NPM Roundtable: Deaths in custody – Wednesday 6 September

Key emerging themes

On 6 September 2023, the UK NPM hosted a roundtable on deaths in detention. A range of stakeholders participated, including:

- NPM member organisations
- Ombudspersons
- Independent experts
- Other stakeholders across the UK

Deaths in, and on release from, all forms of custody are a global and increasing concern. There is no comprehensive, UK-wide analysis of why deaths in custody are increasing. In England and Wales, 322 people died in prison custody in the 12 months to March 2023, a 12% increase from the previous year. Scotland has one of the highest prison mortality rates, which is rising. Northern Ireland saw the number of deaths in the prison system double between 2016 and 2017.

The roundtable aimed to gather perspectives and shared learning, in order to identify opportunities to strengthen preventive methodology, to contribute to efforts to prevent deaths in detention. The Independent Advisory Panel on Deaths in Custody (IAPDC) has identified 8 cross cutting themes through its joint work: staff culture, leadership, training, capacity, SHS Prevention processes, family involvement, custodial landscape and the untherapeutic nature of detention, learning and accountability, facilitating research in custody.

This document is based on the day's discussion and summarises the key themes that arose throughout the roundtable. Reflecting on the points raised, the NPM Secretariat has made a series of suggested recommendations related to each theme. The day was held under Chatham House rule, and all points are unattributed. The settings discussed included prisons, police custody, and mental health hospital settings. Much of the discussion focussed on prisons. However, this note includes observations and recommendations relevant to all settings. Immigration detention should also be considered in terms of improving preventive methodologies.

Based on the day's presentations and discussions, participants agreed that better cooperation to prevent deaths in detention was a priority, and resolved to work together on this matter.

Prison population increases and capacity

Across the UK, it is likely that the number of people dying while deprived of their liberty will increase as prison populations increase. England, Wales and Scotland currently have some of the highest rates of imprisonment in western Europe and the number of people remanded in custody is rising. Meanwhile there are problems with the recruitment, retention and training of staff. Prison staff want to help and support prisoners and their families, but recruitment and retention issues undermine efforts to deliver regimes. There are long waits for transfer to community mental health treatment, where provision is also affected by lack of capacity. It was suggested that lack of community provision may itself have influenced a person's eventual contact with the police and the criminal justice system.

Consequent causes of ill health in prisons include little time out of cell, lack of key work and purposeful activity, which in many institutions lead to a reliance on drugs, alcohol, and diverted prescription medication. While efforts currently focus on disrupting the supply of illicit substances to prisons and to chemical detoxification, participants at the roundtable reflected that psychosocial support and a full regime could provide more effective support for the full range of psychiatric and addiction needs.

Current concerns include the lack of structured peer support, lack of identification and support in first few days of custody, and insufficient analysis of data to understand the causes of self-harm. These contribute to poor planning to change outcomes and mean that not enough is learnt after risks are averted.

While it is appreciated that the mandate of investigations can be narrow, it was highlighted that recommendations can too often focus on specific case circumstances and do not take in the picture of systemic contributory factors, such as increasing prison population and limited regime. Roundtable delegates reflected that recommendations could be considered more broadly to fully capture possible preventive actions.

Suggested recommendation:

Investigative and preventive bodies could consider systemic issues more comprehensively.

Access to and use of information/data:

The roundtable discussed access to information. Preventive and investigative bodies face a difficulty in getting disaggregated data on deaths in **mental health detention settings**, and a lot of learning is impossible because of lack of access to data. The fragmented nature of health commissioning leads to inconsistent quality of information and expertise in quality assurance processes. Ongoing work with NHS must focus on how to use information to identify problems, in order to fix them.

There is also a lack of disaggregated data for **prisons**, that could outline different risks for different groups, which is key to understanding who is at risk, and when. In addition to concerns around the increase in population, the fast moving and changing population means that dynamic risk assessments are required to mitigate risks. Changes of circumstances can also be a factor in an individual's distress, for example length of detention, a difficult family visit, an unexpected court decision or particular times of year. There is a greater need than ever for places of detention to regularly consider the needs of new arrivals in prison - but also to regularly review the existing population.

Suggested recommendation:

Senior leaders should analyse trends across jurisdiction, as well as within each institution, to identify emerging issues and opportunities for change.

Establishment management should maintain and analyse consistent, comprehensive documentation on individuals, risks and trends to enable full inspections and investigations.

Research opportunities and funding must be prioritised to identify risk factors and causes. While there is a necessary level of bureaucracy to ensure safeguarding and an ethical approach to research, it was expressed that some institutions are still hostile to research, while research committees can be over-cautious about research in prisons and custody settings.

Participants shared concerns that some terms of reference with institutions inspected, visited or investigated did not make explicit reference to the psychological safety of staff to raise concerns – within the institution or with investigators. This was particularly noted for healthcare settings. For these activities to have a preventive effect, institution staff need to be supported to have confidence to raise specific issues, so that these can be reflected in published recommendations but crucially, so that risks can be addressed at as early an opportunity as possible. Staff surveys do allow for an indication of concerns, and an opportunity for anonymous whistleblowing.

Delays to inquiries and investigations also undermine the availability of evidence, while affecting the receptiveness of staff to findings and recommendations.

Suggested recommendation:

Terms of reference should be revisited, focussing on opportunities and support for staff to disclose issues. Bodies that scrutinise can make greater use of PFD reports – and MoJ should support chief coroner to produce a yearly review to comment on learning and comment on response.

Notification of serious incidents:

Different procedures exist in each jurisdiction to inform preventive and investigative bodies of deaths that occur in prisons, police custody, and mental health detention.

For example, where no-one is obliged to report on post-release deaths, the Prisoner Ombudsman for Northern Ireland relies on families, hospital management, the prisons, or police to proactively communicate that the death occurred and its link to detention. Similarly, referral of Serious Adverse Incidents (any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage)[1] relies on the prisons themselves.

There is good practice from MoJ regarding notifications, with some disaggregated detail when somebody dies. But there are issues of access to mental health data sets and waits for cause of death. Information sharing between healthcare and justice institutions can also be a challenge.

Suggested recommendation:

Families' Article 2 rights entitle them to an investigation when a relative dies in circumstances that involve the state, and the state is required to investigate deaths in custody.[2] Implementation of this right relies on notification of the appropriate investigative body. These procedures should therefore be revised.

Working with families:

Families, and listening to families' concerns and questions, is essential both in preventing deaths in detention, and in investigating deaths. Several speakers emphasised that families of people in prison or in mental health detention believe that their relative will be safe in state care. Although nothing will bring back their family member, all families want to prevent others from experiencing the same loss. Families are often disadvantaged and discouraged through adversarial processes or a lack of information about their Article 2 rights. They do ~~not always/often feel they hav~~e choice or control in the investigatory process, both are key elements of trauma-informed approaches. Non-means-tested public funding for families to

[1] Serious Adverse Incidents | Department of Health (health-ni.gov.uk)
[2] Article 2: Right to life | EHRC (equalityhumanrights.com)

be represented at inquests is available in England and Wales but is needed in Northern Ireland and Scotland as well.

Suggested recommendation:

Family members must be informed of their legal rights following the death of their relative in state care and supported in accessing theses rights.

Bodies should also assume a policy position supportive of non-means tested public funding for families to be represented at inquests in Scotland and Northern Ireland.

Detainee voices

Listening and responding thoroughly to the complaints of people deprived of their liberty is key to preventing incidents of hopelessness, self-harm, and death by suicide and, in prisons, substance misuse. Clear visibility of rates of self-harm is important to prevention.

Delegates considered a key consideration on the question of whether a death was preventable is around decency, compassion and dignity in the setting, and the relationships between staff and prisoners is essential. Not only frontline operational staff with the right skills and training, but staff teams who reflect populations in terms of language and ethnicity is important.

Suggested recommendation:

Frontline operational staff, who are often those involved with particular issues regarding culture and concerns, should attend inquest or investigations, as well as middle and top management.

How to make recommendations:

There was some consensus that system wide recommendations on endemic failures will go further than very specific, officer-by-officer recommendations. On the other hand, very broad recommendations allow for lethargy, and where there are quick fixes to be made, specific recommendations are valuable. It must be clear where recommendations are aimed, e.g. at EDs, at staff, at policy-makers. There is a need for independent reviews of progress against recommendations. The necessary staff skills, as well as financial resources, must be considered when implementing recommendations.

Is there a role for the NPM in communicating the more specific recommendations to policy makers and the wider prison service, or for bringing together the recommendations from different jurisdictions to create collective responses? There is value in applying even specific recommendations cross-sector, especially where work is already underway in one location and could support work elsewhere. The Recommendations database will enable identification of systemic or cross cutting issues/themes.

Training and education:

Due to resource constraints, budget and recruitment applications and criteria within large organisations, not all investigative bodies can ensure human rights training for, or expertise among, staff. Some participants even noted that it can be challenging to agree basic criteria for investigative staff, and that ensuring human rights expertise among staff is rarely possible. Training is not always available due to resource constraints. Ensuring consistent recommendations and expectations between inspectorates and investigators allows identification of key lines of enquiry, and of repeated recommendations as causes of concern.

Suggested recommendation:

NPM produced guidance documents and fact-finding templates can somewhat mitigate this. The NPM/SHRC could propose Human Rights training as a vital part of training and provision. This must also include focus on families' rights. In a Scotland context this could be picked up by HIS for NHS education for investigations.

A note on the NPM's role

The Optional Protocol to the Convention Against Torture (OPCAT) places emphasis on states' responsibility to *prevent* torture, cruel, inhuman or degrading treatment form occurring. OPCAT provides the mandate of the NPM, whose function is therefore different to that of bodies who deal with complaints and investigatory bodies. However, their functions are complementary in their aim to end any form of ill treatment in detention settings.

An important element of the NPM is that it is proactive, rather than reactive.[3] Preventive visits can take place at any time, even when there is no apparent problem or specific complaints from detainees. NPMs should also be global, rather than individual: preventive visits ought to focus on assessing all aspects related to the deprivation of liberty as a system, to identify problems which could lead to torture and ill-treatment. On top of preventive visits and recommendations, NPMs are also empowered to submit proposals and observations concerning existing or draft legislation.

Taken together, these elements of the NPM's mandate situate it to identify systemic and national issues and concerns relating to human rights, treatment and conditions in places of detention, and to take preventive action. The right to life and the prohibition of torture, cruel, inhuman and degrading treatment and punishment are absolute rights under international law, and Articles 2 and 3 of the ECHR. Contributory factors to deaths in detention most often engage Article 3 rights. The central NPM role is to support members and other actors in considering standards, treatment and conditions, both inside institutions and out, that will impact on treatment and conditions of those deprived of their liberty. The NPM as a whole make preventive recommendations to institutions and policy-makers.

[3] https://www.apt.ch/