



Submission to the UN Committee against Torture on behalf of INQUEST Charitable Trust in respect of the 6th Periodic examination of the United Kingdom

March 2019

About INQUEST

INQUEST Charitable Trust is an independent charity which provides expertise on state-related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people.

Our specialist casework with bereaved families focuses on deaths in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question, such as Hillsborough and the Grenfell Tower fire. INQUEST works primarily in England and Wales, and advises on a small number of cases in Scotland.

INQUEST's Executive Director Deborah Coles acted as a Special Advisor to the recent *Independent review on deaths and serious incidents in police custody* chaired by Dame Elish Angiolini QC, and has advised on many other official reviews. She currently sits on the cross government sponsored Ministerial Board on Deaths in Custody, and is a member of the Independent Advisory Panel on Deaths on Custody.

For almost forty years, INQUEST has worked alongside families to ensure their participation in post death investigations, through access to legal support and advice. This evidence-based submission is informed by INQUEST's specialist casework and policy and parliamentary work. It is also informed by evidence from bereaved families at Listening Days and Family Forums.

Introduction

INQUEST welcomes the opportunity to bring to the attention of the UN Committee against Torture the issues arising from our work on deaths in places of detention which, evidence indicates, contravene the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Our comments relate primarily to Article 11 of the convention, and briefly on Article 2 with regard to access to justice for bereaved people. This submission is reporting on circumstances in England and Wales, unless otherwise stated.

Acronyms used:

ACCT – Assessment, Care in Custody & Teamwork
CQC – Care Quality Commission
MOJ – Ministry of Justice
NHS – National Health Service
NCISH - National Confidential Inquiry into Suicide and Safety in Mental Health

IPCC – Independent Police Complaints Commission
IOPC – Independent Office for Police Conduct
PPO – Prison Probation Ombudsman
PFD – Prevention of Future Deaths report
ROI – Record of Inquest
UKG – United Kingdom Government

Executive Summary

Based on the evidence from our casework and monitoring, alongside official reports and data, described in detail below, INQUEST recommends the following actions to the UK Government, for the consideration of the Committee Against Torture as part of the UK's state examination process.

Legal aid reform:

- Automatic non means tested public funding for bereaved families for specialist legal representation immediately following a state related death.
- Funding equivalent to that enjoyed by state bodies/public authorities and corporate bodies represented for bereaved families.

Deaths in custody and detention:

- Creation of a national oversight mechanism for deaths in custody and detention.
- Better resourcing of detention inspectorate, monitoring and investigation bodies.
- Halt prison building, commit to an immediate reduction in the prison population and divert people away from the criminal justice system to protect lives.
- Sustained action on the recommendations of the independent review of Deaths and serious incidents in police custody by Dame Elish Angiolini QC.
- Introduction of a truly independent investigation system for deaths in mental health settings.

Prison healthcare:

- Improved training for prison staff, including healthcare staff, to meet minimum standards to ensure the health, well-being and safety of prisoners.
- Improve standards of post-death investigations by the Prison Probation Ombudsman to better identify failures in care.

Deaths following release from prison:

- The government should conduct a national review of deaths of people on post-release supervision in the community following a custodial sentence, to establish the scale, nature and cause of the problem.
- Improve scrutiny and learning on deaths following release from prison.

Women in prison:

- Redirect resources from criminal justice to welfare, health, housing and social care.
- Divert women away from the criminal justice system.
- Halt prison building and commit to an immediate reduction in the prison population.

Immigration detention:

- An independent review commissioned by Government on how best to reduce the population of immigration detainees and phase out the use of immigration detention.
- An immediate end to the use of indefinite detention under immigration legislation in prison and immigration removal centres and release of all immigration detainees considered vulnerable or at risk, such as victims of torture and those with mental or physical ill health.
- Public reporting on deaths and safety in immigration detention from the Home Office and contractors.

Legal aid reform

Shortcomings in access to justice and effective remedies for bereaved people following a state-related death (such as those in custody and detention) have been a consistent issue of the work of INQUEST since we began in 1981. Inquests following state related deaths are intended to seek truth and expose unsafe practices and ill treatment. They are the primary means by which the government of England and Wales discharges the duty to investigate a death under Article 2 of the European Convention on Human Rights (ECHR), as enshrined in the UK Human Rights Act 1998. As such, INQUEST and a range of experts have argued that bereaved families should be granted automatic non means tested public funding for legal representation following state related deaths.

In England and Wales, state bodies and their representatives have automatic unlimited access to public funding for the best legal teams and experts. At a time when they are grieving and at their most vulnerable, bereaved families face complex and demanding funding application processes.

There has been growing pressure from multiple independent reports, experts and Chief Coroner's, recommending public funding for families. These include those by the Joint Committee on Human Rights (2018), the previous and current Chief Coroner (2016-17), the Independent Review of the response to the Hillsborough Stadium Disaster by Rt. Rev James Jones (2017), the Independent Review of Deaths and Serious Incidents in Police Custody by Dame Elish Angiolini QC (2017), and the Independent Review of the Mental Health Act 1983 (2018).¹

In August 2018, the Ministry of Justice (MOJ) undertook a review of Legal Aid for Inquests.² INQUEST, bereaved families and members of the INQUEST Lawyers Group submitted evidence.³ The final report of this review was published in February 2019.⁴ Only one out of 54 submissions made to the review was opposed to ending means-testing for legal aid funding for bereaved families.⁵

Despite the widespread support, both prior to and in response to the review, the MOJ rejected the proposal for automatic non means tested public funding, with little justification. In responding to the announcement, INQUEST said, "The Ministry of Justice have failed to confront the reality of the uneven playing field faced by bereaved families, and the considered recommendations of all those who have looked at this issue".⁶

¹ See **Timeline, Page 9-10** of INQUEST (February 2019), *Now or never! Legal Aid for Inquests briefing*. Available: <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=a1ec7dcc-9ed6-405c-8af6-2639438e8d00>

² Ministry of Justice (19 July – 31 Aug 2018), *Review of legal aid for inquests*. Available: <https://consult.justice.gov.uk/digital-communications/review-of-legal-aid-for-inquests/> (Accessed: 1 March 2019)

³ INQUEST (2018) *INQUEST response to the Ministry of Justice call for evidence on legal aid for inquests*. Available: <https://inquest.eu.rit.org.uk/Handlers/Download.ashx?IDMF=b69371de-3daa-4f91-adf2-6f8e58829c65> (Accessed: 1 March 2019)

Also see: INQUEST Lawyers Group (2018), *INQUEST Lawyers' Group response to Ministry of Justice's Review of legal aid for inquests - call for evidence*. Available: <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=c07bc721-0e43-418c-98ea-9a3f446e2ab9> (Accessed: 1 March 2019)

⁴ Ministry of Justice (2019) Final report: Review of legal aid for inquests. Available: <https://www.gov.uk/government/publications/review-of-inquests> (Accessed: 1 March 2019)

⁵ Katie Gibbons and Neil Johnston, The Times (26 February 2019), *Bereaved families demand end to inquest 'injustice'*. Available: <https://www.thetimes.co.uk/article/bereaved-families-demand-end-to-inquest-injustice-ldqgk3p8x> (Accessed: 1 March 2019)

⁶ INQUEST Media Release (7 Feb 2019), *Ministry of Justice rejects widespread call for automatic legal aid for bereaved families following state-related deaths*. Available: <https://www.inquest.org.uk/moj-legal-aid-review> (Accessed: 1 March 2019)

As the UK Government (UKG) notes in their Sixth Periodic Report, “exceptional case funding is available where failure to provide legal aid would breach the applicant’s rights under the ECHR”.⁷ Some bereaved families can access legal aid through exceptional case funding for inquests, however the application process is lengthy, complicated and invasive.⁸

Many bereaved people are refused funding, or face paying large contributions towards legal costs. Some are forced to represent themselves, while others have to crowdfund for legal representation. Even when funding is granted, it is rarely equal to that made available to state bodies for their representation. This is detailed further in our recent Legal Aid for Inquests briefing (February 2019).⁹

Sean Rigg died on 21 August 2008 in Brixton police station, following prolonged restraint by multiple police officers. He was a 40-year-old Black British musician who was diagnosed with paranoid schizophrenia and was in mental health crisis when he came into contact with police. Sean’s sister Marcia Rigg describes her family’s experiences accessing legal aid after his death: *“When we attempted to get legal representation for the inquest hearing, we faced an intrusive legal aid means testing process, which resulted in our family being asked to contribute £21,000. We were being asked to pay this sum to find out how Sean died, despite coming to this process through no fault of our own.*

I hugely benefitted from legal representation during the inquest as I came up against a team of five state lawyers. These included lawyers representing the police, ambulance and other health services. Rather than helping me understand the reason Sean died, I felt that they were more interested in protecting their interests.”¹⁰

Over the past ten years, Sean’s family’s efforts (supported by an expert legal team) prompted the organisation then known as the Independent Police Complaints Commission to review its own investigation processes. It was one of the key cases that led to the seminal Angiolini review on deaths in custody. Significant changes in policing and mental health policy and practice have also been introduced due to the dedicated work of Sean’s family and legal team. The case exemplifies the impact legal representation can have on families’ access to justice, as well positive changes to prevent future deaths.¹¹

Inquests following state related deaths are intended to be an inquisitorial ‘fact finding’ process rather than an adversarial one. But the reality faced by most bereaved families is of multiple expert legal teams defending the interests and reputations of state and corporate bodies - fighting to shut down or narrow lines of enquiry.

Connor Sparrowhawk was 18 when he drowned in a locked bathroom in a unit run by the NHS on 4 July 2013. Connor had a learning disability, autism and epilepsy. The NHS Trust initially argued that his death was caused by natural causes and fought against an Article 2 inquest (exploring issues in his care) being held. While Connor’s family eventually secured an

⁷ UK Government (10 November 2017), *6th periodic report of the United Kingdom, British Overseas Territories and Crown Dependencies: to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, (Paragraph 6.12).

⁸ Ministry of Justice (2012), *Lord Chancellor’s Exceptional Funding Guidance (Inquests)*, available: www.gov.uk/government/publications/legal-aid-exceptional-case-funding-form-and-guidance

⁹ INQUEST (February 2019), *Now or never! Legal Aid for Inquests briefing*, available: www.inquest.org.uk/legal-aid-for-inquests

¹⁰ INQUEST website (March 2019), *Family experiences accessing legal aid*. Available: <https://www.inquest.org.uk/family-experiences-accessing-legal-aid> (Accessed: 1 March 2019)

¹¹ For more information see: INQUEST Media Release (1 March 2019), *Misconduct hearing conclusions: Notes to Editors, Case Background*. Available: <https://www.inquest.org.uk/sean-rigg-misconduct> (Accessed: 1 March 2019)

Article 2 inquest, they did not to pursue Exceptional Case Funding because of challenges they faced in seeking legal aid.

The family had to crowdsource funding of up to £27, 000 and were aided by pro bono support from specialist lawyers. The inquest concluded finding neglect and critical failures in care.¹² At the inquest the family faced seven other legal teams representing public bodies and intent on removing any responsibility for failings. They say Connor's mother "was brutalised by the seven barristers employed by the NHS to defend itself".

The family's campaign #JusticeForLB prompted the pivotal Mazars Review, a critical report examining a series of deaths under the Trust's care. It also led to the successful prosecution of Southern Health, to which the Trust pleaded guilty to Health and Safety charges in March 2018.¹³

This imbalance between bereaved people and the state is the most significant injustice of the coronial system. It undermines the preventative potential of inquests to interrogate the facts and ensure harmful practices and incidents of ill treatment are exposed and addressed. Every review and public inquiry exploring these issues since 1999 has supported the case for funding reform.¹⁴ The evidence from bereaved families and their representatives is that bereaved people need automatic non means tested funding for legal representation following state related deaths.

INQUEST recommends the following actions on legal aid reform:

- **Automatic non means tested public funding for bereaved families for specialist legal representation immediately following a state related death.**
- **Funding equivalent to that enjoyed by state bodies/public authorities and corporate bodies represented.**

Deaths in custody

Prison

Deaths in prison in England and Wales have risen to historically high levels in the past five years, since the fifth periodic report was adopted by the Committee in 2013.¹⁵

In particular, the calendar year 2016 saw the highest number of deaths ever recorded. The MOJ reported 122 self-inflicted deaths, 12 of which were in women's prisons. Within those figures, one transgender woman died in a men's prison, and one in a women's prison.

¹² INQUEST Media Release (16 October 2015), *Jury found neglect contributed to the death of 18 year old Connor Sparrowhawk*. Available: <https://www.inquest.org.uk/connor-sparrowhawk-inquest-conclusions> (Accessed: 1 March 2019)

¹³ Josh Halliday, The Guardian (26 March 2018), *NHS trust fined £2m for Connor Sparrowhawk and Teresa Colvin deaths*. Available: <https://www.theguardian.com/society/2018/mar/26/nhs-trust-fined-2m-over-death-of-teenager-connor-sparrowhawk>

¹⁴ See Timeline 1999-2019, Page 9, INQUEST (February 2019), *Now or never! Legal Aid for Inquests briefing*, available: www.inquest.org.uk/legal-aid-for-inquests (Accessed: 1 March 2019)

¹⁵ INQUEST, Online statistics (rolling), *Table: Deaths in prison (England & Wales) 1990-date*. Available: www.inquest.org.uk/deaths-in-prison (Accessed: 1 March 2019)

The MOJ also reported three homicides, and 204 deaths classified as ‘natural causes’ (5 of which were in women’s prisons), and 25 deaths classified as ‘other’ (5 in women’s prisons).¹⁶ Levels of self-harm reached record highs and were up by 23% from the previous year.

Dean Saunders died in HM Prison Chelmsford on 4 January 2016. His parents, Donna and Mark Saunders, joined INQUEST in giving oral evidence to parliament’s Joint Committee on Human Rights inquiry on Mental Health and Deaths in Prison.¹⁷ Mark told the committee: “*In this country we do not give a death sentence, but for everyone who has taken their life in prison that is exactly what they got.*”¹⁸

Dean, 25, showed signs of acute mental ill health in the days before his imprisonment. He was taken from his home by the police on 16 December 2015, after an incident during which he tried to take his own life. At the police station, he was not detained under the Mental Health Act or transferred to hospital. Instead, he was given criminal charges and subsequently transferred to prison. An inquest found that neglect contributed to his death, alongside multiple serious failings by police, prison healthcare staff employed by private provider Care UK, and the prison itself.¹⁹

Between May 2013 and February 2019 there have been fourteen self-inflicted deaths at HMP Chelmsford, as well as three deaths which await classification and one accidental death involving drug overdose. Most of those who died were known to have mental ill health.²⁰

The findings of the inquest into Dean Saunders’ death are all too common, with inquests repeatedly highlighting failures to enact safeguarding mechanisms, implement suicide and self-harm monitoring guidelines (such as the Assessment Care in Custody and Teamwork, or ACCT) and deliver a duty of care, sometimes amounting to neglect.

The measures for self-harm and suicide prevention reported by UKG in their sixth periodic report²¹ have not had a significant or sustained impact in reducing the number of self-inflicted deaths or serious self-harm.

In the year 2017, the MOJ reported a 17% reduction in deaths compared to 2016 (to 295 total deaths, eight of which were in women’s prisons), with the number of self-inflicted deaths going down to 70. Two of the self-inflicted deaths were in women’s prisons and one was a transgender woman in a men’s prison. While the number of deaths was lower than the record highs of 2016, it remained historically high. At the same time, levels of self-harm reached new record highs.²²

¹⁶ Ministry of Justice (2017), *Safety in Custody Statistics Bulletin, England and Wales, Deaths in prison custody to December 2016*, Available:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/595797/safety-in-custody-quarterly-bulletin.pdf (Accessed: 1 March 2019)

¹⁷ Joint Committee on Human Rights (26 April 2017), *Mental Health and Deaths in Prison: Interim Report*, Available:

<https://www.parliament.uk/business/committees/committees-a-z/joint-select/human-rights-committee/inquiries/parliament-2015/mental-health-death-prison-16-17/> (Accessed: 1 March 2019)

¹⁸ Joint Committee on Human Rights (8 March 2017), Uncorrected oral evidence: Mental Health and Deaths in Prison.

Available: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/mentalhealth-and-deaths-in-prison/oral/48600.pdf> (Accessed: 1 March 2019)

¹⁹ INQUEST Media Release (20 January 2017), *Jury concludes neglect contributed to death of Dean Saunders at HMP Chelmsford*. Available: <https://www.inquest.org.uk/dean-saunders-inquest-closing> (Accessed: 1 March 2019)

²⁰ INQUEST casework and monitoring.

²¹ UK Government (10 November 2017), *6th periodic report of the United Kingdom, British Overseas Territories and Crown Dependencies: to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, (Paragraph 27).

²² Ministry of Justice (2018), *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2017 Assaults and Self-harm to September 2017*. Available:

The latest figures from the Ministry of Justice for the twelve months to December 2018 show that the number of deaths is rising once again. Of the 325 deaths, 92 were recorded as self-inflicted, 162 'natural causes' and four homicides. A further 67 deaths were recorded as 'other', 54 of which are awaiting further information before classification. Eleven of the total number of deaths were in women's prisons, and one was of a transgender woman in a men's prison. Levels of distress in prison are rising as demonstrated by the fact that in the 12 months to September 2018 the MOJ recorded 52,814 incidents of self-harm in prison, up 23% from the previous year. Recorded incidents of self-harm in prison have more than doubled in ten years from 25,234 incidents in 2008.²³

Reports from HM Inspectorate of Prisons in the period under consideration have detailed appalling conditions, which are some of the worst INQUEST have seen since our organisation began in 1981. Poor conditions found by the inspectorate have often been consistent with extremely high numbers of self-inflicted deaths, as is the case for HMP Liverpool and HMP Nottingham.^{24 25}

The conclusions and reports arising from inquests (Record of Inquest or Prevention of Future Deaths reports) are a unique and valuable resource for understanding the conditions and issues behind the number of deaths. **At present, no national body oversees these reports or reviews their findings on deaths in any detention setting. No detention inspection or monitoring body is tasked with routinely reviewing these reports, and in fact they only receive them on an ad hoc basis.**

Through our casework and monitoring, INQUEST can offer a sample of these resources. For the period January to December 2018, INQUEST identified casework files on 31 prison death inquests which concluded in 2018. Inquests can conclude months or years after a death, so these relate to deaths which took place between 2013 and 2018, and comprised of eight women and 23 men, aged between 20 years and 53 years of age. Twenty-one were self-inflicted, nine were non-self-inflicted and one cause of death is still inconclusive.

The most common issue highlighted at these recent inquests was failures with the suicide and self-harm monitoring procedures, such as ACCT. This was followed by issues with observation and communication. Other common themes were issues with record keeping, medicine prescribing processes, health care (for both physical and mental health), and staff training.

The Prisons and Probation Ombudsman (PPO), who investigate deaths in prison, probation and immigration detention, noted in their annual report 2017/18, that on 316 death investigation in the period, they made 857 recommendations. The majority were on healthcare provision (189), emergency response (114) and suicide and self-harm prevention (109). They noted that, *"A key concern is that we have been identifying the same lessons and making the same recommendations for many years – and we are still doing so."*²⁶

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/676144/safety-in-custody-q3-2017.pdf

²³ Ministry of Justice (2019) Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2018 Assaults and Self-harm to September 2018. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774880/safety-in-custody-bulletin-2018-Q3.pdf (Accessed: 1 March 2019)

²⁴ INQUEST media release (18 January 2018), *INQUEST responds to inspectors 'Urgent Notification' on HMP Nottingham*. Available: <https://www.inquest.org.uk/hmip-urgent-notification-nottingham> (Accessed: 1 March 2019)

²⁵ INQUEST media release (19 January 2018), *Inspectors find further evidence of abject failures at HMP Liverpool, one of the worst prisons for self-inflicted deaths*. Available: <https://www.inquest.org.uk/hmp-liverpool-inspection-2017> (Accessed: 1 March 2019)

²⁶ Prisons and Probation Ombudsman (11 October 2018), *Annual Report 2017 – 18*. Available: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhkjmjgw/uploads/2018/10/PPO_Annual-Report-2017-18_WEB_final.pdf (Accessed 1 March 2019)

Despite growth in demand for the services of the PPO, they report continued cuts to their budgets and note *“the resource pressures have become increasingly difficult to sustain.”* Through casework at INQUEST, we have seen the damaging effects of those pressures.

With no national oversight on deaths in detention and inquest findings, the valuable information and potential learning arising from inquests often gathers dust. There is no one to follow up arising issues, or ensure action is taken. Sadly, this means failings are repeated and found time and time again at inquests, and preventable deaths occur. One stark example is that of these two women, who died ten years apart:

Emily Hartley was only 21 years old when she was found dead in HMP New Hall in April 2016. Emily was imprisoned for arson, having set fire to herself, her bed and curtains. She had a history of serious mental ill-health including self-harm, suicide attempts and drug addiction. This was Emily’s first time in prison. Her family said, *“Whilst we were shocked to find Emily sent to prison, the one consolation was that we believed she would be kept safe.”*²⁷

On 1st February 2018, the inquest investigating Emily’s self-inflicted death concluded with deeply critical findings about her care and the failure to transfer her to a therapeutic setting. What made her premature and preventable death all the more shocking is that ten years ago to the day of Emily’s inquest, the same coroner had dealt with a strikingly similar case.

Petra Blanksby was 19 years old when she was found dead in HMP New Hall in November 2003. She was imprisoned for arson, having set fire to her bedroom in an attempt to take her own life. Petra too, had a history of mental ill health and suicide attempts. At the end of her inquest in February 2008, the coroner recommended to the Prison Service and Department of Health that they should deal with the lack of secure therapeutic facilities outside prison.

At the conclusion of Emily’s inquest, the same coroner David Hinchliff wrote: *“I repeat ten years later that the Prison’s Department and the Department of Health should conduct a collaborative exercise to achieve the provision of suitable, secure, therapeutic environments in order to treat those with mental health problems”.*

Through almost 40 years of working with families bereaved by state related deaths, INQUEST has come to the conclusion that preventable deaths are an inherent feature of prisons and the wider criminal justice system. While systems for preventing deaths at a local and national level could be greatly improved, there must also be focused, long-term and sustainable action on safety in prisons. This would require a shift in focus by UKG.

Prisons in the UK are for the most part repositories for some of the most disadvantaged people in society. They fail and do harm to those they seek to reform, and in turn fail victims of harms caused by those they imprison. In their sixth periodic report, UKG notes investment in *“innovations aimed at improving safety”*, as well as *“investment of £100 million for recruitment of new staff”*²⁸ and new training on suicide and self-harm. These investments only seek to refill holes created by significant cuts to staffing and funding of prisons since 2012. The UKG is also running a ‘Prison Estate Transformation Programme’ with the aim of building 10,000 new prison places.²⁹

²⁷ INQUEST Media release (February 2018), *Lack of professionalism and failures in care at New Hall prison criticised at inquest into the death of Emily Hartley*. Available: <https://www.inquest.org.uk/emily-hartley-closing>

²⁸ Paragraph 27, UK Government (10 November 2017), *ibid*

²⁹ House of Commons Library (12 December 2018), *Briefing paper: The prison estate*. Available: researchbriefings.files.parliament.uk/documents/SN05646/SN05646.pdf

The wholesale expansion of the prison system has had little or no impact on prisoner rehabilitation, public protection or reducing victimisation. Prisons are, at their core, unhealthy and dangerous environments. These issues can only be addressed with decisive action addressing the excessive and inappropriate use of custody. The government must halt the prison building programme, tackle sentencing policy, promote well-funded alternatives to custody, invest in healthcare, social housing and education. The evidence for each of these actions as more effective, economically rational and socially just than resort to imprisonment is overwhelming. **Until there is a dramatic reduction in the use of prison and a redirection of resources into community alternatives, then needless deaths and harms will continue.**

Police Custody

In the financial year 2017/18, the Independent Office for Police Conduct (IOPC) reported a total of 283 deaths following police contact. Of these, 23 deaths were classified as ‘in or following police custody’, the highest figure recorded in the past 14 years, and an increase of nine since the previous year. There were also four police shootings (three of which were ‘terrorism related’), 29 relating to road traffic incidents, 57 apparent suicides following custody and 170 ‘other’ deaths following police contact.³⁰

Seventeen of the 283 who died were restrained or had force used against them by the police or others. Of these, nine were white and eight were black. Recently and historically, black men have disproportionately died following use of force by the police.

Twelve people of the 23 who died in or following custody were identified as having mental health concerns, and four were detained under the Mental Health Act 1983. This is an increase from eight in 2016/17 and seven in 2015/16.³¹ The IOPC reports that the types of mental health concerns identified included, psychosis, depression and self-harm or suicidal tendencies. Eighteen of the 23 deaths had links to drugs and/or alcohol.

Kevin Clarke, a 35 year old black man, died on 9 March 2018 following restraint by police.

He came into contact with police during a mental health crisis on a residential street in South London. The Independent Office for Police Conduct report that Kevin was restrained by up to nine police officers before he “became unwell” and was taken to hospital and later pronounced dead. Their investigation into the circumstances of his death is ongoing and an inquest is awaited.³²

Kevin’s family have said, “We’re shocked to the core to learn that the police felt it necessary to use the force of nine officers to restrain one unwell man. The very fact that the police called an ambulance to provide medical assistance for Kevin tells us that they knew he was unwell and potentially experiencing a mental health episode, so we’re struggling to

³⁰ Independent Office for Police Conduct (25 July 2018), *Deaths during or following police contact: Statistics for England and Wales 2017/18*. Available: <https://www.policeconduct.gov.uk/news/iopc-publishes-figures-deaths-during-or-following-police-contact-201718> (Accessed: 1 March 2019)

³¹ Independent Office for Police Conduct, *Annual deaths during or following police contact statistics*. Available: <https://www.policeconduct.gov.uk/research-and-learning/statistics/annual-deaths-during-or-following-police-contact-statistics> (Accessed: 1 March 2019)

³² Independent Office for Police Conduct investigations, *Kevin Clarke - Metropolitan Police Service*. Available: <https://policeconduct.gov.uk/investigations/kevin-clarke-metropolitan-police-service> (Accessed: 1 March 2019)

*understand the reason for such an excessive response. Kevin must have been petrified in his final minutes and it is agony for us to even think about this.*³³

As noted by the UKG, in 2015 Dame Elish Angiolini QC was commissioned by the Home Office to undertake the first ever independent review of deaths and serious incidents in or following police custody. This came as a result of pressure from bereaved families working alongside INQUEST.

INQUEST's Director Deborah Coles was Special Advisor to the review and the organisation facilitated input from large number of bereaved families, as well as groups of lawyers who regularly represent families. The final report, published in 2017, made over 100 recommendations on issues with policing, related services, and the investigation of deaths.³⁴

These include important recommendations on:

- Access to justice for families, including through non-means tested legal representation for bereaved families from the earliest point following the death.
- Strengthening systems and structures of accountability, holding the police to account at an individual and corporate level.
- National Oversight and learning from deaths, such as through an 'Office for Article 2 Compliance' which would monitor and report on recommendations arising from deaths.
- Improved investigation, including through the phasing out of ex-police officers as lead investigators within the IPCC.
- Tackling discrimination through recognition of the disproportionate number of deaths of people with Black, Asian and Minority Ethnicities following restraint, and the role of institutional racism, both within IPCC investigations and police training.
- Better treatment of vulnerable people, including through proper resourcing of national healthcare facilities to accommodate and respond to vulnerable people in urgent physical or mental health needs coming into contact with the police.
- An end to delay, in which Article 2 related cases should be dealt with in the same time scales as a civilian homicide case.

INQUEST welcomed this seminal review and support the range of pragmatic recommendations. However, the value of this report must ultimately be judged by the changes it brings about.³⁵ On 12 December 2018, the UKG published a progress report.³⁶ There have been steps forward on some of the softer issues, including better access to information for families following a death through a new early information leaflet, developed in collaboration with INQUEST and the bereaved families we work with.

³³ INQUEST Media Release (8 May 2018), *IOPC announce nine police officers are under investigation for gross misconduct in relation to the death of Kevin Clarke*. Available: <https://www.inquest.org.uk/iopc-misconduct-investigation-kevin-clarke> (Accessed: 1 March 2019)

³⁴ Dame Elish Angiolini QC (2017), *Report of the independent review of deaths and serious incidents in police custody* (Para 33). London: Home Office. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf (Accessed: 1 March 2019)

³⁵ For more information and a briefing of the report's findings, see: INQUEST (October 2017), *Angiolini Review into Deaths and Serious Incidents in Police Custody: Policy briefing*. Available: <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=297f4a05-8581-4b44-8d08-09b0182e904f> (Accessed: 1 March 2019)

³⁶ HM Government (December 2018), *Deaths in Police Custody: Progress Update*. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/763654/181211_DiC_progress_update_HMG_template.pdf (Accessed: 1 March 2019)

However, Dame Angiolini's review made important recommendations on use of force and restraint by police, institutional racism, and the treatment of intoxicated people. The progress report by the Government does not mention any action on these recommendations, despite commitments in their original response to the review.³⁷ There is also limited development on the treatment of those with mental ill health by police. The lack of clear progress in these areas is particularly concerning given the recent deaths, which underline the urgency and necessity of action.

Police forces in England and Wales have been required to publish use of force data since April 2017. In December 2018, the first annual national statistics were published, revealing that police officers report most commonly using force because of alcohol and drugs, the 'size, gender or build' of the subject, or mental ill health; rather than other issues such as prior knowledge or possession of a weapon. Black people were overrepresented, as subject in 12% of incidents but representing only 3.3% of the general population.³⁸

There has also been a lack of progress on Angiolini's recommendations in terms of greater accountability for police officers involved in deaths. As Dame Angiolini reports, there has never been a successful criminal prosecution for murder, manslaughter or corporate manslaughter, of any police officer or force involved in a death. This is despite numerous deeply critical inquest findings, such as unlawful killing, neglect, or critical narrative conclusions.

However, the Office of the Chief Constable for Devon and Cornwall Police are being charged under the Health and Safety Act 1974 in relation to the police force's use of an Emergency Response Belt to restrain Thomas Orchard. On 19 October 2018, the police force pleaded guilty to these charges.³⁹ Proceedings are ongoing.

Thomas Orchard, a 32 year old white man, died on 10 October 2012 following restraint by police officers. He was a fit and physically healthy church caretaker, living independently in supported accommodation at the time of his death. He had a history of mental ill health and a diagnosis of schizophrenia. On 3 October 2012 Thomas was arrested and detained by Devon and Cornwall officers following reports of bizarre and disorientated behaviour.

He was transported by police van to a police station. Upon arrival, in addition to the triple limb restraints applied, an 'Emergency Response Belt' made from a tough impermeable webbing fabric, was put around his face. The belt remained held around his face as he was carried face down to a cell, where he was then left lying unresponsive on the floor. By the time officers re-entered his cell, Thomas was in cardiac arrest. He was transferred to hospital and pronounced dead on 10 October 2012.

This is only the second ever Health and Safety prosecution of a police force in relation to a death following contact with police. It will also be the first ever successful prosecution relating to a death

³⁷ Home Office (30 October 2017), *Deaths and serious incidents in police custody: government response*. Available: <https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody-government-response> (Accessed: 1 March 2019)

³⁸ Note: Alcohol was the most common factor impacting the decision to use force (127,000 incidents), followed by drugs (85,000 incidents) size/gender/build (79,000), mental health (68,990), prior knowledge (59,177) and possession of a weapon (40,214). See INQUEST media release (13 December 2018), *INQUEST responds to police use of force statistics*. Available: <https://www.inquest.org.uk/police-use-of-force-stats> (Accessed: 1 March 2019)

³⁹ INQUEST media release (19 October 2018), Devon and Cornwall Police plead guilty to a criminal failure to ensure safety of Thomas Orchard, Available: <https://www.inquest.org.uk/thomas-orchard-guilty-plea> (Accessed: 1 March 2019)

in police custody.⁴⁰ Of eight other prosecutions brought against police officers in connection with a death in custody in the last 15 years, including murder and manslaughter prosecutions, all have ended with acquittals.

In her review Dame Angiolini reported, *“There is a strong perception that families of those who die in police custody are not treated as ‘victims’ in the same way that relatives of murder or manslaughter victims would be, and that the criminal justice system is resistant to and uncomfortable in treating deaths or serious incidents in custody as a potential crime from the outset.”*⁴¹

This perception remains and has been maintained by a lack of critical findings and sanctions for police misconduct hearings (professional disciplinary hearings), again in contrast with critical inquest findings. Most recently, in February 2019 gross misconduct charges officers involved in the death of Sean Rigg (detailed above) were dismissed, despite evidence proving some of the charges and the critical of other reports.⁴² Many of Angiolini’s recommendations on police misconduct are also outstanding.⁴³

The processes following a death in police custody, like prison, are also weakened by a lack of oversight to enforce change and sustain learning from deaths. The public interest requires responses to post death investigations to be transparent and accountable, but no administrative framework has yet been developed to formalise and realise the potential of this preventative role. There are initiatives such as the Ministerial Board on Deaths in Custody and the judiciary website for coroners’ reports, but these have been established with limited objectives and without significant resources or powers.

At present learning is fragmented and disparate with the result that we are seeing the same institutional and individual failings time and again across different cases:

- recommendations are not followed up in any systematic way
- there has been a routine failure to share and disseminate information and guidance across sectors
- a lack of ability to effectively enforce and review compliance with recommendations and their implementation

The Angiolini review, supporting INQUEST’s longstanding call for national oversight on deaths in detention, recommended an ‘Office for Article 2 Compliance’. ⁴⁴

The Angiolini Review recommended that, *“The Government should consider whether there is a need for an independent Office for Article 2 Compliance, accountable to Parliament, and tasked with the collation and dissemination of learning, the implementation and monitoring of that learning, and the consistency of its application at a national level. It should report publicly on the accumulated learning and compliance arising from Inquest outcomes and recommendations. It should provide a role for bereaved families and community groups to voice their concerns and help provide a mandate for its work.”*

⁴⁰ The previous prosecution relates to the fatal shooting of Jean Charles de Menezes in 2005. In November 2007, the Metropolitan Police Authority were fined £175,000 and ordered to pay £385,000 costs, for being guilty of a series of errors under the Health and Safety Act, during the operation that led to the shooting.

⁴¹ See page 179, Dame Elish Angiolini QC (2017), *ibid*

⁴² See INQUEST Media Release (1 March 2019), *All charges of gross misconduct against officers involved in the death of Sean Rigg dismissed*. Available: <https://www.inquest.org.uk/sean-rigg-misconduct> (Accessed 1 March 2019)

⁴³ See page 177, Dame Elish Angiolini QC (2017), *ibid*

⁴⁴ See pages 229-232, *ibid*

Mental health detention

Unlike deaths in other detention settings in the UK, there remains a lack of detailed public reporting on the deaths of people in mental health detention, de facto detention (i.e. voluntary inpatients), and closed inpatient care for learning disabilities and autism.

The Care Quality Commission (CQC) receive notifications from care providers on the deaths of those who are detained under the Mental Health Act 1983, or liable to be detained. This system is lacking in that the deaths of those classed as voluntary inpatients who are de facto detained, which is often the case for children in mental health settings and for patients with learning disabilities and autism, are not captured or reported on.

Limited information on notifications of deaths in mental health detention is published by the CQC in their annual report *Monitoring the Mental Health Act*.

In the financial year 2017/18, the CQC were notified of 189 deaths of detained patients by 'natural causes', 48 deaths by unnatural causes and 10 deaths where the cause is yet to be confirmed by an inquest. Of those deaths, 12 were from 'natural causes' of people aged up to 40 years old, all of whom were detained in hospital. Eleven of the deaths that occurred were within seven days of restraint being used. This includes seven people aged 61 and over and four aged under 60.⁴⁵ The following table from the report details deaths in previous years:

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Natural causes	200	126	182	201	186	189
Unnatural causes	48	36	34	46	54	48
Undetermined	27	36	11	19	7	10
Total	275	198	227	266	247	247

Source: CQC

Detailed information on the protected characteristics of those who have died, the circumstances of deaths, and the NHS Trust involved in care, is not published. This is in contrast with the significantly more detailed and regular reporting of deaths in prison by the MOJ (through safety in custody reports and regular death notifications sent to relevant NGOs), and annual reporting of deaths in police custody by the IOPC. This lack of transparency limits opportunities for analysis of trends.

In addition to CQC reporting, data on unnatural deaths of mental health patients across the United Kingdom is available in the annual report of the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) by the University of Manchester.⁴⁶ The inquiry monitors, collects and analyses data on all suicides, homicides and 'sudden unexpected deaths' by mental health patients. In their 2018 annual report they present data and analysis on deaths between 2006 and 2016. They

⁴⁵ Care Quality Commission (26 February 2019), *Monitoring the Mental Health Act in 2017/18*. Available: <https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-report> (Accessed 1 March 2019)

⁴⁶ The University of Manchester (webpage), *National Confidential Inquiry into Suicide and Safety in Mental Health*. Available: <https://sites.manchester.ac.uk/ncish/> (Accessed 1 March 2019)

report 1,612 patient suicides in the UK in 2016. During 2006-2016, they report 17,931 suicides by mental health patients, 28% of suicides in the UK general population.⁴⁷

In 2016, the CQC undertook a review of investigations into deaths in NHS Trusts, including those in mental health settings. INQUEST submitted evidence to the review and ran and reported on a family listening day which heard from families bereaved by deaths in mental health settings and detention.⁴⁸ These submissions detail the range of issues concerning the current systems in place for the investigation and learning from deaths in mental health settings, the majority of which are outstanding.

The final report of the review of investigations into deaths was published by the CQC in December 2016.⁴⁹ Their recommendations included:

- Learning from deaths needs much greater priority within the NHS to avoid missing opportunities to improve care.
- Bereaved relatives and carers must receive an honest and caring response from health and social care providers and the NHS should support their right to be meaningfully involved.
- There needs to be a clear approach to support healthcare professionals' decisions to review and/or investigate a death, informed by timely access to information.
- Greater clarity is needed to support agencies working together to investigate deaths and to identify improvements needed across services and commissioning.
- Learning from reviews and investigations needs to be better disseminated across trusts and other health and social care agencies, ensuring that appropriate actions are implemented and reviewed.
- More work is needed to ensure the deaths of people with a mental health or learning disability diagnosis receive the attention they need.

In March 2019 the CQC published a progress report on these recommendations. While they found some developments in the NHS at large, particularly in terms of awareness of new guidance, they said many of these issues are outstanding. The CQC also found the need remains “*for a focused assessment of the progress made on reviews and investigations of deaths of people with mental health problems or a learning disability.*”⁵⁰ INQUEST agrees that not enough is being done by UKG in this area.

As in other detention settings, the lack of national oversight on learning from inquests on deaths in mental health settings is a barrier to the prevention of deaths and ill treatment. **Of particular concern in mental health settings is the lack of independent investigations into deaths. There is no**

⁴⁷ The University of Manchester (October 2018), *Annual report: National Confidential Inquiry into Suicide and Safety in Mental Health* <https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-69-Mental-Health-CORP-annual-report-v0.4.pdf>

⁴⁸ INQUEST (October 2016), *INQUEST's submission to the CQC review of investigations into deaths in NHS Trusts*. Available: <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=2989105e-1f7d-4465-b244-bd36431c9c60> (Accessed 1 March 2019)

INQUEST, (October 2016), *Report on the CQC Family Listening Day*. Available: <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=4f83b20d-57da-4355-9f11-045726e02708> (Accessed 1 March 2019)

⁴⁹ Care Quality Commission (December 2016), *Learning, candour and accountability*. Available: <https://www.cqc.org.uk/publications/themed-work/learning-candour-and-accountability>

⁵⁰ Care Quality Commission (March 2019), *A review of the first year of NHS trusts implementing the national guidance*. Available: <https://www.cqc.org.uk/publications/themed-work/learning-deaths> (Accessed 1 March 2019)

equivalent body to the PPO or IOPC, to independently investigate deaths and monitor and report on findings of investigations nationally.

When a person dies in a mental health setting, guidance for investigations comes under the NHS Serious Incident Framework (2015).⁵¹ The only mechanism of pre-inquest independent investigation is currently a 'Level 3 investigation' under this framework. In terms of deaths, the framework says these independent investigations "should be considered" for the following circumstances:

"Deaths (and near deaths resulting in severe harm) of those detained under the Mental Health Act (1983) and, in certain circumstances, the deaths of informal psychiatric in-patients where;

- the cause of death is unknown; and/or*
- where there is reason to believe the death may have been avoidable or unexpected i.e. not caused by the natural course of the patient's illness or underlying medical condition when this is managed in line with best practice. This includes suicide and self-inflicted death...[including recently transferred prisoners]."*

In practice, INQUEST casework demonstrates that Level 3 investigations are inconsistently used and rarely take place. INQUEST has seen many cases where, given the seriousness of the death, we would have expected an independent investigation to take place, but there has been a failure of the NHS Trust to commission one.

While the Serious Incident Framework may provide for an independent team to conduct an investigation, commissioning and management of the 'independent' process is not institutionally and practically independent as it continues to sit within the NHS management structure. There is also no oversight outside of the NHS on whether investigations take place, and no oversight or external assessment as to the quality of these investigations.

The investigations which do take place are of varying quality, and are often deficient in terms of scope, timeliness, quality, independence and family involvement. There is a lack of transparency and scrutiny of the investigation and its findings as the reports are not published. There are also concerns about the methods of identifying learning beyond that of the individual Trust/private provider. The internal nature of the investigations means that there is no visibility or oversight around the implementation of recommendations, and identification of common themes or issues which may be of relevance nationally.

NHS Trusts, Clinical Commissioning Groups and NHS England could argue that an independent investigation is not needed as the coroners' process will satisfy the need for independence.

However, there are many issues with relying on inquests, such as:

- The nature and extent of the investigations carried out before the inquest are critically important as they can impact on the subsequent inquest regarding its remit, the issues requiring scrutiny, as well as the witnesses to be called.
- Coroner's inquests can take up to a year or more to take place. If you rely on the inquest for learning and change, which is the primary aim of NHS investigations, there will be a significant delay which may risk future deaths occurring.
- Coroners do not have the resources or scope to undertake their own investigations and are reliant on the investigation undertaken by the Trust or private provider.

⁵¹ NHS England (2015), *Serious Incident Framework: Supporting learning to prevent recurrence*. Available: <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf> (Accessed 1 March 2019)

For more information and case studies see *Independent investigations: the current system is not enough* (June 2018), a briefing for parliamentarians.⁵² Also see our detailed report, *Deaths in mental health detention: An investigation framework fit for purpose?* (February 2015).⁵³

It is iniquitous that institutions responsible for the treatment and care of mental health patients should not be subject to the same scrutiny as other institutions of detention such as police, prison and immigration detention. This risks ongoing injustices for bereaved families. **INQUEST considers that a system of truly independent, pre-inquest investigation (equivalent to other detention settings) is absolutely necessary to reduce deaths and serious incidents in mental health settings.**

As with other detention settings, accountability and redress following deaths is lacking. There is a widespread culture of defensiveness and denial, and an absence of accountability for failings at both an individual and corporate level. However, there have been a small number of prosecutions regarding deaths in mental health detention and closed care settings such as those for learning disability and autism.

In March 2018 the NHS Trust, Southern Health, were fined £2million after pleading guilty to criminal charges brought by the Health and Safety Executive, for a breach of health and safety laws in relation to two deaths. Teresa Colvin, 45, died on 26 April 2012, due to self-inflicted injuries whilst at a mental health unit, where she had been admitted only 48 hours earlier. The details of Connor Sparrowhawk's death are reported above (under Legal Aid).⁵⁴ In October 2017, the same Trust were also fined £125,000 and ordered to pay £36,000 in costs, following the serious injury of a mental health inpatient.⁵⁵

There is also an ongoing prosecution of private provider, the Priory Group, following the death of a child in a specialist mental health unit. This case is illustrative not only of a rare level of accountability in terms of a successful prosecution following a death, but also of the common issues which prevent such accountability. It is only due to the persistence of the family in pursuing justice and publicity for the case, alongside a specialist legal team and INQUEST, that this prosecution was brought about.

Amy El Keria was 14 years old when she died a self-inflicted death in November 2012. She was an NHS funded inpatient in a specialist children's unit at Ticehurst House, a private mental health hospital run by the Priory Group, in November 2012. Amy had a history of complex mental and physical ill health. Her family had been fighting for years to get the help and support to address her needs.

An inquest jury in 2016 found that neglect by the Priory contributed to Amy's death, and identified failures across all aspects of the care and treatment provided during her three month admission.⁵⁶ This was Amy's first admission to hospital.

⁵² INQUEST briefing (June 2018), *Independent investigations: the current system is not enough*, Available: www.inquest.org.uk/Handlers/Download.ashx?IDMF=055390cb-459c-4df0-bbb7-cc860ad3d3f8 (Accessed: 1 March 2019)

⁵³ INQUEST report (February 2015), *Deaths in mental health detention: An investigation framework fit for purpose?* Available: <https://www.inquest.org.uk/deaths-in-mental-health-detention> (Accessed: 1 March 2019)

⁵⁴ Josh Halliday, The Guardian (26 March 2018), *NHS trust fined £2m for Connor Sparrowhawk and Teresa Colvin deaths*. Available: <https://www.theguardian.com/society/2018/mar/26/nhs-trust-fined-2m-over-death-of-teenager-connor-sparrowhawk> (Accessed: 1 March 2019)

⁵⁵ BBC News (12 October 2017), *Southern Health fined £161,000 over Melbury Lodge roof fall*. Available: <https://www.bbc.co.uk/news/uk-england-hampshire-41593756> (Accessed: 1 March 2019)

⁵⁶ INQUEST Media Release (June 2016), *Jury Finds Priory's Gross Failings Contributed To The Death Of 14 Year Amy El-Keria In Child Mental Health Unit*. Available: <https://www.inquest.org.uk/amy-el-keria-inquest-closing> (Accessed: 1 March 2019)

Despite being classed as a 'voluntary inpatient', Amy was de facto detained. However, the Priory Group refused to commission an independent investigation into her death, and instead one was conducted by another part of The Priory Group. The final investigation report has been highly criticised and contrasted with the findings of the inquest. The Priory Group also made legal arguments against an Article 2 inquest (more wide ranging) and a jury. The police conducted little or no investigation and concluded within 24 hours that no further action would be taken.

After the critical conclusion of the inquest, there was significant media coverage of the case. Following this, the Health and Safety Executive opened a criminal investigation into the death, and later announced they would bring charges regarding breaches of the Health and Safety at Work Act 1974. On 9 January 2019, The Priory Group pleaded guilty. Further hearings are awaited to establish the basis of this plea and sentence.⁵⁷

INQUEST recommends the following actions on deaths in custody and detention:

- **Creation of a national oversight mechanism for deaths in custody and detention.**
There is an overwhelming case for the creation of a national oversight mechanism tasked with the duty to collate, analyse, monitor and implement learning arising from all custodial deaths. This would include oversight of inquest findings across all detention settings through Record of Inquests, and recommendations arising from Prevention of Future Death reports. As well as the findings of post death investigations by the PPO, IOPC and mental health trusts.

These should be considered in the context of findings from existing detention inspectorate and monitoring bodies, such as HM Inspectorate of Prisons, HM Inspectorate of Constabulary and Fire and Rescue Services, the Care Quality Commission, and the National Preventive Mechanism at large. The mechanism should be accountable to parliament and ensure involvement of bereaved families.

- **Better resourcing of detention inspectorate, monitoring and investigation bodies.**
Despite growth in demand for the services of the PPO, they report continued cuts to their budgets and note *"the resource pressures have become increasingly difficult to sustain."*⁵⁸ Through casework at INQUEST, we have seen the damaging effects of those pressures. The UK National Preventive Mechanism also report cuts for some of their member organisations and to the secretariat who coordinate joined-up work. This lack of resources comes at a time of increased need.
- **Halt prison building, commit to an immediate reduction in the prison population and divert people away from the criminal justice system.** Criminal justice resources should be reallocated away from prisons to well-funded, well-staffed community alternatives, involving drug, alcohol and mental health services, supported by NGOs and involving the families of those accessing these services. Welfare, health and social care in the community is both a humane and sustainable response to dealing with social problems, which cannot be meaningfully addressed through the criminal justice system. Instead of imprisonment, treatment and support must be prioritised.

⁵⁷ INQUEST Media Release (9 January 2019), *Priory Group plead guilty to health and safety charges on death of 14 year old Amy El-Keria*. Available: <https://www.inquest.org.uk/amy-el-keria-priory-guilty> (Accessed: 1 March 2019)

⁵⁸ Prisons and Probation Ombudsman (11 October 2018), *Annual Report 2017 – 18*. Available: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjkhjmgw/uploads/2018/10/PPO_Annual-Report-2017-18_WEB_final.pdf (Accessed 1 March 2019)

- **Sustained action on the recommendations of the independent review of deaths and serious incidents by Dame Elish Angiolini QC.** This seminal report was the first ever independent review of deaths in police custody in the UK. This was something which bereaved families and INQUEST had campaigned for over decades. The suggested changes outlined could save lives and improve systems of policing and post death investigation immeasurably. The recommendations of the report cannot be allowed to gather dust.
- **Introduction of a truly independent investigation system for deaths in mental health settings.** The current system for investigating deaths in mental health settings is not fit for purpose. It profoundly impacts upon the understanding of and response to the deaths of mental health patients and has implications for patient safety and the prevention of future deaths. A new, fully-independent system for investigating deaths in mental health settings should be developed; bringing standards for investigating deaths in mental health settings in line with those across all other detention settings.⁵⁹

Detention conditions

Healthcare in prisons

Deaths in prison are at the sharpest end of the failure of UKG to adequately address concerns regarding healthcare provision in prisons. ‘Natural cause’ deaths (as defined by the Ministry of Justice) are the leading cause of mortality in prisons. This is often attributed to the ageing prison population. However, evidence from inquests and official reports suggests that many people are dying prematurely and unnecessarily due to inadequate healthcare provision.

The UK Parliament Health and Social Care committee conducted a review of Prison Health, the final report of which was published in November 2018.⁶⁰ INQUEST submitted evidence and conducted a review of casework files and associated documents to identify deaths where healthcare (physical and/or mental) had been of particular concern.⁶¹ Drawing on ROI and PFD reports from inquests, as well as reports from the PPO, INQUEST found that poor prison healthcare is impacting on both physical and mental health, in many cases resulting in findings of ‘neglect’ at inquests.

In summary, this review identified the following issues (detailed further in the full submission):

- **Healthcare:** Standard of care is inadequate and not in line with provision in the community. Inadequate staffing levels and reliance on bank or agency staff who may lack relevant training. Failure to provide basic medical care. Lack of provision for those with complex physical and/or mental health needs. Insufficient health screenings and incomplete care plans. Failure to assess, monitor and review existing health conditions, such as asthma. Cancelled and delayed

⁵⁹ This recommendation is detailed further from p.41-43 of INQUEST report (February 2015), *Deaths in mental health detention: An investigation framework fit for purpose?* Available: <https://www.inquest.org.uk/deaths-in-mental-health-detention> (Accessed: 1 March 2019)

⁶⁰ House of Commons Health and Social Care Committee (1 November 2018), *Prison Health: Twelfth Report of Session 2017–19*. Available: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf> (Accessed 1 March 2019)

⁶¹ INQUEST (May 2018), *Submission to the Health and Social Care Committee Inquiry into Healthcare in Prisons*. Available: <https://inquest.eu.rit.org.uk/Handlers/Download.ashx?IDMF=b60fe35b-0e93-40f9-89c6-3ad4718c3538> (Accessed 1 March 2019)

appointments and systems for prioritising appointments being left to custody staff rather than clinicians.

- **Communication:** Failures in communication between healthcare, mental health and prison staff. Inadequate recording of important medical and mental health related information. A failure to share information between: the police and the courts, different prisons when prisoners are transferred and different agencies inside and outside of the criminal justice system.
- **Emergency responses:** Poor and inadequate training of staff in first aid skills to identify medical emergencies and attempted resuscitation. Faulty cell bells or failure to respond. Delays in calling for emergency services.
- **Drugs:** Failures to review prescriptions and delays in accessing medication (both for physical and mental health needs). Failures of staff to understand risks of substance misuse, toxicity and withdrawal and to identify emergencies.
- **Mental health:** Inconsistent and insufficient mental health care and assessments. Failure to share information about risk of suicide and self-harm. Inadequate understanding and application of suicide and self-harm monitoring forms and procedures used in prisons (known as 'ACCT').

This review of cases included the following non-self-inflicted deaths in prison:

Shalane Blackwood was 29 years old when he died in HMP Nottingham from internal bleeding caused by a burst duo-denal ulcer in August 2015. He arrived from his previous prison with a history of stomach problems. His health deteriorated significantly in July 2015. He was not eating, sleeping or drinking properly and was also behaving strangely and crying out. Shalane was found with blood in his cell. Despite his poor health, he was still not taken to hospital. He was found dead the next morning. The staff giving evidence at his inquest stated that due to inadequate staffing levels sometimes the medical professionals were assessing him through a hatch behind a closed door and they accepted that when he was found with blood in his cell he should have been taken to hospital. The jury found that neglect by both prison and healthcare staff contributed to his death. Nottinghamshire Healthcare NHS Foundation Trust provide healthcare in this prison.

Ashley Gill was 25 years old when he died in HMP Liverpool after suffering a serious asthma attack in April 2015. The inquest heard that healthcare staff at HMP Forest Bank, a privately operated prison, failed to transfer information relating to Ashley's asthma and prescribed medication when he was transferred to HMP Liverpool. In HMP Liverpool, he was not assigned a chronic disease manager due to staff shortages in the prison. He was also not prescribed his essential asthma medications after his transfer. He raised his concerns and even made a formal complaint about this prior to his death. In hearing evidence regarding failures to provide Ashley with basic healthcare, the jury concluded that neglect contributed to his death.

Nicola Jayne Lawrence was 38 years old when she died from a combination of methadone toxicity and multi drug administration at HMP New Hall in September 2016. Nicola had complex physical and mental health needs and suffered from Multiple Sclerosis (MS). In May 2018, the jury at her inquest found the decision to prescribe methadone should have been checked with Nicola's MS specialist and that when she was seen lying face down on the floor of her cell and snoring loudly, prison staff should have recognised this as obvious signs of methadone toxicity. Had the staff responded and administered a drug to reverse the effects of toxicity, Nicola's life could have been saved. Evidence at the inquest showed that the staff did not have basic first aid training or training to recognise medical emergencies.

The Health and Social Care committee echoed INQUEST's concerns in their final report, which recognised 'so-called natural cause deaths too often reflect serious lapses in care'.

INQUEST's review also identified issues in the investigation of non-self-inflicted deaths by the Prison Probation Ombudsman. The PPO relies heavily on clinical reviews to assess the level of care provided to the deceased and whether there were any shortcomings. The quality of these reviews vary greatly, as does the level of expertise of the clinical reviewers. INQUEST has ongoing concerns about the independence and expertise of clinical reviewers, who are appointed by NHS England. In our experience some appointed clinical reviewers may not always hold the appropriate, specialist or clinical expertise required.

Much needed and urgent improvements to prison healthcare could help to prevent deaths in custody. However, the prison environment is inherently unhealthy with limited access to fresh air and exercise, poor nutrition and unsanitary impoverished regime conditions. Prisons, at their core, are environments of toxic, high health-risk and therefore, greater attention should also be paid to the need for public health approaches to tackling ill-health in the community.

INQUEST recommends the following actions on prison healthcare:

- **Prison staff, including healthcare staff, require improved training to meet minimum standards to ensure the health, well-being and safety of prisoners.** Enhanced training is also required to disrupt the apparent view among many prison staff that prisoners who self-harm, or who are affected by physical or mental ill-health, are manipulative attention seekers who are a disciplinary problem. There should also be improved engagement with families who may be able to provide life-saving information about physical and mental ill-health.
- **Improve standards of post-death investigations by the Prison Probation Ombudsman to better identify failures in care.** In particular, to ensure that so called 'natural cause' deaths are investigated by independent specialists.

Post release supervision

In their sixth periodic report, UKG notes that, "measures to help reduce reoffending include, as of 1 February 2015, that all offenders released from short prison sentences receive 12 months of supervision in the community".⁶²

Between 2010-11 and 2017-18, a total of 1,774 people died during post-release supervision in the community following a custodial sentence (MOJ, 2018).⁶³ Since the introduction of the Offender Rehabilitation Act in 2015, the numbers of people under post-release supervision increased. However, the number of deaths have far outstripped increases in caseload.

The rising number of deaths have occurred against a backdrop of significant changes to probation services and alongside rising levels of deaths, self-harm and violence within the prison system.

These deaths raise serious questions about the suitability of transition arrangements available for people as they leave prison. For example, continuity of care and probation support alongside links

⁶² Paragraph 23, UK Government (10 November 2017), *ibid*.

⁶³ Ministry of Justice (2018), *Deaths of Offenders in the Community, annual update to March 2018*. London: Ministry of Justice. Available at: <https://www.gov.uk/government/statistics/deaths-of-offenders-in-the-community-annual-update-to-march-2018> (accessed 15 February 2019).

between outside healthcare and mental health agencies and prisoners at the start, during, and at the end of a prisoner's sentence.

In November 2018, informed by the evidence from INQUEST, the House of Commons Health and Social Care Committee report on Prison Health recommended that, "*the Government undertake a thorough investigation of deaths during post-release supervision in the community, including the reasons for the rise in death rate that has been described.*" They further recommended that the Government clarify where responsibility for oversight of such deaths should lie and set out a plan to reduce this death rate.⁶⁴

There is a distinct lack of oversight when it comes to investigating and learning from these deaths. This is exacerbated by the lack of independent oversight from bodies such as the Prison and Probation Ombudsman and Her Majesty's Inspectorate of Probation.

INQUEST recommends the following actions on deaths following release from prison:

- **The government should conduct a national review of deaths of people on post-release supervision in the community following a custodial sentence,** to establish the scale, nature and cause of the problem.
- **Improve scrutiny and learning.** Confirm oversight at a local and national level. Explore options for probation trusts and CRCs to ensure better monitoring and learning from deaths of people in their care. As part of their inspection regime, HMI Probation should also seek include monitoring and reporting back on deaths, similar to that of the HMI Prisons.

Women in detention

There have been 104 deaths in women's prisons since the 2007 review of women in the criminal justice system by Baroness Corston.⁶⁵ There have also been seven deaths of transgender women in men's prisons in this period.

In May 2018, INQUEST published a new report *Still Dying on the Inside: Examining deaths in women's prisons*, considering developments in women's prisons since the publication of the Corston review 11 years prior.⁶⁶ With anger, sadness and deep frustration, we reported almost no progress on the systemic and structural change needed to address the ongoing harms caused by women's imprisonment. The death of Sarah Reed, a 32 year-old black woman, is illustrative.

Sarah Reed was 32 when she died in HMP Holloway on 11 January 2016. Sarah was remanded to prison by the courts for the sole purpose of obtaining psychiatric reports to confirm whether she was fit to plead, for an alleged offence which took place while she was sectioned at a mental health unit. Due to various delays, Sarah had not been assessed by the date the report was supposed to be ready in December. The final reports were due to be finalised on 11th January, the day she died and 15th January, four days after her death.

⁶⁴ House of Commons Health and Social Care Committee (1 November 2018), *Prison Health: Twelfth Report of Session 2017–19*. Available: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf> (Accessed 1 March 2019)

⁶⁵ INQUEST, Online statistics (rolling), *Table: Deaths in prison (England & Wales) 1990-date*. Available: www.inquest.org.uk/deaths-in-prison (Accessed: 1 March 2019)

⁶⁶ INQUEST (May 2018), *Still Dying on the Inside: Examining deaths in women's prisons*. Available: <https://www.inquest.org.uk/still-dying-on-the-inside-report> (Accessed: 1 March 2019)

In prison, Sarah's mental health deteriorated. In her final days she was sleepless, hallucinating, chanting, and without the medication she had relied on for years. Much of her behaviour was interpreted by prison staff as a discipline issue. Sarah was put on a basic regime and denied visits from family and lawyers, despite her right to visits as a remand prisoner.

Sarah was put on 'four man unlock' and a screen was placed before her cell door. Sarah was found unresponsive, lying in her bed with a tight ligature around her neck and could not be resuscitated. The jury at the inquest concluded that unacceptable delays in psychiatric assessment, inadequate treatment for her high levels of distress, and the failure of prison psychiatrists to manage Sarah's medication contributed to her death.

Our report details the persistence and repetition of the same key issues over an 11-year period, as well as a failure of government to act upon recommendations to prevent future deaths of women in prison. While the Corston Review pre-dates the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) they share a common theme, that women should be diverted from prison as much as possible, especially where they have health concerns or caring responsibilities. The evidence of INQUEST's casework and monitoring supports this focus.

On 27 June 2018, the Ministry of Justice launched their 'Female Offenders Strategy', which had been awaited since early 2017.⁶⁷ While the strategy acknowledges the many disadvantages faced by women in prison, and the need for better community services and support, rather than more prisons, much of this appears to be empty rhetoric. Shortcomings include lack of clarity on the funding of much-needed alternatives to custody, no implementation plan, and no substantive strategy on sentencing reform. We believe this strategy will not result in the structural change needed to prevent the ongoing harms and deaths in women's prisons.

INQUEST recommends the following actions on women in prison:

- **Redirect resources from criminal justice to welfare, health, housing and social care.** Reallocated criminal justice resources should be invested in refuges and rape crisis centres, drug and alcohol support services, gender appropriate community services and small community based therapeutic centres. They should be independent, specialist and dedicated services run by and for women and include culturally specific provision for BAME girls and women.
- **Divert women away from the criminal justice system.** Diversion from criminal justice towards treatment and support must be the preferred option. Strategies and holistic interventions that address the many complex reasons why women enter the criminal justice system— sexual and physical abuse, poverty, homelessness, addiction, and mental and physical ill health – offer the best option for tackling the issues that underlie the deaths of women in prison. Part of the former Holloway women's prison site could be developed as a women's building to deliver these gender specific services.
- **Halt prison building and commit to an immediate reduction in the prison population.** INQUEST believes imprisonment should be abolished as a response to women who have broken the law.

⁶⁷Ministry of Justice (27 June 2018) *Female Offender Strategy*. Available: <https://www.gov.uk/government/publications/female-offender-strategy> (Accessed: 1 March 2019)

For the 100 women or so whose offence is so serious that they may be considered a danger to others, a network of small therapeutic secure units should be created.

Immigration detention

Between March 2013 and March 2019 there have been 26 deaths of immigration detainees held in immigration detention, prison, during deportation, or within four days of release.⁶⁸ Since 2000 the annual number of deaths of immigration detainees has ranged between one and five. Yet in 2017, there were a total of 11 deaths marking an unprecedented and dramatic rise. More than half of the deaths in 2017 were of EU citizens, (five Polish men and one Slovenian man). This is particularly concerning given the UK's exit from the EU.⁶⁹

INQUEST contributed to the 2016 report *Death in immigration detention: 2000 – 2015* published by Medical Justice.⁷⁰ Home Office policy states immigration detention is intended for use in exceptional circumstances for as little time as possible, primarily as a pathway to deportation. The deaths detailed in this report add to the ample evidence that this is not the case.

The vast majority of immigration detainees who die could have had their claims processed in the community. Many deaths show failures of safeguarding practices (such as Rule 35) in preventing the unnecessary detention of vulnerable people suffering from mental or physical ill health. They also show that the practice of indefinite detention, as well as the poor conditions and treatment, itself creates vulnerability. When detainees do become ill, either through physical or mental illness, there is frequently inadequate healthcare, and an inadequate emergency response.

Four of the deaths of immigration detainees in 2017 were of those held in prisons. These deaths are routinely ignored by the Home Office in their reporting, yet are often due to the failures in communication and access to the resources and conditions to which immigration detainees are entitled.

Michal Netyks, 35 years old, was found dead on 7 December 2017 at HMP Altcourse. He had been serving a short criminal sentence at the privately run prison. On the day he was due to be released, Michal had packed his belongings and was looking forward to reconciling with his partner. However, on the morning of 7 December, Michal was served with a notice that he would continue to be detained pending possible deportation to Poland. Distressed and with no access to support or clear explanation, the inquest into his death found that Michal died due to a blunt force head injury after jumping head first from a first-floor landing at the prison.

The coroner at the inquest called for the Home Office to address concerns which he believed could lead to further deaths. These included that foreign nationals who are liable for deportation have no access to free legal advice, for example through duty lawyer schemes, if they are not detained in an immigration detention centre. The coroner also found that prison officers required to serve papers related to deportation "*would be more effective if*

⁶⁸ INQUEST (online rolling statistics), *Deaths of immigration detainees* – source: INQUEST casework and monitoring. Available: <https://www.inquest.org.uk/deaths-of-immigration-detainees>

⁶⁹ INQUEST (September 2018), *INQUEST Submission to the Joint Committee on Human Rights: Immigration Detention inquiry*. Available: <https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=26167b21-82e2-44f9-91fb-0744f3b055ef>

⁷⁰ Medical Justice (2016), *Death in immigration detention: 2000 – 2015*. Available: www.medicaljustice.org.uk/about/what-we-do/research-and-campaigning/publications/

they were provided with a training package, making them aware of the deportation process" by the Home Office.⁷¹

Some immigration detainees who die in prison have been held for weeks or even months after their sentence has ended. Ketheeswaren Kunarathnam, a Sri Lankan national, was an immigration detainee when he died in February 2018. He was found hanging in HMP Wormwood Scrubs, five months after finishing a 28 day sentence.

The UK Home Office's public response to deaths of immigration detainees is one of denial, delay and obfuscation. They do not routinely publish data, only confirm that deaths have occurred if asked, and generally avoid or delay confirmation. INQUEST relies on information shared between other NGOs. This is in contrast with the more open reporting on deaths in prison and police custody. Stephen Shaw also highlighted this issue in his report, *Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons* (July 2018).⁷²

INQUEST is also concerned that deaths of those within days of release from immigration detention are less visible and subject to less scrutiny. It is at the discretion of the Prison Probation Ombudsman as to whether they investigate deaths shortly after release from detention. In practice they seldom do. Delays in opening PPO investigations in immigration detention cases can also mean that evidence is lost, when potentially key witnesses are deported following deaths.

Overall, immigration detention is unnecessary, expensive, unsafe and inhumane. Deaths revealing the cruel and unnecessary detention of vulnerable individuals, poor treatment and conditions, and a lack of access to adequate health care, all raise questions about the UK's compliance with Article 2 and 3. The monitoring of these rights by the public and NGOs is made difficult by the closed culture of the Home Office around deaths. Ending the use of immigration detention is a call supported by numerous expert NGOs, including the British Medical Association. INQUEST believes this is the only way to prevent further deaths and suffering.

INQUEST recommends the following actions on immigration detention:

- **An independent review commissioned by Government on how best to reduce the population of immigration detainees and phase out the use of immigration detention.**
- **An immediate end to the use of indefinite detention under immigration legislation in prison and immigration removal centres and release of all immigration detainees considered vulnerable or at risk, such as victims of torture and those with mental or physical ill health.** There should also be provision for community healthcare and support for former detainees.
- **Public reporting on deaths and safety in immigration detention from the Home Office and contractors.** This should include deaths within 48 hours of release from detention, and all deaths of detainees in hospital. Transparency is an essential part of democratic accountability. It allows the public and civil society organisations to monitor the protection of detainees' rights, such as those under Article 2 and Article 3 of the Human Rights Act.

⁷¹ INQUEST Media Release (19 December 2018), *Critical inquest highlights Home Office failures following death of immigration detainee in prison*. Available: <https://www.inquest.org.uk/michal-netyks-conclusion>

⁷² Stephen Shaw (July 2018), *Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons*. Available: <https://www.gov.uk/government/publications/welfare-in-detention-of-vulnerable-persons-review-progress-report>

For more information contact:

INQUEST

www.inquest.org.uk

+44 (0)20 7263 1111

lucymckay@inquest.org.uk