circumstances in which it can be overridden where proportionate to do so. While appropriate consideration should be taken of a person’s desire for confidentiality, where protection of health is the reason for needing to share information, confidentiality should not always be a trump card. This may especially be the case where a person is in the custody of the state, and where the state has a positive duty to protect life, and to ensure that proper medical treatment is provided, as described above.

374 General Medical Council (2008). *Consent: patients and doctors making decisions together*. London: GMC. http://www.gmc-uk.org/static/documents/content/Consent_-_English_0914.pdf. Accessed 11 March 2015.

375 Council of Europe (1950). *European Convention of Human Rights*. Strasbourg: Council of Europe. See also <http://www.coe.int/en/web/human-rights-convention>. Accessed 11 March 2015.

- 6.98. As the Joint Committee of Human Rights said: “Under Article 8 the prisoner has a right to a private life and could use Article 8 to object to his or her medical history being shared from outside of the immediate treating team. This has resulted in the situation where any medical history, including being treated or detained for mental illness, would not be routinely shared without positive consent. A pro-active approach is vital in order to reduce the rate of self-inflicted deaths among people in custody and help the state meet its obligations under the Human Rights Act.”³⁷⁶
- 6.99. Despite this, it would appear that too frequently it is assumed that prisoners will not have given consent for their previous health information to be disclosed.
- 6.100. The independent qualitative research, which we commissioned RAND Europe/University of Cambridge to carry out for us on staff views, highlighted some of these concerns among prison officers. Wing staff who informed the researchers that they wanted access to more of the information collected by Healthcare, said that “*medical in confidence*” is used indiscriminately to prevent information sharing and that “*we need to have more confidence to challenge the blanket ban of medical in confidence*” (page 27).³⁷⁷
- 6.101. Independent research commissioned by the National Institute for Health Research (NIHR)³⁷⁸, noted that those in custody generally did not object to their health care information, regarding risk of suicide, being shared with the police and other criminal justice organisations when asked to consent.
- 6.102. The Review was unable to find evidence that those in custody refuse permission to clinicians to obtain information or clinical records from other health care providers. Instead, it appears that either they are not asked for consent, or that healthcare staff are reluctant to share. The Review feels that some organisations have become too risk averse, through a misreading of the legislation and guidance. Requests to obtain medical records should become part of basic health screening and information gathering. If individuals agreed at early stages to sharing their medical information, then this will best inform patient care.
- 6.103. The other pivotal issue that needs to be addressed is inconsistency across different IT systems. The Review heard repeatedly that the different information sharing systems used across the CJS and co-commissioning bodies are not compatible and make information sharing more difficult.

376 House of Lords/House of Commons Joint Committee on Human Rights (2004). *Deaths in Custody - Third Report of Session 2004-05*. London: TSO. <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/15.pdf>. Accessed 30 March 2015.

377 Ludlow, A. et al. (2015). *Self-inflicted Deaths in NOMS' Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*. Further information available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

378 Senior, J., McDonnell, S., Lennox, C., Yao, L. & Zhang N. (2012). *The Development of a Pilot Electronic Multi-Agency Information Sharing System for Offenders with Mental Illness Final report*. Retrieved from the webpages of the National Institute for Health Research. http://www.nets.nihr.ac.uk/___data/assets/pdf_file/0009/64539/FR-08-1803-225.pdf. Accessed 11 March 2015.

- 6.104. We heard from the Health & Justice Information Service, which aims to try and resolve a number of these problems across England. The Welsh Government are working with the HJIS delivery team to ensure that similar information sharing will be delivered across Wales. The HJIS system intends to build on the IT system currently in place, and to expand it to all places of detention. It also intends to connect these systems to the wider NHS.
- 6.105. While the Review welcomes developments such as this, further steps need to be taken to ensure that CJS staff, particularly healthcare staff and the CARO, have access to any clinical IT system which contains the health and risk dataset.
- 6.106. In addition, consideration needs to be given to the efficacy and long term risks of continuing to develop further IT systems designed to collate information, including risk assessment and offender management tools on offenders, whether in custody or the community, while these problems remain unresolved.

Summary and Recommendations on Managing Vulnerability, Health and Mental Health

- 6.107. This chapter has looked at the complicated area of offender health and mental health, and what further actions can be taken to improve the delivery of health and mental health in order to reduce the risk of self-harm and self-inflicted death.
- 6.108. While progress has been made on improving provision of health and mental health in custody, our assessment of the detailed case material available to us has convinced us that further improvements are needed in order to protect this particularly vulnerable population.
- 6.109. Despite the fact that the policy is comprehensive, the ACCT process is not being effectively implemented, and the focus is too much on procedure and not enough on care. A new process must be introduced for young adults (18-24 years), because this age group has specific vulnerabilities and needs that are not currently being addressed.
- 6.110. There is much that should be done quickly to improve the emergency response within prisons and YOIs. In particular, having more staff that are trained to deal with emergencies will save lives.
- 6.111. Finally, information sharing needs to improve with regards to medical information. While there are many ways that this might be achieved, two areas where actions need to be taken are around obtaining consent for access to medical records, and ensuring that IT systems are more compatible in the CJS.

Primary Recommendations:

60. Each young adult (18-24 years) in custody must be assigned to a suitably qualified and experienced staff member who will act as their personal Custody and Rehabilitation Officer (CARO) whose responsibility it will be to build a supportive relationship with them, to oversee their security and well-being, to ensure their health, education, social care and rehabilitation needs are met, and to oversee the assessment for and delivery of their Individual Custody Plan (ICP).
61. With a view to developing an ICP, all young adults entering custody must undergo a full multi-disciplinary holistic needs assessment within 48 hours of their arrival in custody. This process, to be known as the Safety and Vulnerability, Risk Assessment and Support (SAVRAS) process, should be co-ordinated by a CARO, who will ensure that as part of this process an appropriate assessment is made by suitably qualified practitioners (properly trained in issues of gender and cultural sensitivity) of any physical, social care, and mental health needs of, or other vulnerabilities and risks faced by, the young person. These needs will include those currently covered by the ACCT process.
62. The ICP should be developed by the CARO, in consultation with the young adult concerned in order to identify how, by whom and when their needs identified by the SAVRAS process will be met.
63. NOMS should consider whether the ICP, SAVRAS and CARO approach might also usefully apply to older adult prisoners.
64. There must be parity of health care services in prisons and YOIs with those in the community and NHS England and Local Health Boards in Wales should commission the services necessary to do this and deliver what is set out in this chapter.
65. NHS England should commission prison mental health services in line with the recommendations of this report.
66. Responsibility for prevention of self-harm and self-inflicted deaths in custody should be jointly owned by both NOMS and Healthcare.
67. Further to the statement of the purpose of prison, the European Prison Rules (5) state the principle of approximation as closely as possible the positive aspects of life in the community; therefore healthcare must take a central responsibility in this area.
68. There should be a consistent approach throughout the criminal justice system to requesting consent to share medical information, which should happen at the first point of contact with the health services in a CJS setting, whether that be at a police station or at a prison, and that that consent should apply to the remainder of the prisoner's journey through the CJS. If consent is declined it should be revisited regularly particularly if a serious health incident occurs.

Secondary recommendations:

69. All young adults should have an up to date ICP, and SAVRAS that is co-ordinated by their CARO, who will be accountable for assuring the quality of the documentation, its regular review, and ensuring that its various elements are implemented.
70. Families must be provided with sufficient opportunities to feed into the SAVRAS process, including through providing potentially relevant information on the dedicated concern line, and any such information must be recorded within the SAVRAS documentation.
71. All commissioning, contract and performance management policies and documents for health and mental health provision in custody should include responsibilities for SAVRAS and will include the following:
 - 71.1 Health teams must be actively involved in the operation of the SAVRAS process, although the delivery of services through the ICP to meet assessed needs should be multidisciplinary;
 - 71.2 Where a mental health, learning difficulty or significant social issue(s) are identified through the SAVRAS process, a full age-appropriate psychosocial assessment must also be carried out by a suitably qualified health care professional. The results will inform the content of the ICP.
 - 71.3 Where a SAVRAS contains an element of need elevated to a crisis stage, only a suitably qualified health care professional, in conjunction with the CARO, will have the authority to terminate the services designed to meet that need.
72. Case Reviews of the SAVRAS and ICP will be led by the CARO and must be multi-disciplinary and where necessary must include representatives from healthcare. Where appropriate, the CARO should consider including chaplaincy, education, relevant in-reach staff, VCS and prisoners' families/friends. CRC/NPS probation and TTG workers should also be involved when the individual is being prepared for resettlement.
73. At any stage during the young adult's time in custody, all prison staff must be under a positive obligation to notify the CARO (or the person acting on their behalf in their absence) of any concerns about an individual's risk/vulnerability. Appropriate out of hours cover arrangements for the role of the CARO should also be made.
74. When the transfer is between the youth estate and an adult institution, the YJB will be accountable for the transfer of all relevant information from the YOT, including health, mental health and care leaver status.
75. During any transfer, where a prisoner has a SAVRAS (as all young adults will have) as part of their ICP, the receiving establishment must ensure that there must be no interruption of the ICP and/or SAVRAS as a result of the transfer.
76. Where a prisoner who is being transferred to another prison has been on an ACCT, and when the crisis plan of the SAVRAS has been implemented, which was closed within the last three months this must be highlighted and the Care Plan (ICP) reviewed within 24 hours of receiving the prisoner.

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77. A record of any time a prisoner has spent on an ACCT/or the crisis plan of a SAVRAS must be recorded on System 1 (or replacement) so that it is available for prison healthcare staff.
 78. Any health assessment (both physical and mental) produced at the police station by the liaison and diversion practitioner and others at the start of a prisoner's journey through the criminal justice system should be shared amongst specified CJS organisations (e.g. CPS, legal team, NOMS, HMPS) in order to assist them in making reasoned decisions subject to the issues relating to the sharing of data.
 79. Department of Health, Home Office and the Ministry of Justice need to issue joint guidance to the effect that when consent to sharing medical information has been given by a person in custody, then the assumption is that that consent remains valid (unless withdrawn) throughout the criminal justice journey of the person in custody.
 80. An appropriate consent form should be available which reflects the above, and in particular requesting of such consent should be a standard part of any prison reception assessment.
 81. Should such consent not be given, the person in custody should have an informed discussion periodically with healthcare professionals to revisit the decision made.
 82. Guidance from health organisations should be considered to reflect the duties of the State to protect life in custodial settings, with appropriate guidance given as to the disclosure and sharing of health information in such settings (including in those instances where consent is not provided).
 83. All Healthcare staff must be trained to the minimum level of the Immediate Life Support Course of the Resuscitation Council with scenarios adapted to suit the prison environment. All prison staff must also be trained to a minimum of basic life support level.
 84. Each prison and YOI should have an emergency medical response plan that contains the following elements:
 - 84.1. A mandatory Medical Emergency Response exercise each year, including emergency medical codes, in conjunction with local health care providers and emergency services.
 - 84.2. NHS needs to consider developing an appropriate health "NEVER" event in a custodial setting.
 - 84.3. A system for checking that standard emergency medical equipment is available and in good condition in appropriate locations within the prison/YOI.
 85. The Secretary of State for Justice should introduce legislation to create a statutory duty of cooperation for the sharing of information with the Prison Service to be placed upon those organisations that have direct engagement with the Prison Service (including health, mental health services, police, etc.).



7. After a Self-Inflicted Death

“ ...Recently my cell mate has tried to hang himself, and I’ve been finding it... I’ve been... I’ve been in shock...I’m still in shock... ”

Caller to National Prison Radio, in response to Harris Review targeted young adult engagement.

- 7.1. It would have been impossible to conduct this Review without developing the most profound sympathy towards the tragedies of the individual cases and those affected by them. This report has repeatedly referred to the heart-breaking experiences of the families and friends of those who have died, and indeed we feel that their loss and experiences need to be at the forefront of any discussion about what should happen after there has been a death in a prison. It is also important to recognise the impact of a death on other prisoners and staff members and their particular support needs. While our Terms of Reference did not specifically ask us to look at the processes that follow a self-inflicted death, the Review considers that to do so is essential for full understanding of the deaths of the young adults that we have examined and the mechanisms for learning or (as has too often been the case) failing to learn from them.

Liaison with Families following a Death

“ When they first told us about the death it was on a Friday. We were in shock. They told us that our son was found hanging and left us a number for us to ring for more information. We tried ringing this number all weekend but we couldn’t get through to anyone ”

(Extract from evidence given by a family member to the panel.
Report of the Family Listening Events, page 28).

- 7.2. As we listened to the distressing stories of bereaved families who were still openly grieving, we were frequently left dismayed by examples of apparent callousness and insensitivity shown by some prisons and staff.
- 7.3. The Prison Service Instruction (PSI 64/2011 – Safer Custody) details a number of mandatory steps that must take place following the death of a prisoner, and covers what should be done in terms of contacting the prisoner’s family, including the next-of-kin. The prison governor is required to take certain steps, including writing a personal letter of condolence to the family and offering to contribute towards their reasonable funeral expenses. The governor is required to write again to the family after the prison’s response to the draft PPO report has been agreed, and again following the conclusion of the inquest. The governor should also arrange for the chaplain or other faith adviser to offer to hold a memorial service for the family, prisoners and staff, subject to any specific faith considerations and the views of the family.
- 7.4. In their response to the Review, NOMS said that the standards outlined in PSI 64/2011, “...describes the procedures to be followed after a death in custody, including the family liaison process” (page 18).³⁷⁹ The response also assured us that “the IAP document ‘Family Liaison Common Standards and Principles’³⁸⁰ has been circulated to all Family Liaison Officers. These standards are considered to be good practice and are embedded in the Family Liaison training course” (page 19).

³⁷⁹ Submission to the Harris Review received from NOMS on 3 February 2015. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁸⁰ Independent Advisory Panel on Deaths in Custody (2013). Family Liaison Common Standards and Principles. Retrieved on 30 March 2015 from IAP website at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2013/02/Family-Liaison-Common-Standards-and-Principles-IAP.pdf>.

- 7.5. As with a number of Prison Service Instructions, the written policy appears to be reasonably comprehensive and well thought out. However, as we have found throughout our Review, the reality is different. What is supposed to happen does not always happen and what is supposed to happen is interpreted in different and inconsistent ways. Moreover, NOMS centrally does not appear to monitor what is done in practice despite having issued the instruction.
- 7.6. While the policies are intended to ensure families are more supported, the evidence we have considered suggests that families have found liaison with the prison following a death to be unnecessarily distressing.
- 7.7. In their submission to the review, Bindmans solicitors reflected upon the observations from some of their clients who had had experience of the post-death process. They noted:
- “...generally, the families that we have represented have not had particularly positive experiences with regard to contact with a prison following the death of their family member. Some families we have represented have had no contact whatsoever from the prison after the death and some have found the contact to be unsympathetic and insensitive.”*
- 7.8. This was also reflected by what we heard at the Family Hearing Days in October and November 2014. At those events, some families complained that the prison had not contacted them after their relative was found, during the period when the young adult was still alive. One family told the Review: *“[He] was taken to hospital. I could have gone to the hospital to see him. But they didn’t phone me straight away (at 4am) but only at 8am the following morning. He was still alive when he went to hospital. I could have been with him when he had his last moments. They said they called me late because they weren’t sure it was [him] as prisoners move cells. The day after he died I got a letter from him saying ‘come visit me, here’s a VO’. But the prison forgot to put the VO in with the letter”.*
- 7.9. In some of these cases where the young adult did not immediately die, prison staff interacted with the family of the dying relative in a manner that demonstrates institutional insensitivity. This was described movingly by one family member:
- “When we attended the hospital the governor was there and the prison FLO. It was so disgusting, so degrading, they had him chained to the bed as if he was going to spring up and run away. He was cuffed to the bed first time round but then they removed them. The officers however remained. One officer was sitting at the bottom of the bed and another was waiting outside. Governor spoke to us in a very matter of fact way. He didn’t offer his condolences or said he was sorry or anything”*
(Family Listening Event Report).³⁸¹

³⁸¹ INQUEST (2015). *Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds*. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.



- 7.10. Other families described brief and procedural letters which could have been pro-formas.’

“After the inquest we received a one line letter from him [the governor] saying he was sorry for our loss. We received this one month after the inquest where the jury found that ‘neglect’ contributed to [his] death. I was disgusted. It was an insult, a waste of paper!” (Family Listening Day report).

- 7.11. Families are understandably in shock, when they receive the news about their relative, and many reported that they found it difficult to take in the information provided. However, they often found that the prison’s response to this was neither supportive nor transparent. One family member told the panel: *“...when we were told they gave us very little information and the officers also withheld information about how he was found. They had no need to do this as the information didn’t impact on the cause of death but it did make me feel like I couldn’t trust the prison about everything they were telling us about his death”*. Another said *“they even lied about where he was found hanging, first it was the window then it was the bed. I knew that I had to fight them to get the truth”* (page 31).³⁸² A family member explained that they felt that this indicated the prison was worried about how they would be perceived, and that the staff *“become defensive and close ranks which makes things worse because families feel as if they are ignored at a time when they need help and support and simply want the truth.”*

- 7.12. The failure of the prison to involve the family in a transparent manner clearly leads to distrust about the process. This is a concern. Article 2 of the Human Rights Act recognises the importance of effective family participation in the investigation following a death. In their submission to the Review, INQUEST commented that *“bereaved families have a vital role to play in ensuring inquests do not merely sanction the official version of events”* (page 21).³⁸³ Similarly, the submission from Action for Prisoners Families said *“families should be informed immediately following self-inflicted death and should be included in the information gathering process”* (page 2).³⁸⁴

- 7.13. The Review agrees with this and considers that it is important that prisons openly and compassionately engage families from the start.

- 7.14. NOMS should take urgent steps to ensure that the principles enshrined within PSI 64/2011 and the IAP Family Liaison Principles are fully applied across the custodial estate, and furthermore that the perceived culture of defensiveness and recalcitrance, when it comes to engaging with the families, is addressed. A culture that encourages constructive and open engagement between the custodial establishment and the family is absolutely necessary and, where a death occurs, the distress of the family must not be further compounded by the failure to provide accurate information, and signposting to independent sources of advice and support must be given.

³⁸² *ibid*

³⁸³ Submission to the Harris Review received from INQUEST on 13 October 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁸⁴ Submission to the Harris Review received from Action for Prisoners Families on 4 August 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.



Duty of Candour

- 7.15. The Francis Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry³⁸⁵ recommended the introduction of a statutory duty of candour³⁸⁶ upon healthcare professionals in any investigations.

*'Insufficient openness, transparency and candour lead to delays in victims learning the truth, obstruct the learning process, deter disclosure of information about concerns...'*³⁸⁷ This duty is now being introduced throughout the health service.

- 7.16. The Equality and Human Rights Commission has recently proposed that a duty of candour could be extended to investigations and inquiries into non-natural deaths in detention.³⁸⁸

- 7.17. This Review agrees that an analogous duty should be imposed in respect of deaths in prison custody. It should be made clear, through the guidance set out in the PSI, that there is, for example, a duty to co-operate with any inquest, particularly in light of the institutional defensiveness we have just described.

- 7.18. Echoing some of the findings of the Francis Report, a family member in her written evidence submitted to INQUEST's report on the Family Hearing days, said

"I realise a litigation culture puts organisations in a position where apologies are seen as admitting wrong but sometimes they need to recognise both publically and privately that they wished none of it had happened... If people actually followed policy, implemented changes and learnt from practice there might be some hope that these appalling statistics of deaths in custody of young men might be reversed. This might have to include a culture change where the deaths of these young men are seen as unacceptable tragedies amongst POs, Governors, the government and the general public."

- 7.19. The Review is of the view that a statutory duty of candour should be placed on NOMS towards organisations involved in the investigative post-death process. This should encompass NOMS, the Prison Service, any private provider involved, the relevant NHS Trust and any other people or organisations working in the prison or YOI concerned and should ensure full cooperation with the PPO and the coroner. It should also relate to NOMS' communications with members of the deceased young adult's family and their friends.

385 Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Chapter 22 (Openness, transparency and candour), Volume 3. London: TSO. <http://www.midstaffpublicinquiry.com/report>. Accessed 11 March 2015.

386 Candour is defined in this way by the Francis Report (para. 22.1): *'Candour: the volunteering of all relevant information to persons who have, or may have, been harmed by the provision of services, whether or not the information has been requested, and whether or not a complaint or a report about that provision has been made.'*

387 Ibid, Francis Report, note [x], at 1441.

388 Equality and Human Rights Commission (2015). *Preventing Deaths in Detention of Adults with Mental Health Conditions: An Inquiry by the Equality and Human Rights Commission*. London: EHRC. http://www.equalityhumanrights.com/sites/default/files/publication_pdf/Adult%20Deaths%20in%20Detention%20Inquiry%20Report.pdf. Accessed 31 March 2015.

The role of the Prison Family Liaison Officer

- 7.20. The role of the prison Family Liaison Officer (FLO) is to be a point of contact for the family, and starts when the news of the death is broken to the family. The FLO is then required to maintain contact with the family, and provide information and practical support, as appropriate. From the outset, the FLO must open a logbook in order to record contacts with the next of kin.
- 7.21. Some of the families' experiences of the prison FLO were positive. One FLO was described as *"really lovely when we went to identify the body"*.³⁸⁹ These examples show that proper engagement can make the experience more bearable.
- 7.22. In other cases, however, the experience was much more negative. One family described an FLO who was new and inexperienced, saying *"they rang up the voicemail and left their name, but no contact number. In the end I was giving him support. His head was all over the place."* Another noted administrative failings that meant they could not contact their FLO: *"the family liaison officer said 'contact me at any time'. We phoned the family liaison officer after [his] death and [the prison] said they don't know who he is"* (Family Hearing Day).³⁹⁰
- 7.23. In support of this, some PPO recommendations point out the need for better or further training for FLOs. For example, one PPO recommendation states *"I recommend that the Head of Safer Custody speedily arrange for more staff to receive FLO training."* In another case, the PPO recommended, *"the Governor should ensure that all family liaison officers are aware of the current PSO guidance and the information is explained to the next of kin as soon as practicable."* Another gives the recommendation *"The Director should include in the Family Liaison policy a requirement for the FLO to inform the family that the Prison Service press office will release a statement."*

³⁸⁹ INQUEST (2015). *Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds*. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁹⁰ INQUEST (2015). *Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds*. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

- 7.24. Other family members expressed their concern that the member of prison staff acting as the point of contact for the family also appeared to have a dual (and potentially conflicting) role when attending the inquest:

“One matter which we have particularly noted is that the person who is often allocated as the family liaison person from the prison and who has contact with the family in the early days following a death, is also a senior officer or governor who supports staff at the inquest itself or who gives evidence at the inquest. This dual role can undermine any support that has previously been offered to the family and we would suggest that any person allocated as a family liaison officer should not then be a person who gives evidence at the inquest or provides a support role to staff at the inquest”
(Bindmans submission, page 13).³⁹¹

- 7.25. This practice contravenes the guidance set out in PSI 64/2011, which specifies *“In order to maintain role clarity and professional boundaries, it is advisable that the member of staff undertaking the investigations/inquest liaison role does not undertake the FLO role”*.

³⁹¹ Submission to the Harris Review received from Bindmans (Solicitors) on 1 August 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

The Role of Other Organisations in Supporting the Family after a Death

- 7.26. Despite also being called a family liaison officer, which can be confusing for families, the PPO FLO has a very distinct role as part of the investigation team. They are the family's point of contact with the Ombudsman's office and their role is to enable families to be involved in the investigation, to answer their questions and keep them informed of the progress of the investigation.
- 7.27. Linked to the lack of consistency in the quality of the support provided by the prison FLO, is the fact that families are not routinely provided with adequate information about the processes that occur following a death.
- 7.28. The psychiatrists who analysed the 66 clinical reviews that were available to the Review told us that none of the families were contacted as part of the clinical review process, even though the guidance says that they should be. This is also something that we consider needs to change in order to better support families and ensure lessons are more effectively learned.
- 7.29. There are also other organisations that might be involved in supporting families. PSI 64/2011 refers to a number of leaflets and organisations that might offer particular support to the families, but the Review understands that copies of the leaflets are not routinely distributed to custodial establishments. We have heard of some situations when families have not been made aware of these leaflets or of voluntary organisations that could support them. For example, at the Family Hearing Day we were told: "... *It was our son's solicitor who gave us the details of INQUEST. [The] Prison did not give us any information about the investigation and inquest process. They gave us a leaflet about local counselling and I threw it in the bin*" (Family Listening Event Report).³⁹²
- 7.30. The INQUEST report on the Family Hearing Days comments that:
- "INQUEST has observed some poor enforcement of family liaison common standards and principles. Problems have arisen where no family liaison officer has contacted the family, and where timely dissemination of information regarding the family's rights to help and support during the inquest process has been lacking. Families have also reported no or very little access to information about their entitlements to financial compensation for funeral costs and independent advice about a death in custody"* (INQUEST Family Listening Event Report, page 21).³⁹³

³⁹² INQUEST (2015). *Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds*. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁹³ Ibid

- 7.31. There are also other potential ways in which families could be better engaged with voluntary and NGO organisations that might help them during their bereavement. In their submission to the Review, Action for Prisoners Families suggest that “*Criminal justice staff should help families to access community based support- Family engagement workers should play a key role in this*” (page 2).³⁹⁴
- 7.32. Losing a child, at whatever age, through self-inflicted death in custody is a devastating experience, and families need to be supported through this in a dignified and empathetic way. We consider it should be the duty of the FLO to help engage families with the organisations and individuals who can help them. Rather than have the families research the support available themselves, the FLO should be specially trained to support the family effectively and to ensure that appropriate information is provided about relevant organisations and contact with them is facilitated. This is a recommendation that has been made repeatedly before – for example, in the HMIP report *Suicide is Everyone’s Concern*³⁹⁵ and in the IAP report *Family Liaison: Common Standards and Principles*.³⁹⁶
- 7.33. NOMS should review their policy on how they communicate with families after an inquest has taken place, particularly in respect of any improvements that have been made in response to a PPO investigation or an inquest finding. At the Family Listening day, we were told that where information had been passed to families informing them about changes that had been made in response to the self-inflicted death of their relative this had been particularly welcome. One family described how they found comfort in knowing that ligature points have been removed. One family member described the value of knowing that “*two suicides had been prevented in the prison where my son died because of changes made after his death*”. Another took similar comfort, saying “*I waited three years for someone to tell me he didn’t die for nothing*”.

394 Submission to the Harris Review received from Action for Prisoners Families on 4 August 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

395 HM Chief Inspector of Prisons (1999). *Suicide is Everyone’s Concern*. A thematic review by HM Chief Inspector of Prisons for England and Wales, May 1999. London: HMIP. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/thematic-reports-and-research-publications/suicide-is-everyones-concern-1999-rps.pdf>. Accessed 9 March 2015.

396 Independent Advisory Panel on Deaths in Custody (2013). *Family Liaison Common Standards and Principles*. Retrieved on 30 March 2015 from IAP website at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2013/02/Family-Liaison-Common-Standards-and-Principles-IAP.pdf>.

Impact on Prison Staff of a prisoner's Self-Inflicted Death

- 7.34. In chapter 6, we looked at the improvements that need to be made to the prison's response to an emergency, such as finding someone attempting self-harm or self-inflicted death. While it is clear that some staff who found individuals hanging in their cell were not sufficiently trained, it is also clear to the Review that such an event can have a devastating impact on staff.
- 7.35. The independent research that the Review commissioned to look at staff perspectives found that some staff described their involvement with a death in custody as having had a significant impact on their emotions and practices.³⁹⁷ The research report concluded “...deaths in custody can adversely affect future management of SID risk. Staff described a more ‘defensive’ professional and institutional reorientation and an erosion of confidence following a death in custody, stemming particularly from their fear of inquests. This adversely affected the ability of staff to provide high-quality support for vulnerable prisoners.”
- 7.36. It was also apparent during our prison visits that staff were distressed by self-inflicted deaths in prisons. We met with a number of prison staff who voiced their strong wish for the Review to help reduce the numbers of deaths – a sentiment, indeed, that has been reflected by NOMS staff at all levels. One governor, who had recently experienced a death, expressed anguish on hearing of the death and spoke of subsequent distress and sleep disturbance.
- 7.37. The Panel were concerned about the support needs of staff as they were going through these experiences. This was backed up by the findings of the research we commissioned into staff perspectives, which found that while staff recognised that institutional support mechanisms were in place, they questioned whether the Care Teams were adequately trained to support staff after a self-inflicted death. It was found that staff preferred to find support from colleagues rather than the Care Teams. Some staff also reported that they were expected to carry on with their jobs with limited or no practical support (e.g. taking the shift or day off to get over the event, and then returning to work as usual) as if they should not be affected by the death (RAND Europe/University of Cambridge, 2015, page 59).³⁹⁸
- 7.38. The research on staff perspectives also highlighted the risks for future suicide prevention where staff became hardened or disengaged by exposure to death. One staff member from a Safer Custody team said “*there are official areas for staff support but I don’t need it really. I know it sounds cold but I’ve just learned to switch off. When someone dies they just become the trigger for a process and lots of paperwork for me.*”

³⁹⁷ Ludlow, A. et al (2015). *Self-inflicted Deaths in NOMS’ Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*. For more information see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

³⁹⁸ Ludlow, A. et al (2015). *Self-inflicted Deaths in NOMS’ Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*. For more information see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

You've just got to get on with it, get the job done" (2015, page 60).³⁹⁹ The research also reported that other staff (particularly those on the wings) reported that they did not seek support because they felt themselves to be unaffected by a Self-inflicted deaths and therefore did not need help. For example, one staff member said *"he's not a family member, he's just a number"*.

7.39. One of the issues that staff raised during the course of the study conducted by RAND Europe/University of Cambridge was their concern about being unfairly blamed following a death. A fear of being blamed, and of the inquest process itself, was also something we observed during prison visits.

7.40. Staff who took part in the research study suggested that more support was needed in preparing staff for the inquest process and that that more support would help secure more positive learning experiences from deaths in custody. The research study also showed that staff felt that their successes in preventing deaths go unrecognised. One member of the Chaplaincy team said:

*"Literally all the time we are preventing suicide. We actually do it extremely well and I don't think that's anywhere near widely enough recognised. You never hear of the success stories. You only ever hear of the failures. Our staff are very good at preventing suicide."*⁴⁰⁰

7.41. NOMS guidance stresses the importance of procedures to *"facilitate and disseminate learning from incidents of self-harm, violence and deaths in custody to prevent future occurrences and improve local delivery of safer custody"* (PSI64/2011 Safer Custody). The guidance does not, however, provide any detail about what good practice entails or how learning is best achieved.

7.42. As the RAND Europe/University of Cambridge study concluded, there was evidence across all prisons that some *"straightforward lessons from inquests had not been learned"*, while others were of the view that *"SIDs could act as catalysts for reflection and changes to practice that make SID prevention more effective."* A prison officer noted *"Listening to colleague's stories and experiences would help you grow. Retrospective learning from such incidents would be great. We do too little of it now – we're always in defensive mode"* (page 66).⁴⁰¹

7.43. The Review considers that NOMS should consult with relevant stakeholders and develop a model of best practice for learning. Such a model could take a reflective learning approach, enabling staff who have been impacted by a death, or indeed by an incident where the person was saved, to discuss outcomes and what could have been done differently.

399 Ibid

400 Ludlow, A. et al (2015). *Self-inflicted Deaths in NOMS' Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*. For more information see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

401 Ludlow, A. et al (2015). *Self-inflicted Deaths in NOMS' Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*. For more information see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

The Experiences of Other Prisoners

- 7.44. During the course of this Review, the Panel has been struck by the impact that a death in custody can have on other young adults, particularly if the death occurs in a cell close to theirs.
- 7.45. Some young adults have shown remarkable awareness of, and empathy towards, the suffering of those around them. One 19 year old, who responded to the survey the Review conducted with young adults in five custodial institutions, said that *“one of the prisoners on the wing felt suicidal and had self-harmed. I spoke to him about what had happened and why and gave support. I then notified staff about it and he was put on an ACCT.”* It is difficult to imagine many 19 year olds in normal circumstances being in a position where they would need to give that level of support and understanding. Another young man, also only 19 years of age, referred to another young prisoner who was feeling suicidal and said that he *“just didn’t see a future for himself. He didn’t have much on the out[side] and felt he would be nothing but a burden to anyone he knew. He’s not dead but I wouldn’t exactly say he got through, he self-harms and uses drugs frequently.”*
- 7.46. The impact of a death of someone with whom they were living had a profound impact on some young adults from whom we have heard. This was brought home to us powerfully when we spoke to a group of young adults who had previously been in custody.⁴⁰² We heard first-hand accounts of the trauma that some of these vulnerable young people still lived with as a consequence of a self-inflicted death in a nearby cell. For example, one young woman told the Panel: *“there was a lady self-harmer, she cut too deep. Night staff didn’t have keys so prisoners heard the woman screaming and die... the staff couldn’t go into the cell.”* The young woman said she still remembers the sound of the woman screaming.
- 7.47. The same young woman also suggested that the prison’s response to the death seemed institutional and unsympathetic: *“half an hour after her body was moved someone else was moved in.”*
- 7.48. The submission from the Samaritans warned about the importance of taking into account the needs of other prisoners following a death. They said:
- “This is particularly important, as we know that the risk of suicide increases in the aftermath of an incident”* (Samaritans submission, page 11).⁴⁰³
- 7.49. The Review suggests that further work needs to be done to ensure that the welfare of other vulnerable young adults is taken into account following a death. Prisons should consider arranging for relevant staff, including CAROs, Chaplaincy and local Samaritans to meet and organise debriefing and support sessions with young adults who have been impacted by the death.

⁴⁰² Stakeholder Hearing 14 (4 September 2014) *User Voice*. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/User-Voice.pdf>.

⁴⁰³ Submission to the Harris Review received from Samaritans on 17 July 2014. Submissions can be accessed at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Conclusions and Recommendations on After a Death

- 7.50. It is understandable that a self-inflicted death in custody will have a profound impact on the family of the young person who died. We have found the response of some prisons to such an event to be particularly disturbing. It is evident that more needs to be done to ensure the family is sympathetically and compassionately engaged right from the start.
- 7.51. Others are also impacted by the death, and prisons need to do more to address the distress that is experienced by staff and other prisoners following such an event.

7.52. Our recommendations on the actions that need to be taken following a death are:

Primary Recommendations

- 86 Following a death there should be a 'Duty of Candour' upon NOMS and its staff both towards those organisations responsible for managing the post death processes (such as the PPO and the coroner) and the families and friends of the deceased young adult
- 87 NOMS must establish requisite monitoring and reporting systems to ensure that all custodial establishments comply with PSI 64/2011, with regard to engagement with families after a death, and to ensure the timely provision of appropriate levels of information and support and the appointment of the FLO. The FLO must not have been the young adult's CARO. A meeting should be convened possibly chaired by Chaplaincy, in conjunction with the local Samaritans, to come together and provide support prisoners and staff following a self-inflicted death.
- 88 Families of the deceased should have a right to non-means tested public funding for legal representation at an inquest. The costs of legal representation for the families should be borne by NOMS.

Secondary Recommendations

- 89 A meeting should be convened possibly chaired by Chaplaincy in conjunction with the local Samaritans, to come together and provide support to prisoners and staff following a self-inflicted death.



8. The Role of Inspection, Monitoring and Investigation Bodies

- 8.1. The role of investigating self-inflicted deaths and learning from them are carried out by official bodies that have been set up to do just this. This chapter explores their role in some further detail and identifies further actions that need to be taken in order to reduce deaths in custody in 18-24 year olds.

HM Inspectorate of Prisons

- 8.2. HM Inspectorate of Prisons states on their website that “*Her Majesty’s Inspectorate of Prisons for England and Wales (HM Inspectorate of Prisons) is an independent inspectorate which reports on conditions for and treatment of those in prison, young offender institutions, secure training centres, immigration detention facilities, police and court custody suites, customs custody facilities and military detention.*”⁴⁰⁴
- 8.3. Since December 2003, the UK has been a signatory to the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Article 2 of OPCAT requires state parties to “*set up, designate or maintain at the domestic level one or several visiting bodies for the prevention of torture and other cruel, inhuman or degrading treatment or punishment.*”⁴⁰⁵ These visiting bodies are known collectively as the National Preventative Mechanism (NPM). The United Kingdom has 20 separate visiting or inspecting bodies that make up the NPM. They contribute to ensuring compliance with OPCAT (including 10 in England and Wales).⁴⁰⁶ It is the role of HM Inspectorate of Prisons (HMIP) to coordinate the work of the NPM in the UK (see HMIP, 2014, page 4).⁴⁰⁷

404 HM Inspectorate of Prisons (online, updated February 2014). About HMI Prisons. Retrieved 30 March 2015 from: <https://www.justiceinspectorates.gov.uk/hmiprison/about-hmi-prisons/#.VXF1QlocRBQ>.

405 Office of the High Commissioner for Human Rights (2006, 22 June). *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*. Adopted on 18 December 2002 at the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199 entered into force on 22 June 2006. Retrieved 30 March 2015 from <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx>.

406 In England and Wales, these bodies are: HM Inspectorate of Prisons, Independent Monitoring Boards, Independent Custody Visiting Association, HM Inspectorate of Constabulary, Care Quality Commission, Healthcare Inspectorate Wales, Children’s Commissioner for England, Care and Social Services Inspectorate Wales, Office for Standards in Education and Lay Observers.

407 HM Inspectorate of Prisons (2014). Inspection framework. London: HMIP. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/04/1.-INSPECTION-FRAMEWORK-April-2014-02.pdf>. Accessed 31 March 2015.

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- 8.4. HMIP predominantly operates an unannounced inspection programme. Their reports are usually published within 18 weeks of an inspection. Agreed protocols⁴⁰⁸ require establishments which have been inspected to produce an initial action plan within two months of the publication of the HMIP report. The action plan should set out how the establishment proposes to respond, and should indicate whether or not it accepts or rejects the findings.
- 8.5. HMIP states that completed action plans form part of their intelligence database, which they utilise to support future inspections. It is expected that subsequent reports, arising from inspections, will refer back to previous action plans. Of those custodial establishments that the Review either visited, or otherwise engaged with, all of the HMIP reports referenced progress against earlier recommendations; however, details of the action plans were not enclosed and were therefore not publicly known.
- 8.6. The Review emphasises that it is also important for the HMIP to review progress achieved on implementing previous PPO recommendations (using any reviews the PPO may have conducted) and any previous Coroners' jury findings and PFD reports. The Review has heard from a number of witnesses who questioned the adequacy of responses to HMIP reports and the overall accountability for demonstrating sufficient progress towards improvement. Various contributors to the Review felt that prisons and, by extension, NOMS, must be held accountable for demonstrating improvements (examples are discussed in the following sections).
- 8.7. Reference was made to the system operated by Ofsted for inspecting schools, and in particular the placement of a school into 'special measures'; similar arrangements also apply to NHS Trusts (usually triggered by a CQC inquiry).
- 8.8. In the same way that the CQC routinely consults patients on their experience, the Review believes that HMIP should ensure that it takes account of the views of prisoners' families, as well as prisoners, on the prison regime.

⁴⁰⁸ HMIP (2014) Inspection framework (Online) <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/04/1.-INSPECTION-FRAMEWORK-April-2014-02.pdf>. Accessed 31 March 2015.

Independent Monitoring Board

- 8.9. Under the Prisons Act 1952, every prison is required to be monitored by an independent board, whose members are appointed from the local community where the establishment is situated. The Independent Monitoring Board (IMB) is specifically required to undertake the following functions:⁴⁰⁹
- Satisfy itself as to the humane and just treatment of those held in custody within its prison and the range and adequacy of the programmes preparing them for release;
 - Inform the Secretary of State promptly of any concern it has, and
 - Report annually to the Secretary of State on how well the prison has met the standards and requirements placed on it and what impact these have on those in its custody.
- 8.10. The local IMB is provided with a right of access to every prisoner and every part of the prison, together with access to the prison's records, in order to undertake its statutory duties. Each Independent Monitoring Board produces an annual report, and the National Council of the IMB produces its own annual report. The IMBs occasionally produce focussed reports looking at common areas of concern across the custodial estate, which the MOJ formally responds to. At present, however, neither the focussed report nor Ministry response is published.
- 8.11. The Review recognises the role that IMBs play in holding custodial establishments to account, and their role as part of the UK NPM. Nevertheless, the Review has concerns about their independence and composition.
- 8.12. The Justice Committee has documented the concerns that have been raised with them about the lack of confidence prisoners had in the IMB in the context of prisoner complaints. They took evidence from a number of IMB members, who reported that several Chairs of IMBs themselves believed that the MoJ did not have sufficient regard for concerns about prison conditions which IMBs had conveyed. Dr Penzer, Chair of the IMB at Thameside told the committee, *"I know of little evidence that IMB reports have a significant impact on NOMS or MoJ, or that changes are made in response to IMB judgements. Generally the responses to IMB reports go along the lines 'ABC is an important point and the reason things are as they are is XYZ'. Rarely is the response 'ABC is an important point that we did not know about and we are going to do PQR to put it right.'"*⁴¹⁰

409 See, for example: National Council of the Independent Monitoring Boards June (2012). *Issues of Concern - Major Issues Raised in Annual Reports to the Secretary of State by Independent Monitoring Boards in Prisons in England & Wales*. An Occasional Report by the National Council of the Independent Monitoring Boards. Retrieved from <http://www.imb.org.uk/wp-content/uploads/2015/03/imb-issues-concern.pdf>.

410 House of Commons Justice Committee (2015). *Prisons: planning and policies – Ninth Report of Session 2014-15*. London: TSO. <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmjust/309/309.pdf>. Accessed 30 March 2015.

- 8.13. The Review believes that to strengthen their independent position, overall responsibility for the IMB should be transferred from the Ministry of Justice to HMIP. This would also enhance the ability of the IMBs to inform the work of the Inspectorate.
- 8.14. We are also concerned about the overall make-up of IMBs and in particular the lack of diversity of their members (as regards both ethnicity and social background). The Review considers that the local IMB should be reflective of its community (which includes the prisoners themselves). The Review has heard that some prisoners feel they are not able to relate to local IMB members because they do not appear to fully understand the challenges faced by prisoners (for example, because of their ethnicity, age or social background).
- 8.15. For example, when they gave evidence to the Review, representatives of the Zahid Mubarek Trust said that BAME young adult prisoners have low confidence in the IMB. They suggested that, for that reason, in most prisons there are very few complaints to the IMB about religious or race issues, and argued that IMB membership is not representative of the prison population.⁴¹¹
- 8.16. This point was made very frankly to us when we met young adult ex-offenders from *User Voice* in September 2014. They complained that they could not relate to the IMB members who they met when they were in prison. One told us “*the IMB are all too old, we don’t relate to them. Outside services who are more in tune with young people should be available.*”⁴¹²
- 8.17. It was the strong perception of the Review that for some prisoners, particularly young adults, IMB members appeared to be too close to the prison management – creating for prisoners a perception of ‘them and us’, for example some prisoners pointed out that IMB members have keys like management.
- 8.18. The Review therefore believes that recruitment arrangements for IMB membership should be reviewed to take account of best practices elsewhere in recruiting a diverse and representative membership.

411 Stakeholder Hearing 19 (6 November 2014) The Zahid Mubarek Trust. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-ZMT.pdf>.

412 Stakeholder Hearing 14 (4 September 2014) *User Voice*. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/User-Voice.pdf>.

Prisons and Probation Ombudsman

- 8.19. The Prisons and Probation Ombudsman (PPO) investigates all deaths that occur in prison and young offender institutions, including self-inflicted deaths. The purpose of these investigations is to understand what happened, inform bereaved families, identify learning, and to assist the coroner. After each investigation the PPO publishes a report, which is passed to the Coroner and the deceased's family for consideration; this stage of the process takes place in advance of the inquest taking place.
- 8.20. The PPO shares a draft of the report with the bereaved family and the relevant service, to enable them to comment on its factual accuracy. Hickman & Rose commended the good practice of the PPO in engaging families at this stage. They explained "*this goes some way to ensuring families feel part of the process and catching any gaps or areas of further investigation at an early stage*" (page 17).⁴¹³ As explained in chapter 7, this engagement is important both for families and for the process.
- 8.21. Before the report is finalised, the prison/ YOI produce an 'action plan' setting out how they intend to respond to the specific recommendations made by the PPO, and this is appended into the final report. Copies of the final report are sent to the bereaved family, to the relevant prison, and to the coroner who will conduct the inquest. It is also anonymised and published on the PPO website after the coroner's inquest has been concluded.⁴¹⁴
- 8.22. The PPO shares information about its investigations, and its recommendations, with HMIP who have confirmed to the Review that in several establishments where there have been deaths of young adults, subsequent HMIP inspections have identified that learning from earlier PPO investigations had not been given enough attention.
- 8.23. The follow-up to PPO recommendations is of course a critical issue. Bindmans told the Review that they were unclear to what extent such recommendations are analysed and shared within NOMS to ensure that lessons are learnt across the whole prison estate. They said that "*our experience shows us that the same failings are occurring across institutions*" (page 12).⁴¹⁵ The PPO acknowledges that it "*does not have the resources to return to establishments to monitor progress on recommendations*" nor indeed would this be an appropriate role for the PPO (page 7).⁴¹⁶

413 Submission to the Harris Review received from Hickman Rose (Solicitors) on 21 July 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

414 They are published on the 'fatal incidents reports' section of the website: <http://www.ppo.gov.uk/publications/fatal-incidents-reports/> Until September 2014, Prisons and Probation Ombudsman reports were completely anonymised (with all names removed, including that of the deceased). For deaths after 1st February, 2015 the name of the deceased will remain in the reports, but other names will be anonymised.

415 Submission to the Harris Review received from Bindmans (Solicitors) on 1 August 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>,

416 Prisons and Probation Ombudsman (2015b). *Learning from PPO Investigations: Self-inflicted deaths of prisoners – 2013/14*. London: PPO. <http://www.ppo.gov.uk/wp-content/uploads/2015/03/self-inflicted-deaths-2013-14-Final-for-publication-5.pdf>. Accessed 11 March 2015.

- 8.24. The submission from Hickman Rose pointed out (p17) the need for the PPO to have the ability to make recommendations about internal disciplinary proceedings that should be brought, in the same way that the Independent Police Complaints Commission does in the context of police custody death investigations.
- 8.25. Bindmans acknowledged in their submission that there have been improvements in the quality of PPO investigations, but argued that there could still be further improvements, including PPO investigators attending a prison in a timelier manner after a death. They told the Review that “*often particular documents are not retained and staff accounts are not immediately taken...often CCTV is destroyed*” (page 11).⁴¹⁷ Prompter attendance by the PPO, they suggest, would mean a greater likelihood of interviewing key individuals, and improve the quality of information obtained from prison staff.
- 8.26. When we met the Prison Governors’ Association (PGA), they told the Review that the processes following a death take too long. They said that it is a drawn out process and so the family suffers unnecessarily.⁴¹⁸ The Prison Reform Trust was also critical of delays, pointing out in their submission that “*the more delayed the investigation the more reduced the chances of impact of any resulting recommendations for change*” (page 18). They argued that it is not unreasonable to expect PPO investigations to be completed within 6 months of a death.⁴¹⁹
- 8.27. There were some criticisms from staff at prisons we visited about the nature of PPO recommendations, which they found difficult to implement. The research conducted for us by RAND Europe/University of Cambridge also found that staff viewed PPO recommendations to be unrealistic or inappropriate. One manager told the researchers that there were times where “*the PPO overplay the significance of their recommendations. They have to be seen to be doing something*” (page 56).⁴²⁰
- 8.28. The Review believes that the PPO needs to be properly resourced in order to ensure that timely and effective investigations are carried out. The PPO must aim to deliver a service level agreement whereby an investigator arrives at the scene of a death in a timely fashion, perhaps learning from the approach taken by the IPCC.⁴²¹

417 Submission to the Harris Review received from Bindmans (Solicitors) on 1 August 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

418 Stakeholder Hearing 16 (6 November 2014), Prison Governors’ Association. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-Prison-Governors-Association.pdf>.

419 Submission to the Harris Review received from Prison Reform Trust on 18 July 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

420 Ludlow, A, et al (2015). *Self-inflicted Deaths in NOMS’ Custody amongst 18-24 Year Olds. Staff Experience, Knowledge and Views*. For further information see: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

421 Independent Police Complaints Commission (2013) Statutory Guidance to the police service on the handling of complaints https://www.ipcc.gov.uk/sites/default/files/Documents/statutoryguidance/2013_statutory_guidance_english.PDF. Accessed 30 March 2015.

- 8.29. The Review considers that giving the PPO independence from the MoJ and making it accountable through Parliament would enhance public confidence in the inspection and complaints procedure.
- 8.30. Furthermore, the Review considers that the PPO would be more effective if it had statutory status. This would give it powers to require the production of relevant documents and to require individual staff members from relevant organisations to appear before its investigations to answer questions. The placing of the PPO on a statutory footing was recommended by the Joint Committee on Human Rights in 2004; this proposal was accepted by the then Parliamentary Under Secretary for Correctional Services.⁴²² Indeed, the JCHR said that “*until such a statutory basis is provided, investigations by the Ombudsman are unlikely to meet the obligation to investigate under Article 2 ECHR*”.⁴²³ The need for a statutory basis for the PPO was reiterated again by the Independent Advisory Panel on Deaths in Custody in 2011, and was accepted by the Ministerial Board on Deaths in Custody. However, it has still not been implemented. In giving evidence to the Review, the Ombudsman Nigel Newcomen agreed that the role of the PPO should have a statutory basis.⁴²⁴
- 8.31. The Review is also of the view that the clinical review process, which is carried out as part of the PPO investigation, should be enhanced. When representatives from NHS England gave evidence to the Review, they acknowledged inconsistencies in the quality of clinical reviews.⁴²⁵ This was backed up by the analysis we commissioned a group of psychiatrists to conduct on the clinical reviews available on our cohort. When the psychiatrists examined the reviews, they found that there was inadequate information on the clinical skills and experience of the reviewers. Only 17 out of the 65 clinical reviews for which information was available were led by someone with clear experience of prisons and mental health. While 52 of the reports made recommendations, none of these had agreed actions and timescales for their implementation. Furthermore, none of the 65 clinical reviews documented any record of family involvement.⁴²⁶ These findings indicate that there are clearly gaps in the quality of the current process, and a quality assurance process should be introduced.

422 House of Lords/House of Commons Joint Committee on Human Rights (2004). *Deaths in Custody - Third Report of Session 2004-05*. London: TSO. <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/15.pdf>. Accessed 30 March 2015.

423 Ibid. Para. 332.

424 Stakeholder Hearing 3 (22 May 2014) Nigel Newcomen, the Prisons and Probation Ombudsman <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/07/Prisons-and-Probation-Ombudsman.pdf>.

425 Stakeholder Hearing 1 (15 May 2014) NHS England. Summaries of hearings can be accessed <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/07/NHS-England.pdf>.

426 Harris Review (2015). Examination of PPO Clinical Reviews. Consideration conducted on behalf of the Harris Review by Ambreen Aslam, Sunil Routhu, Matthew Tovey and supervised by Dr Dinesh Maganty. <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Coroner's Inquests

- 8.32. Following every self-inflicted death in prison custody an inquest will be held by a coroner.⁴²⁷ The purpose of the investigation is to determine how, when and where, and in what circumstances, the deceased came by his or her death.⁴²⁸
- 8.33. The coroner's inquest, together with the PPO investigation, are the principal means in England and Wales by which the State seeks to meet its obligations to carry out an effective and timely investigation of deaths in prison (as required by Article 2 of the European Convention on Human Rights).⁴²⁹
- 8.34. The Safer Custody prison service instruction (PSI 64/2011) further stipulates that *"An inquest is inquisitorial and not adversarial and cannot apportion blame to named individuals. The verdict does not in itself determine any issue of civil or criminal liability."* The Coroners and Justice Act 2009 established, for the first time, a post of Chief Coroner, who reports annually to the Lord Chancellor on matters such as the number and length of inquests, and on consistency of standards between coroners' areas.
- 8.35. One of the issues that has been highlighted during our discussions with the families of young adults who have died in prison, prison staff and the Chief Coroner, is the often very considerable delays between the death and the date of the inquest.
- 8.36. The Ministry of Justice's guidance on the role of the Coroner's service⁴³⁰ states that *"The main inquest hearing should normally take place within six months or as soon as practicable after the death has been reported to the coroner. Sometimes you may need to wait longer than six months for the inquest due to the complexity of the case or other factors."* However, in the majority of cases within our cohort, the inquest has been heard more than 12 months after the death, and, in many cases longer delays have occurred. Where there is a delay of 12 months or more, this must now be reported to the Chief Coroner and an explanation provided (paras. 22 & 65-66).⁴³¹

427 NOMS (2011b). *Prison Service Instruction 64/2011 (Safer Custody)*. London: NOMS. <http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc>. Accessed 18 March 2015.

428 *Coroners and Justice Act (2009)*. Chapter 25 sections 1 & 5. Retrieved from: <http://www.legislation.gov.uk/ukpga/2009/25>. Accessed 31 March 2015.

429 Council of Europe (1950). *European Convention of Human Rights*. Strasbourg: Council of Europe. See also <http://www.coe.int/en/web/human-rights-convention>. Accessed 11 March 2015.

430 Ministry of Justice (2014c). *Guide to Coroner Services*. London: Ministry of Justice. Retrieved on 31 March 2015 from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/363879/guide-to-coroner-service.pdf.

431 Chief Coroner (2014). *Report of the Chief Coroner to the Lord Chancellor- First Annual Report: 2013-2014*. London: Chief Coroner's Office. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/330652/chief-coroner-annual-report-july-2014.pdf. Accessed 31 March 2015.

- 8.37. Such delays often have a serious impact on the families, who face a lengthy period of time when very important questions remain unanswered. This impacts both on the grieving process but also frustrates organisational learning. We heard some specific examples of this during the Family Hearing Days, where families told us that they were *“putting their lives on hold”* waiting for things to happen. The grieving process was delayed because closure could not be reached. One family member explained *“they keep giving you dates, and then you build yourself up and concentrate on that one, and then it’s changed. You want answers but you don’t want shortcuts either, it take a very long time”* (page 32).⁴³²
- 8.38. Such delays also place considerable emotional strain upon prison staff who are called to give evidence at the inquest as witnesses. We spoke to a number of staff at prisons who had felt a lot of personal distress, both following a death, and during the course of waiting for the inquest.⁴³³
- 8.39. The Review welcomes the initiatives being taken forward by the Chief Coroner. In his evidence to the Review, the Chief Coroner, His Honour Judge Peter Thornton QC, noted that the delays in producing PPO reports, in turn, cause delays in the holding of inquests.
- 8.40. The Review concludes that the Chief Coroner should work closely with the PPO to reduce the time taken between death and the inquest hearing. Where there are delays, families should be kept regularly updated as to progress and told when an inquest will be heard

⁴³² INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

⁴³³ Stakeholder Hearing 8 (3 July 2014), His Honour Judge Peter Thornton QC, Chief Coroner. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-Chief-Coroner.pdf>.

Legal aid for Inquests

- 8.41. Previous reports in this field (e.g. the Luce Report, 2003;⁴³⁴ the JCHR's 'Deaths in Custody' report, 2004;⁴³⁵ the Corston Report, 2007;⁴³⁶ and the INQUEST/T2A 'Stolen Lives' report, 2015)⁴³⁷ have emphasised the importance of effective family participation in an inquest, and have recommended that legal assistance should be provided to the next-of-kin (without being means-tested).⁴³⁸ Such recommendations are underpinned by Article 2 of the European Convention on Human Rights which requires, amongst other things, that "*the next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests*".⁴³⁹
- 8.42. Those reports highlighted the inequality of the families' situation. For example, the Corston Report noted that "*The state has unlimited access to legal funding and will always have legal representation and Counsel at inquests that engage Article 2 of the European Convention on Human Rights, the right to life*".⁴⁴⁰ Bindmans referred in their submission to the Review to the inequality inherent in the inquest process when they said "*Those bereaved families have been thrown into a legal process, which is not of their own choosing. The inquest is usually the only forum in which they are allowed to put questions to witnesses and truly understand how their loved one came by his or her death*" (p13).⁴⁴¹ In his oral evidence to the Review, the Chief Coroner, His Honour Judge Peter Thornton QC, recognised the imbalance where the representation of multiple

434 Luce, T. (2003, chair). *Death Certification in England, Wales and Northern Ireland - Report of a Fundamental Review*, Cm 5831. London: TSO. <http://webarchive.nationalarchives.gov.uk/20131205100653/http://www.archive2.official-documents.co.uk/document/cm58/5831/5831>. Accessed 31 March 2015.

435 House of Lords/House of Commons Joint Committee on Human Rights (2004). *Deaths in Custody - Third Report of Session 2004-05*. London: TSO. <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/15.pdf>. Accessed 30 March 2015.

436 Corston, J (2007). *The Corston Report: A Report by Baroness Jean Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice System*. London: Home Office. <http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>. Accessed 31 March 2015.

437 INQUEST & T2A (2015). *Stolen Lives and Missed Opportunities: The deaths of young adults and children in prison*. London: Barrow Cadbury Trust. http://www.barrowcadbury.org.uk/wp-content/uploads/2015/02/Inquest-Report_finalversion_Online.pdf. Accessed 20 March 2015.

438 Corston, J (2007). *The Corston Report: A Report by Baroness Jean Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice System*. London: Home Office. <http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>. Accessed 31 March 2015.

439 See, for example, *Letts v Lord Chancellor* (2015). EWHC 402 (Admin), at 68, 15 February 2015. <http://www.bailii.org/ew/cases/EWHC/Admin/2015/402.html>. See also *Hugh Jordan v UK*, No. 24746/94, 4 May 2001, para. 142. <http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-59450>.

440 Corston, J (2007). *The Corston Report: A Report by Baroness Jean Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice System*. London: Home Office. <http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>. Accessed 31 March 2015.

441 Submission to the Harris Review received from Bindmans (Solicitors) on 1 August 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.



agencies at an inquest is funded by the state, and acknowledged that the exceptional provision of legal aid to families under the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (see below) may not be sufficient.⁴⁴²

- 8.43. *The Stolen Lives* report made the important point that “skilled advocacy for the family aids the inquisitorial process and can contribute to the writing of Coroners reports to prevent future deaths”.⁴⁴³ In the *Amin* case in 2003, the House of Lords emphasised that the investigation into a death in custody has various purposes:

“...to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.”⁴⁴⁴

- 8.44. These points were recently reiterated by the High Court in the Joanna Letts judgment (20 February 2015), which noted that “an inquest is by no means limited to the attribution of blame to the State. It has other, very important, purposes such as to learn lessons and thereby protect those who are in custody or detained in vulnerable circumstances”.⁴⁴⁵
- 8.45. During the course of this Review, some of the families we heard from believed that without legal representation, there was a risk that important information could have been overlooked or lost, leading to problems in establishing the truth. For example, one family told the Review that “initially the prison tried to delete the CCTV of [his] death and this only became apparent when our lawyers requested a copy and realised that this was attempted. One week before the start of the inquest the prison eventually disclosed the full CCTV” (quote given during Family Hearing Day).⁴⁴⁶

442 Stakeholder Hearing 8 (3 July 2014), His Honour Judge Peter Thornton QC, Chief Coroner. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-Chief-Coroner.pdf>.

443 INQUEST & T2A (2015). *Stolen Lives and Missed Opportunities: The deaths of young adults and children in prison*. London: Barrow Cadbury Trust. http://www.barrowcadbury.org.uk/wp-content/uploads/2015/02/Inquest-Report_finalversion_Online.pdf. Accessed 20 March 2015.

444 *R (Amin) v Home Secretary [2003] UKHL 51; [2004] 1 AC 653*. <http://www.bailii.org/uk/cases/UKHL/2003/51.html> Accessed 31 March 2015.

445 *Letts v Lord Chancellor* (2015). EWHC 402 (Admin), at 68, 15 February 2015. <http://www.bailii.org/ew/cases/EWHC/Admin/2015/402.html>.

446 INQUEST (2015). Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds. Full report is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.



- 8.46. As a result of the introduction of the Legal Aid, Sentencing and Punishment of Offenders Act 2012, changes were made to the provision of legal aid, including its availability, in exceptional cases, for families attending a relative's inquest. The problem we described already, where there is inequality between the assistance provided to the families compared to the public bodies, is compounded by the contracting out of many services. It is not uncommon at a prison death inquest for there to be several legal teams representing an array of public services. In their submission to the Review, INQUEST noted "*Lawyers instructed on behalf of a prison, the Prison Service and other public bodies whose conduct may be subject to scrutiny during the inquest are paid for from public funds*" (page 22).⁴⁴⁷
- 8.47. In order to ensure that the inquest process is as effective as possible in finding the full facts, and also to ensure equality of arms at inquests, we recommend that families should have a right to non-means-tested public funding for legal representation at an inquest. The costs of this should be covered by NOMS.

Improving Learning and Taking Action

- 8.48. The Coroners and Justice Act 2009 introduced a range of new processes to the Coronial system, including the issuing of reports where the coroner believes that action should be taken to prevent future deaths ('Prevention of Future Deaths reports' or 'PFD reports' - formerly known as 'Rule 43 reports'). Such reports *must* be issued by the coroner where "*anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future*".
- 8.49. The PFD reports can be directed at any organisation (or post) considered to be in a position to take action. The recipient of the report is obliged to provide the coroner with a written response (usually within eight weeks) which sets out what action has been taken (or will be taken) as a result, together with a timetable. All reports and responses relating to deaths in custodial establishments are additionally sent to HM Inspectorate of Prisons, together with NOMS and the Independent Advisory Panel on Deaths in Custody. The Chief Coroner may publish the PFD reports and the responses to them.
- 8.50. The Chief Coroner's Guidance underlines the significance of PFD reports (para 2):
- "These reports are important. Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. A bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it shouldn't happen to somebody else.'" ⁴⁴⁸*

⁴⁴⁷ Submission to the Harris Review received from INQUEST on 13 October 2014. Submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

⁴⁴⁸ Chief Coroner (2013). *Guidance No. 5, Reports to Prevent Future Deaths*. Courts and Tribunals Judiciary (online). Office of the Chief Coroner. Retrieved from: <https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/coroners/guidance/guidance-no5-reports-to-prevent-future-deaths.pdf>. Accessed 11 March 2015.

- 8.51. However, as the Chief Coroner confirmed to the Review when he gave oral evidence, there is no specific mechanism to ensure that the recommendations in the PFD report are implemented. He agreed that there does need to be a mechanism to make sure they are followed up.⁴⁴⁹
- 8.52. PSI 64/2011 provides some information on how NOMS as an organisation should respond to reports from either the PPO or the Coroner *“The National Safer Custody Managers and Learning Team hold responsibility for analysing and co-ordinating responses to Prisons and Probation Ombudsman (PPO) investigation reports. Themes from the reports are extracted, good practice disseminated across the estate and ‘lessons learned’ reflected in policy and practice.”*
- 8.53. The Review considers that the restricted remit of the inquest can sometimes mean that important issues concerning the journey into custody may not be explored, including adequate consideration of non-custodial sentencing options. In 2004, the Joint Committee on Human Rights noted problems in ensuring that judges and magistrates had reliable information about alternatives to custodial sentences and the vulnerability of offenders committed to prison. Accordingly, the JCHR recommended that inquests should address such issues.⁴⁵⁰
- 8.54. Having giving careful consideration to the various processes of inspection and scrutiny relating to deaths in prison, the Review has concluded that there is still insufficient rigour, accountability or transparency in the follow-up processes.
- 8.55. The evidence for this is long-standing. For example, reporting back in 2007 on self-inflicted deaths of women in prison, Jean Corston said:

“Most depressing was the familiarity of these events, which followed the same patterns time and again with little indication that lessons were being learned to prevent further deaths.”

449 Stakeholder Hearing 8 (3 July 2014), His Honour Judge Peter Thornton QC, Chief Coroner. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/03/Stakeholder-Hearing-Chief-Coroner.pdf>.

450 House of Lords/House of Commons Joint Committee on Human Rights (2004). *Deaths in Custody - Third Report of Session 2004-05*. London: TSO. <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrightts/15/15.pdf>. Accessed 30 March 2015.

8.56. More recently, the EHRC's inquiry report on *Preventing Deaths in Detention of Adults with Mental Health Conditions* noted that, despite some good practice in improving the implementation of PPO recommendations, "problems with the sustained implementation of its recommendations in some prisons remain". The EHRC also concluded that:

"Although PPO may be aware that its recommendations have not been fully implemented in a particular prison, it is limited in the actions it can take to address this" (page 61).⁴⁵¹

8.57. The PPO's recent report on self-inflicted deaths in prison in 2013/14 acknowledged that it is "troubling that many investigations repeated criticisms that we have made before."⁴⁵² This was reinforced by INQUEST who said "The most troubling aspect of INQUEST's work is the failure of state bodies and agencies to act on the compelling evidence from numerous PPO investigations, inquest findings, coroners' reports resulting in the relentless number of preventable deaths. The inquests and investigations into the deaths should be a forum through which lessons can be learned. However lessons are far too frequently lost, they are analysed poorly or ignored; misunderstood or misconstrued, dissipated or dismissed" (INQUEST submission, page 22).⁴⁵³

8.58. In giving evidence to this Review, Steve Gillan, the General Secretary of the Prison Officers' Association, said that it is frustrating for staff and families when the PPO and HMIP make recommendations that are then ignored.⁴⁵⁴

8.59. The Care Quality Commission (CQC) acknowledged that there was no one within CQC with direct responsibility for learning from self-inflicted deaths in custody. They identified an 'accountability gap', with no one being responsible for auditing whether recommendations following a death in custody are followed up.⁴⁵⁵

8.60. The Review welcomes the fact that the Chief Coroner has the power to publish PFD reports, and the responses to PFD reports and we believe that a similarly open and transparent approach must be adopted by NOMS in response to all reports produced, following an investigation into a death in custody. NOMS must engage with the Chief Coroner, the HMIP and the PPO to discuss and agree their approach.

⁴⁵¹ Equality and Human Rights Commission (2015). *Preventing Deaths in Detention of Adults with Mental Health Conditions: An Inquiry by the Equality and Human Rights Commission*. London: EHRC. http://www.equalityhumanrights.com/sites/default/files/publication_pdf/Adult%20Deaths%20in%20Detention%20Inquiry%20Report.pdf. Accessed 31 March 2015.

⁴⁵² Prisons and Probation Ombudsman (2015b). *Learning from PPO Investigations: Self-inflicted deaths of prisoners – 2013/14*. London: PPO. <http://www.ppo.gov.uk/wp-content/uploads/2015/03/self-inflicted-deaths-2013-14-Final-for-publication-5.pdf>. Accessed 11 March 2015.

⁴⁵³ Submission to the Harris Review received from INQUEST on 13 October 2014, submissions can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

⁴⁵⁴ Stakeholder Hearing 17 (6 November 2014), Prison Officers Association. Summaries of hearings can be accessed at <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.

⁴⁵⁵ Stakeholder hearing 13 (17 July 2014) The Care Quality Commission (CQC). Summaries of hearings can be accessed at, <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/12/Care-Quality-Commission.pdf>.

- 8.61. In its recently published report on *Preventing Deaths in Detention of Adults with Mental Health Conditions*, the Equality and Human Rights Commission (EHRC) highlighted similar issues over the learning of lessons arising from inspectorate reports. The EHRC recommended that “*structured approaches for learning lessons in all three settings*⁴⁵⁶ *should be established for implementing improvements from previous deaths and near misses, as well as experiences in other institutions. As part of this, there should be a statutory obligation on institutions to respond to recommendations from inspectorate bodies and to publish these responses.*”⁴⁵⁷
- 8.62. Concerns about the lack of accountability and effective learning following deaths in custody are long-standing. In his foreword to the ‘*Fatally Flawed*’ report, Lord Ramsbotham said that “*Until and unless named individuals are made responsible and accountable for ensuring that things happen, nothing will happen.*”⁴⁵⁸ HMI Prisons found that lessons from deaths in custody had not always been effectively acted on or recommendations implemented. They said “*the usual prison forum for discussing deaths in custody is the safer custody committee but we often find no, or inconsistent, discussion at these meetings. Completion of actions too often relies on a notice or instruction to staff with no means of ensuring that all staff read it or understand their role in the implementation of recommendations. We are not always confident that recommendations are consistently reinforced where necessary*” (HMIP Thematic review of the Zahid Mubarek Inquiry).⁴⁵⁹
- 8.63. HMIP also underlined this point to the Review, considering it “*essential that greater emphasis be placed on learning lessons from previous deaths in custody and near misses. In several establishments where deaths of young adults have occurred, HMIP inspections have revealed that learning from PPO recommendations was not being given enough attention.*”
- 8.64. The Review reiterates this. There must be clear accountability and the Review reminds all concerned of the possible institutional prosecutions that might in the future be brought under the terms of the Corporate Manslaughter and Corporate Homicide Act 2007.

456 The three settings referred to are prison, police and hospital settings.

457 Equality and Human Rights Commission (2015). *Preventing Deaths in Detention of Adults with Mental Health Conditions: An Inquiry by the Equality and Human Rights Commission*. London: EHRC. http://www.equalityhumanrights.com/sites/default/files/publication_pdf/Adult%20Deaths%20in%20Detention%20Inquiry%20Report.pdf. Accessed 31 March 2015.

458 Prison Reform Trust & INQUEST (2012). *Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?* London: PRT. <http://www.prisonreformtrust.org.uk/Portals/o/Documents/Fatally%20Flawed.pdf>. Accessed 31 March 2015.

459 HM Inspectorate of Prisons (2014). *Report of a review of the implementation of the Zahid Mubarek Inquiry recommendations: A thematic Review*. London: HMIP. <https://www.justiceinspectores.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/07/Mubarek-final-published.pdf>. Accessed 30 March 2015.

Independence and accountability of the HMIP and PPO

8.65. The Review has been concerned about the relationship between the various inspection and monitoring bodies and Central Government - predominantly the Ministry of Justice. If public confidence in complaints processes and the inspection and monitoring and investigation system is to be improved and maintained, the bodies concerned not only have to be robustly independent, but there must also be the public perception that they cannot be subject to hidden pressure by those whom they may need to investigate or whose performance they are assessing.

8.66. Such concerns are long-standing. For example, in 2004, the Joint Committee on Human Rights reported that

*“In both written and oral evidence we were overwhelmingly met with concern that the Prisons and Probation Ombudsman was still not on a statutory footing, and that this would undermine the independence, and perception of independence, of inquiries into deaths in custody.”*⁴⁶⁰

8.67. John Wadham, a legal expert in human rights and former Executive Director of INTERIGHTS (the Centre for the Legal Protection of Human Rights), has recently advocated that *“constitutional bodies with a role in holding the government to account, protecting the rights of the citizen or regulating public bodies with state powers should be sponsored, supported and accountable to Parliament and not to government departments or ministers”*.⁴⁶¹

8.68. Clearly, the inspection and investigation organisations will face budgetary pressures which are similar to the rest of the public sector. However, having their budgets set by the sponsoring department (which also controls the budgets of the organisations which they inspect or investigate) creates a potential for conflict. This can inevitably lead to difficult debates about whether operational staff in, say, prisons should be cut to allow for more HMIP or PPO staff.

8.69. The potential for conflict also means that there is going to be a perception that criticisms of the sponsoring department, or its policies, may be muted as a result of pending budget decisions. This point has been made very recently by the Public Accounts Committee in its report on Inspection in home affairs and justice (HC975 – March 2015)⁴⁶² which states *“There is a risk that the independence of the inspectorates is undermined by the current arrangements for appointing Chief Inspectors and setting*

⁴⁶⁰ House of Lords/House of Commons Joint Committee on Human Rights (2004). *Deaths in Custody - Third Report of Session 2004-05*. London: TSO. <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/15.pdf>. Accessed 30 March 2015.

⁴⁶¹ Wadham, J. (2014). *Proper accountability for public bodies with constitutional significance*. Retrieved on 20 March 2015 from Johnwadhamdotcom at: <http://johnwadham.com/2014/06/01/proper-accountability-for-public-bodies-with-constitutional-significance>.

⁴⁶² House of Commons Committee of Public Accounts (2015). *Inspection in home affairs and justice - Fifty-third Report of Session 2014-15*. London: TSO. <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmpubacc/975/975.pdf>. Accessed 2 April 2015.

their budgets. Chief Inspectors were clear that the independence of how they conducted inspections was not in doubt. However, decisions on the appointment of Chief Inspectors, the length of their tenure, and the size of their budgets, are taken by the relevant secretaries of state responsible for the sectors under inspection, rather than by bodies independent of that responsibility, such as the Cabinet Office or Parliament. Current arrangements potentially pose a significant threat to inspectorate independence. For example, although Chief Inspectors considered that the departments had made sufficient resources available to provide effective inspection, departments could potentially use their control over inspectorate budgets as a lever to influence Chief Inspectors. Similarly, the requirement to re-apply for their posts towards the end of their tenure created a clear conflict of interest for Chief Inspectors, while a short tenure could allow Ministers not to re-appoint a Chief Inspector they did not like.”

- 8.70. In light of these concerns, we consider that the advantages of parliamentary oversight and responsibility for the HMIP and PPO are clear. At present, Justice Committee consideration is required before the appointments of the PPO and HMCIP are confirmed. This has already provided an important outlet for the organisations when they have had a contentious issue with their sponsoring departments. We recommend that this role should now be extended.
- 8.71. The Review accordingly believes strongly that accountability for the HMIP and PPO must be transferred from Central Government to Parliament. The beneficial consequences of this approach would include the following:
- Each year the organisations would be required to produce a report to Parliament (submitted via the Justice Committee). If a body is required to produce its annual report to Parliament (rather than the Government), publication without amendment can be guaranteed. There will be no pressure to modify or soften conclusions in advance of publication.
 - An annual report to Parliament could be debated by both Houses of Parliament and considered in detail by the relevant Select Committee. Moreover, there is an obligation on the Government to reply to a Parliamentary debate and publish a response to a report of a Parliamentary Select Committee.
 - The Justice Committee could approve the nomination by the Crown of the PPO and the HMCIP.
 - Their financial accounts would be submitted via the Comptroller and Auditor General to Parliament each year (also via the Justice Committee). Furthermore, the organisations' budgets would be set by the Justice Committee following the submission each year of an annual estimate of expenditure (analogous to the process followed by the Speaker's Committee in respect of the Electoral Commission). It would be possible, preferably, to have a longer-term financial settlement. For example, the Parliamentary and Health Services Ombudsman has a four-year Parliamentary funding allocation.

- As an adjunct to their independence, some of the organisations' powers might be derived from Parliament – for example, the right to require individuals to attend and give sworn testimony (potentially very important for investigating complaints).
- Such an arrangement would avoid the perception or reality that those organisations with an oversight function in respect of prisons might be hampered in their ability openly to report their concerns by administrative restrictions on their activities or by potential budgetary reprisals.

The Independent Advisory Panel on Deaths in Custody

8.72. In order to strengthen its capacity and independence, the Review believes that it is important that the sponsorship of the Independent Advisory Panel on Deaths in Custody (IAP) must move from NOMS to the MoJ, with staff support transferred accordingly. Furthermore, the IAP resourcing must be reviewed to ensure that the Panel has the capacity to commission external research and consultancy to support its work, that its members are able to give the necessary time to enable the Panel to deliver useful and constructive advice and that the members have an appropriate level of staff support.

Overseeing the Implementation of the Harris Review Recommendations

- 8.73. The Review believes that robust systems must be put in place to ensure the implementation of its various recommendations. The following outlines how the recommendations should be delivered and how progress should be monitored:
- Each body to which a recommendation is directed should produce an action plan on implementing those recommendations within three months of the Government's response to the Harris Review being published;
 - These action plans should contain 'SMART' targets;⁴⁶³
 - The IAP should have responsibility for discussing these action plans with the bodies concerned and monitoring progress; and
 - The MoJ (on behalf of the Government) should produce an annual report on progress on delivering the action plans. This should be accompanied by a commentary from the IAP. The annual report should be published and presented to Parliament. This should be supplemented by a thematic report produced each year, jointly by the PPO and HMCIP, on deaths in prison and a report produced every two years by MoJ on the human rights of prisoners. We anticipate that the relevant select committees (including the Justice Committee and the Joint Committee on Human Rights) would scrutinise such annual reports and hold hearings to consider them, as they deem appropriate.

⁴⁶³ In other words, targets that are specific, measurable, attainable, relevant and time-bound.

Summary and Recommendations for the Role of Inspection, Monitoring and Investigation Bodies

- 8.74. This chapter has shown that the UK has a number of very important inspection and scrutiny bodies that, collectively, can help improve processes by which prisons and other services are held to account when someone dies through self-inflicted death.
- 8.75. There are still improvements to be made to the services these bodies provide, particularly around ensuring the PPO investigations and coroner's inquests happen quicker, and that there is more accountability for ensuring recommendations are implemented.
- 8.76. Ensuring Parliamentary oversight, and removing sponsorship of these bodies from the Ministry of Justice, will ensure that processes are more transparent and fair.

Primary recommendation is:

- 90 Parliament should have a much greater role in oversight of the inspection process and in driving change.
- 91 The Review acknowledges that NOMS cannot deliver these recommendations without significant resource investment. Although in the longer term, it is anticipated that this investment will be funded through savings delivered by earlier intervention and diversion from the CJS, the government response to this report must detail how this extra resource will be given to NOMS.

Secondary Recommendations:

- 92 Oversight of the HMIP and PPO must be transferred from the Ministry of Justice to Parliament who would set their budgets and appoint their respective heads.
- 93 HMIP and the PPO should have a statutory duty in consultation with the NPM and the IAP present a public report annually to the MoJ on deaths in NOMS custody and the progress in addressing the underlying issues identified from previous deaths. MoJ should be under a statutory duty to publish a detailed thematic response each year to this report. This should be considered by the Justice Committee of the House of Commons.
- 94 Every two years MoJ and NOMS should produce a report for the Joint Committee on Human Rights on the extent to which prisons and YOIs are meeting their obligations inter alia under the Human Rights Act and other relevant national and international standards.

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- 95 The PPO should be placed on a statutory footing and should have statutory powers to require the production of documents and to compel witnesses to participate with PPO investigations.
- 95.1 The PPO must look to develop standards of service for the process of investigating deaths in custody, similar to those operated by the IPCC for the securing of a crime scene, following a death in custody.
- 95.2 The PPO should ensure that clinical reviews are independent and conducted by appropriately qualified and experienced clinicians and reviewers and should take over the management of this function by being funded to appoint a panel of suitably qualified clinical reviewers. Clinical reviews should take account of information from the families/primary carer of the deceased if at all possible.
- 95.3 The PPO should review the action plan produced in response to its recommendations and have the right to reject it, and require a new action plan to be produced if the PPO considers that it does not adequately address the recommendations made.
- 96 NOMS should consider each PPO recommendation and any Coroners' jury finding and PFD reports individually, decide whether it applies only to the establishment where a death occurred or more widely across the estate, and then put in place an appropriate action plan in response to that recommendation (which may involve other establishments). Such action plans should be made public and monitored by the Equality Rights and Decency Group within NOMS to ensure that the letter and spirit of such recommendations is being followed and they should report each year to the IAP and HMIP.
- 97 HMIP should have a statutory duty (as opposed to an informal arrangement) when inspecting an establishment to review progress achieved on implementing previous PPO recommendations (using any reviews the PPO may have conducted) and any previous Coroners' jury findings and PFD reports.
- 98 During inspections, HMIP should ensure that they take account of the views of prisoners' families on the prison regime.
- 99 In the event of HMIP producing a poor grading for an establishment, NOMS should consider whether that prison should be placed under special measures which might include the replacement of some or all of the management team and – where relevant – the running of the establishment by an alternative provider.
- 100 We recommend that HM Inspectorate of Prisons should have a statutory duty to check that their recommendations are being acted upon.

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- 101 The responsibility for the oversight and funding of the IMBs should transfer to HM Inspectorate of Prisons.
 - 101.1 The IMB membership must be representative of the community it serves, and where possible should reflect the local prison population. HMIP should develop an action plan to address this, which might include provision of a living wage for participation.
 - 102 PPO and Coroners should be given the remit, where they think it appropriate, to look beyond the circumstances of any individual death to see whether there were other factors that occurred earlier in the prisoner's history that might have contributed to the death.
 - 103 The Chief Coroner should be provided with sufficient resources to enable him to report on themes emerging from prevention of death reports involving deaths in custody.
 - 104 All inquest findings, PFD reports and responses that relate to deaths in custody should be centrally collated and available for public search (subject to any necessary redaction).
 - 105 CQC should undertake regular inspections of health provision in prisons and YOIs and these should include an assessment of whether initial health screening and the 48 hour multi-disciplinary holistic needs assessment is occurring, and how well healthcare is engaging and leading in the SAVRAS work.
 - 106 Responsibility for the co-sponsorship role for the work of the IAP should be transferred from NOMS to the MoJ.
 - 107 Each body to which a recommendation in this Review is directed should produce an action plan on implementing those recommendations within three months of the Government's response to this review being published. These action plans should contain SMART targets. The IAP should have responsibility for discussing these action plans with the bodies concerned and also monitoring the progress of the implementation.
 - 108 The MoJ (on behalf of the Government) should produce and present to Parliament an annual report on progress on delivering the action plans, accompanied by a commentary from the IAP. This should be informed by a Cross-Departmental working Group.



9. Concluding Comments

“When the situation was manageable it was neglected, and now that it is thoroughly out of hand we apply too late the remedies which then might have effected a cure. There is nothing new in the story. It is as old as the sibylline books. It falls into that long, dismal catalogue of the fruitlessness of experience and the confirmed unteachability of mankind. Want of foresight, unwillingness to act when action would be simple and effective, lack of clear thinking, confusion of counsel until the emergency comes, until self-preservation strikes its jarring gong—these are the features which constitute the endless repetition of history.”

Winston Churchill, House of Commons debate on Foreign Office funding in light of the remilitarization of Germany, 2 May 1935⁴⁶⁴

Over the last year, this Review has considered an enormous volume of evidence. In practice, this means that, despite its focus on the deaths of young adults in custody, it is the most comprehensive independent consideration of penal policy in this country for at least the last three decades.

That in itself should be a reason for Government to take our recommendations seriously. However, an even more compelling reason is our finding that so many previous investigations have found the same problems time and time again, but that these have never been adequately remedied.

Those who ignore the lessons of past failures are condemned to repeat them. And that will be the fate of policy-makers who fail to act on the proposals that we are putting forward.

Our central propositions are simple and straightforward. Our starting point is the need to restate the purpose of prison. The penalty of imprisonment is the removal of liberty. But those whose liberty has been removed by the State must still be treated with respect for their human rights. Above all, they must be kept safe.

For those whose liberty has been removed by the Courts, the primary goal of the prison regime should be rehabilitation. At present, prisons are an expensive failure as far as this objective is concerned. The prison environment is grim. Current restricted regimes frequently do not allow for the delivery of planned core activities. The experience of young adults in prison is by and large not purposeful, frequently not meaningful, and above all is impoverishing to the spirit. It does not facilitate rehabilitation. And, if individuals are going through a period of distress, the consequence of spending prolonged hours alone inside a cell with nothing to do other than stare at potential ligature attachment points is a recipe for tragedy.

⁴⁶⁴ HC Deb 2 May 1935, vol. 301 cols 602-603 (House of Commons debate 2 May 1935, volume 301 column 602-603). HYPERLINK “<http://hansard.millbanksystems.com/commons/1935/may/02/foreign-office>”http://hansard.millbanksystems.com/commons/1935/may/02/foreign-office#S5CV0301Po_19350502_HOC_289. Accessed 2nd April 2015

Delivering this restated purpose of prison will require leadership. And that leadership must start with Ministers. But it does not end there. It must also refocus the attention of civil servants in the Ministry of Justice and permeate all the activities of senior management in NOMS, who must do more to ensure that the policies they promulgate are actually implemented locally.

Likewise, within each prison and YOI, there must be leadership from the Governor, so as to ensure that safety and rehabilitation imbue all aspects of life within that establishment. This will require further professionalization of the prison workforce and addressing the current staffing and recruitment pressures.

The well-being of individual prisoners must be the personal responsibility of a named officer, whom we have called the Custody and Rehabilitation Officer. That person's job should be to ensure that the prisoner's health, education, social care and rehabilitation needs are met, whilst making sure that their safety and vulnerabilities are addressed. This will require multi-disciplinary working and the provision of health care services within the prison on a par with those available outside.

No doubt this change of focus within prisons will mean that the cost per prisoner will rise. However, prison – particularly for young adults – should be a last resort and much more should be done to divert young people from ever entering the criminal justice system in the first place. A reduction in the overall prison population in this way would make it easier for prisons to provide the sort of regime that we are recommending.

The experience of the Troubled Families Programme demonstrates how effective a multi-disciplinary and cross-departmental approach to the intractable issues that some families face can be. A similar approach should be taken to support young adults who have entered or at risk of entering the criminal justice system.

There is no doubt that the better availability of child and adolescent mental health services would be beneficial in this, as would targeted programmes of early family intervention. Alcohol and drug rehabilitation schemes and the roll-out of the liaison and diversion initiatives are all likely to play an important part in reducing the numbers in prison and tackling the underlying problems of many who currently end up in custody in a much more cost-effective way.

For those young people who do end up in prison much more must be done to ensure that their families can provide support to them and help keep them safe from harm. Contact through visits or by telephone must be made easier. And families will often have an essential contribution to make in the decisions that need to be taken about a young adult's Individual Custody Plan and any concerns there may be about specific vulnerabilities.

Within prisons, more coherent and effective policies must be developed to address bullying and manage gang issues. More cells should be made safer and there should be greater use made of the Listener scheme and other forms of peer-support.



Those who are determined to kill themselves will no doubt always find a way to do so. However, when a self-inflicted death does occur, the current barriers to identifying what went wrong and learning the lessons need to be eliminated. There must be a “duty of candour” on those within the system to cooperate with the investigative processes. And the families should be supported throughout, including by ensuring that their legal representation costs at the ensuing inquest are met.

Much can be done to strengthen the Prison and Probation Ombudsman and also the role of HM Inspectorate of Prisons. They should be made independent of the Ministry of Justice. At the same time, Parliament should have a much greater role in their oversight and in monitoring progress on the issues highlighted in this report.

The proposals that we have put forward are rooted in the impressive body of evidence that we have received and considered. We recognize that they will involve some substantial changes. However, they are changes that are urgently needed, if the waste of resources that is our present penal policy is to be stemmed and if – even more importantly – the tragic preventable loss of young lives is to be halted.

Our deliberations were rooted in the 87 tragic cases of the young people who died in NOMS custody in the period covered by this Review. And it is in their memory that we submit this report.

Toby Harris



Recommendations

The Review has identified three categories of Recommendations, each of which is defined below:

Fundamental – The first and most fundamental recommendation made by the Review reflects our belief that, after considering the evidence, the elementary action that needs to be taken in order to reduce the risk of self-inflicted death in custody of 18-24 year olds is a cross-organisational cultural change in the approach towards rehabilitation and the management of offenders in custody.

Primary – Primary recommendations are those where we believe that the implementation of the recommendation will have a more direct impact on the numbers of self-inflicted deaths in custody, and without which some of the secondary recommendations could not be effectively implemented.

Secondary – Many of the secondary recommendations enable and support the primary recommendations. Others, however, are lesser magnitude recommendations that may have a less direct impact on the experience of young adults in custody.

Chapter 2 – The Purpose of Prison

Fundamental Recommendation:

1. MoJ must publish a new statement setting out that the purpose of prison is to hold safely and securely those people sent there by the courts, either because they have been sentenced to imprisonment or because they have been remanded in custody while awaiting trial or sentencing. A prison should provide to those in custody a regime whose primary goal is rehabilitation. The penalty of imprisonment is the removal of liberty; all persons deprived of their liberty shall be treated with respect for their human rights (including the European Convention on Human Rights) and their individual protected characteristics (as defined by the Equality Act 2010). Restrictions placed on persons deprived of their liberty shall be the minimum necessary and proportionate to the legitimate objective for which those restrictions are imposed. Life in prison should approximate as closely as possible the positive aspects of life in the community.

Primary Recommendations:

2. In line with the European Convention on Prevention of Torture (CPT), all young adults in custody must be able to spend a reasonable part of the day (8 hours or more) outside their cells, engaged in purposeful activity of a varied nature. Levels of purposeful activity must be sustained for prisoners on all levels of the IEP scheme.
3. We recommend that the application of the current IEP scheme must urgently be reviewed so that the shortcomings associated with the current scheme be addressed and resolved. With immediate effect prisoners must not be automatically downgraded to the entry level of IEP on return to the prison following sentencing.
4. HMIP must conduct a thematic review on Safer Cells, which includes an analysis of what the right number of safer cells is for each prison and YOI. The review should identify which prisons are maintaining enough cells at the correct 'Safer Cells' level. Once this is established, whether the prison continues to maintain the right level should become a standard part of HMIP inspection process.
5. NOMS must identify and keep a record of the number of certified 'Safer Cells' (PSI 17/2012) both in use and available for use across the estate.
6. NOMS must develop and publish a distinct policy for management of gangs, including an identification of what strategies are most likely to deliver better outcomes in relation to the management and support of those individuals who may be perceived as being part of a gang.

Secondary recommendations:

7. All young adults should spend at least 8 hours a day outside of their cell and must be entitled to at least one hour of daily exercise in the open air every day. NOMS must record details of instances when a prisoner has not been able to comply with these minimum standards.
8. Any young adult where there are current concerns about their vulnerability recorded as part of their SAVRAS should not have their regime (IEP) status downgraded.
9. All light fittings within cells should as standard be tested to ensure that they are not able to bear the weight of a young adult before any cell can be signed off as being fit for purpose as a safer cell.
10. Window design in safer cells should allow an air flow and be free of possible attachment points for a ligature.
11. Each establishment, guided by instructions from NOMS if necessary, should review their estate and their population demographics and make a formal ongoing assessment of the minimum number of “Safer Cells” that are considered necessary to accommodate those requiring this additional protection.
12. NOMS should provide sufficient capital funds to allow for the building or the modernisation of sufficient cells to “Safer Cell” standards to meet that assessment and also for the subsequent maintenance of the sufficient cells to that standard.
13. All cells that have achieved certified to “Safer Cell” standards should then be maintained to that standard unless there is a documented decision by the Governor to allow the “Safer Cell” designation for that cell to cease.
14. Every prison should record and publish details of the time spent out of the cells for every prisoner; including time spent engaging in purposeful activity out of their cells. This information should be collated nationally for management information purposes and also to enable further analysis of outcomes.

Chapter 3 – Leadership & Ownership of Prisoner Safety and rehabilitation

Primary Recommendations

15. A new specialist role must be created to work specifically with all young adults in custody. The Custody and Rehabilitation Officer (CARO) will be required to take responsibility for the overall well-being of the young adult and must have a caseload of no more than fifteen or twenty prisoners, so that as a central part of the role it is possible to build and sustain a close and effective relationship with each individual prisoner. This role will be specialist and skilled, understanding developmental and maturity issues that impact on young adults, and will require competencies at least equivalent to a professional youth worker or qualified Social Worker.
16. A senior individual, supported by a dedicated unit within NOMS, must be given clear responsibility for ensuring the particular needs of all young adults are provided for appropriately across the estate.
17. CARO training must begin within 12 months of publication of this report.
18. The role of all operational staff including governors must be further professionalised, with the improvement of skills and knowledge across the workforce, including governors. A process of Continuous Professional Development must be introduced so that these skills are kept up to date.
19. MoJ and NOMS must take urgent steps to fill the recruitment gap that is putting undue pressure on an already stretched workforce in prisons.
20. From the evidence given to the panel from many sources, it is apparent that the current operational staffing levels in prisons are not adequate. Following the recruitment that NOMS is currently undertaking, Benchmarking levels should be reviewed immediately to allow for full compliance with Prison Service Instructions that concern the safety and well-being of prisoners and must include implementation of this report.
21. NOMS should ensure that the implementation of Prison Service Instructions is properly resourced in order that the intended benefits can be effectively delivered throughout the prison system. NOMS must have systems in place to ensure that this is happening.

Secondary Recommendations:

22. Following each self-inflicted death in custody, the Minister for Prisons should personally phone the family of the prisoner who has died to express their condolences on behalf of the State and to promise that a full and thorough investigation will take place, and that any lessons from the death will be studied and acted upon to avoid similar deaths in the future.
23. All staff working in prisons who have contact with prisoners, including prison officers, contracted staff, and in-reach workers must receive regular mandatory training to enable them to recognise and deal with vulnerabilities, particularly mental health needs, and also in relation to the Safety and Vulnerability, Risk Assessment and Support (SAVRAS) (referred to in chapter 6) process. All staff should be subject to regular continuous professional development requirements that are subject to external moderation.
24. Remuneration of prison officers should reflect this professionalization, because it is otherwise unrealistic to expect to recruit and, retain a workforce capable of successfully managing complex vulnerabilities in a custodial environment.
25. Governors must commend every frontline member of staff who has actively implemented measures and made judgments that lead to the prevention of a self-inflicted death and that a record of every commendation and the action taken be shared with the Equality Rights and Decency Group, who must disseminate this across the custodial estate where appropriate.
26. The management of young adults is distinct from the management of the older prison population. The specific skills and personal qualities that are required to work successfully as a prison officer in these situations needs to be assessed and provision made for regular, progressive and monitored training.
27. NOMS must properly assess the impact of each PSI, both new and existing, with relevant practitioners and experts consulted as appropriate. An impact assessment must also be carried out every time a PSI is changed. If a policy decision has been made that the benefit of a PSI is required then sufficient resources must be provided to ensure its delivery.
28. NOMS must put in place a more effective central system for auditing the implementation of PSIs at individual establishments and to assure NOMS senior management that the Instructions are practical and are being implemented with all anticipated benefits being delivered.

Chapter 4 – The Vulnerability of Young Adults in Custody

Primary Recommendations

29. There must be a legal recognition of the concept of ‘maturity’. As well as chronological age, maturity should be a primary consideration in making decisions relating to diversion, sentencing and, where a custodial sentence must be given, how and where a young adult (18-24) should be accommodated. The work to achieve this should be the responsibility of the Ministry of Justice, who should report on progress within 1 year of the publication of this review.
30. A multidisciplinary and cross-departmental approach must be adopted to support young adults who have entered or are at risk of entering the Criminal Justice System. The Government Departments involved should be the Ministry of Justice, the Home Office, the Department of Health, Department for Innovation, Business and Skills, Department for Work and Pensions, and Department for Communities and Local Government. The initiative should be coordinated by the Cabinet Office, with input from the Government Equalities Office. Similar arrangements should be developed in Wales under the auspices or working with the Welsh Government.
31. NOMS must accept that bullying wherever it occurs is a specific problem that requires specific, focussed responses. We recommend that NOMS must publish a specific Prison Service Instruction to cover the issue of bullying both from other prisoners and from staff and how custodial establishments can tackle and aim to reduce numbers of incidents. Bullying should not be subsumed into the policies that cover Violence Reduction.
32. Local authorities must have an explicit statutory duty to provide a corporate parenting and support role to all young people who are in NOMS custody, in addition to their existing statutory duties towards care leavers in custody. This should include providing a ‘Significant Adult’ who would be able to visit during normal visiting hours and to act as a mentor and personal advisor to these young adults.

Secondary recommendations:

33. The Review recognises that there is no simple answer as to whether young adults should be accommodated in separate institutions or mixed with older adults. All young adults (18-24 years), however, must be accommodated in small units that have the specialist staff and regime to meet their needs and that, when their maturity or vulnerability mean it is in their best interests, they should have the facilities to accommodate them in specialised wings or blocks.
34. All custodial establishments should have in place a process whereby a prisoner can arrange for a visit from family within three days of their arrival at the prison for the first time.
35. NOMS should continue its useful work on developing a tool to measure maturity effectively, the aim of which should be to better identify and support those in custody who are vulnerable because of a relative lack of maturity. This tool should be appropriately tested and made operational as soon as possible. Progress on this tool should be reported within one year of the publication of this Review.
36. If the YOT and other key organisations believe that due to an individual's lack of maturity, it would be in the best interest of a vulnerable young adult to remain in the under-18 estate after they reach 18, suitable accommodation should be found for that person within the juvenile estate, recognising safeguarding issues.
37. YOTs and other relevant agencies should be required to remain in contact with a young adult who transfers from the youth estate to an adult or young adult establishment for at least 6 months after they reach 18, and longer if particular vulnerabilities are identified. This may extend to 21 or 24 (if they are in full-time education), comparable with the local authority duty for young adults who were 'looked after' before they reached 18.
38. NOMS should further develop its work on care leavers, in order to ensure that care leavers can be accurately and reliably identified upon arrival in Prison and that data is collected to ensure that progress through custody for care leavers is properly recorded, researched and improved.
39. NOMS should introduce a robust assurance process for the safe transfer of every prisoner. As part of the preparations for transfer and on completion of transfer there must be a mandatory obligation on both the sending and the receiving establishments to ensure that the full details of a prisoner's record, including any current or former SAVRAS, is transferred. There must also be a positive duty on the receiving establishment to review and, if necessary, to act on the information provided, and also to follow up, in a timely manner, when information is thought to be missing.
40. As part of their response to bullying NOMS must provide (for example through an external contractor or NGO, if appropriate) a 24 hour anti-bullying helpline. This service should be provided through a free telephone hotline, so that prisoners or their families could report problems. All calls would be logged and passed to the relevant prison which would be expected to record the action taken, including consideration of urgency and appropriate management of the issues raised.

Chapter 5 – Diverting the Vulnerable from Prison

On Diversion

Primary Recommendations

41. The Review strongly supports the view expressed to us by our judicial representative that prison should be a last resort, it should not be used as the default solution when other alternatives are appropriate and available. A reduction in the prison population will enable prisons to provide an environment which meets appropriate standards of decency, safety and respect, and will assist prison authorities to comply with their human rights obligations, including the obligation to protect life. Diversion to healthcare, social care and other alternatives to custody can be a better means of addressing the complex needs of young people, and, in turn, better serve the victims of crime and society in general. It is essential that all magistrates and judges involved in sentencing decisions must be adequately trained on the vulnerabilities of young people, and the range of diversion schemes and alternatives to custody available within the local area.
42. Where a young adult is at risk of being placed in custodial remand for reasons that include concern that they do not have suitable alternative accommodation to which they can be remanded, the relevant local authority should either have to provide it, in something similar to the ‘Bail Hostel’ provision, or pay the costs of the custody provided through NOMS.

Secondary Recommendations:

43. The scope of the Troubled Families Programme should be expanded to address early family intervention. The Welsh Government should be invited to expand their own programmes to address the same issue.
44. There should be a parallel Programme focussing on the needs of vulnerable young people who are at risk of entering or already have had a number of encounters with the criminal justice system.
45. Further funding should be made available by the Department of Health to CAMHS services (and Welsh Government equivalent) to ensure early identification of mental health issues that, if properly supported, can be dealt with more effectively at an early age. CAMHS services need to be more closely linked to educational facilities, including custodial ones, to children up to the age of 18.
 - 45.1 Further investment is needed by the Department of Health (and Welsh Government equivalent) in Liaison & Diversion schemes, with a view to providing more appropriate services to vulnerable young people. Equal commitment should be provided to supporting Alcohol and Drug use and addiction services and services relating to the meeting of housing needs of individuals.

- 45.2 CCGs should consider ways to prioritise access to NHS treatment services for those diverted from custody via the liaison and diversion process.
- 45.3 Mental Health Assessment and Treatment Programmes must be expanded to cover all custody suites and criminal courts in England & Wales.
- 46. When a court is considering passing any form of custodial sentence upon a young adult (18 to 24) then a full written pre-sentence report must be commissioned.
- 47. It is the collective responsibility of all relevant public agencies to ensure that no young adult who is identified as requiring detention and treatment/assessment in hospital under the Mental Health Act 1983 should be detained in police or prison custody. This should be a 'Never Event'.

On Family Support

Primary Recommendation

- 48. Families are integral to supporting young people in custody and can help to keep them safe from harm. They must be included, where appropriate, as a central component of the management and care of young people in custody.

Secondary recommendations

- 49. Assistance should be given to families/principal carers to become more involved with their relative in custody where appropriate, including providing relevant information to help them understand the CJS, how to contact the prison, how to contact the CARO, and how to contact the Visitor Centre.
- 50. Visits and contact with family are usually a protective factor against harm and should not be withdrawn as part of punishment, IEP or because of restricted regimes.
- 51. All custodial establishments should have in place a process that will ensure that all prisoners will be able to contact a family member or a friend within 2 hours of their arrival in Prison, including following a transfer.
- 52. All custodial establishments must produce and publish information for families and prisoners on the arrangements for contacting their relatives in properly appropriate and accessible form. Arrangements should be made for this information to be widely available, for example at Magistrates' Courts and online.
- 53. Prisons must improve their processes for receiving information direct from the families of prisoners, particularly young adults. We recommend there should be a dedicated telephone line for families/friends and others to pass on concerns about prisoners, which should be continuously available over a 24 hour period. Information received should be logged and passed on appropriately to be recorded as part of the SAVRAS. This process should be audited.

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54. A young adult should be given the opportunity to include on the PER two personal phone numbers for friends and family, before a mobile telephone is retained by the police/ prison authorities.
 55. NOMS should invest in new technology, such as in-cell telephony and video call facilities, (for example Skype), similar to those used successfully in other jurisdictions in order to facilitate better contact with family. If necessary, to support this, families should be assisted through provision of access to facilities at an appropriate place close to where they live.
 56. Whenever an 18 – 24 year old is being considered for a prison transfer, the distance from the address of the family/primary carer must be considered and the transfer needs to be agreed with the recommended new dedicated young adult unit in NOMS.
 57. Governors should place high priority on peer support systems, such as Buddy schemes, Peer Mentors and Prisoner Councils and should ensure that there is a guaranteed commitment from their staff towards these schemes.
 58. Prison Governors should assure themselves that there is guaranteed commitment from all staff to the operation of the Listener scheme, and that Listeners feel supported and enabled.
 59. Governors should ensure that Listener Suites are provided within their establishments and that they are a safe and supportive environment.



Chapter 6 – Managing Vulnerability, Health and Mental Health

Primary Recommendations:

60. Each young adult (18-24 years) in custody must be assigned to a suitably qualified and experienced staff member who will act as their personal Custody and Rehabilitation Officer (CARO) whose responsibility it will be to build a supportive relationship with them, to oversee their security and well-being, to ensure their health, education, social care and rehabilitation needs are met, and to oversee the assessment for and delivery of their Individual Custody Plan (ICP).
61. With a view to developing an ICP, all young adults entering custody must undergo a full multi-disciplinary holistic needs assessment within 48 hours of their arrival in custody. This process, to be known as the Safety and Vulnerability, Risk Assessment and Support (SAVRAS) process, should be co-ordinated by a CARO, who will ensure that as part of this process an appropriate assessment is made by suitably qualified practitioners (properly trained in issues of gender and cultural sensitivity) of any physical, social care, and mental health needs of, or other vulnerabilities and risks faced by, the young person. These needs will include those currently covered by the ACCT process.
62. The ICP should be developed by the CARO, in consultation with the young adult concerned in order to identify how, by whom and when their needs identified by the SAVRAS process, will be met.
63. NOMS should consider whether the ICP, SAVRAS and CARO approach might also usefully apply to older adult prisoners.
64. There must be parity of health care services in prisons and YOIs with those in the community and NHS England and Local Health Boards in Wales should commission the services necessary to do this and deliver what is set out in this chapter.
65. NHS England should commission prison mental health services in line with the recommendations of this report.
66. Responsibility for prevention of self-harm and self-inflicted deaths in custody should be jointly owned by both NOMS and Healthcare.
67. Further to the statement of the purpose of prison, the European Prison Rules (5) state the principle of approximation as closely as possible the positive aspects of life in the community; therefore healthcare must take a central responsibility in this area.
68. There should be a consistent approach throughout the criminal justice system to requesting consent to share medical information, which should happen at the first point of contact with the health services in a CJS setting, whether that be at a police station or at a prison, and that that consent should apply to the remainder of the prisoner's journey through the CJS. If consent is declined it should be revisited regularly particularly if a serious health incident occurs.

Secondary recommendations:

69. All young adults should have an up to date ICP and SAVRAS that is co-ordinated by their CARO, who will be accountable for assuring the quality of the documentation, its regular review, and ensuring that its various elements are implemented.
70. Families must be provided with sufficient opportunities to feed into the SAVRAS process, including through providing potentially relevant information on the dedicated concern line, and any such information must be recorded within the SAVRAS documentation.
71. All commissioning, contract and performance management policies and documents for health and mental health provision in custody should include responsibilities for SAVRAS and will include the following:
 - 71.1 Health teams must be actively involved in the operation of the SAVRAS process, although the delivery of services through the ICP to meet assessed needs should be multidisciplinary;
 - 71.2 Where a mental health, learning difficulty or significant social issue(s) are identified through the SAVRAS process, a full age-appropriate psychosocial assessment must also be carried out by a suitably qualified health care professional. The results will inform the content of the ICP.
 - 71.3 Where a SAVRAS contains an element of need elevated to a crisis stage, only a suitably qualified health care professional, in conjunction with the CARO, will have the authority to terminate the services designed to meet that need.
72. Case Reviews of the SAVRAS and ICP will be led by the CARO and must be multi-disciplinary and where necessary must include representatives from healthcare. Where appropriate, the CARO should consider including chaplaincy, education, relevant in-reach staff, VCS and the prisoners' families/friends. CRC/NPS probation and TTG workers should also be involved when the individual is being prepared for resettlement.
73. At any stage during the young adult's time in custody, all prison staff must be under a positive obligation to notify the CARO (or the person acting on their behalf in their absence) of any concerns about an individual's risk/vulnerability. Appropriate out of hours cover arrangements for the role of the CARO should also be made.
74. When the transfer is between the youth estate and an adult institution, the YJB will be accountable for the transfer of all relevant information from the YOT, including health, mental health and care leaver status.
75. During any transfer, where a prisoner has a SAVRAS (as all young adults will have) as part of their ICP, the receiving establishment must ensure that there must be no interruption of the ICP and/or SAVRAS as a result of the transfer.
76. Where a prisoner who is being transferred to another prison has been on an ACCT, and when the crisis plan of the SAVRAS has been implemented, which was closed within the last three months this must be highlighted and the Care Plan (ICP) reviewed within 24 hours of receiving the prisoner.

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77. A record of any time a prisoner has spent on an ACCT/or the crisis plan of a SAVRAS must be recorded on System 1(or replacement) so that it is available for prison healthcare staff.
 78. Any health assessment (both physical and mental) produced at the police station by the liaison and diversion practitioner and others at the start of a prisoner's journey through the criminal justice system should be shared amongst specified CJS organisations (e.g. CPS, legal team, NOMS, HMPS) in order to assist them in making reasoned decisions subject to the issues relating to the sharing of data.
 79. Department of Health, Home Office and the Ministry of Justice need to issue joint guidance to the effect that when consent to sharing medical information has been given by a person in custody, then the assumption is that that consent remains valid (unless withdrawn) throughout the criminal justice journey of the person in custody.
 80. An appropriate consent form should be available which reflects the above, and in particular requesting of such consent should be a standard part of any prison reception assessment.
 81. Should such consent not be given, the person in custody should have an informed discussion periodically with healthcare professionals to revisit the decision made.
 82. Guidance from health organisations should be considered to reflect the duties of the State to protect life in custodial settings, with appropriate guidance given as to the disclosure and sharing of health information in such settings (including in those instances where consent is not provided).
 83. All Healthcare staff must be trained to the minimum level of the Immediate Life Support Course of the Resuscitation Council with scenarios adapted to suit the prison environment. All prison staff must also be trained to a minimum of basic life support level.
 84. Each prison and YOI should have an emergency medical response plan that contains the following elements:
 - 84.1 A mandatory Medical Emergency Response exercise each year, including emergency medical codes, in conjunction with local health care providers and emergency services.
 - 84.2 NHS needs to consider developing an appropriate health "NEVER" event in a custodial setting.
 - 84.3 A system for checking that standard emergency medical equipment is available and in good condition in appropriate locations within the prison/YOI.
 85. The Secretary of State for Justice should introduce legislation to create a statutory duty of cooperation for the sharing of information with the Prison Service to be placed upon those organisations that have direct engagement with the Prison Service (including health, mental health services, police, etc.).

Chapter 7 – After a Self-inflicted Death

Primary Recommendations

86. Following a death there should be a 'Duty of Candour' upon NOMS and its staff both towards those organisations responsible for managing the post death processes (such as the PPO and the coroner) and the families and friends of the deceased young adult.
87. NOMS must establish requisite monitoring and reporting systems to ensure that all custodial establishments comply with PSI 64/2011, with regard to engagement with families after a death, and to ensure the timely provision of appropriate levels of information and support and the appointment of the FLO. The FLO must not have been the young adult's CARO. A meeting should be convened possibly chaired by Chaplaincy, in conjunction with the local Samaritans, to come together and provide support prisoners and staff following a self-inflicted death.
88. Families of the deceased should have a right to non-means tested public funding for legal representation at an inquest. The costs of legal representation for the families should be borne by NOMS.

Secondary Recommendations

89. A meeting should be convened possibly chaired by Chaplaincy in conjunction with the local Samaritans, to come together and provide support to prisoners and staff following a self-inflicted death.

Chapter 8 – The Role of Inspection, Monitoring and Investigation Bodies

Primary recommendations:

90. Parliament should have a much greater role in oversight of the inspection process and in driving change.
91. The Review acknowledges that NOMS cannot deliver these recommendations without significant resource investment. Although in the longer term, it is anticipated that this investment will be funded through savings delivered by earlier intervention and diversion from the CJS, the government response to this report must detail how this extra resource will be given to NOMS.

Secondary Recommendations:

92. Oversight of the HMIP and PPO must be transferred from the Ministry of Justice to Parliament who would set their budgets and appoint their respective heads.
93. HMIP and the PPO should have a statutory duty in consultation with the NPM and the IAP present a public report annually to the MoJ on deaths in NOMS custody and the progress in addressing the underlying issues identified from previous deaths. MoJ should be under a statutory duty to publish a detailed thematic response each year to this report. This should be considered by the Justice Committee of the House of Commons.
94. Every two years MoJ and NOMS should produce a report for the Joint Committee on Human Rights on the extent to which prisons and YOIs are meeting their obligations inter alia under the Human Rights Act and other relevant national and international standards.
95. The PPO should be placed on a statutory footing and should have statutory powers to require the production of documents and to compel witnesses to participate with PPO investigations.
 - 95.1 The PPO must look to develop standards of service for the process of investigating deaths in custody, similar to those operated by the IPCC for the securing of a crime scene, following a death in custody
 - 95.2 The PPO should ensure that clinical reviews are independent and conducted by appropriately qualified and experienced clinicians and reviewers and should take over the management of this function by being funded to appoint a panel of suitably qualified clinical reviewers. Clinical reviews should take account of information from the families/primary carer of the deceased if at all possible.
 - 95.3 The PPO should review the action plan produced in response to its recommendations and have the right to reject it, and require a new action plan to be produced if the PPO considers that it does not adequately address the recommendations made.

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96. NOMS should consider each PPO recommendation and any Coroners' jury finding and PFD reports individually, decide whether it applies only to the establishment where a death occurred or more widely across the estate, and then put in place an appropriate action plan in response to that recommendation (which may involve other establishments). Such action plans should be made public and monitored by the Equality Rights and Decency Group within NOMS to ensure that the letter and spirit of such recommendations is being followed and they should report each year to the IAP and HMIP.
 97. HMIP should have a statutory duty (as opposed to an informal arrangement) when inspecting an establishment to review progress achieved on implementing previous PPO recommendations (using any reviews the PPO may have conducted) and any previous Coroners' jury findings and PFD reports.
 98. During inspections, HMIP should ensure that they take account of the views of prisoners' families on the prison regime.
 99. In the event of HMIP producing a poor grading for an establishment, NOMS should consider whether that prison should be placed under special measures which might include the replacement of some or all of the management team and – where relevant – the running of the establishment by an alternative provider.
 100. We recommend that HM Inspectorate of Prisons should have a statutory duty to check that their recommendations are being acted upon
 101. The responsibility for the oversight and funding of the IMBs should transfer to HM Inspectorate of Prisons.
 - 101.1 The IMB membership must be representative of the community it serves, and where possible should reflect the local prison population. HMIP should develop an action plan to address this, which might include provision of a living wage for participation.
 102. PPO and Coroners should be given the remit, where they think it appropriate, to look beyond the circumstances of any individual death to see whether there were other factors that occurred earlier in the prisoner's history that might have contributed to the death.
 103. The Chief Coroner should be provided with sufficient resources to enable him to report on themes emerging from prevention of death reports involving deaths in custody.
 104. All inquest findings, PFD reports and responses that relate to deaths in custody should be centrally collated and available for public search (subject to any necessary redaction).
 105. CQC should undertake regular inspections of health provision in prisons and YOIs and these should include an assessment of whether initial health screening and the 48 hour multi-disciplinary holistic needs assessment is occurring, and how well healthcare is engaging and leading in the SAVRAS work.

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106. Responsibility for the co-sponsorship role for the work of the IAP should be transferred from NOMS to the MoJ.
 107. Each body to which a recommendation in this Review is directed should produce an action plan on implementing those recommendations within three months of the Government's response to this review being published. These action plans should contain SMART targets. The IAP should have responsibility for discussing these action plans with the bodies concerned and also monitoring the progress of the implementation.
 108. The MoJ (on behalf of the Government) should produce and present to Parliament an annual report on progress on delivering the action plans, accompanied by a commentary from the IAP. This should be informed by a Cross-Departmental working Group.



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Appendix 1 – Biographies of the Members of the Harris Review Panel

Lord Toby Harris

Lord Harris has been Chair of the IAP since it was established in 2009. He was made a Life Peer in June 1998 and is Chair of the Labour Peers. He is a former Chair of the Metropolitan Police Authority and the Association of London Government. In Parliament, he chairs the All-Party Parliamentary Group on Policing, was a member of the Joint Committee on National Security and in 2013 he chaired the House of Lords Committee on the Olympic and Paralympic Legacy. He has been Chair of the National Trading Standards Board since 2013.

Professor Philip Leach

Philip Leach is Professor of Human Rights Law at Middlesex University, a solicitor, and Director of the European Human Rights Advocacy Centre. He has extensive experience of representing applicants before the European Court of Human Rights. He is on the Editorial Board of European Human Rights Law Review, a Trustee of the Media Legal Defence Initiative and a member of the Legal Advisory Board of the Human Dignity Trust. He has been a member of the Independent Advisory Panel on Deaths in Custody since 2009, leading on its work relating to Article 2-compliant investigations.

Deborah Coles

Deborah Coles is co-director of INQUEST, a charity providing expertise on contentious deaths and their investigation with a particular focus on custodial deaths. She leads its policy, legal and strategic work and is called upon as an expert to numerous committees and inquiries including the IPCC Review on investigation of Article 2 deaths. She has expertise in specialist areas including coronial reform, policing, human rights compliant investigations, family engagement, traumatic bereavement, juvenile and youth justice, race and gender and criminal justice. Deborah has been a member of the Independent Advisory Panel since 2009, leading its work stream on cross-sector learning, equalities and family liaison.

Professor Richard Shepherd

Professor Richard Shepherd is Consultant Forensic Pathologist at the Royal Liverpool Hospital and a leading forensic pathologist in the field of deaths during restraint, with experience of deaths in all forms of custody, including those from natural, suicidal and homicidal causes. He has sat as an expert on the Restraint Advisory Board Panel for the Children's Secure Estate (MMPR) and the UKBA panel for Non Compliance Management. Richard has been a member of the Independent Advisory Panel on Deaths in Custody since 2009 and leads the IAP work stream on the use of physical restraint.

Stephen Cragg QC

Stephen Cragg is a barrister specialising in public law, and human rights. His main areas of public law include police law, community care and health law, the retention and disclosure of information by public bodies, the criminal justice system, and coroners' inquests. He has acted in many deaths in custody inquests on behalf of families of the deceased. Stephen sits as a part-time judge for the mental health review tribunal.

Matilda MacAttram

Matilda MacAttram is founder and director of Black Mental Health UK (BMH UK), a human rights campaigns group established in 2006 to raise awareness and address the stigma associated with mental illness in the UK's African Caribbean communities. She is a member of the Government's Ministerial Working Group on Mental Health and Equalities, as well as the Care Quality Commissions' Annual Mental Health Act Report Expert Advisory Group, and New Scotland Yard's Vulnerability Independent Advisory Group. Matilda is also a fellow of the United Nations, Office of the High Commissioner for Human Rights and the Working Group of Experts on People of African Descent. Also a journalist and public speaker, she is frequently asked to comment in print and broadcast media on issues arising from BMH UK's work.

Dinesh Maganty

Dinesh Maganty is currently Lead Consultant for intensive care for Birmingham and Solihull Mental Health NHS Foundation Trust Secure Care Services. He is a member of the National Clinical reference group for Health and Justice for NHS England. He has acted as a Psychiatric expert instructed by coroners in cases of death in prisons and psychiatric hospitals for the last decade. Dinesh has also acted as an expert for the NHS litigation authority in cases of deaths in hospitals and in the community and has been an expert in over 700 criminal and civil cases.

Meng Aw-Yong

Dr Meng Aw-Yong is a Forensic Medical Examiner and Medical Director for the Met Police, Medical Advisor for St John Ambulance, crowd doctor at QPR and works in Emergency Medicine at Hillingdon Hospital. Meng is also a Medical Member Social Entitlement Chamber, a council member of the British Academy of Forensic Science and council member of the Emergency Medicine and Clinical Forensic and Legal Medicine sections of the Royal Society of Medicine, Founding Member and examiner for the membership exam of the Faculty of Forensic and Legal Medicine, advisory member of the Health in Justice Strategic Clinical Network, and the NICE Guideline Development Group - Physical Health of People in Prison. He has provided expert evidence at inquests and deaths in custody. He is an instructor in Trauma and Life courses (ATLS, ALS), a lecturer in Forensic Medicine (QMUL, Society of Apothecaries), Fitness to Practice assessor, Drs Supporter and Suitable Person for the GMC.

Graham Towl

Professor Graham Towl is Pro Vice Chancellor and Deputy Warden at Durham University. He is a Professor of forensic psychology and was formerly Chief Psychologist at the Ministry of Justice. He has extensive experience working in criminal justice and mental health and is widely published. Previously he chaired the Prison Service Suicide Awareness Support Unit research partners group. He is a Council Member of the Health and Care Professions Council and the national mental health advisor to the student helpline, Nightline.



Appendix 2 – Terms of Reference

On 6th February 2014 the Justice Secretary announced an independent review into self-inflicted deaths in National Offender Management Service custody of 18-24 year olds.

The purpose of the review was to make recommendations to reduce the risk of future self-inflicted deaths in custody. The review focussed on issues including vulnerability, information sharing, safety, staff prisoner relationships, family contact, and staff training and explored these through calls for submissions alongside existing and commissioned research and meetings with stakeholders and people affected and interested more broadly. The review was to report their findings and recommendations to the Minister for Prisons.

Terms of reference

The methodology of the review will be at your discretion but should adopt the following broad outline:

- The review should take into account deaths of young adults aged 18-24 in prisons and Young Offender Institutions in England and Wales.
- The review should examine cases since the roll out of ACCT was completed on 1st April 2007.
- The review should identify whether appropriate lessons have been learned from those deaths and if not, what lessons should be learned/what actions should be taken to prevent further deaths.

The review should focus on the following themes:

- Vulnerability – including the management of the risk of self-harm or suicide, mental health and other healthcare needs; learning disability and other complex needs.
- Information sharing – the provision of information to NOMS (including from agencies outside of the criminal justice system such as health, education and social care agencies; and including any relevant factors arising from their experiences prior to entering the custodial system) the transfer of information within the criminal justice system and whether information can be better utilised to assess risk factors.
- Safety – including violence reduction (bullying), the built environment and emergency response.
- Staff prisoner relationships.
- Family contact.
- Staff training.

Whilst the review will focus on the 18-24 age groups, you should take account of learning which has been undertaken in respect of the youth estate and identify wider learning that will be of benefit to any age group.

As part of your review, you will take into account the views of stakeholders including:

- Prison Reform Trust, INQUEST, Howard League, Coroner's Society, Prisons and Probation Ombudsman, HMIP and YJB.
- Young adults in custody.
- Practitioners.
- Families of those who have died in custody during this period.

Stakeholder views may be obtained by written or oral evidence (or both) and by site visits. Evidence should seek to elicit the experience of stakeholders of deaths in prison custody and what improvements could be made but should not reinvestigate nor consider issues of liability in respect of individual deaths.

You are entitled to consider any information which is publicly available, which has been made available to you as part of your evidence gathering exercise or which can be disclosed by the Ministry of Justice in accordance with data sharing laws.

The Ministry of Justice will make available two full time members of staff of relevant experience and expertise for the period of the review and will cover reasonably incurred expenses which arise as a result of the review.

You should report to the Parliamentary Under-Secretary of State, Minister for Prisons, Probation and Rehabilitation with your conclusions and with your recommendations as to what further action should be taken. Your report is due to be presented by spring 2015 and will subsequently be published in full.

Appendix 3 – The Approach and Methods used by the Review

The Harris Review considered a range of evidence, which was gathered using different sources and methods. This appendix describes what the more substantial sources were, and how the evidence was gathered.

Interpreting the Terms of Reference

The Terms of Reference of the Review (see Appendix 2) sets out expectations of the ministers who commissioned the Review, including indicating the range of evidence that should be considered and stakeholders from whom the Review should hear.

From the beginning, the Review panel was determined to ensure that this sensitive issue would be explored as thoroughly as possible. *The Terms of Reference* set by the Ministry of Justice were quite broad and provided a strong signpost. The panel felt that the directive need to identify the lessons that had not been learned from deaths was key, and in addition realised that in order to identify “*what lessons should be learned/what actions should be taken to prevent further deaths*” (see Appendix 2), they would need to explore some areas in more detail.

In particular, at the first meeting on 10 April 2014 (Harris Review meeting 1⁴⁶⁵), it was agreed that the Review should also be informed by the experiences the children under 18 who died in custody during the same period as the young adults being examined. This was felt particularly pertinent because their experiences were likely to be similar to the young adults who were often just a few months older than them, and may have also experienced the youth justice system. This was backed up by several calls to look at the journey into custody by submissions received by the Review, including those made by The Howard League, The Prison Reform Trust and INQUEST.

Later, the panel also felt it was necessary to explore in more detail areas that might initially have felt to be peripheral, such as liaison and diversion from the Criminal Justice System. This was necessary because the Review felt that there was evidence in the details of the case we considered that lessons about diversion and intervention during earlier crises, that would otherwise have prevented some of these tragic deaths, were not being learned.

465 Harris Review meeting 1, 10th April 2014, <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/05/The-Harris-Review-Meeting-1.pdf>

Consideration of Evidence

The panel met a minimum of three times a month between April 2014 and March 2015 (with the exception of August). These sessions were usually a full day in length, and consisted of a mixture of oral hearings from a range of stakeholders and ordinary panel meetings to discuss and consider other evidence. A full list of stakeholders consulted, and in what capacity, is outlined in Appendix 6. Summaries of all of the Stakeholder Hearings (listed in Appendix 8) and the minutes of all of the meetings can be viewed on the Harris Review website at <http://iapdeathsincustody.independent.gov.uk/harris-review>.

The meetings provided the Panel with opportunities to consult researchers and officials from NOMS and MoJ in order to help them understand specific operational processes and activities. This included, for example, discussions with Chaplaincy, psychologists, and a session to familiarise the panel with the ACCT document and processes.

The Review also conducted a number of events and prison visits and commissioned research in order to understand the issues in greater depth. The documents relating to the deaths in scope were also explored in some detail.

Review of Deaths in Scope

The panel considered in detail the information available on all self-inflicted deaths of young adults (18-24 years) in prisons or YOIs from April 2007 until the time the Review was being conducted. Practically speaking, sufficient information for a more detailed analysis was only available on the 83 deaths that occurred up to and including those who died in December 2013. We also attempted to get as much information as possible about the four deaths of children under the age of 18 that we included in the Review.

The Review received basic information about each death from NOMS. In addition, we obtained information from additional documents as set out in Table Appendix 3 a.

Table Appendix 3 a: Documents available for the 87 deaths of considered (83 young adults and four under 18's).

		No cases document available	No cases document not available	Reasons why Review did not have this document
PPO Report	Young adults	70	13	8 inquests not yet held or concluded
	Under 18's	4	0	3 cases no response from Coroner's office 2 cases no reason given as to why report could not be provided
Inquest finding	Young adults	53	30	14 inquests not yet held or concluded 12 cases no response from coroner's office
	Under 18's	3	1	5 cases where the information could not be found or located by coroner
Rule 43 or Regulation 28 recommendations	Young adults	27	56	49 cases there was no recommendation 9 cases it was not known whether there had been any recommendations
	Under 18's	1	3	1 case where there was no response from the Coroner

This Review is the first time that so many related documents were considered together for such a large number of individual cases. As there was no central repository for all of these documents, it proved time-consuming and often quite difficult to collate full information on each death and to obtain permission for reports to be sent to the Secretariat. The Review noted that this difficulty is likely to impact on how efficiently recommendations might be disseminated, understood and implemented. Developing a more effective way of facilitating access to reports and their recommendations and findings would better enable learning of lessons.

While the Review considered all of the considerable material available, we also commissioned our legal team to have the reports confidentially summarised in a more easily accessed form. Part of this, a summary of the recommendations and findings of the reports, is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

With the co-operation of the PPO and NHS England, the Review was also able to access the Clinical Reviews that are commissioned by the PPO for each death it investigates. The Review did not have resources to analyse these fully themselves, but we were fortunate enough to have a senior forensic psychiatrist on the panel who could supervise volunteers with the analysis. The Review advertised in the online versions of the Guardian, the Evening Standard, and the Metro, as well as the Harris Review website for pro bono researchers with a background in forensic psychiatry to support the Review by carrying out this work. The report, produced after consultation with the anonymised reports that describes their findings is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Call for Submissions

Between March and 18th July 2014, the Harris Review issued its formal Call for Submissions (<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/05/Call-for-Submissions-Final.pdf>). The *Call for Submissions* was sent to over 900 individuals and organisations and publicized through an article in INSIDE TIME, which was published in June 2014, and through the IAP and Harris Review websites. The *Call for Submissions* included 38 questions that were grouped under a number of key themes. We received 54 submissions, including 13 from individuals currently in custody. Some organisations clearly went to great lengths in collating their submissions. User Voice, for example, carried out focus groups with young adults at HMP Onley and HMP/YOI Pentonville using the questions asked in the published *Call for Submissions*.

The submissions received are listed in Appendix 4 unless unpublished for reasons of sensitivity, are available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Note: A very small number of the responses the Harris Review received included distressing comments about a prisoner's wish to harm themselves. Although the Review took the confidentiality of respondents very seriously, in these cases it was felt the Review had a duty of care for the sake of the respondents' well-being to pass concern about them on to NOMS Equality, Rights and Decency Group, who have procedures in place for dealing with these concerns.

Background documents and Out of Committee Papers

The panel were also provided with over one hundred relevant documents, which assisted the panel in their understanding of the relevant topics of the Review. These include relevant Prison Service Instructions and bulletins, significant public reports and research. A list of all papers circulated to the panel is included at Appendix 8.

Official Questions

During the course of the panel's consideration of evidence, there were a number of times when clarity was needed on particular issues or facts. When this happened, the panel often needed to communicate with individuals or with organisations in order to gain the information.

Stakeholder Hearings

The Review took into account the views of a variety of stakeholders. Key stakeholders were invited to present official evidence before the panel relating to their areas of expertise or professional involvement. Twenty-six oral hearings were held, all of which are listed in Appendix 5.

Hearings ranged from government departments, such as Michael Spurr, CEO of NOMS, whose perspective provided essential context, to researchers such as Professor Louis Appleby whose expertise in the area gave the Review valuable insight. Summaries of each Stakeholder Hearing are available at <http://iapdeathsincustody.independent.gov.uk/harris-review/stakeholder-hearings>.

Prison Visits

Prison visits were an integral part of the Review, enabling essential understanding of the context and environment in which young adults are held, as well as the operational circumstances in which staff are working. There was also an opportunity to see at first hand the concepts, procedures, processes and policies that are integral to day to day prison life. One visit in particular was arranged to enable the opportunity to view reception at its busy period in the late afternoon and early evening. Visits also enabled panel members to engage with staff, prisoners and Listeners.

The establishments that the panel visited are listed in Appendix 7. Summaries of prison visits are available at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Engagement Events

In addition to the Stakeholder Hearings that are listed in Appendix 5, the Review held a number of events to which those who could not be heard from individually were invited. These included a number of roundtable events, which are described later, a Public Hearing, and a Local and Community Groups Seminar.

Public Hearing

The Harris Review held an open Public Hearing on the 25th of September in London. Invitations were sent out to a broad variety of organisations and individuals and was publicised on the Harris Review website and by organisations such as CLINKS.

The agenda for the hearing and a summary of the discussion are available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/events>. Further details of who attended are set out in Appendix 6.

Local and Community Groups Seminar

The Review felt it was important to hear from organisations working in local communities, especially smaller organisations that might not be part of the CJS, and those representing ethnic minorities, to support the young adult age group and who are involved with liaison and diversion before and/or after custody. In part, this was necessary in order to examine things such as information sharing to NOMS from agencies outside of the criminal justice system. Additionally, the Review also recognised that organising such an event was the best way of ensuring that smaller organisations were enabled to contribute to the Review in a meaningful way.

An invitation was sent out to individuals and organisations that work within local communities, particularly with Black, Asian and Minority Ethnic young people, to support the needs of vulnerable young people, young adults, ex-offenders and also those who provide through the gate support in prisons. In addition, panel members publicized the event to their own networks and through their websites.

The Local and Community Groups Seminar was held on 2nd October 2014 and included key note speakers Lord Adebawale and Diane Curry, OBE. A list of attendees is provided in Appendix 6. Details of the agenda and a summary of discussion is provided at <http://iapdeathsincustody.independent.gov.uk/harris-review/events>.

Family Hearings

Hearing first hand from bereaved family members and friends was an imperative part of the Review. As well as allowing the Review to hear the unique perspective of family members, family hearings allowed the families to feed back their perspective and experiences back into the Criminal Justice System, via the Review.

The panel was mindful that these hearings would require special sensitivity, and that very particular experience of working with these families and allowing them to engage in a dignified manner was important. To this end, the Harris Review, through the MoJ procurement portal, issued an invitation to tender to organisations with the capacity to organise and facilitate hearings between relevant families and the Harris Review panel.

Bids were assessed by MoJ officials, independently of the Harris Review. The contract was eventually awarded to INQUEST in September 2014. INQUEST is one of only a very limited number of organisations with sufficient contact with families of those who have died in custody to be in a position to successfully hold such an event. INQUEST also has extensive experience working alongside bereaved families, and their case workers are trained to work with bereaved families and are experienced in convening similar hearing events.

INQUEST arranged two hearing days for the panel, the first of which was an open day on 16th October 2014, attended by representatives of families of young adults (18-24) who had died in custody since April 2007. This event was attended by eleven members of the panel and secretariat. Attendees divided into different groups for morning and afternoon sessions to explore different themes, and the group discussion was facilitated by experienced INQUEST case workers. The day also included an opportunity for family members to address the panel and to ask questions.

The second event was held on the 27th of November 2014 and was a smaller event attended by a more discrete number of the Review, and consisted of two closed sessions to facilitate the privacy of the family members. The first session was with the family of a child who had taken his own life in custody, and was held to give the panel an opportunity to explore similar themes and understand the situation for the slightly younger age group.

Both events were designed around the themes of the Review's Call for Submissions, and were structured to take the panel through the young adult's chronological journey into custody, their experience there and the families' experiences following the death. The, often harrowing, accounts helped the panel to understand the impact of each individual death, and the common threads experienced by the families that were heard from.

The families were supported by INQUEST case workers before, during and after the event. INQUEST produced a comprehensive report that summarises the events and the themes that emerged. The report can be accessed on the Harris Review website: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Research and Analysis

In order to explore the evidence base more effectively, the Review commissioned some pieces of original research. As well as contributing to the findings of the Review, and supporting the process by which recommendations and conclusions were reached, this research is a lasting legacy of the Review that will help develop the evidence base in this area.

Analysis of NOMS Data

Drawing on the skills and experiences of Review panel members with a background in research, the Review met with analysts from MoJ and NOMS early in the Review to discuss what might be learned from the potentially productive data held by NOMS. Based on these discussions, MoJ and NOMS analysts' collated data from 30 years of data, which is the first time an attempt has been made to summarise and analysis this rich data set. The final presentation on this research was made to the Review at a meeting on the 29th January 2015.

A summary of the analysis has been published by MoJ, and can be accessed via the Harris Review website at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

It showed, for example:

- 26% of self-inflicted deaths between 1978 and March 2014 were 18-24 year olds;
- The average rate of self-inflicted death for males generally increases with age, with those aged 50-59 more likely to commit suicide;
- Over a quarter of all 18-24 year old self-inflicted deaths occurred within a week of arriving into the prison.

Review of the Literature

The University of Greenwich, through an ongoing contract with the Independent Advisory Panel for Deaths in Custody, was commissioned to conduct a review of the literature on deaths in custody of 18-24 year olds. In order to ensure sufficient scope to capture enough material, their remit was extended beyond the young adult age range, and was to include national and international studies that were both directly and indirectly relevant to the subject of the Review. The final report, titled *Understanding and Addressing Self-Inflicted Deaths in Prison Amongst Those Aged 18 – 24*, was presented to the panel on 29 January 2015 and is available on the Harris Review website at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

The report concluded that there was a lack of robust evidence on which to base decisions concerning which approaches would be most effective in reducing self-inflicted deaths of young adults in custody, including a lack of randomised control trials of interventions and approaches. Despite this, the Literature Review recognised some common preferred approaches, including:

- the importance of identifying and addressing mental health of those identified ‘at risk’ for self-harm and/ or suicide;
- that cognitive-behavioural treatments (CBT) and dialectical behaviour therapy (DBT) are considered promising approaches for young people, and
- The importance of skilled and motivated staff who can identify individuals ‘at risk’ of self-harm/ suicide (gatekeepers) and delivery prison regimes with empathy.

The literature review also identified some key risk factors in terms of how those in custody experience prison life. Examples include being more bored and daydreaming more, more likely to experience problems sleeping at night, more likely to have difficulties with other prisoners, more likely to be adverse to physical education and less likely to receive visits or keep in touch with people.

Qualitative Study of Perceptions of Staff

The Harris Review commissioned original and independent research into the perspectives of staff in prisons about deaths in custody. MoJ Analytical Services issued an invitation to tender, on behalf of the Harris Review, for an original and innovative piece of research exploring the views and experiences of staff working with young adults in prisons and YOIs. Following an open competition, the contract was awarded to RAND Europe & the University of Cambridge. The contractors visited five institutions and, through semi-structured questionnaires, gathered valuable qualitative information from prison and YOI staff. This original and unique research added a very interesting dimension to the evidence available for the panel to consider. The final report, *Self-Inflicted Deaths in NOMS’ Custody amongst 18–24 Year Olds: Staff Experience, Knowledge and Views* was presented to the panel on 15 January 2015. It is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

MQPL data

Measuring the Quality of Prison Life (MQPL) is a questionnaire-based survey of a prison's 'moral culture', which bears similarity to other concepts such as its social or rehabilitative culture. The MQPL team currently surveys each prison in England & Wales roughly once every 30 months, which it has done since 2003. Some items have changed in that time, however, making comparisons and identification of trends difficult. MQPL findings tell us about prisoner perceptions of a prison's moral culture but the relationship of this to other outcomes is complex, and, for some, the evidence base is yet to be established. MQPL data is self-reported and, while it provides some interesting insights, is not as rigorous as other analysis. The Review understands that NOMS is doing further work to improve the reliability and validity of the data set that could help inform experiences relating to mental well-being and distress in custody, and welcomes this, as MQPL is potentially a rich and untapped source of information on prison life.

The Review met with the MQPL team in October in order to discuss how the data might be used to help inform the panel. The report produced, which was presented to the Review on 29 January 2015, provided an overview of MQPL data and provided some basic descriptive statistics from the data set. This includes prisoners' self-reported history of self-harm and attempted suicide, their current psychological and emotional distress, suicidal ideation, and feelings of safety, and the response from the prisons. The report considered by the Review is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Harris Review Sub-Groups

After considering the evidence, the Review decided that some areas needed to be explored in more detail in order to more effectively explore lessons that needed to be learned in order to prevent future deaths of young adults in custody. As time and resources were limited, the panel divided into sub-groups in order to explore three identified areas in more detail. These areas were: *Health and Mental Health* (particularly from a clinical perspective), *Liaison and Diversion and Characteristics of Young Adults*. The sub-groups met as necessary between November 2014 and January 2015, when they reported back to the panel. This section summaries briefly how evidence was explored and collated by the sub-groups.

Health and Mental Health

The objective of the health and mental health sub group was to be able to express fully the relevant medical information in the context of the Review, to ensure that the information obtained was scrutinised by the medical professionals on the panel, understood by all and utilised most effectively to support the recommendations. The sub group met twice in September and November and further papers were considered in correspondence in January.

The sub group identified a number of key issues for the Review, including failures to effectively share medical information, the tension between given and implied medical consent, equivalence of healthcare services in prison with those in the community, and whether some mentally ill offenders should have been diverted from custody, either at court or during their sentence.

Liaison and Diversion

The purpose of the Liaison and Diversion sub group was:

- To consider what more could be done to divert young adult offenders from the CJS and/or a custodial sentence when appropriate;
- To investigate the particular issues associated with young adults (18-24 years) within the Criminal Justice system that inhibit the police and courts from making informed decisions about charging and sentencing;
- To consider the barriers that prevent an offenders health needs being known by all CJS participants, and
- To report back the findings of the sub-group to the full Review Panel.

In order to achieve this, three roundtable discussions were convened, with key individuals identified by the Panel members invited to either attend or to contribute through submitted documentation. The agenda and summaries of these roundtable events can be seen at <http://iapdeathsincustody.independent.gov.uk/harris-review/events>. Details of those who attended and the focus of the events are provided in Appendix 6.

Characteristics of Young Adults

The objective to the Characteristics of Young Adults sub group was to investigate the particular characteristics of young adults (18-24 years) that might increase their vulnerability in custody, and to report these back to the panel, with suggestions around which recommendations might be made. The group considered some key papers on this age group and identified a number of key themes, Maturity, Brain Development and Other Developmental Issues, Troubled Families, Care Leavers & Development of Life Skills and the Context of Custody for Young Adults and its Impact on Relationships.

A round-table event was held on the 11th of December that was based around these key themes. The event highlighted consistent concerns around the relative immaturity of young adults compared to older adults, the lack of support and consistency for those transitioning between youth and adult services, and their vulnerability due to life experiences and unsupported mental health difficulties and the lack of support and guidance from a 'significant adult'. A full list of attendees is available at Appendix 6. A summary of the event is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/events>.

Young Adult Engagement

The *Terms of Reference* for the Review state that the stakeholder's views that should be taken into account should include young adults in custody. Because of the limited resources to commission research, the Review had to come up with innovative means of constructively engaging young adults in order to meet the *Terms of Reference* and ensure the Review was effectively informed from a user perspective. The engagement strategy for young adults had three distinct strands, which are summarised briefly here. Further details are available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Prison Visits

Where possible, it was decided that the panel would request direct access to young adults in custody during the course of prison visits. This would allow them to chat to the young adults about their current experiences. The panel had an opportunity to chat informally to young adults during a number of visits, but formal sessions were specifically set up at Glen Parva, Swinfen Hall, Holloway, Chelmsford and Leeds. Some of these sessions were arranged in particular with volunteers from the Listener Scheme, which provided valuable insight into how the young adults involved viewed the scheme. In Swinfen Hall, the panel also met with individual young adults who had self-harmed and/ or who were in the segregation unit.

Some of the more consistent messages fed back to the Review by young adults during these visits was a sense of frustration at the more limited regime and excessive time in cells that most of them endured at that time. They also described the importance of family contact during early days in prison when they felt particularly vulnerable, and the sense of frustration when highly valued time with loved ones during official visit times was shortened due to process or delays being brought to the visit centre.

Hearing Facilitated by User Voice

The Review liaised with User Voice, a charity that is led and delivered by ex-offenders with the aim of reducing re-offending and getting access to and insight from people within the criminal justice system to prompt changes in policy and to improve services. Through User Voice, it was arranged that a group of young adults who had previously spent time in custody would be invited to come and speak to the panel about their experiences.

On the 4th September 2014, a group of eight people from User Voice met with the panel at MoJ HQ in 102 Petty France. An emotional and challenging session, the hearing successfully brought the perspectives of the young adults to the attention of the Review, and provided excellent insight into their experiences. Key points that the Review noted included how the young adults felt alone and vulnerable at the beginning of their sentence and how they needed more contact with family, the disparity between the behaviour and attitudes of prison officers who were trusted and those who were not, and the need to engage with something purposeful during the day while in custody. The summary of the hearing can be accessed at: <http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/User-Voice.pdf>.

Targeted Survey

The Review developed a short, simple and targeted questionnaire to distribute to young adults in custody, which was quality assured and advised on by the Samaritans, User Voice and the National Council - Independent Monitoring Boards (IMBs). This can be seen at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>. With the support of NOMS Director of Public Sector Prisons, the Review approached five institutions to ask for their participation in the survey, and all institutions agreed. The Review negotiated with the president of the National Council – IMBs, and for whose support we remain very grateful, for IMB volunteers to distribute the questionnaire rather than ask already overburdened staff to do so. The questionnaires could be completed anonymously and posted in drop boxes on the wings. Returns (65 in total, of which 55 were from young adults 18-24 years) can be seen in table Appendix 3 b.

Table Appendix 3 b: Questionnaire Returns from Targeted Survey

Institution	Responses Received	Other Information
HMP/YOI Isis	30	20 received from Young adults and 10 from prisoners over 25
HM YOI Aylesbury	10	
HMP/YOI Norwich	16	
HMP/YOI Rochester	9	8 received from adults, and 1 from a 17 year old.
HMP/YOI Stoke Heath	Nil	Local IMB declined to participate
Total	65 (54 from young adults)	

Young adults were also given the opportunity to offer views, opinions and responses to the questions by phoning a prison radio Freephone number and leaving a recorded message. These messages were later transcribed and included as evidence with the questionnaires.

This exercise was publicized through an article in ‘INSIDE TIME’ and through an advertisement and an interview with Lord Toby Harris in Prison Radio. In total, 65 questionnaires were returned, and 50 recordings were made on Prison Radio. The recordings were later transcribed so that the panel could consider them alongside the questionnaire responses. Key findings included consistent messages about a desire for more family contact, concern about a perceived lack of respect from staff and concern about how vulnerable people were dealt with. A summary of findings is available at: <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>.

Some of the responses the Harris Review received included distressing comments about the young adult’s wish to harm themselves. Although the Review took the confidentiality of respondents very seriously, in these cases it was felt the Review had a duty for the sake of the respondents’ well-being to pass concern about them on to NOMS Equality, Rights and Decency Group, who have procedures in place for dealing with these concerns.

Appendix 4 – Submissions Received

In response to the Call for Submissions that the Harris Review published on the Harris Review website and Citizen Space on 1 May 2014, we received a total of 54 responses. Of these, 13 were from individuals who were at the time of their submission serving a sentence. In respect to their privacy, we are not publishing their names. The remaining 41 responses that were received are listed here. The full responses are available at <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2>, unless details have been withheld for reasons of confidentiality.

Number	Name	Date Received
1	Harrison Bundy Solicitors	08.05.2014
2	Carly Speed	18.05.2014
3	Serious Case Review	28.05.2014
4	Women in Prison	01.07.2014
5	Scottish Prison Service	08.07.2014
6	Frances Done	09.07.2014
7	Northumbria University	11.07.2014
8	Michael Sieff Foundation	15.07.2014
9	Rob Allen	17.07.2014
10	Samaritans	17.07.2014
11	Youth Justice Board	17.07.2014
12	Equalities and Human Rights Commission	17.07.2014
13	Prison and Probation Ombudsman	17.07.2014
14	Transition to Adulthood Alliance	18.07.2014
15	Office of the Children's Commissioner	18.07.2014
16	Arts Alliance	18.07.2014
17	Who Cares? Trust	18.07.2014
18	Prison Reform Trust	18.07.2014
19	NHS England	01.07.2014
20	Royal College of Nursing	21.07.2014

Number	Name	Date Received
21	Hickman Rose Solicitors	21.07.2014
22	Criminal Justice Alliance	29.07.2014
23	Her Majesty's Inspector of Prisons (HMIP)	24.07.2014
24	Howard League for Penal Reform	28.07.2014
25	Kathy West	30.07.2014
26	Bindmans	01.08.2014
27	Action for Prisoners' Families	04.08.2014
28	Prison Officer's Association	28.08.2014
29	User Voice	15.09.2014
30	Marija Krlic	04.09.2014
31	The Young Review	26.09.2014
32	Catch22	02.10.2014
33	Safe Ground	02.10.2014
34	2ndChanceproject	03.10.2014
35	Inquest	13.10.2014
36	Professors Sim and Tombs (Liverpool St John Moore)	27.10.2014
37	Dr David Scott (Liverpool St John Moore)	29.10.2014
38	Safe – Offender Healthcare (Claire Shepherd)	12.12.2014
39	Marny Zimmer	12.12.2014
40	Jane MacKenzie (Health Inspectorate Wales)	09.12.2014
41	NOMS	03.02.2015

Appendix 5 – Oral Stakeholder Hearings

During the course of the Review, we heard official evidence from stakeholders at 26 separate sessions. These are listed here:

Date	Stakeholder	Attended on behalf by:
15.05.2014	NHS England	Kate Davies, Christine Kelly
22.05.2014	Youth Justice Board	Lord McNally, Lin Hinnigan
22.05.2014	HM Inspectorate of Prisons	Nick Hardwick
22.05.2014	Prison and Probation Ombudsman	Nigel Newcomen
19.06.2014	Department of Health	Anne McDonald
19.06.2014	NOMS	Michael Spurr
26.06.2014	Independent Monitoring Board	John Thornhill, Val Meachin
03.07.2014	Chief Coroner	Peter Thornton
03.07.2014	Professor Louis Appleby	
03.07.2014	Prison Reform Trust	Juliet Lyon and John Drew
03.07.2014	Samaritans	Fiona Malcolm
17.07.2014	Howard League	Frances Crook
17.07.2014	Care Quality Commission	Fergus Currie
04.09.2014	User Voice	Paula Harriott - User Voice (Head of Programmes), Nicole Stanbury - User Voice (Assistant Programme Manager) and Six Young Adults from User Voice
30.10.2014	Baroness Young	Baroness Young, Jessica Mullen
06.11.2014	Prison Governor's Association	Dave Hoskins, Jag Mavi, Mark Ike
06.11.2014	Prison Officer's Association	Steve Gillan
06.11.2014	Black Training and Enterprise Group	Mark Blake
06.11.2014	Zahid Mubarek Trust	Imtiaz Amin, Ray Bewry, Khatuna Tsintsadze
04.12.2014	Magistrates' Association	Fiona Abbott, Jo Easton

Date	Stakeholder	Attended on behalf by:
04.12.2014	Senior Judiciary	Mr Justice Holroyde, Yvonne Powell
15.01.2015	Health and Justice Information Service (HJIS) Project	Dr Jake Hard
15.01.2015	Crown Prosecution Service	John Edwards
29.01.2015	Welsh Government – Health	Sarah Watkins, Mike Hardy
29.01.2015	Health Inspectorate Wales	Lisa Bresner, Jane Mackenzie
12.02.2015	Troubled Families Programme	Emma Jones, Emma Scowcroft

Appendix 6 – Stakeholder Engagement

The Terms of Reference (see Appendix 2) of the Harris Review lists stakeholders with whom the Review was asked to engage. The panel also considered that there were a number of other relevant organisations and people from whom they wanted to hear. As well as the official oral hearings listed in Appendix 5, the Review organised a number of events to enable consideration of a wider range of views and experience. This appendix summarises these events.

Public Hearing - 25th September 2014

The Harris Review into self-inflicted deaths on NOMS custody of 18-24 year olds held a Public Hearing on Thursday 25 September 2014 between 2-4.30pm at the National Council for Voluntary Organisations Society Building, 8 All Saints Street, London. The event was held in order to hear from anyone who would like to contribute to the Review but would prefer to give their views directly to the Panel or who do not wish to submit formal evidence. A public invitation was issued, and invitations were sent to organisations via CLINKS.

Attendees:

Zahid Mubarak Trust	Nina Murphy Associates LLP
British Alliance of African and African Caribbean People (BAACP)	Middlesex University
BTEG (Black Training and Enterprise Group)	NOMS
Oxford Health Trust	Criminal Justice Alliance
Catch 22	HMI Prisons
RAND	Safe Offender Healthcare
Howard League	Lambeth CPCG
IMB	Prisons and Probation Ombudsman
Care UK Clinical Services Limited	Safe Ground

The agenda for the event is available via the Harris Review website (<http://iapdeathsincustody.independent.gov.uk/harris-review/events/>). The event was facilitated by members of the Review Panel and sought views from attendees on topics such as liaison and diversion of young adults; dealing with mental illness of young adults in the criminal justice system; the importance of prisoner-staff relationships and the role of families in maintaining the mental health and well-being of young adults in custody.

Community & Local Stakeholders Seminar – 2nd October 2014

The Harris Review into self-inflicted deaths in NOMS custody of 18-24 year olds invited representatives from groups or organisations that work within local communities to support the needs of vulnerable people, young adults, ex-offenders and also who provide through the gate support in prisons to attend a seminar at the Abbey Centre, 34 Great Smith St, London on 2 October.

Attendees:

Communities for Youth Justice,
The Association of Panel Members (AOPM)
BTEG (Black Training and Enterprise Group)
Noh Budget Films Training and Workshops
Only Connect
NOMS
Atrium Clinic & Therapy Centre
PAPYRUS UK
Durham University

GEO Group UK
Independent Academic Research
Studies (IARS)
London Voluntary Service Council
(LVSC)
Barrow Cadbury Trust
Howard League for Penal Reform
Fair Shares
National Association for People
Abused in Childhood (NAPAC)

Keynote addresses were given by Lord Adebowale⁴⁶⁶ and Diane Curry OBE, CEO of Partners of Prisoners⁴⁶⁷ working to promote, develop and support services and resources for families and friends of prisoners. The agenda for the event is available via the Harris Review website (<http://iapdeathincustody.independent.gov.uk/harris-review/events/>).

The objectives for the day included hearing evidence on relevant issues and experiences that would help inform the overall evidence base for the Harris Review; engage the knowledge of local experts who work closely with young adults and explore key themes relevant to these groups and this cohort, including mental health, support networks, particular issues relevant to BAME young adults.

Family Hearing Events - 16th October 2014 and 27th November 2014

The Harris Review into self-inflicted deaths on NOMS custody of 18-24 year olds held two events to hear directly from the families of those who had died. Both events were held at the National Council for Voluntary Organisations Society Building, 8 All Saints Street, London. The events were facilitated by INQUEST (<http://www.inquest.org.uk/>), following an open competition for the commission.

The names of those who attended have not been recorded here.

⁴⁶⁶ Turning Point (online) <http://www.turning-point.co.uk/news-and-events/media-spokespeople.aspx>.

⁴⁶⁷ Partners of Prisoners (online) <http://www.partnersofprisoners.co.uk/meet-our-ceo>.

Harris Review Young Adult Characteristics Roundtable – 11th December 2014

In order to better understand the particular characteristics of young adults, and how these might impact on their vulnerability in custody, the Harris Review held a roundtable to explore the issue in more detail. The event focussed on such issues as maturity, Care Leavers and transitions between youth and adult services. The agenda for the event is available via the Harris Review website (<http://iapdeathsincustody.independent.gov.uk/harris-review/events/>). Key stakeholders were invited to the event from the following organisations:

Attendees:

The Care Leavers Association

Transition To Adulthood Alliance (T2A)
and Barrow Cadbury Trust

St Giles Trust

Young Minds

Howard League

College of Social Work

NOMS Care Leavers Champion

Probation Services

MoJ, young adult lead

HM Prisons Inspectorate

Deputy Children's Commissioner

Catch 22

Harris Review Liaison and Diversion Roundtable

In order to gain clarity concerning the issues relating to liaison and diversion, and in particular the benefits that could be achieved through greater application to the young adult age group, the Panel undertook an assessment of the challenges and ongoing initiatives within this field. There were three events arranged, each looking at different stages of a young adults engagement with the Criminal Justice System. The agenda for all three events are available via the Harris Review website (<http://iapdeathsincustody.independent.gov.uk/harris-review/events/>).

First Roundtable event – 11th December 2014

The first roundtable event looked at potential diversion of young adults before they become known to the Criminal Justice System and considering what more could be done and by whom.

Attendees:

Just for Kids Law
Family Lives
Crime Reduction Initiative

Second Roundtable event – 19th December 2014

The second event focussed upon the challenges of supporting and diverting young adult offenders at the point of their first experience of the Criminal Justice System and looking to identify what more could be done to ensure that they do not go on to re-offend.

Attendees:

West Midlands Police
NHS England
Youth Justice Board
Just for Kids Law
NHS England - Birmingham and Solihull Mental Health Trust
Action for Prisoners and Offenders Families
Crime Reduction initiative

Third Roundtable event – 14th January 2015

The third and final event looked at the issues associated with sentencing and in particular whether all options were considered and/or presented to Sentencers when deliberating on the most appropriate sentence to reflect the circumstances of the crime and offender and if not what more could be done.

Attendees:

NAPO

Criminal Justice Alliance

TV Edwards NOMS

Home Office, (Safeguarding and Vulnerable People Unit)

Appendix 7 – Prison Visits

Prison visits were considered essential in order to understand the context of the evidence the Review was assessing. A range of establishments were chosen in order to allow the Review to visit, for example, YOIs, local prisons, women's prisons and establishments where young adults were mixed with older adults.

The purpose of these visits was for the panel members to familiarise themselves with the custodial environment and see how a prison operates on a day to day basis. Each visit included a meeting with the governor/ director and key staff, and where possible direct contact with young adults was facilitated. The panel took notice of reception processes (including one visit organised specifically to view a busy evening reception period), association time, prisoner movements, cell conditions, and health and purposeful activity provision.

A short note that summarises each visit is available on the Harris Review website on <http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2/>.

Establishment	Date of Visit	Panel Member(s)
HMP Holloway	8th July 2014	Deborah Coles Professor Philip Leach
HMYOI Brinsford	25th July 2014	Stephen Cragg QC Matilda MacAttram Professor Richard Shepherd
HMYOI Parc	31st July 2014	Lord Toby Harris Matilda MacAttram Dr Meng Aw Yong

Establishment	Date of Visit	Panel Member(s)
HM YOI Aylesbury	15th September 2014	Lord Toby Harris Prof Philip Leach Dr Meng Aw-Yong
HMP&YOI Chelmsford	8th September 2014	Deborah Coles Professor Richard Shepherd Dr Meng Aw Yong
HMP&YOI Swinfen Hall	16th September 2014	Stephen Cragg QC Dr Dinesh Maganty Professor Richard Shepherd
HMYOI Glen Parva	9th October 2014	Lord Harris
HMP&YOI Isis	1st December 2014	Professor Philip Leach Matilda MacAttram
HMP Leeds	16th December 2014	Professor Richard Shepherd Professor Graham Towl

Appendix 8 – Out of Committee Papers

During the course of the Review, the panel considered a significant number of reports, Prison Service Instructions (PSIs), policy documents and other documents that were circulated out of committee (OOC) rather than for the purpose of a specific agenda item. Some of these papers were also discussed during meetings. This appendix lists these papers, most of which can all be accessed at <http://iapdeathsincustody.independent.gov.uk/about/learning-library/>. A small number of papers sent to the panel have been redacted for legal and confidentiality reasons.

OOC Paper Number	Document Title	Date Distributed to Panel
1.	NOMS (2011). <i>Prison Service Instruction 64/2011 (Safer Custody)</i> . London: NOMS. http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc .	13 June 2014
2.	NOMS (2015). <i>Prison Service Instruction 30/2013 – (Incentives and earned privileges)</i> . London: NOMS. http://www.justice.gov.uk/downloads/offenders/psipso/psi-2013/psi-30-2013-1.doc .	13 June 2014
3.	NOMS (2011). <i>Prison Service Instruction 75/2011 (Residential Services)</i> . London: NOMS. https://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-75-2011-residential-services.doc .	13 June 2014
4.	NOMS (2011). <i>Prison Service Instruction 74/2011 (Early days in custody - reception in, first night in custody, and induction to custody)</i> . London: NOMS. http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-74-2011-early-days-in-custody.doc .	13 June 2014
5.	NOMS (2011). <i>Prison Service Instruction 11/2011 (Incentives and earned privileges)</i> . London: NOMS. http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi_2011_11_incentives_and_earned_privileges.doc .	13 June 2014
6.	NOMS (2011). <i>Prison Service Instruction 09/2011 (The cell sharing risk assessment)</i> . London: NOMS. http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi_2011_09_CSRA_final.doc .	13 June 2014

OOC Paper Number	Document Title	Date Distributed to Panel
7.	NOMS (2012). <i>Prison Service Instruction 08/2012 Care Management of Young People</i> . London: NOMS. http://www.justice.gov.uk/downloads/offenders/psipso/psi-2012/psi-08-2012-care-management-young-people.doc .	13 June 2014
8.	NOMS (2013). <i>Prison Service Instruction 72/2011 (Discharge)</i> . London: NOMS. http://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-72-2011.doc .	13 June 2014
9.	NOMS (2010). <i>Prison Service Instruction 58/2010 (The Prisons & Probation Ombudsman)</i> . London: NOMS. http://www.justice.gov.uk/downloads/offenders/psipso/psi-2010/psi_2010_58_prisons_probation_ombudsman.doc .	13 June 2014
10.	NOMS (2014). <i>Prison Service Instruction 15/2014 (Investigations and Learning following Incidents of Serious Self-Harm or Serious Assaults)</i> . London: NOMS. http://www.justice.gov.uk/downloads/offenders/psipso/psi-2014/psi-15-2014-self-harm-serious-assaults.pdf .	13 June 2014
11.	Saunders, A. (2014). <i>Young adults (18-24) in transition, mental health and criminal justice</i> . The Bradley Commission, Briefing 2. London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf .	13 June 2014
12.	Criminal Justice Joint Inspection (2012). <i>Transitions: An inspection of the transitions arrangements from youth to adult services in the criminal justice system</i> . London: CJI and Inspection of Youth Offending. http://www.cqc.org.uk/sites/default/files/documents/cji-transitions-thematic.pdf .	13 June 2014
13.	Offender Health Research Network (2013). <i>Comprehensive Health Assessment Tool (CHAT): Young People in the Secure Estate</i> . London: OHRN. http://www.ohrn.nhs.uk/OHRNResearch/CHATToolV3June2013.pdf .	13 June 2014
14.	Offender Health Research Network (2013). <i>Manual for the Comprehensive Health Assessment Tool (CHAT): Young People in the Secure Estate</i> . London: OHRN. http://www.ohrn.nhs.uk/OHRNResearch/CHATManualV32013.pdf .	13 June 2014

OOC Paper Number	Document Title	Date Distributed to Panel
15.	Royal College of Paediatrics and Child Health (2013a). <i>Healthcare Standards for Children and Young People in Secure Settings</i> . London: RCPCH. http://www.rcpch.ac.uk/system/files/protected/page/Healthcare%2ostandards%20A4%2oreport%2opages%20english%20compressed%20FINAL.pdf .	13 June 2014
16.	Durcan, G., Saunders, A., Gadsby, B. & Hazard, A. (2014). <i>The Bradley report - 5 years on</i> . London: Centre for Mental Health. http://www.centreformentalhealth.org.uk/the-bradley-report-five-years-on .	13 June 2014
17.	Bradley, K. (2009). <i>The Bradley Report: Lord Bradley's review of people with mental health problems or learning disability in the criminal justice system</i> . London: DH. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf .	13 June 2014
18.	NOMS (2010). <i>Quick Time Learning Bulletin: Safer custody</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
19.	NOMS (2012). <i>Quick Time Learning Bulletin number 12 Responding to Medical Emergencies</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
20.	NOMS (2012, issue 10). <i>Quick Time Learning Bulletin, Increased Risks in Young Offenders and Young People</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
21.	NOMS (2013). <i>Quick Time Learning Bulletin, Clarification on appropriate use of Cell Sharing Risk Assessment</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014

OOC Paper Number	Document Title	Date Distributed to Panel
22.	NOMS (2013) <i>Quick Time Learning Bulletin - Improving Self Harm outcomes by working effectively with Approved Premises</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
23.	NOMS (2011). <i>Quick Time Learning Bulletin - Retention of Documents for Investigations following a Death in Custody and Inquests</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
24.	NOMS (2011). <i>Quick Time Learning Bulletin - Managing Violent Behaviours</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
25.	NOMS (2011). <i>Quick Time Learning Bulletin - Assessment, Care in Custody & Teamwork (ACCT)</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
26.	NOMS (2013). <i>Quick Time Learning Bulletin - Risks Associated with Offence & Status</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
27.	NOMS (no date, issue 3). <i>Quick Time Bulletin 3: Constant Supervision</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
28.	NOMS (2012). <i>Quick time learning bulletin: Family liaison</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
29.	NOMS (2012). <i>Quick Time Learning Bulletin Issue 12</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014

OOO Paper Number	Document Title	Date Distributed to Panel
30.	NOMS (2011). <i>Quick time learning bulletin Concerted Indiscipline</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
31.	NOMS (2011). <i>Quick-Time Learning Bulletin - Early Release on Compassionate Grounds</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
32.	NOMS (no date). <i>Quick Time Learning Bulletin Disruptive Behaviour</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
33.	NOMS (2013). <i>Quick Time Learning Bulletin Enhanced Case Review</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
34.	NOMS (2013). <i>Shouting Out – Young People and Young Adults</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
35.	NOMS (2010). <i>Quick Time Learning Bulletin Safer cells bulletin</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014
36.	Grubin, D., Carson, D. & Parsons, S. (2002). <i>Report on new prison reception health screening arrangements: the results of a pilot study in 10 prisons</i> . London: NHSE. https://www.networks.nhs.uk/nhs-networks/health-and-criminal-justice-liaison-and-diversion/messageboard/implementation-plans/466291528/917135531/don-grubin-reception-screen-doc	13 June 2014
37.	NOMS (no date, issue 2). <i>Quick Time Learning Bulletin – Cell fires and self-harm</i> . London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	13 June 2014

OOO Paper Number	Document Title	Date Distributed to Panel
38.	IMB (2013). <i>Behind Closed Doors: The Sixth Annual Report of the National Council for IMBs</i> . London: IMB. http://www.imb.org.uk/wp-content/uploads/2015/03/behind-closed-doors-2013.pdf .	1 July 2014
39.	Department of Health (17 November 2009). <i>Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board</i> . London: DH. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_109155.pdf .	1 July 2014
40.	HMG/Department of Health (10 September 2012). <i>Preventing suicide in England: A cross-government outcomes strategy to save lives</i> . London: DH. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf .	1 July 2014
41.	OOO Paper 41 has been redacted as it was a draft report received from commissioned research.	31 October 2014
42.	OOO Paper 42 has been redacted as it included personal information about notification of deaths.	31 October 2014
43.	OOO Paper 43 has been redacted as it contains advice from the Review's legal advisors.	20 November 2014
44.	MBDC (2013). <i>A review of unclassified deaths in custody-2010-12</i> . London: IAP. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	24 November 2014
45.	NOMS (2014). <i>Factors underlying the increase in the prison population</i> . London: NOMS. http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2	24 November 2104
46.	NOMS (2012). <i>Review of Unclassified Deaths</i> . London: NOMS. http://iapdeathsincustody.independent.gov.uk/harris-review/harris-review-research-2	25 November 2014

OOO Paper Number	Document Title	Date Distributed to Panel
47.	Young, L. (2014). <i>The Young Review: Improving outcomes for young black and/or Muslim men in the Criminal Justice System</i> . London: Barrow Cadbury Trust. http://www.youngreview.org.uk/sites/default/files/clinks_young-review_report_dec2014.pdf .	15 December 2014
48.	OOO Paper 48 has been redacted as it was an interim report about research that had not been completed.	15 December 2014
49.	NHS (2012). <i>The National Health Service, Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012</i> . London: TSO. http://www.nhs.uk/choiceintheNHS/Rightsandpledges/Waitingtimes/Documents/nhs-england-and-ccg-regulations.pdf .	15 December 2014
50.	Department of Health (2014). <i>Care and Support Statutory Guidance – Chapter 17</i> (online publication). London: DH. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf .	15 December 2014
51.	NOMS (January 2011). <i>Working with personality disordered offenders - A practitioner's guide</i> . London: NOMS. https://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/working-with-personality-disordered-offenders.pdf .	15 December 2014
52.	Health & Social Care Information Centre (2014). <i>Offender Health IT (OHIT) programme</i> (online publication). London: HSCIC. http://systems.hscic.gov.uk/offender .	15 December 2014
53.	Prison Reform Trust (2001). <i>Troubled Inside: Responding to the Mental Health needs of Children and Young People in Prison</i> . London: PRT. http://www.prisonreformtrust.org.uk/Portals/o/Documents/Troubled_Inside_Children.pdf .	15 December 2014
54.	Department of Health (2014, version 2). <i>Closing the Gap: Priorities for essential change in mental health</i> . London: DH. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf .	17 December 2014

OOC Paper Number	Document Title	Date Distributed to Panel
55.	Setty E., Sturrock, R. & Simes,E. (2014). <i>Gangs in Prison: The nature and impact of gang involvement among prisoners.</i> London: Catch22. http://www.catch-22.org.uk/wp-content/uploads/2014/11/Dawes-Unit-Gangs-in-Prison-full-report.pdf .	17 December 2014
56.	NOMS (no date). <i>Five Minute Intervention – Portland.</i> London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	17 December 2014
57.	NOMS (no date). <i>Five Minute Intervention – Portland</i> (supporting slides). London: NOMS. Can be accessed at http://iapdeathsincustody.independent.gov.uk/about/learning-library/	17 December 2014
58.	Department of Health (2009). <i>Improving Health, Supporting Justice The National Delivery Plan of the Health and Criminal Justice Programme Board.</i> London: DH. http://www.revolving-doors.org.uk/documents/improving-health-supporting-justice/ImprovingHealth,SupportingJustice.pdf .	17 December 2014
59.	Department of Health (2011). <i>No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.</i> London: DH. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf .	17 December 2014
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Appendix 9 – Glossary of Terms

Acronym/Term	Definition
ACCT	Assessment, Care in Custody & Teamwork. <i>“ACCT is a prisoner-centred, flexible care-planning system which, when used effectively, can reduce risk. The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed”</i> (PSI 64/2011, page 26). ACCT is used for those who are believed to be at risk of self-harm or suicide.
ACR	Automatic Conditional Release. ACR is when someone will automatically be released from prison to serve the rest of their sentence in the community. There are different arrangements depending on the length of the original sentence. For more information see: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/218139/oms-definitions-measurement.pdf .
ADAPT	Alcohol and Drug Addiction Prevention and Treatment. This is an accredited programme to help people desist from the use of drugs and alcohol.
ADHD	Attention Deficit Hyperactivity Disorder
AED	Automated External Defibrillator
Allocation	The process of deciding to which institution an offender should be sent.
AMHP	Approved Mental Health Professional
APVS	Assisted Prison Visits Scheme. This means-tested scheme provides funding to lower income families to enable them to travel to visit an offender in prison.
Association time	Association time is time when prisoners are allowed to mix with each other outside their cells.
BAME	Black, Asian and Minority Ethnic
BCST	Basic Custody Screening Tool. All those in custody will receive a basic custody screening (BCS), carried out by prison staff as part of the reception and induction process, to identify immediate and resettlement needs (see PSI19/2014, page 2).
BLS	Basic Life Support. Basic life support refers to maintaining airway patency and supporting breathing and the circulation without the use of equipment other than a protective device (adapted from https://www.resus.org.uk/pages/bls.pdf , page 1).

Acronym/Term	Definition
Bradley Report	Lord Bradley’s Review of people with mental health problems and learning disabilities in the criminal justice system, which was published April 2009. Archived at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694
BTEG	Black Training and Enterprise Group
CAMHS	Child and Adolescent Mental Health Service
CARO	Custody and Rehabilitation Officer. This is a new role proposed in the Harris Review Report, which gives one individual responsibility for managing the care and rehabilitation of each young adult in custody.
Categorisation	Prisoners are categorised according to their security risk and the threat they might pose to the public if they were to escape. PSI 40/2011 states that <i>“the purpose of categorisation is to assess the risks posed by a prisoner in terms of: likelihood of escape or abscond; the risk of harm to the public in the event of an escape or abscond; any control issues that impact on the security and good order of the prison and the safety of those within it and then to assign to the prisoner the lowest security category consistent with managing those risks”</i> (page 6).
Category A	<i>“Prisoners whose escape would be highly dangerous to the public or the police or the security of the State and for whom the aim must be to make escape impossible”</i> (PSI 40/2011, page 6).
Category B	<i>“Prisoners for whom the highest conditions of security are not necessary but for whom escape must be made very difficult”</i> (PSI 40/2011, page 6).
Category C	<i>“Prisoners who cannot be trusted in open conditions who do not have the will or resources to make a determined escape attempt”</i> (PSI 40/2011, page 6).
Category D	<i>“Prisoners who present a low risk; can reasonably be trusted in open conditions and for whom open conditions are appropriate”</i> (PSI 40/2011, page 6).
Cell bell/call	Call button in cells to summon staff in an emergency
CJS	Criminal Justice System
CPT	European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CQC	Care Quality Commission

Acronym/Term	Definition
CRC	Community Rehabilitation Companies are part of the Transforming Rehabilitation work to transform the way offenders are managed. <i>“There are 21 Community Rehabilitation Companies (CRCs) responsible for the management of low to medium risk offenders [and] supervising short-sentence prisoners (those sentenced to less than 12 months in prison) after release”</i> (quoted from http://www.clinks.org/criminal-justice-transforming-rehabilitation/introduction-transforming-rehabilitation).
CSRA	Cell sharing risk assessment. <i>‘The CSRA is an essential tool in the identification of prisoners at risk of seriously assaulting or killing a cell mate in a locked cell. It must be implemented as part of the Violence Reduction Strategy’</i> (PSI 09/2011, page 1). Since the Review, PS109/2011 has been superseded by PS120/2015.
DCLG	Department for Communities and Local Government
DH	Department of Health
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EPR	European Prison Rules
FNO	Foreign National Offenders
GMC	General Medical Council
HCA	Health Care Assistant
HCO	Health Care Officer
HIW	Healthcare Inspectorate Wales
HJIS	Health & Justice Information Service
HMCIP	Her Majesty’s Chief Inspector of Prisons
HMIP	Her Majesty’s Inspectorate of Prisons
HRA	Human Rights Act
IAP	Independent Advisory Panel on Deaths in Custody (http://iapdeathsincustody.independent.gov.uk/)
IAPT	Improving Access to Psychological Therapies
ICP	Individual Care Plan

Acronym/Term	Definition
IEP	Incentives and earned privileges; this is an internal prison policy for incentivising prisoners. In order to earn privileges, prisoners will [now] have to work towards their own rehabilitation, behave well and help others. The absence of bad behaviour alone will no longer be sufficient to progress through the scheme (PSI 30/2013, page 3).
IMB	Independent Monitoring Board
Induction	Induction introduces prisoners to custody. PSI 74/2011 states that <i>“induction consists of two modules; one that provides an introduction to custody for new prisoners only, and a second on preparation for life in the specific establishment for all. This avoids repetition while focusing on individual needs”</i> (page 2). Since the Review PSI 74/2011 has been superseded by PSIO7/2015.
IPCC	Independent Police Complaints Commission
JCHR	Joint Committee on Human Rights
LCJB	Local Criminal Justice Board
Listener Scheme	Prisoners volunteer to provide confidential emotional support to fellow prisoners. The Samaritans’ team at the prison select those who are suitable for this role and train them. Samaritans provide ongoing support to Listeners and the prison. http://www.samaritans.org/your-community/our-work-prisons/listener-scheme
MAPPA	Multi-agency public protection arrangements: is the name given to arrangements in England and Wales for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public.
MCDC	Ministerial Council on Deaths in Custody
MDT	Multi-disciplinary team who support the CARO to review the Individual Care Plan
MHIRT	Mental Health In-Reach Team - these are mental health professionals working in prisons.

Acronym/Term	Definition
MQPL	'Measuring the Quality of Prison Life' is a questionnaire-based survey designed to gauge 'decency' and other vital aspects of a prison's moral, social or rehabilitative culture. MPQL data is self-report data that is usually presented under overarching 'dimensions'. It should be noted that analysis of individual items might be less reliable than analysis of the dimensions. The Review has been cautious in its interpretation of the data and understands that future reports produced by NOMS may provide more reliable interpretation. It is most often used as a management tool by NOMS, although the panel felt that it had the potential to have wider application.
Moj	Ministry of Justice
Never Events	Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented (see http://www.nrls.npsa.nhs.uk/neverevents).
NGO	A Non-Governmental Organisation
NHS	National Health Service
NHS England	National Health Service, England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NOMS	National Offender Management Service
NPS	National Probation Service: a statutory criminal justice service that supervises high-risk offenders released into the community
OASys	Offender Assessment System . Assessment system for both prisons and probation, providing a framework for assessing the likelihood of reoffending and the risk of harm to others.
Observation book	A log kept on residential units in prisons in which staff record significant events or observations during their shift. It provides an ongoing record of these for staff on the next shift.
OCC	Office of the Children's Commissioner
OHRN	Offender Health Research Network
OPCAT	Optional Protocol to the Convention against Torture
PECS	Prisoner Escort and Custody Services. The service that moves prisoners between police custody, courts and prisons. Contracted providers of the service are overseen by NOMS.

Acronym/Term	Definition
PER	Person Escort Record. This is a form that is designed to ensure that information about the risks posed by, and vulnerabilities of, prisoners being transferred within the criminal justice system is communicated between those responsible for their custody.
PGA	Prison Governors' Association
PIN	Personal identification number. This is the number that each prisoner will need to be issued with in order to use the prison telephones to make calls.
P-Nomis	Prison Service IT system for holding the data collected about each individual prisoner.
POA	Prisons Officers' Association
POELT	Prison Officer Entry Level Training. This is the initial training offered in order to become a prison officer.
PPO	Prisons and Probation Ombudsman
PRT	Prison Reform Trust
PSI	Prison Service Instruction. There are a number of rules, regulations and guidelines by which prisons are run. These are outlined in Prison Service Instructions (PSIs) and Prison Service Orders (PSOs). They cover various aspects of prison life and the management of prisoner. For more information see: http://www.justice.gov.uk/offenders/psis .
PSO	Prison Service Order. As above, these have largely been replaced by PSIs but there are still some in use.
PSRs	Pre-sentence reports – produced by the National Probation Service to assist the sentencing court
RCUK	Resuscitation Council UK
ROTL	Release on Temporary Licence. This is <i>“the mechanism that enables offenders to participate in necessary activities, outside of the prison establishment, that directly contribute to their resettlement into the community and their development of a purposeful, law-abiding life”</i> (PSI 13/2015, page 8).
Safer cells	Safer cells are designed to make the act of suicide or self-harm by ligaturing as difficult as possible. However, where a prisoner is accommodated in a safer cell this forms only a part of the package of support measures that are put in place to manage the risk of self-harm or suicide (adapted from PSI 64/2011, page 32).

Acronym/Term	Definition
SAVRAS	Safety and Vulnerability, Risk Assessment and Support: a new process proposed in the Report.
SCH	Secure Children's Home. Holds children under the age of 17 who have been given a custodial sentence or are being remanded in custody. Usually holds more vulnerable young people.
Self-inflicted death	Self-inflicted death is the inclusive term used to describe the death of a prisoner who has apparently taken his or her own life irrespective of intent. This not only includes suicides but also accidental deaths as a result of the person's own actions. This classification is used because it is not always known whether a person intended to commit suicide.
SMART	Specific, measurable, achievable, realistic and time bound is a management term used to ensure that objectives are clearly defined.
SPCR	Surveying Prisoner Crime Reduction is 'a longitudinal cohort study of adult prisoners sentenced to between one month and four years in England and Wales in 2005 and 2006.' https://www.gov.uk/government/collections/surveying-prisoner-crime-reduction-spcr
STC	Secure Training Centre. Holds children under the age of 18 who have been given a custodial sentence or who are being remanded in custody.
SystemOne	Electronic clinical information system used by clinicians to hold and share confidential electronic medical information.
T2A	Transition to Adulthood Alliance is a Non-Government Organisation.
TTG	Through the Gate. This term is used to encompass services for offenders leaving prison custody and returning to the community.
YJB	Youth Justice Board
YOI	Young Offender Institution. These are establishments that hold younger inmates. There are YOIs for 15-17 year olds and for 18-20 year olds. Under the sentence of DYOI (Detention in a Young Offender Institution), young adults who are 18-20 years cannot be sentenced to imprisonment or committed to a prison. Instead they are accommodated in a YOI.
YOT	Youth Offending Team. YOTs work with offenders up to age 18.

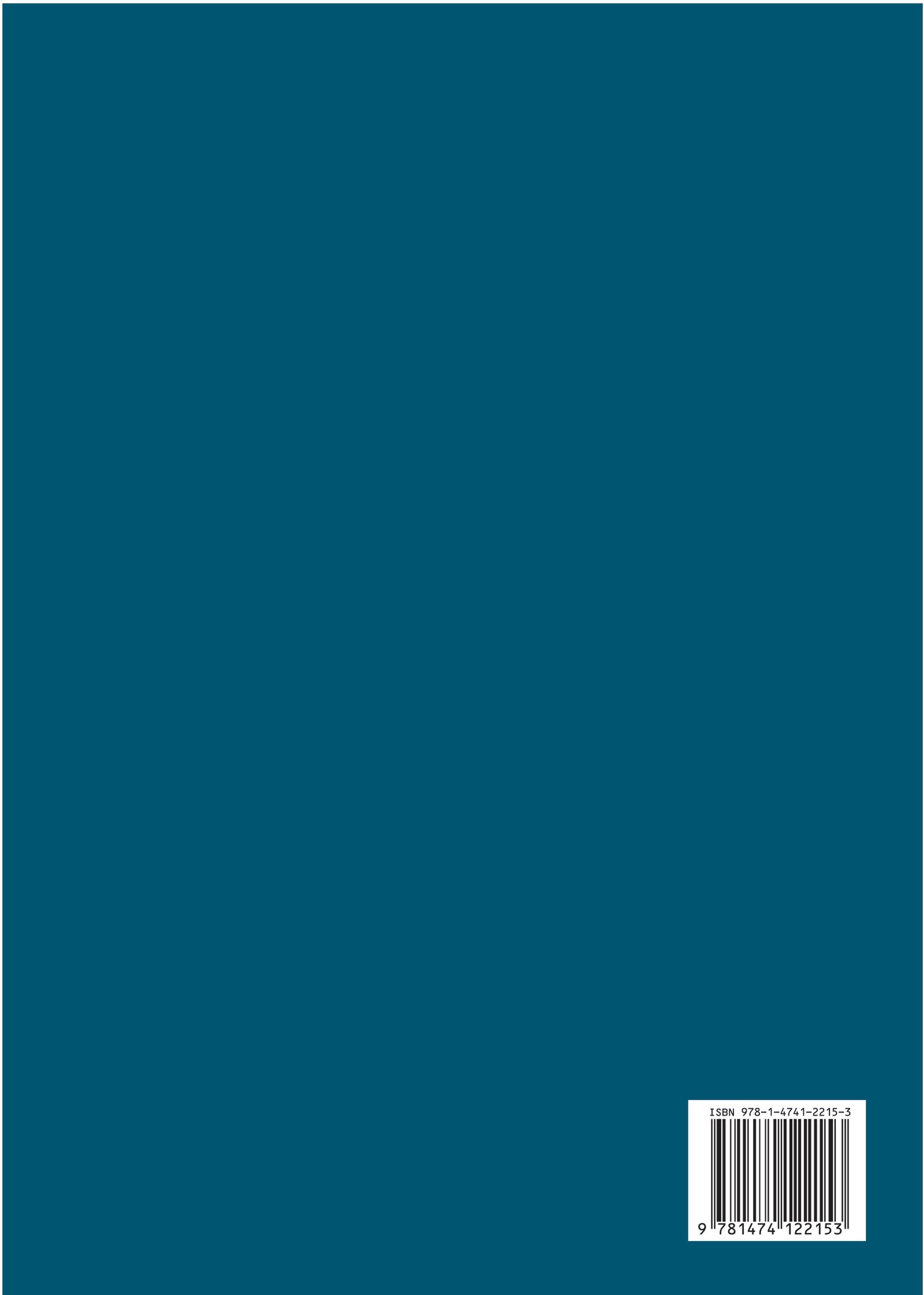


Acronym/Term	Definition
Young Adults	The term ‘young adult’ can be used widely in society to refer to adults anywhere between 18 years and mid to late twenties. In the context of the CJS, it can have a more specific meaning and refers to 18-20 year old offenders who are sentenced under DYOI (see entry of YOI above). Under DYOI, young adults cannot usually be sentenced to imprisonment, and instead are accommodated in a YOI. The Harris Review was commissioned to look more broadly at the self-inflicted death of young adults between 18 and 24 years. For this reason, when ‘young adults’ are referred to in this report, we mean those individuals who are aged 18-24 years, unless otherwise specified.
Young People	The term ‘young people’ can be used widely in society to refer to teenagers and young adults alike. In NOMS and the CJS in general, the term ‘young people’ usually refers more specifically to children under the age of 18 who are held in YOIs, STCs or SCHs. During the writing of the report, we used the term ‘young people’ when referring more generally to 15-17 year olds and also to young adults (for example, if referring to all of the 87 cases we examined).









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