Written evidence from the Independent Advisory Panel on Deaths in Custody

About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel (IAP)
- Practitioner and Stakeholder Group

The remit of the IAP (and overall of the Council) covers deaths, both natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAP, a non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAP's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE chairs the IAP.

Members of the IAP appointed in July 2018 are:
- Deborah Coles, Director, INQUEST
- Professor Seena Fazel, professor of Forensic Psychiatry, University of Oxford
- Professor Jenny Shaw, professor of Forensic Psychiatry, University of Manchester
- Jenny Talbot OBE, Prison Reform Trust
- John Wadham, Chair, National Preventative Mechanism

Further information on the IAP can be found on its website: www.iapondeathsincustody.org.

Key points:

- **It is essential to improve the confidence of the courts in community sentences in order to avoid the misuse of prison as a 'place of safety' for vulnerable people. And the role of probation services and good pre-sentence reports is pivotal here. In turn this would reduce the risk of suicide and self-harm in custody.**
- **Better integration of roles between prison and probation staff, healthcare and housing, proper preparation for release and ongoing support and supervision could, and should, reduce the risk of self-harm and suicide posed by fear of release. It should also improve communication between agencies and reduce the number of natural deaths where health conditions have gone undiagnosed and untreated.**
- **Further work should be done to build on research conducted into deaths on release from custody under probation supervision and those that occur in approved premises. Particular attention should be paid to drug toxicity.**

- **Lessons should be learned from other jurisdictions. Steps can be taken to ensure safety is always considered fully during major policy decisions that affect lives. A statutory safety impact assessment should be introduced and maintained.**

1. The Independent Advisory Panel on Deaths in Custody (IAP) welcomes this inquiry into the effectiveness of the Probation Service. The IAP's focus falls on the deaths of people in custody, including residents of Approved Premises.[1] There were 19 deaths of offenders with residence in Approved Premises in 2018/19.[2]

2. The IAP broadly welcomes the proposed reforms of the probation system and believes the responsibility for the supervision of all offenders' transfer to the National Probation Service will improve outcomes for individuals and public safety.

3. This evidence draws on relevant IAP research and the expertise of panel members to call for greater resourcing and promotion of alternatives to custody.

Building confidence in community sentences

4. In response to concerns about unmet mental health needs, the worrying rise of self-inflicted deaths in custody and exceptionally high levels of self-harm, the IAP has carried out work to improve – and increase the poor take-up of – community mental health and liaison and diversion services.

5. Prompted by MoJ figures revealing that fewer than one per cent of community sentences handed down in 2018 contained a mental health treatment requirement (MHTR), in partnership with the Magistrates Association (MA) the IAP carried out and published the results of an independent survey of the views of magistrate Bench Chairs and Mental Health Champions on sentencing powers and practice in relation to offenders with mental health conditions, learning disabilities and other needs.[3]

6. The survey showed that, while magistrates appeared keen to make use of Community Sentence Treatment Requirements (CSTRs), they were deterred from doing so by a lack of availability in their area and/or lack of information and adequate pre-sentence reports from probation services. Over half of magistrates responding to the survey said they had 'never' included a mental health treatment requirement as part of a community sentence, with the remaining respondents saying that they 'rarely' had.[4]

   Use of community sentence treatment requirements 2018.[5]

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[1] Independent Advisory Panel, 'About the Independent Advisory Panel on Deaths in Custody', https://www.iapondeathsincustody.org/about-us-1.
[2] Ministry of Justice, Deaths of Offenders in the Community, England and Wales, 2018/19, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843140/deaths-offenders-community-2018-19-bulletin.pdf.
[3] Magistrates Association and the Independent Advisory Panel on Deaths in Custody, 'Survey Effective community sentences and the role treatment requirements can play in preventing deaths in custody', June 2019: https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5d760017df09514a97a4f6ce/1568014366659/MA+IAP+survey+final+270619.pdf.
[4] ibid
[5] Juliet Lyon and Jenny Talbot, 'Effective community sentences and the role treatment requirements can play in preventing deaths in custody, MAGISTRATE, December 2019 – January 2020, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5e32ab4d1e28eb2e4b199c02/1580378957983/Effective+community+sentences+and+the+role+treatment+requirements+can+play+in+preventing+deaths+in+custody+-+MAGISTRATE+December+2019-January+2020.pdf

	Community orders 2018 Total: 75,750	Suspended sentence orders 2018 Total: 34,257
Mental health treatment requirement	0.6% (454)	0.6% (205)
Drug rehabilitation requirement	5.7% (4,317)	7.7% (2,637)
Alcohol treatment requirement	4.1% (3,105)	4.7% (1,610)

7. This can and must be rectified. The IAP and MA are continuing to work with senior probation leadership and will monitor delivery of planned improvements to the quality of pre-sentence reports (PSRs), improvements in the availability of treatment nationwide and, importantly a significant increase in the use by the courts of community sentences with treatment requirements.[6]

8. We have evidence to suggest that courts default to short prison sentences when not confident in/informed about community sentences.

9. Alternatives to custody are essential in preventing the deaths of women.[7] IAP research into women in prison demonstrates that deaths can be prevented through addressing unmet mental health requirements in order to meet the complex needs of a particularly vulnerable population.[8] Recommendations were presented to the Ministry of Justice's Advisory Forum on Female Offenders, accepted by government and included in its strategy on female offenders.

10. The report found that:

    a. Insufficient attention is paid to preventative work and effective community sentences which would avoid separation from family, the losses sustained by imprisonment and the uphill battle on release to find somewhere safe to live and a means of earning a living – all of which increase the risk of suicide and self-harm.
    b. Concerns were raised about insufficient information for the courts, an absence of pre-sentence reports and a tendency to resort to use of prison as a place of safety.

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[6] See also Juliet Lyon and Jenny Talbot, 'Effective community sentences and the role treatment requirements can play in preventing deaths in custody: an update', MAGISTRATE, August 2020 – September 2020, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5f2c0dc9aed380004a350016/1596722636347/Effective+community+sentences+MAGISTRATE+August-September+2020.pdf ; Juliet Lyon and John Bache, 'Effective community sentences: the role of treatment requirements', Probation Quarterly, September 2020 https://static1.squarespace.com/static/5ec3ce97a1716758c54691b7/t/5f438e00b398394e2d99d1ac/1598262837547/PQ17.pdf.

[7] Independent Advisory Panel on Deaths in Custody, 'Preventing the Deaths of Women in Prison – initial results of a rapid information gathering exercise by the Independent Advisory Panel on Deaths in Custody', March 2017, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5f5207216dd18341fc2848a2/1599211305040/IAP%2Brapid%2Bevidence%2Bcollection%2B-%2Bv0.3.pdf.

[8] *Ibid.*

c. There are examples of good practice before, during and after custody – however, these providers are struggling with resource pressures and the lack of a gender-specific approach to safeguarding women.
d. Too many women are released with insufficient support – particularly in fundamental areas such as safe housing – leading to a quick return to addiction, crime and custody: "the revolving door".

11. In the community, the report concluded the need to:
    a. Ensure adequate information is provided to the courts including reports covering mental health need, vulnerability and safeguarding concerns.
    b. Encourage greater use of community sentences by the courts to include treatment orders.
    c. Coordinate national and local government leadership focus on prevention and the strategic reduction of women's prison numbers.
    d. Roll-out liaison and diversion services across police stations and courts
    e. Increase investment in women's services in the community and look to models of local authority pooled budgeting as in Greater Manchester.
    f. Develop a sustained network of women's centres.
    g. Co-ordinate a multi-disciplinary response to vulnerable women involving family support and domestic violence services as well as health and justice provision.

Prisons and probation integrating through-the gate roles

12. It should come as no surprise that the very real fear of release from custody with little or no support, no work or money and nowhere safe to live can lead to self-harm and suicide. Better integration of roles, proper preparation for release and ongoing support and supervision could, and should, reduce that risk.

13. As part of its Keeping Safe prisoner consultation, the IAP was told:

> *"People who are released then tell probation they are suicidal – probation then send them back as they are a risk to themselves."*
>
> *"Probation I know are over-worked but that area needs to be looked into"*[9]

14. Efforts made by probation services to work with colleagues in prisons, healthcare and local authority housing departments could, and should, be developed and maintained.

15. The challenges posed by COVID-19 have put these issues into sharp focus:

> *'I would like to ask if there is any chance of asking questions about the Coronavirus as I am being released in 35 days with no license sentence. I've got no housing in place, no benefits, and I've got nowhere to go. I've got no healthcare place. And this coronavirus thing is getting more and more lock down and transfers to other place, I don't know what to do.'*[10]

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[9] P.46. Independent Advisory Panel on Deaths in Custody, 'Keeping Safe: Preventing Suicide and Self-harm in Custody', December 2017, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ed5178d95645801a7a5e321/1591023614282/Keeping+Safe+-+FINAL+-+Dec+2017.pdf .

[10] Independent Advisory Panel on Deaths in Custody, '"Keep Talking, Stay Safe": A rapid review of prisoners' experience under Covid-19', 1 June 2020, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ee115af9592717e002903f8/1591809460419/200601+IAP+rapid+review+of+prisoner+experiences+under+Covid-19+-+FINAL+CLEAN.pdf.

Preventing deaths in approved premises

16. There were 19 deaths of offenders with residence in Approved Premises in 2018/19.[11] Compared to deaths in prison custody only limited attention is paid to such deaths in regard to learning from them and applying research to policy and practice.

17. In 2012 the Prisons and Probation Ombudsman (PPO) published 'Learning from fatal incidents in approved premises'[12] which focussed largely on probation staff understanding and responding to drug toxicity. Subsequently in 2017 the PPO published a report on approved premises and substance misuse[13] which concluded that there needs to be more effective drug testing practices and better staff guidance to identify and address the risks associated with substance misuse and support individuals.

18. Notable academic research in this field has been conducted by Dr Jake Phillips, Sheffield Hallam University, and Professor Nicola Padfield and Professor Lorraine Gelsthorpe, University of Cambridge[14], commissioned by, amongst others, the Howard League for Penal Reform[15] and the Equality and Human Rights Commission.[16]

19. Recently the BBC shared data unit drew attention in 2019 to a significant rise in people dying in approved premises between 2015/16 and 2017/18 during the period of 'transforming' probation.

20. The IAP would like to see a more concerted effort made by the probation service, HM Inspectorate of Probation and the Prisons and Probation Ombudsman as well as coroners and academic partners to embed the learning from reports on deaths in approved premises and reduce the risk of further such tragic events.

Lessons from probation reforms in Wales

21. Self-harm is particularly prevalent among people still serving the long since abolished indeterminate sentence for public protection (IPP).[17]

22. Information from probation and prison psychology managers indicates that Progression Panels, established and piloted in Wales co-led by probation, prison and psychology services, have helped to introduce some progress and hope into the lives of those still

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[11] Ministry of Justice, Deaths of Offenders in the Community, England and Wales, 2018/19, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843140/deaths-offenders-community-2018-19-bulletin.pdf.

[12] PPO, Learning from Approved Premises 2012 http://www.ppo.gov.uk/app/uploads/2014/07/LLB_FII_01_Learning_from_approved_premises_final_web.pdf#:~:text=Probation%20Ombudsman%E2%80%99s%20%28PPO%29%20first%20Learning%20Lessons%20Bulletin%20relating,There%20are%20approximately%20100%20approved%20premises%20across%20England

[13] PPO Learning Lessons Bulletin, Fatal Incidents Investigation, Approved Premises – substance misuse https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2017/11/PPO-Learning-Lessons-Bulletin_AP-deaths-substance-misuse_WEB.pdf

[14] Deaths While under Probation Supervision: What Role for Human Rights Legislation? https://onlinelibrary.wiley.com/doi/abs/10.1111/1467-923X.12746

[15] Howard League, Deaths on Probation https://howardleague.org/wp-content/uploads/2016/05/Deaths-on-probation.pdf

[16] Equality and Human Rights Commission, Non-natural Deaths following Prison and Police Custody, https://www.equalityhumanrights.com/sites/default/files/research-report-106-non-natural-deaths-following-prison-and-police-custody.pdf

[17] Indeterminate sentences for public protection (IPPs): preventing self-harm and deaths in custody, June 2019, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ec5081628025026638c805a/1589970970941/IPP+briefing+paper+for+Ministers+FINAL.pdf

left serving an IPP sentence. The IAP welcomes this development and would like to see further evaluation of outcomes and consistent use of these panels across England and Wales.

23. Wales has been selected to establish and pilot a network of women's centres with multi-disciplinary engagement including probation as an alternative to custody. This reflects recommendations made in the IAP's review on preventing deaths of women as well as those of the Corston review and the recent Thomas Commission on Justice in Wales.[18]

Safety Impact Assessment

24. Use of a safety impact assessment (SIA) is currently under consideration in the Ministry of Justice. Its aim is to enable Ministers to meet their obligations to protect life and keep people safe. It is designed to ensure that all major policy and resource decisions are assessed for their impact on staff and prisoner/detainee safety. If any risks are identified, for example when major reorganisations are being conducted at pace or significant budget cuts are proposed, then mitigating steps must be put forward and considered before Ministerial or other senior sign-off.

25. Had an SIA been in place in policy and legislation when probation was being transformed and (as has been shown) damaged in many ways, it might have led to a more considered approach or at the least helped to maintain safety and the protection of lives as a top priority.

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[18] IAP, 'Preventing the Deaths of Women in Prison'; Baroness Jean Corston, 'The Corston Report, report by Baroness Jean Corston of A review of women with particular vulnerabilities in the Criminal Justice system', March 2007, https://webarchive.nationalarchives.gov.uk/20180207155341/http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf.; The Commission on Justice in Wales, 'Justice in Wales for the People of Wales', October 2019, https://gov.wales/sites/default/files/publications/2019-10/Justice%20Commission%20ENG%20DIGITAL_2.pdf.