Equality and Human Rights Commission
Research report 106

Non-natural deaths following prison and police custody

Executive summary

Data and practice issues

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Background

The Commission undertook this research as a follow up to our 'Preventing deaths in detention of adults with mental health conditions' Inquiry. During this inquiry, we were told of concerns about gaps in knowledge about those who died shortly after leaving police or prison custody. This was outside of the Inquiry's terms of reference but we decided to take a closer look at this following publication of the Inquiry report. We commissioned Sheffield Hallam University and the University of Cambridge to undertake this work.

The original inquiry made four principal recommendations. These were:

- There needs to be a more structured approach to learning lessons to implement changes identified as necessary during investigations of previous deaths and near misses, as well as learning from experiences in other institutions.
- There should be a clearer focus on getting the basics right, including implementing recommendations, improving staff training and ensuring more joined up working.
- There needs to be increased transparency to ensure adequate scrutiny, holding to account and the involvement of bereaved families.
- All detention settings should use the Commission's Human Rights Framework to reduce non-natural deaths and ensure that their policies and practices meet their legal obligations under the Human Rights Act.

The research into deaths following custody identified similar factors, suggesting that issues which could contribute to deaths in custody, are also relevant on release.

Findings and conclusions

For those leaving police custody and prison there is a clear frequency of substance abuse and mental health conditions.

Prisons

Of the 66 non-natural deaths recorded following release from prison over the period of 2010-15, 44 died from drug overdoses and 14 were unclassified. The majority of those who died of a drug overdose did so within 10 days of release. This suggested a lack of continuity of care where, for example, records or referrals for treatment

were not passed on or acted upon. End to end sentence management does not yet work; and an offender's progression through the prison estate to the community (and sometimes back, when recalled) is proving difficult to navigate for the prison authorities. This echoes a theme we identified in our inquiry into adult deaths in detention of a lack of adequate assessment of mental health levels in prisons.

The research raises a concern with the quality of the data that the National Offender Management Service (NOMS) collates with regard to deaths under supervision, which may have led to under- reporting. This is in part due to recent structural reforms and privatisation, including the introduction of Community Rehabilitation Companies (CRCs), that have yet to be completed. In addition, prisoners sentenced to less than 12 months were not included in the data collated by NOMS prior to 2014.

Police custody

Over the six years, 2009/10-2014/15, 31% of those who committed suicide had been charged with sexual offences and 19% with violent offences. Sexual offences - especially those against children - are associated with high levels of shame. The role of shame associated with the suicides is potentially a significant factor. Research has highlighted the particular challenges faced by convicted sex offenders in transitioning successfully to the community and the shame and stigma attached to this particular offending.

The Independent Police Complaints Commission (IPCC) has a critical role in investigating deaths of individuals in and after custody. When those released die a non-natural death within two days, the police will make a referral of the death to the IPCC, if they think the custody had a bearing on the death. However we found it difficult to understand how the police make a judgement as to when they should make this referral. The reality is the police may not know that the detainee has died orthat someone who has died was recently detained. Without robust mechanisms linking custody and the death, the number of referrals made is likely to be an underestimate of the true figures.

Problems were identified in custody record-keeping, risk assessments and communications. The IPCC reports identified a lack of detail in custody reports, for example cell checks were not recorded adequately. The police we spoke to reported that risk assessments are difficult to undertake in custody, because it is a non-private space and detainees often don't disclose important information.

The perception from custody sergeants is that cases involving those who are detained are more complex and difficult even than a few years ago. Not having access to NHS records (the 'NHS spine') in custody is a key issue. Often detainees do not remember what medication they are on because of the use of alcohol or illegal drugs or withdrawal from them. This is a particular concern as the proposed national handover for custody healthcare to the NHS has now been cancelled. Each force will continue to contract its own providers, which will have an adverse impact on integration into NHS systems and meeting NHS standards of care.

Methods

The researchers conducted a literature review and found that the majority of the research to date related to those leaving prison and not police custody.

The NOMS shared their data from 2010-15, which included those who had died under probation supervision, within 28 days of release. Interviews were conducted with prison staff, a coroner and Public Heath England.

The IPCC publish data for apparent suicides within two days of release from police custody. They shared 11 investigation reports with us, either in full or as a summary. The IPCC also provided a sample of 30 police referral forms out of a total of 289 from 2010-15, 6 at random from each year. These referrals are made when the police think that there is a possible link between someone having been in custody and the subsequent suicide. Two focus groups were held with custody sergeants.

Recommendations

- The Home Office should give further consideration as to whether responsibility for health and mental care in police stations should be given to the NHS. As a minimum requirement, custody health care staff should have prompt access to NHS records in order to provide the best care and support.
- An inter-agency summit is convened to explore how these ‘hidden’ deaths can be better exposed, and how the data can be made more reliable and comprehensible. Following the obligations set out in the Equality Act 2010, data collection and analysis should, in future, include reference to protected characteristics such as gender, where this does not compromise anonymity for those concerned, in order to monitor progress and identify any problems.

- More training is provided to support police custody staff in the identification and treatment of suspects who may be traumatised by the fact of arrest and investigation, and of others with mental health issues. Notwithstanding the progress made by the Mental Health Crisis Care Concordat around improving liaison between the police and mental health services, there is a need for police custody staff to understand the responsibilities of different agencies who work with people with mental health problems. The College of Policing is currently in the process of rolling out training and we would encourage prioritisation of this by individual police forces.
- More training is provided for all probation and CRC staff (including those who work in Approved Premises) particularly in relation to inter-agency co-operation when working with those at risk of abusing illegal and prescription drugs.
- Criminal justice agencies review how far relevant policy documentation is immediately accessible and comprehensible for staff. This includes providing a 'checklist' of actions for dealing with people at crucially vulnerable moments in their lives.
- There should be an obligation on the appropriate authorities to carry out effective risk assessments before release from prison and police custody and information disseminated to all relevant agencies to enable them to provide appropriate safeguards and support. These obligations should be monitored within a framework of accountability.
- All apparent suicides within two days of release from police custody should be referred by the police to the IPCC, to assess whether to carry out an Article 2 compliant investigation.
- All non-natural deaths within two weeks of release from prison should be referred to the Prison and Probation Ombudsman to assess whether to carry out an Article 2 compliant investigation.

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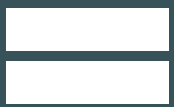

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