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The deaths of children and young people in custody: the need for an independent review

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Background and INQUEST's work

The number of deaths of children in custody, and the recurring themes raised by them, has been an area of concern for INQUEST since the death of 15 year old Philip Knight in Swansea prison in 1990.

In 2005 INQUEST published the first analysis of these deaths: *In the Care of the State* (by Professor Barry Goldson and Deborah Coles). Following the inquest into the 2002 death of 16 year old Joseph Scholes in Stoke Heath YOI, the coroner took the unusual step of writing to the Home Secretary to recommend a public inquiry into "all the circumstances... include[ing] sentencing policy which is an essential ingredient but outside the scope of this inquest." INQUEST, the Prison Reform Trust (PRT), Nacro, other penal reform groups, MPs and the Joint Committee on Human Rights supported the call for a public inquiry. However, it was rejected by the government in 2006.

In 2012 INQUEST and PRT published *Fatally Flawed: has the state learned lessons from the deaths of children and young people in prison.* The evidence based report drew on INQUEST's extensive casework on the 143 deaths of children and young people (aged 24 years old or younger) between 2003 and 2010 and included six individual stories outlining the experiences of some of the children and young people who have died¹.

Fatally Flawed was groundbreaking in its analysis of the deaths of 18 to 24 year olds as well as children. The report's scope was influenced by our casework which has flagged up the overlap between the problems faced by the two age groups and that their experiences are intrinsically linked. We have worked on a number of cases involving 18 to 24 year olds who have taken their own lives in the adult estate having previously been in custody as a child. The scope of the research in Fatally Flawed was also influenced by clear evidence, including from the Transition to Adulthood Alliance, revealing that cognitive behaviour and development processes by which the brain develops and matures in young people typically continue until they are in their early to mid-twenties.

Analysis of the data in *Fatally Flawed* underlined that children *and* 18-24 year olds who have died in custody had commonly experienced multiple disadvantage and typically had complex needs such as histories of substance misuse, mental health difficulties, learning disabilities and self-harm. It confirmed our view that the needs and problems of those aged 24 and under are often not only acute but, in many cases, different from other, adult prisoners. As a result, INQUEST believes a complementary, coherent approach should be adopted to preventing the deaths of children *and* young people (whilst recognising each group also has distinct needs which need targeted provision of support and services).

2

¹ The full report can be found here: www.inquest.org.uk/publications/books/fatally-flawed.



Fatally Flawed concluded that there needs to be an overhaul of the use of imprisonment for vulnerable children and young people and recommended:

"An Independent Review should be established, with the proper involvement of families, to examine the wider systemic and policy issues underlying the deaths of children and young people in prison."

Why an independent review?

The state has been put on notice of the problem of deaths of children and young people in custody for many years. In resisting previous calls for an inquiry, the government has argued they would adopt alternative strategies to try to prevent future deaths including: internal reviews by Ministry of Justice agencies; commissioning of discrete reports by specialists on specific issues such as the use of force; better publication of information relating to the deaths of children and young people; and expanding the scope of the law governing inquests. These piecemeal, fragmented initiatives have not had the desired effect of substantially reducing the numbers and patterns of these deaths with 51 further deaths between 1 January 2011 and 30 January 2014.

The government must try something different. For the following reasons, a comprehensive, holistic independent review must now be established to help find a solution:

Limits of the current system in understanding and preventing these deaths

The deaths of children and young people in custody do not just raise criminal justice issues but important social and public health issues that go beyond the prison walls. However, the current mechanisms in place to examine these deaths, principally the investigation and inquest systems, are not set up or permitted to tackle these crucial, broader contextual questions underlying the deaths.

The remit of the Prisons and Probation Ombudsman (PPO) does not include investigating actions and decisions relating to issues arising prior to a child or young person's remand or sentencing to custody. It also does not encompass monitoring the take-up of any recommendations made following fatal incident investigations. Following the last three deaths of children in custody, the PPO took the unusual but helpful step of publishing a learning bulletin before the inquests have taken place which draws out "several, recurring concerns that arise from the three investigations". The PPO noted that investigations "have a role to play" in taking effective steps to avoid repetition of deaths but expressed his desire that "I hope these lessons are learned"² - implicitly acknowledging that his office has a limited role in this.

² Published in March 2013. Full Bulletin from: http://www.ppo.gov.uk/docs/LLB_FII_03_Child_deaths.pdf



The law governing inquests means the coroner's scrutiny is focussed on specific questions of 'how' and, following the landmark case of <u>Middleton</u>, 'in what circumstances' the child or young person died in custody. Even with the expanded jurisdiction following the court's decision in <u>Middleton</u>, this normally confines the inquest to an examination of an individual's experiences in a prison at a given moment in time and is held in isolation from a consideration of other deaths.

The current mechanisms do not allow for collective lessons to be drawn from an aggregated understanding based on multiple cases. For example, the law on the scope of inquests means that coroners can not look at other previous deaths - even in the same prison. Compounding this, none of the statutory investigation, regulation or inspection bodies have robust follow-up powers to monitor any action taken following recommendations (from the coroner, PPO, LSCB reviews or HMIP). Instead, as INQUEST has previously documented in our research report *Learning from death in custody inquests*³, we have fragmented learning and patchy follow-up to similar recommendations made following individual deaths. This hampers learning and hinders the prevention of further, avoidable deaths.

The inquest process does not allow fundamental questions to be explored about why a child or young person was imprisoned in the first place or whether there were suitable community alternatives to custody. The coroner's inquest is also abstracted from a broader analysis of justice policy and consideration of the wider social, structural and institutional arrangements beyond the prison walls that feature in a child or young person's life. It does not usually allow for an examination of:

- support and treatment offered in the community such as CAMHS, health, substance misuse or psychiatric interventions;
- the role of youth offending teams;
- any diversion schemes; or
- questions of sentencing.

For example, we know from our casework that a significant number of those who have died were care-leavers or had experience of care yet this context may not be fully analysed by an inquest. At the recent inquest into the April 2011 death of 17 year old Ryan Clark the jury heard evidence from the Chair of Leeds Safeguarding Board that the system failed Ryan, a "looked after" child, who had been in care since he was 16 months old. She said that during the last 12 months of his life there was no single consistent professional responsible for him, his housing situation prior to his remand was dire, his care plan was insufficient and he "was treated as troublesome rather than troubled." However, the inquest jury's conclusions had to be limited to factors which directly caused or contributed to Ryan Clark's death so were focussed on what happened to him in Wetherby YOI.

These are exactly the kinds of issues that could and should be scrutinised by a Review.

³ Learning from death in custody inquests: a new framework for action and accountability (INQUEST, September 2012). Available from: www.inquest.org.uk/publications/books/learning-from-death-in-custody-inquests



Continuing pattern of deaths

Perhaps the most compelling evidence that the current mechanisms are not working is that deaths continue to occur and, crucially, the *pattern* of deaths with worryingly familiar themes continues.

The in-depth analysis of INQUEST's monitoring and casework evidence in *Fatally Flawed* covered the period from 2003-2010. Between 1 January 2011 and 30 January 2014:

- There have been a further 3 deaths of children and 48 deaths of young people aged 18-24 years old in prisons (including 12 self-inflicted deaths since the Minister announced his original decision on 14 May 2013 not to hold a review);
- of the 51 children and young people who died nearly all (48) were boys or young men;
- over a quarter (14) of those who died were from a black or minority ethnic background;
- nearly a third (16) of the children and young people who died were on remand;
- o the vast majority (44) were self-inflicted deaths;
- of the self-inflicted deaths, 2 of the 3 children who died and a third of the young people aged 18-24 years old were subject to an ACCT at the time of their death; and
- the majority (38) of the 48 young people aged 18-24 years old died in adult establishments (including 6 teenagers).

An analysis of INQUEST's casework on the more recent deaths reveals:

- A large number of young people who died in custody were diagnosed with ADHD, special educational needs, personality disorders, conduct disorders, attachment disorders and other vulnerabilities – some of which have a statistical link to self-harm and suicide;
- Inadequacy of staff training in mental health awareness and issues to deal with these vulnerabilities;
- Multi-agency failures in verbal and written communications so individual vulnerabilities and specific needs failed to be identified and addressed by prison staff;
- In those individuals where vulnerability had been properly identified, high numbers of deaths took place whilst on ACCTs (see statistics above).

As well as the inquest into the death of the 18 year old son of E (the claimant in the judicial review proceedings which have prompted the Ministry of Justice's reconsideration of the 14 May decision not to establish an independent review), examples of these recurring themes from recently concluded inquests into the deaths of young people include:

• Christopher Neale (19) HMYOI Glen Parva: where the jury found that whilst they were satisfied it was Christopher's intention to take his own life, on the facts more could have been done to protect him. For example, monitoring was inadequate and could have been better managed and an



ACCT (Assessment, Care in Custody and Treatment) should have been opened.

- Ben Grimes (18) HMYOI Portland: who had a number of vulnerabilities including severe special education needs and possibly ADHD. Formerly in the youth secure estate, Ben was transferred to Portland on turning 18 and services were withdrawn. The inquest jury found multi agency failure in communication, failure to pass on relevant information on transfer, failure to understand his individual and specific needs and an interruption to his social care support.
- Billy Spiller (21) HMYOI Aylesbury: who had been diagnosed with ADHD, learning disabilities and autism. He had a history of extreme attempts to self harm. The inquest jury found that levels of observations should have been increased and the coroner criticised the lack of suicide and mental health awareness training at Aylesbury.
- Nicholas Saunders (18) HMYOI Stoke Heath: who had previously attempted to take his own life whilst in HMP Woodhill. He was transferred to Stoke Heath but ACCT information about risk and triggers for risks did not go with him. The inquest jury found the following contributed to his death: failure to transfer risk information between institutions and lack of awareness of wing staff of the risk, error in visitor booking for his mother to visit. The coroner issued a rule 43 recommendation targeted at the prison's practice of condoning construction of washing lines from torn bed sheets and light fittings.

On a positive note, the fact that there are often common features to many of these deaths gives an invaluable opportunity to identify common solutions.

For example, an independent review could analyse national patterns and trends in the use of ligatures in self-inflicted deaths throughout the youth and adult prison estate (including as highlighted by coroners in Rule 43 or Action to Prevent Further Death reports). This data could then be analysed in conjunction with experts (including those with relevant experience from outside the prison estate – eg in mental health settings) to draw up recommendations for safer cell design and elimination of possible ligature points. This could inform a Ministry of Justice/NOMS national action plan which sets out how (and when) these recommendations would be implemented by all individual prison establishments to reduce risk and, as a result, help prevent future deaths. To monitor progress HM Inspectorate of Prisons could then, as part of their inspection regime, check whether the national action plan had been complied with.

Addressing public concern

Finally, given the continuing high number of deaths we believe that an independent review offers an important opportunity for transparent scrutiny of this problem which has been the focus of much public concern. It would provide an opportunity to consider, in a less charged forum than individual inquest hearings, the wider systemic issues.

INQUEST were pleased that, as part of their inquiry into youth justice following publication of *Fatally Flawed*, the parliamentary Justice Committee took our evidence and concerns on board. In their March 2013 report the Committee identified, as one of the "three very serious issues in the custodial estate that require action" that "it is imperative to draw together and act upon lessons



arising from the deaths of vulnerable young people in custody" because it "is unacceptable that vulnerable young people continue to die in the custody of the state".4

As well as the Justice Committee, other bodies and key public figures have expressed concern about the problem and supported greater scrutiny and analysis – including the Children's Commissioner and Deputy Children's Commissioner for England.

INQUEST's call for an independent review has been backed by leading organisations including:

- Prison Reform Trust;
- Howard League for Penal Reform;
- Children's Rights Alliance England (CRAE);
- Standing Committee on Youth Justice;
- Transition to Adulthood Alliance and Barrow Cadbury Trust;
- Criminal Justice Alliance;
- National Association for Youth Justice;
- National Children's Bureau;
- Just for Kids Law;
- Revolving Doors Agency;
- the Care Leavers' Association;
- the National Council for Voluntary Youth Services;
- the Centre for Crime and Justice Studies;
- Barnardo's;
- JUSTICE and
- Liberty⁵.

The need for an independent review is particularly urgent in light of the government's proposed changes to the youth secure estate and to the approach to 18-24 year olds in prison. In January 2014, the Ministry of Justice announced plans to spend £85million building and opening a secure college in Leicestershire which will hold up to 320 young people in custody. This is planned to be the first step towards building several other "fortified schools" which will eventually cater for the vast majority of young people in custody. The government has said that it does intend to retain some specialist provision for "the very youngest and most vulnerable of young people" (but details have yet to be published). Placing these demonstrably vulnerable children in large institutions, significant distances from home in an environment focussed on "strong discipline" will not address or tackle the underlying causes of their difficulties. 6

This move towards warehousing children and young people in custody comes at the same time as the government has outlined its intention to scrap Young

⁴ Justice Select Committee, *Youth Justice: Seventh Report of Session 2012-13*. Full report from: www.publications.parliament.uk/pa/cm201213/cmselect/cmjust/339/33902.htm

⁵ See *Young people are still dying in prison* Letter to the Editor, Daily Telegraph, 5 February 2014: http://www.telegraph.co.uk/comment/letters/10617755/Young-people-are-still-dying-in-prison.html

The plans have been heavily criticised by a former chair of the Youth Justice Board, Rod Morgan, and Pam Hibbert, Chair of the National Association for Youth Justice: www.theguardian.com/society/2014/jan/19/fortified-schools-become-colleges-crime. PRT and the Howard League have also gone on the record to express their concerns: www.cypnow.co.uk/cyp/news/1141590/government-unveils-secure-college-offenders-plans.



Offender Institutions and place all those aged 18 or older in mainstream adult prisons. In response to the MoJ's recent consultation on *Transforming Management of Young Adults in Custody,* INQUEST said "the proposals in the consultation paper would create significant risks for young adults in custody. As the Ministry of Justice is aware, we have longstanding, well-documented concerns about the treatment and care of young people in YOIs. However, the solution to those problems is not, as the government proposes, to place young people in mainstream adult prisons which, rather than addressing them, risks exacerbating the existing flaws in the system."

A process offering independent, public scrutiny of the ongoing pattern of deaths, with proper involvement of bereaved families, is needed to rebuild confidence in the robustness and safety of the government's plans for children and young people in custody.

What would be the scope of an independent review?

We suggest that the detailed scope and terms of reference of any process should be determined by the Chair and team conducting the review (following representations from interested parties such as families). However, as a minimum we think it must encompass:

- 1. analysis of deaths of children *and* young people under 24 since 2003 to date to draw out and identify underlying issues, missed opportunities and failures in procedures and systems both before and in custody;
- examination of the provision and support offered to children and young people beyond the prison walls to include their journey into custody; the roles of social services, health (particularly psychiatric) and youth justice teams; and, the availability of alternatives to custody for children and vulnerable young people;
- 3. recommendation making powers and a monitoring function to review the action taken to implement those recommendations which are accepted by the government.

What format might an independent review take?

The need for independent, holistic scrutiny of the deaths of children and young people should not become mired in debates about the relative merits and efficacies of inquiries as opposed to reviews. What is important is that a systematic examination capable of identifying and tackling the most important issues takes place.

We envisage a process which incorporates:

- collation and analysis of all relevant data and material;
- taking further evidence (both written and oral) from stakeholders and experts;
- a report incorporating findings from evidence, recommendations and suggested timescales for implementation;



 a detailed response from government, including action plans for implementing accepted recommendations.

While it may be for Ministers to decide on the most appropriate model the review must, as a minimum, have:

- Proper guarantee of independence with a suitably robust Chair supported by two Assessors recognised as experts in the issues raised;
- meaningful involvement of bereaved families⁷;
- input from children and young people in custody about their experiences;
- involvement and "buy-in" from those with experience of working with children and young people in conflict with the law (both in custody and beyond);
- evidence from a broad range of experts;
- transparent and open processes to enable public comment on the core issues by all stakeholders;
- reasonable time frames which achieve a balance between quick learning and effective learning⁸;

There are models of Reviews and Inquiries which could be usefully built on in devising the format.

For example, following the self-inflicted deaths of six women at Styal prison, in 2006 the Government commissioned the independent Corston Review of "women with particular vulnerabilities in the criminal justice system" The review:

- was chaired by an experienced independent figure;
- had a Reference Group of experts in the field;
- conducted a paper exercise bringing together all relevant information including reviewing and analysing the profiles and characteristics of women who had committed suicides in prison and followed the pathways that led them there;
- conducted a range of site visits to prisons and alternatives to custody;
- organised a family listening event to enable relatives to share their experiences directly;
- held other stakeholder events as part of the process;
- produced a comprehensive final report with suggested actions.

Another example is offered by the Bradley review of "people with mental health problems or learning disabilities in the criminal justice system" 10. The review:

- was chaired by a leading expert and independent figure;
- had both a Reference Group of experts in the field and a Working Group comprised of key government departments and agencies;
- analysed available data and conducted literature reviews to inform the focus;

⁷ We would recommend a non-adversarial approach to the review but some bereaved families may need access to support and advice from lawyers (because of their vulnerability or personal circumstances)

⁸ We anticipate 18 months to two years for the entire process

⁹ The Corston review cost approximately £70,000 and took nine months

¹⁰ The Bradley review was conducted over a twelve month period



- sought contributions from a wide range of individuals and organisations through individual meetings with heads of agencies, organisations and professional groups and focus groups with service users and carers;
- conducted site visits across the country to review practice good or otherwise;
- issued a national call for evidence to enable all stakeholders to submit their views, culminating in an analytical report;
- commissioning a cost/benefit analysis of options;
- produced a comprehensive final report which has informed subsequent government action plans and investment.

These models provide a useful foundation to build on. Recent innovations in management of Inquiries and Reviews to streamline the process (and costs) which could usefully be incorporated in a "Corston or Bradley-plus" model include:

- Focussed, public oral evidence and question sessions to enable greater understanding of the core issues;
- Parts of process conducted on the basis of written evidence alone;
- Parts of review conducted as seminar style events with more than one expert giving evidence and discussing possible solutions.

What might it cost?

The format we outline above would not be prohibitively expensive.

The government's own evidence to the ongoing House of Lords parliamentary select committee inquiry on the Inquiries Act 2005 usefully sets out the range of costs of different types of set-ups under that statute¹¹. Based on available figures for Inquiries and the model of "Corston or Bradley-plus" we estimate costs in the region of £1-2 million.

When considering cost, it is important to balance any headline figure against the costs of repeated investigations and inquests into potentially avoidable deaths. INQUEST has sought figures through FOIA requests and parliamentary questions but the government has been unable to provide a comprehensive set of statistics¹². However, it is clear that the cost to the public purse for every individual death is high and includes, at a minimum:

- costs of police and internal, prison investigations;
- costs of PPO investigation;

 costs of legal representation at inquests (both for any Ministry of Justice agencies, prisons or others and, to a much more limited extent given current funding arrangements, for bereaved families' representation);

• costs to local authorities of coroners' investigation and inquest hearings.

¹¹ Annex 1 to Government Response at page 76 of collated written evidence published by Select Committee on Inquiries available here: www.parliament.uk/documents/lords-committees/Inquiries-Act-2005/IA Written Oral evidencevol.pdf.

Parliamentary Question from Jeremy Corbyn MP to the Parliamentary Under-Secretary of State for Justice, Hansard, 18 January 2011: www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110118/text/110118w0001.htm#11 011867003416



If the outcome of the independent review process were recommendations for change which resulted in the prevention of even a small number of deaths, the costs of the review itself would be outweighed by the savings to the public purse.

Ultimately, however, the human cost should not be forgotten: to those children and vulnerable young people who currently continue to die in custody and to their families who are left to pick up the pieces following the untimely death of a relative whilst in the care of the state.

An independent review would be a proactive, positive response to the problem of the deaths of children and young people in prison. It would, INQUEST believes, stimulate greater understanding of the issues and encourage a dynamic interaction between government and non-government agencies to tackle the underlying issues and provide an important foundation for the effective prevention of further deaths.

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