

# STOLEN LIVES AND MISSED OPPORTUNITIES

**The deaths of young adults  
and children in prison**

# **STOLEN LIVES AND MISSED OPPORTUNITIES:**

## **The deaths of young adults and children in prison**

The report '**Stolen Lives and missed opportunities: The deaths of young adults and children in prison**' was funded by the **Barrow Cadbury Trust** as part of the work of the **Transition to Adulthood (T2A) Alliance** – a broad coalition of 13 leading criminal justice, health and youth charities - working to evidence and promote the need for a distinct and effective approach to young adults (18-24 year olds) in the transition to adulthood, throughout the criminal justice process. T2A is convened and funded by the **Barrow Cadbury Trust**. The Trust is an independent, charitable foundation, committed to bringing about socially just change.

[www.barrowcadbury.org.uk](http://www.barrowcadbury.org.uk).

T2A Alliance's 13 membership organisations include: Addaction, BTEG, Catch 22, Centre for Crime and Justice Studies (CCJS), CLINKS, Criminal Justice Alliance (CJA), Howard League for Penal Reform, Nacro, the Prince's Trust, Prison Reform Trust, Revolving Doors Agency, the Young Foundation and Young Minds.

[www.t2a.org.uk](http://www.t2a.org.uk)

### **INQUEST**

INQUEST provides specialist advice and a complex casework service to people bereaved by a death in custody/state detention or involving state agents, and works on other cases that also engage Article 2 of the ECHR and/or raise wider issues of state and corporate accountability. INQUEST's evidence-based policy, research and parliamentary work is informed by its casework and it works to ensure that the collective experiences of bereaved people underpin that work. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; ensures accountability and disseminates the lessons learned from the investigation process in order to prevent further deaths.

This report was written by Deborah Coles and Ayesha Carmouche, with the assistance of Helen Shaw and INQUEST Board members Professor Joe Sim and Professor Steve Tombs. We also want to thank INQUEST caseworkers Anita Sharma, Selen Cavcav, Victoria McNally and Shona Crallan and the many families who shared their experiences with us. INQUEST would like to thank the Barrow Cadbury Trust who supported the report and Max Rutherford from the Trust for his support and reflections.

[www.inquest.org.uk](http://www.inquest.org.uk)

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is convened and funded by **BARROW** **CADBURY**



**TRUST**

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## About INQUEST

1. The Ministry of Justice currently defines children as those aged under 18, and young adults as those aged 18-20. In this report, the term young adult includes all those between 18 and 25, which is consistent with T2A policy and the evidence on which T2A's work is based (for a comprehensive overview of the evidence base in relation to young adults and criminal justice see Pruin and Dunkel (2015) 'Better in Europe: European approaches to young adults offending', available at [www.t2a.org.uk](http://www.t2a.org.uk))

INQUEST's longstanding work on the deaths of children and young adults<sup>1</sup> in custody underpins the evidence gathered for this report for the Barrow Cadbury Trust. INQUEST's work to generate extensive calls for an inquiry into these deaths contributed significantly to the process that led to the establishment of an independent review into the self-inflicted deaths of 18-24 year olds in National Offender Management Service custody. This inquiry is chaired by Lord Harris and seeks to make recommendations which will reduce the risk of future self-inflicted deaths in custody, by looking at key factors such as vulnerability, information sharing, staff prisoner relationships, family contact, and staff training. The evidence from the review will be published in spring 2015.

Based in London INQUEST is a small charity that has a proven track record in delivering a free in-depth specialist casework service to bereaved families following deaths in all forms of state custody or detention or involving state agents in England and Wales. INQUEST also works on other cases that involve multi agency failings and/or engage Article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability. The issues from its evidence based casework and the collective experience of bereaved people informs its strategic policy, research and legal work. INQUEST also involves bereaved families in its policy and campaigning work for change. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; holds those responsible to account and disseminates the lessons learned from the investigation process in order to prevent further deaths occurring.

INQUEST also provides the free *Inquest Handbook: a guide for bereaved families, friends and their advisors*. It works in partnership with members of the INQUEST Lawyers Group who support and advance the work of INQUEST by providing preparation and legal representation to bereaved people; promoting and developing knowledge and expertise in the law and practice of inquests and working for law reform.

INQUEST has made important contributions to reform, including the establishment of independent investigation processes following deaths in police and prison custody in 2004, the Corporate Manslaughter and Corporate Homicide Act 2007 and the Coroners and Justice Act 2009. It has generated cross-party parliamentary interest and debate about deaths in state detention and is represented on the Ministerial Council on Deaths in Custody. Our Co-Director, Deborah Coles is also a member of the Independent Advisory Panel on Deaths in Custody. INQUEST publications include: briefings on individual cases and on thematic issues arising; *Inquest Law*, the journal of the INQUEST Lawyers Group; and a number of extensive reports: *In the Care of the State? Child Deaths in Penal Custody in England and Wales* (2005); *Unlocking the Truth – Families' Experience of the Investigation of Deaths in Custody* (2007), *Dying on the Inside – Examining Women's Deaths in Prison* (2008), *Fatally*

*Flawed: Has the state learned lessons from the deaths of children and young people in prison?* (2012), *Learning from Deaths in Custody: A New Framework for Action and Accountability* (2012) and *Deaths in mental health detention: an investigation framework fit for purpose?* (2015)

### **INQUEST's work on deaths of children and young adults in custody**

Following the inquest into the 2002 death of 16 year old Joseph Scholes in Stoke Heath YOI, the coroner recommended a public inquiry to address the wider policy issues that could not be explored at the inquest. In 2005 Barry Goldson and INQUEST's Co-Director Deborah Coles published a detailed analysis of child deaths in prison in the book *In the care of the state? Child deaths in Penal custody in England and Wales*, which concluded that children should not be imprisoned, unless they are placed in child centred Local Authority Secure Children's Homes (SCHs). Subsequently INQUEST and Nacro called for a public inquiry supported by other penal reform groups, parliamentarians and the Joint Committee on Human Rights. However, the call was rejected by the government in 2006.

INQUEST's casework and related policy work continued to draw attention to the issue and INQUEST was commissioned by the Prison Reform Trust as part of its work on a 'Strategy to Reduce Child and Youth Imprisonment' to produce a report on the deaths of young adults in prison. The resulting report *Fatally Flawed: has the state learned lessons from the deaths of children and young people in prison?*, was published in 2012. The report drew on INQUEST's extensive casework on the 143 deaths of children and young adults (aged 24 years old or younger) between 2003 and 2010. It has been submitted as evidence to the Harris Review. *Fatally Flawed* concluded that there needed to be an overhaul of the use of imprisonment for vulnerable children and young adults and included in its recommendations a suggestion that:



“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.”

2. Available here  
[http://inquest.gn.apc.org/pdf/briefings/INQUEST\\_Briefing\\_on\\_deaths\\_of\\_children\\_and\\_young\\_people\\_in\\_prison\\_JAN\\_2014.pdf](http://inquest.gn.apc.org/pdf/briefings/INQUEST_Briefing_on_deaths_of_children_and_young_people_in_prison_JAN_2014.pdf)

3. 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>

Finally in January 2014 INQUEST published a call for a review highlighting the continuing pattern of deaths and the limits of the current system in understanding and preventing them: *The deaths of children and young people in custody: the need for an independent review*<sup>2</sup>. This was backed by a wide range of leading organisations working in the criminal justice and children's rights fields<sup>3</sup>.

# Executive Summary

**B**etween 1 January 2011 and 31 December 2014, 65 young adults and children died in prison whilst in the care of the state. Of this number, 62 were young adults aged 18-24 years and three were children under 18 (one 15 year old and two 17 year olds). This report analyses the deaths drawing upon the evidence-base accumulated through INQUEST's specialist casework with bereaved families and associated policy work over the last 30 years. It supports the work of the Transition to Adulthood (T2A) programme, which, like this report, is funded by the Barrow Cadbury Trust. Moreover this report supports the independent review into self-inflicted deaths in National Offender Management Service custody of 18-24 year olds. The independent inquiry is chaired by Lord Harris and seeks to make recommendations which will reduce the risk of future self-inflicted deaths in custody. The evidence from the review is expected to be published in Spring 2015.

As with earlier INQUEST reports on youth custody, it exposes a litany of systemic neglect, institutional complacency and shortsighted policies which have contributed to the deaths of children and young adults.

Our analysis is situated within a contextual frame which argues that understanding deaths in prison requires examining their broader social, political and economic context. It builds upon arguments developed in 2005 by Goldson and Coles<sup>4</sup> and in a range of other publications<sup>5</sup>.



First, the number of deaths is high because prison is overused as the societal solution to a range of social problems that need to be addressed elsewhere

Second, there are so many deaths in prison because prison is by its very nature, dehumanising and violent. The limits to which they can be changed or reformed means that prison as currently constructed will continue to be a place where people lose their lives.

This report argues for a fundamental rethink about the use of prison for children and young adults that requires political boldness and a more steadfast willingness to implement evidence-based change. Recent attention has been focused on the prison system following concerns expressed about the rising number of prison deaths, staff cuts and the implications of regime change. The vulnerabilities of young prisoners have been well documented, yet they continue to be sent to unsafe environments, with scarce resources and staff untrained to deal with, and respond humanely to, their particular and complex needs. At a practice level, establishments do not seem to have *learned lessons* from previous deaths in prisons; too many deaths occur because the same mistakes are made time and again. This in turn raises questions about the adequacy of the investigation, inspection and monitoring systems and process of accountability for institutions linked to the state.

In the light of these concerns, this report considers the implications and reasons behind the prison deaths of children and young adults since 2011, stressing the need for new thinking and new strategies if such deaths are to be avoided in the future. There are a number of dimensions to thinking about new strategies and interventions:

4. Coles, D. & Goldson, B. (2005) *In the care of the state? Child deaths in penal custody in England and Wales* London: INQUEST

5. Coles, D. & Shaw, H. (2007) *Unlocking the truth: families' experiences of the investigation of deaths in custody* London: INQUEST

6. National Audit Office  
(2010) *Managing  
offenders on short  
custodial sentences*,  
London: The  
Stationery Office

- 1 Many of the children and young adults who have died have backgrounds and experiences of family discord, bereavement, substance misuse, self harm, mental health difficulties, learning disabilities, exploitation, abuse, trauma underpinned by poverty and inequality. These have also been recognised as **“offending related needs<sup>69</sup>”**
- 2 A combination of **early intervention** in support services, community schemes and therapeutic treatment is needed to address underlying issues and divert young adults away from the criminal justice system.
- 3 The impact of the prison environment itself and links to self harming and self inflicted deaths. Impoverished regimes, characterised by **discipline and widespread bullying**, and increased lock up have further anguished and isolated prisoners.
- 4 The treatment of young adults in custody does not adequately or systematically take account of their specific needs. **Too often a punitive and generic approach has been deployed**, which is counter-productive to the neurological and psychological developmental stage of 18-24 year olds.
- 5 Support for young adults in prisons has been largely absent, particularly at crucial **points in custody** such as inductions, and personal officers are often not assigned to those at risk.
- 6 Although there is notionally a designated provision for young adults aged 18-20, many young adults are held in institutions **not designed or staffed for the young adult age group** (Young Offender Institutions). In addition, many of the deaths of young adults occurred in prisons not a designated YOI.
- 7 A spate of **communication failures** across prison establishments and statutory agencies in the community has meant that **risks of self-harm were not identified**, or not acted upon resulting in a failure to prevent prisoners from taking their lives.
- 8 There is a combination of **increased pressures and chronic under-resourcing across the prison estate**. Budgetary reductions and staff shortages contribute to overcrowded, bleak and unmanageable prison environments.
- 9 Legal mechanisms exist to prosecute systemic failings through the Corporate Manslaughter and Homicide Act 2007, however this has never been used. New Coronial powers support learning from previous inquests yet the repetition of **prison failings continues to undermine the policies designed to make penal institutions, and those who work in them, democratically accountable**.
- 10 **Inconsistencies and extreme delay in the inquest process have added to the psychological distress** of bereaved families. Many have faced a double trauma and waited years to hear about the circumstances of a relative’s death in prison; while recent deaths have not benefited from a full investigation because of new time constraints.
- 11 Inconsistent information, advice and support given to families after a death, along with problems in accessing **legal representation and cuts to legal aid combine to exacerbate inequalities**.
- 12 There is **no effective mechanism to monitor, audit and follow up recommendations** from the investigation and inquest process, resulting in a lack of effective **cross sector learning and the implementation of reform**.



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“Throughout Billy’s life I tried to get proper care and support for him but all the doors were shut in my face. From the moment he was sentenced to imprisonment, I knew that they wouldn’t be able to look after him. They should have diverted him from the courts or made sure that everybody in the prison had training to deal with him. It is really important to get rid of the stigma around mental health and to recognise that people like Billy need treatment and not punishment.”

**Dawn Spiller, mother of 21 year old Billy Spiller, who died at HMYOI Aylesbury (2011)**

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“Alex was a looked after child. The evidence that emerged exposed serious failings in the care and support that Alex and his carers received from Tower Hamlets Social Services and by placing him in a prison that was never going to be able to cater for his many needs. I hope that lessons can be learnt from the tragedy of my child’s death so that another family does not have to go through what I have.”

**Nick Popat, father of 15 year old Alex Kelly who died at HMYOI Cookham Wood (2012)**

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“Steven was let down by mental health services before he even arrived at Glen Parva. He was let down again in Glen Parva. I just wanted Glen Parva to look after him.”

**Lynda Davison, mother of 21 year old Steven Davison who died at HMYOI Glen Parva (2013)**

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“I feel distraught that Jake could have been moved to a safer cell the night he hung himself. Every day we have to wake up to this nightmare that Jake died and some officers could have helped him.”

**Liz Hardy, mother of 17 year old Jake Hardy who died at HMYOI Hindley (2012)**

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# Introduction



“The mental well-being of...prisoners is seriously jeopardised by the prison experience. Many openly demonstrate to staff their inability to cope; they can be self-destructive or confrontational and aggressive. Unless there is a clear policy which stresses the importance to prison staff of retaining a prisoner-centred approach, the culture allows institutional blindness to prevail and for prisoners in need either to be not seen or not responded to.”

**HM Chief Inspector of Prisons for England and Wales, 1999<sup>7</sup>**

These words, spoken by the then Chief Inspector of Prisons, Lord Ramsbotham, in 1999 are no less pertinent to understanding young prisoners' vulnerabilities today. In response to a high number of prison deaths in 2014, underpinned by a 69% rise in self-inflicted deaths<sup>8</sup>, this report makes a specific contribution about the deaths of young adults and children entering the prison system between 1 January 2011 and 31 December 2014.

The four-year period covered by this evidence-based report documents the deaths of 65 children and young adults who have died in prison. Common to these deaths is a familiar pattern of neglect and poor practice across the prison estate, which ranges from a fatally flawed response to the specific vulnerabilities associated with young prisoners, to what appears to be an institutional resignation or complacency towards youth deaths in prison. This is indicated both at the policy level and at the practice level across prison establishments where there has been a failure to respond to a growing body of official and independent evidence.

The most alarming finding is that failures in the care, treatment and rehabilitation of young prisoners, continue to be widespread and endemic features of the prison estate. Despite consistent recommendations following inquests and investigations, and evidence from inspections and monitoring boards, systemic failings are repeated time and again. More fundamentally state institutions, both within prisons and across the community, are reneging on their obligations under article 2, the right to life, of the European Convention on Human Rights; by failing to enforce safeguarding mechanisms and delivering a duty of care, a series of human rights are being violated.

There has been a further deterioration in the conditions and regimes as evidenced by overcrowding, poor prisoner-staff relationships and long lock up hours (23 hours per day locked in a cell is not uncommon in some of the young adult estates).

7. HM Chief Inspector of Prisons for England and Wales, *Suicide is Everyone's Concern A Thematic Review by HM Chief Inspector of Prisons for England and Wales*, (1999) <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2014/07/suicide-is-everyones-concern>

8. HM Chief Inspector of Prisons for England and Wales, (2014) [http://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2014/10/HMIP-AR\\_2013-14.pdf](http://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-14.pdf)

- 9. Response by the Transition to Adulthood Alliance (T2A) to the Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 year olds (2014), p. 4, <http://www.t2a.org.uk/wp-content/uploads/2014/07/Response-by-the-Transition-to-Adulthood-Alliance-to-IAP-FINAL.pdf>
- 10. Coles, D. & Shaw, H. (2012) Physical control, strip searching and segregation: observations on the deaths of children in custody In A. Briggs (Ed.) (2012) *Waiting to be found: Papers on children in care* London: Karnac
- 11. INQUEST Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds (forthcoming)
- 12. Ryan Clark verdict highlights youth custody failings (29 January 2014) in Children and Young People Now <http://www.cypnow.co.uk/cyp/news/1141852/ryan-clark-verdict-highlights-youth-custody-failings#thash.g8NF67hC.dpuf>

The problems in part stem from a series of factors including budget reductions, a lack of purposeful activity and rehabilitation programmes, policy changes (incentives and earned privileges scheme) and a lack of training for prison staff. Changes to the incentives and earned privileges scheme has resulted in it being harder for prisoners to earn privileges and has restricted those that are available.

This takes place against a backdrop of decreasing confidence from prisoners in the role of Independent Monitoring Boards, the difficulties of making complaints via the Prisons and Probation Ombudsman and the recent restrictions in the availability of legal aid to prisoners who want to legally challenge aspects of their treatment.

Moreover, many of those who died were only just out of childhood. Young prisoners are undergoing a unique transition to adulthood and should have special rights to protection during a time of psychosocial and cognitive development. This is supported by T2A research, which has drawn on neuroscience to account for the underdeveloped “*functions linked to ‘temperance’ (impulse control, rational thinking, empathy)*” which “*are not normally fully developed in the adult male brain until the mid-20s*”<sup>9</sup>. Coles and Shaw also identify:



“an adult-centric approach towards child custody focused on punishment, rather than a child-centric approach focused on welfare and protection. Children and young people are detained in unsafe environments and subjected to bullying and degrading treatment such as strip-searching, segregation and restraint. High levels of self harm and suicide attempts prevail”<sup>10</sup>.

INQUEST’s direct work with bereaved families<sup>11</sup> points to underlying failures in support and intervention for young adults prior to custody. Family discord, learning difficulties, early bereavement, exploitation or abuse, drug/alcohol misuse, severe mental health problems and bleak economic prospects blight the lives of many young adults who encounter the criminal justice system. Yet their vulnerabilities often remain undetected. As INQUEST Co-Director, Deborah Coles has previously stated:



“Deaths of children and young people do not just raise criminal justice issues but important issues outside the prison walls such as the role of social services, support for ‘looked after’ children and questions as to why a vulnerable child was imprisoned in the first place”<sup>12</sup>.

The failures, first to divert an extremely vulnerable group away from the criminal justice system and second, to offer adequate protection to them in custody demonstrates a litany of failed social policies and the inappropriate use of prisons for those with complex emotional needs. Those who experience poverty, deprivation and social exclusion are more likely to engage in behaviour defined as criminal and this is further impacted by interconnected discrimination on the basis of race, gender and social class. This can be seen in discrimination in the application of stop and search, charging decisions and disparity in sentencing as evidenced by the disproportionate number of people from Black and Minority Ethnic (BAME) communities in prisons. Successive governments have hardened their political rhetoric to appear *tough on crime*, overlooking appropriate placement in community or therapeutic environments where behavioural change can be supported. In the context of ill-conceived and dangerous future plans to build a child prison under the guise of a secure college and the UK's largest prison in Wrexham, concerns for prisoner welfare and safety has become all the more pressing.

### ***Methodology***

INQUEST's findings rely on a combination of qualitative and quantitative data. They are based on qualitative data generated from INQUEST's integrated approach that involves direct work with families and lawyers during individual investigations and inquests into many of the deaths and subsequent policy work on the issues arising. They also rely on extensive quantitative statistical data, which has been collated across a 30-year period, and is supported by a plethora of coroner recommendations, jury findings, Prisons and Probation Ombudsman (PPO) and Prison Inspectorate reports. Lastly, INQUEST has included a breadth of stories about the young adults who died whilst in prison. These stories have been compiled with the help of families and family lawyers.

# A snapshot of the young adults who died in prison<sup>13</sup>

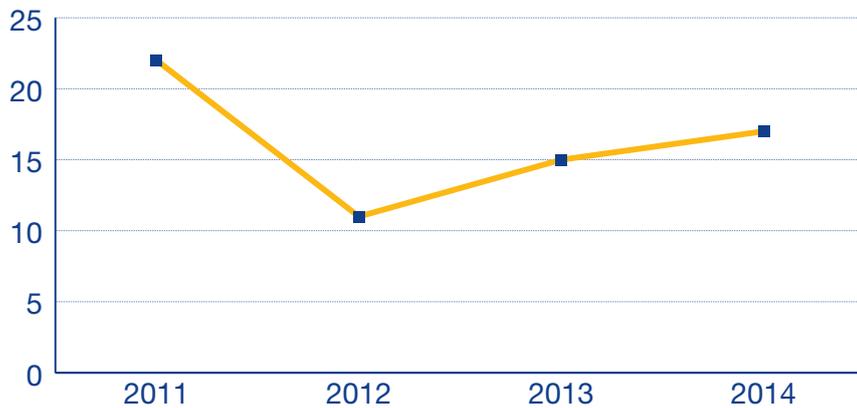
The number of children and young adults who died

# 65

### In the last four years,

65 young adults have died in prison. Of this number, 62 were aged between 18-24 years and three were children under 18 years (one 15 year old and two 17 year olds). One in three of these deaths were also of young adults on remand.

Deaths by Year



The classification of cause of death

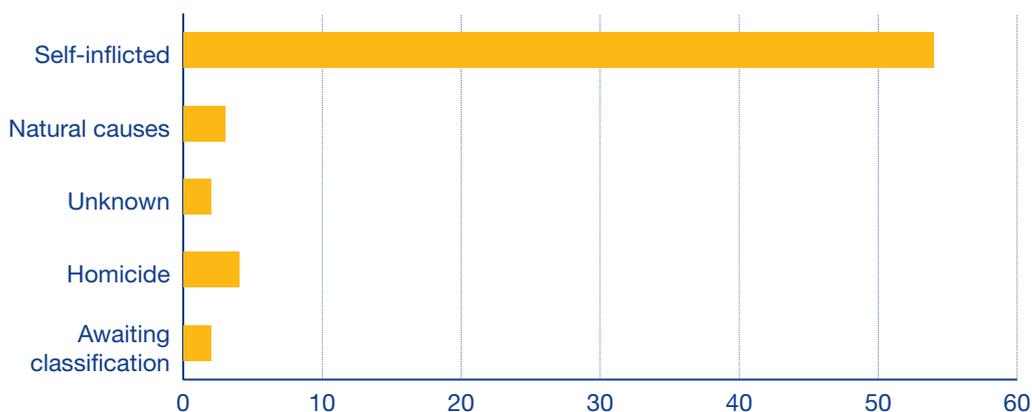
# 83%

### Classified as “self-inflicted”

An overwhelming majority of the deaths have been classified as “self-inflicted”, making up 83% (54) of all youth deaths. Of the total number of “self-inflicted” deaths between 2011 and 2014, young adults made up almost one quarter (23%) of all “self-inflicted” deaths (281). Four of the remaining deaths have been termed “homicide”, three as “natural causes” and a further two have been classified as “unknown” deaths while at the time of writing. The four cases of “homicides” raise serious concerns about prison health and safety, particularly in light of the murder of Zahid Mubarek by his racist cellmate in HMYOI Feltham, March 2000.

13. Data based on Ministry of Justice data, NOMs notifications

### Nature of death



## 29

## Shared single occupancy cells

### Died in single cells

Of the 54 self-inflicted deaths 29 (54% of the total) occurred in single cells. This has raised serious concerns about the quality of risk assessments, particularly as many inquest findings have revealed visible signs of self-harming behaviour or emotional distress among prisoners who have been placed by themselves, with little opportunity to seek support or counselling. National Offender Management (NOMs) notifications, provided by the Ministry of Justice, have also shown that 53 of the 54 self-inflicted deaths were hangings and had involved the use of cell windows, light fittings, shoelaces and bunk beds. December 2014 MOJ statistics show that bedding was the most common item used as a ligature in self-inflicted deaths by hanging and between 2010 and 2013, 70% of self-inflicted deaths by hanging used bedding as the ligature<sup>14</sup>.

(rooms containing bunk beds with one prisoner accommodated) pose another set of safety issues as prisoners have tied a ligature to bunk beds. Previous coroner Prevention of Further Death<sup>15</sup> reports have called for an end to shared single occupancy cells due to the easy access vulnerable prisoners have to ligature points

14. Ministry of Justice (2015) Safety in Custody Statistics England and Wales Deaths in prison custody to December 2014 Assaults and Self-harm to September 2014 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/399071/safety-in-custody-to-sept-2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399071/safety-in-custody-to-sept-2014.pdf)

15. Prevention of Further Death (PFD) reports draw on findings from inquests and can outline the key concerns linked to a death. PFD reports, previously known as Rule 43s, are especially important as they afford new powers to Coroners to highlight prison failures to the relevant authorities and are able to recommend institutional change.

## Age

# 23

### The highest numbers of deaths were of 23 year-olds

making up nearly one fifth of all young adult and child deaths (12). In total 64% (42) of the deaths were of those aged 21 to 24 years, suggesting either limited intervention or support for the 'older' young adult age groups who are assigned "adult" status.

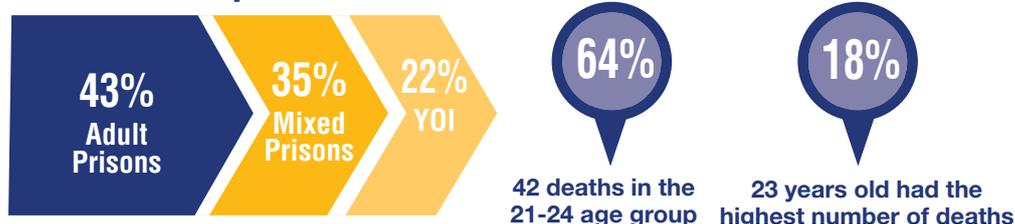
### young adults dying in adult institutions

INQUEST's analysis also shows that 43% (28) of the deaths occurred in adult prisons compared with 35% (23) in mixed prisons of both young adult and adult offenders, and 22% (14) deaths in young offender institutions. These findings feed into wider discussions about the lack of a youth-focused approach in prisons which pays adequate attention to the specific needs of a younger adult cohort. Contrary to current policy and practice, which assumes maturity based on chronological age, a growing body of research (see [www.t2a.org.uk](http://www.t2a.org.uk)) shows that emotional and cognitive maturity is often lacking for young adults aged 18-24<sup>16</sup>. Maturity is not an event marked by a birthday but a process that is often long and complicated. Moreover many young adults involved in crime have often endured other difficult life experiences which have impacted on their development.

16. Transition to Adulthood Alliance (2014) Response by the Transition to Adulthood Alliance (T2A) to the Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 year olds (p. 4) <http://www.t2a.org.uk/wp-content/uploads/2014/07/Response-by-the-Transition-to-Adulthood-Alliance-to-IAP-FINAL.pdf>

17. NQUEST (2013) Preventing the Deaths of women in prison: the need for an alternative approach [http://inquest.gn.apc.org/pdf/briefings/Oct2013\\_updated\\_INQUEST\\_Preventing\\_deaths\\_of\\_women\\_in\\_prison.pdf](http://inquest.gn.apc.org/pdf/briefings/Oct2013_updated_INQUEST_Preventing_deaths_of_women_in_prison.pdf)

### More deaths occurred in adult prisons



# 4

## Gender

### Of the total deaths (6%) were young women

INQUEST has shown in its evidence based report *'Preventing the deaths of women in prison'* that women only constitute five per cent of the overall prison population<sup>17</sup>, that the specific needs of girls and young women have been neglected, and there is a lack of gender specific provision. Many young women enter the criminal justice system as a result of unmet welfare needs including neglect, abuse and poverty. Moreover, there are also extremely high levels of self-harming incidents among women. For example, <sup>18</sup>women accounted for 26% of all

self-harm incidents in the 12 months to March 2014, despite only representing 5% of the total prison population. Self-harming behaviour is regarded as a method of coping with trauma such as sexual abuse, violence and/or isolation from families and separation from children. It is estimated that an average of 18,000 children each year are separated from their mothers (their primary carers) as a result of imprisonment and many of these women self-harm primarily as a means of coping with isolation and separation from family and children.

18. Prison Reform Trust (2014) Bromley Briefings Prison Factfile <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Factfile%20Autumn%202014.pdf>

## Race

<b>44</b>	<b>4</b>	<b>6</b>	<b>3</b>	<b>7</b>	<b>1</b>
<b>UK White</b>	<b>White Other</b>	<b>Black</b>	<b>Mixed Race</b>	<b>Asian</b>	<b>Unknown</b>

44 of the 65 prisoners who died were White UK born, four White Other, six were Black prisoners, three were Mixed Race, seven were Asian and one was ‘unknown’. In 2014, there was a slight increase in the number of deaths involving black and minority ethnic groups (BAME). However, across the four years, the deaths of White UK far exceeded other groups. The disproportionate number of deaths of White UK prisoners (compared to a generally high over-representation of BAME people in prison) is consistent with other findings<sup>19</sup> and some accounts refer to the greater presence of faith and cultural networks for BAME groups in prison, potentially providing them with greater support during difficult periods. Further arguments also refer to a greater stigma associated with self-harm amongst BAME groups.

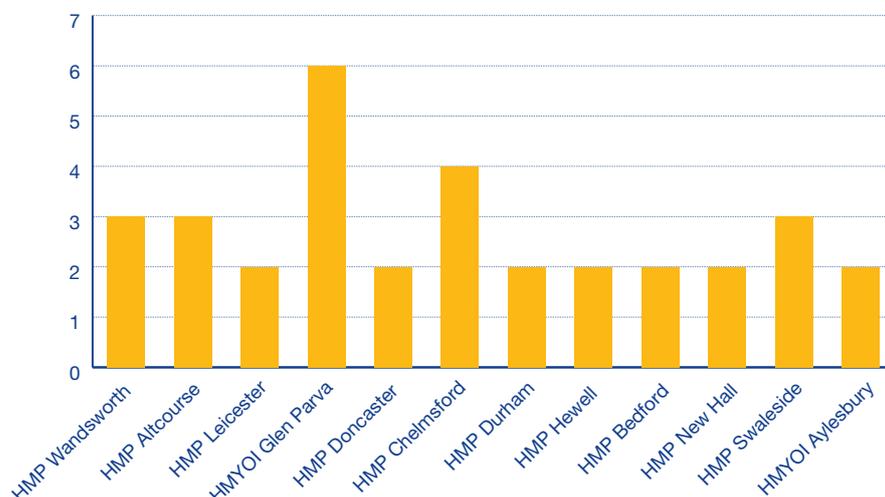
19. Joint Committee On Human Rights (2004) Third Report <http://www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/15/1506.htm>

## Patterns of death in particular institutions

INQUEST notes the frequency of deaths in certain institutions. For example the highest number of deaths have occurred in HMYOI Glen Parva (six), followed by HMP Chelmsford (four) jointly followed by HMP Wandsworth, HMP Altcourse and HMP Swaleside (three). The higher number of deaths in HMYOI Glen Parva and HMP Chelmsford has raised concerns around questions of leadership and accountability within institutions, which show little signs of improving practice or care for vulnerable groups despite repeated deaths. Failure to respond to these stark figures or to implement safeguarding measures, which can prevent future deaths, undermine the entire learning process. It directly jeopardises the welfare of other vulnerable prisoners, both young and old, with respect to the potential for self-harm and self-inflicted deaths. It cannot be coincidental that many of these prisons have received the most critical recent inspection reports and have some of the most impoverished and limited regimes.

An HM Inspectorate of Prisons (HMIP) report in August 2014 identified Glen Parva as of serious concern, with “a direct link between the high levels of bullying and...self-harm and that “prisoners at risk of suicide or self-harm had increased by 32 per cent” and 28 per cent of them were “locked in their cells during the working day.”<sup>20</sup>

Highest number of deaths by establishment



20. HM Chief Inspector of Prisons (2014) Report on an unannounced inspection of HMYOI Glen Parva (p. 5) <http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/08/Glen-Parva-Web-2014.pdf>

## The journey into custody



Steven Davison  
HMYOI Glen Parva

Steven Davison was 21 years old when he took his life at HMYOI Glen Parva in 2013. He was an extremely vulnerable young man and had struggled with acute mental health problems throughout his life. Prior to custody, Steven was diagnosed with a personality disorder and had carried out a number of suicide attempts which ranged from jumping out of windows to overdosing.

His family tried to support him as best they could, spending much of their time caring for him and pleading with local authorities to provide mental health services to treat his illness. Steven spent some time in psychiatric care but during his inquest the jury heard from Steven's mother that support services were woefully inadequate, and that despite continual efforts by the family to get help by the family, they were unable to do so.

Steven was sent to HMYOI Glen Parva for possessing an offensive weapon. His placement in prison was scrutinised during the inquest, as the weapon in question was a knife which Steven had threatened to kill himself with. As such Steven posed more of risk to himself, rather than the public. The jury also heard from Steven's mother that he was sent to prison because there was no capacity to keep him at the local hospital - although she believed his symptoms could have been better treated there.

Steven entered the prison system with a self harm and suicide warning form highlighting his risks. However, the initial assessing nurse did not consider Steven to be at risk of self harm or suicide despite this information. It emerged during the inquest that the nurse had not been trained in the Assessment, Care in Custody and Teamwork (ACCT) procedures (a system used for prisoners at risk of self harm) at the time and that she had only received the training in August 2014 by which time she had worked at the prison for 2 years.

The PPO investigation into the death also highlighted key issues around vulnerability and failings in recognising risk factors. These included Steven's long history of poor mental health and self-harm and the fact that it was his first time in custody. Lynda Davison, Steven's mother described the experience in her own words: "*Steven went to court and it was just like he was another lad being sent to prison. Instead of looking at why he was being sent to prison and what he needed... It was like there you go Steven, there's your cell now get on with it.*"

The jury recorded that Steven's individual needs, risks and vulnerabilities were not properly assessed, understood or recorded in line with the ACCT process. For example on 25th September 2013, four days before Steven took his life, Steven's girlfriend had ended their relationship and he was also informed that his grandfather had died. Both of these serious occurrences occurred immediately after Steven had used a lighter to self-harm, yet no ACCT case review was carried out to gauge his level of risk. The jury was also critical of the lack of continuity in Steven's care, that information was not passed on to the appropriate individuals, that the frequency and recording of observations was inadequate and that there was a failure to allocate Steven to a safer cell (a cell with no ligature points) which would have protected him and kept him safe.

HMYOI Glen Parva has reported the highest number of youth deaths in the last 4 years and has been heavily criticised for persistent levels of bullying and violence. Following an unannounced inspection in April 2014, the HM Chief Inspectorate of Prison found that half of prisoners felt unsafe at some point during their custody; that there was significant levels of under-reporting of recorded assaults, and inadequate support for victims of bullying.

### **Common characteristics found among prisoners**

As T2A research suggests, the process of *becoming mature* (in a neurological, developmental and psychosocial sense) is likely to be impacted upon by other vulnerabilities. The multiple disadvantages and the complex needs shared by many of those who get caught up in the criminal justice system present a distinct set of problems. Many of these children and young adults have previous experience of lives characterised by abuse (including sexual, physical and emotional), exploitation, brutality and degradation. In particular early experience of state care, mental health issues, learning difficulties and disabilities are key factors underpinning vulnerability. These wide ranging characteristics impact on a young individual's emotional and physical welfare; their capacity to deal with life changing circumstances such as going into prison and their ability to withstand the extreme and often brutal and dehumanising conditions of prison life. INQUEST finds that the custodial experience exacerbates and compounds these early life disadvantages; a punitive response, devoid of any rehabilitative capacity refuses to acknowledge the many imported vulnerabilities and disadvantages many young prisoners come in/arrive with. Studies have also found that among young adults in prison<sup>21</sup>:

- 23 per cent of young offenders have learning difficulties and a further 36 per cent have borderline learning difficulties;
- Fewer than 1 per cent of all children in England are in care, but looked after children make up 33 per cent of boys and 61 per cent of girls in custody and;
- 52 per cent of young offenders were permanently excluded from school;
- 16-24 year-olds are more likely than any other age group to become a victim of crime.

### **Analysis of INQUEST's casework**

Further analysis of INQUEST's casework, relating to 47 of the young adults who died in prison, reveals specific concerns about previous experience of care, mental health, alcohol/drug misuse and learning difficulties among young adult prisoners. Within this sample, three children are included; one aged 15 years and two who were 17 years. Of these deaths, 40 were 'self-inflicted', three were 'natural causes', three were 'homicides' and one was 'awaiting classification'. Our findings revealed that:

1

**Care leavers and family breakdown:** 30% (14 of the total of 47) of those who died were care leavers or had suffered some kind of family breakdown which required them to live outside of their immediate family home. These figures are further supported by Prison Population statistics in July 2013, as provided by the House of Commons, which indicated that "24% of prisoners had lived with foster parents or in an institution, or had been taken into care at some point when they were a child"<sup>22</sup>

21. Prison Reform Trust (2014) *Prison: the facts Bromley Briefings Summer 2014*  
<http://www.prisonreformtrust.org.uk/Portals/0/Documents/Prison%20the%20facts%20May%202014.pdf>

22. Berman, G. & Dar, A. (2013) *Prison Population Statistics, House of Commons* (p. 18)  
<http://webcache.googleusercontent.com/search?q=cache:2ObDoBVtQYcJ:www.parliament.uk/briefing-papers/sn04334.pdf+&cd=4&hl=en&ct=clink&gl=uk>

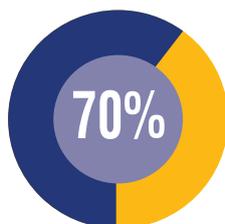
2

**The prevalence of poor mental health:** 70% (33) had mental health issues including diagnoses of personality disorder, schizophrenia, bipolar disorder and unresolved issues relating to childhood bereavement or abuse. In addition, 49% (23) had self-harmed previously. Findings have also been documented by the Prison and Probation Ombudsman Learning Lessons Bulletin 2014.<sup>23</sup> In a sample of 80 self-inflicted deaths, 67 per cent of the young adults had mental health needs, and 27 per cent had previously been admitted for psychiatric care.

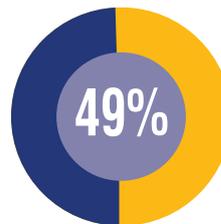
23. Prison and Probation Ombudsman (2014) *Learning Lessons Bulletin: Young Adult prisoners* <http://www.ppo.gov.uk/other-reports-and-publications.html>

24. Gyateng, T. et al. (2013) *Young People and the Secure Estate: Needs and Interventions* London: Youth Justice Board

25. Justice Committee (2013) *Written evidence from HM Inspectorate of Prisons* <http://www.publications.parliament.uk/pa/cm201213/cmselect/cmju/st/339/339we13.htm>



Mental health issues



History of self-harming

1%

Is the national average of care leavers in England



30%

of INQUEST casework samples were care leavers or suffered some family breakdown

3

**Learning difficulties, special needs and drugs misuse:** 23% (11) had special needs or learning difficulties whilst 34% (16) had problems with alcohol and drug misuse. Research by the Youth Justice Board (YJB) has also found that 21% of young adults in custody were reported to have learning difficulties<sup>24</sup>.

Early life volatility can isolate young adults in economic, social and emotional ways. The capacity to develop trusting relationships, benefit from educational opportunities, successfully secure employment and pursue a stable life is seriously jeopardised. PPO and HMIP findings have also linked the above experiences and characteristics to one another, indicating a higher propensity to abuse drugs/alcohol following traumatic early life events, such as family separation, or educational exclusion. Evidence submitted to the Justice Committee in 2012 by the HMIP, estimated that “at any one time, there are around 400 children in custody who have spent time in care”. Furthermore “they were more likely to report problems with drugs and alcohol... and report having mental health issues.”<sup>25</sup>

From our casework, it is clear that in many cases the young adults who died were failed by a range of services well before they entered custody. Community support mechanisms, such as social services, psychiatric treatment and therapy were hard to access or inadequate. Families frequently report the difficulties they have in accessing these services for their children.



## Alex Kelly HMYOI Cookham Wood

Alex Kelly was a 15 year old mixed race boy who was found hanging in his cell at HMYOI Cookham Wood on 24 January 2012. He died the following day.

Alex was a troubled and vulnerable child. He had suffered serious sexual abuse by a member of his maternal family and by age five he was placed into the care of Tower Hamlets Social Services, following which he was placed into long term foster care. London Borough of Tower Hamlets became his “corporate parent” although his father retained parental responsibility.

Initially Alex settled well in his foster placement and was attending school regularly. Over time his behaviour started to deteriorate and he became increasingly difficult to manage. In addition to the trauma from the abuse, Alex was also identified as having complex needs including ADHD, attachment issues and educational difficulties.

Despite his complex needs Alex had a total of eight different social workers from the age of five until his death. He was provided with little in the way of therapeutic support despite his known sexual abuse. An educational psychologist reported that “the behaviour Alex displays has its roots in his very early childhood” which had “remained largely unresolved” and a pre-sentence report also indicated that Alex was “a very psychologically damaged child”. By the age of 15 Alex had been convicted of a number of offences for which he received a number of stringent community sentences.

In October 2011 Alex received a 10-month custodial sentence. This was to be his first time in custody. The Youth Offending Team had recommended that he be placed in a child focused Secure Training Centre because of his age and vulnerabilities. However, he was sent to Cookham Wood Young Offenders Institution and was one of the youngest children there.

On the evening of 24 January 2012 Alex was clearly in a heightened state of distress, having had an emotional telephone conversation with his foster parents. He had also made a disclosure to a prison officer about his childhood sexual abuse for the first time. The frequency of his observations was increased but he was later found hanging from the locker in his cell by his shoelaces.

During the course of the inquest, the jury heard evidence of the limited support provided by Tower Hamlets Social Services throughout the time Alex was in their care. Moreover, the jury at the inquest into Alex’s death identified a number of failings within Cookham Wood and more significantly with Tower Hamlets Social Services. This included the failure to allocate a named social worker, which hampered their ability to communicate with external agencies; to support Alex’s specific mental health needs; and failures to provide an adequate level of support for a vulnerable looked after child.

In making her recommendations, the coroner noted the inconsistencies in the placement process, the Youth Offending Team’s (YOT) lack of awareness of processes to protect Alex (including the failure to transfer him to a more appropriate secure setting) and the failures of YOT workers to take responsibility for Alex’s welfare in custody. She also expressed concern about Alex’s entry into custody without the benefit of a psychiatric assessment, noting that: “I am aware of the deaths of a number of other children in custody who similarly had not had forensic psychiatric assessments”. Had he had a psychiatric assessment, in light of his traumatic early years, Alex may well have been diverted from custody and subsequent fatal actions.

Lastly, in her Report to Prevent Future Deaths the coroner expressed concern about the conflict in the responses to Alex’s self-harming behaviour, commenting that “specific acts by Alex were seen as obstructive/challenging behaviour rather than signs of distress or a means of communicating that he needed help”. She identified a number of significant failures in the ACCT process and noted that there was no holistic consideration at Cookham Wood as to whether the institution could support his needs.

26. Vaswani, N. (2008) *Persistent Offender Profile: Focus on Bereavement* (p. 3)  
<http://www.cycj.org.uk/wp-content/uploads/2014/05/Bereavement-Paper-CJSW-Briefing.pdf>
27. Vaswani, N. (2014) 'The ripples of death: Exploring the bereavement experiences and mental health of young men in custody' *The Howard Journal of Criminal Justice*, 53(4), (p. 341–359)
28. Ibid
29. Ibid
30. Centre for mental health: The Bradley Commission (2014) *Young people (18-24) in transition, mental health and criminal justice*  
[http://www.centreformentalhealth.org.uk/pdfs/Bradley\\_Commission\\_briefing2\\_youngadults.pdf](http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.pdf)
31. Young Minds (2013) *Same Old: The experiences of young offenders with mental health needs*  
[http://www.youngminds.org.uk/assets/0000/9472/Barrow\\_Cadbury\\_Report.pdf](http://www.youngminds.org.uk/assets/0000/9472/Barrow_Cadbury_Report.pdf)
32. February 2015

## Bereavement

There is a disturbing frequency of early life bereavement among young adults in conflict with the law. Previous studies have found that many young prisoners suffered the death of a close family member, some of which have been violent e.g. murder whilst others have involved suicide<sup>26</sup>. For example, Vaswani collected data from 33 young prisoners, aged 16-20 years, and found that 91% had experienced at least one bereavement<sup>27</sup>. Many of the bereavements were traumatic and led to behavioural difficulties, often because of the violent images the young prisoners associated with the death. Importantly the emotional distress caused by loss was linked to higher levels of suicidal ideation, depression and Post Traumatic Stress Disorder<sup>28</sup>. In another study of 105 individuals who had suffered bereavement, Vaswani also recorded that only six young adults took up counselling support, suggesting issues of unresolved trauma and grief. These factors were linked to further issues of offending and drug/alcohol misuse<sup>29</sup>.

Two case studies in this report, on the deaths of Samuel Gale and Amy Friar, involved the bereavement of a close relative. Amy Friar, a 24 year old young woman found hanging in her cell at HMP Downview on 30 March 2011, had experienced her father's suicide at a young age and the murder of her partner just before her death. Her father's bereavement impacted on her mental health, and was thought to have contributed to subsequent problems with drug and alcohol use, which were linked to the reasons for her offending. The murder of her partner also led to much trauma and has been described as the trigger leading to her death. In the case of Samuel Gale, an 18 year old who took his life in HMP Doncaster, 17 May 2014, it was discovered that his father had only recently committed suicide when he was sent to prison. In prison, Samuel openly discussed his father's death and showed signs of self-harming and psychological distress, yet staff failed to offer him sufficient support during a critical time of grief, and underestimated the risk he posed to himself.

## Mental Health

Poor mental health remains a key issue - in terms of understanding its symptoms, inadequate resources for treatment and the continuity of care for young adults. In its 2014 briefing, 'Young adults (18-24) in transition, mental health and criminal justice', The Centre for Mental Health identified key issues around the management of youth mental health services<sup>30</sup>. There are gaps in mental health services when young adults make the transition to chronological adulthood. Care provisions either cease to exist or become patchy around the age of 17, meaning many young adults cannot access services, which identify risks at an early stage. Given that early adulthood is the peak time of offending, there is a counterintuitive approach to how youth mental health services are currently planned. Sustained and specialist intervention is important as it allows support services to divert individuals, with complex mental health problems, away from the criminal justice system and to treat their symptoms in rehabilitative and therapeutic settings<sup>31</sup>. The increasing priority placed on mental health by the government and opposition at the time of writing<sup>32</sup> is a welcome development, but it is vital that there is the necessary investment and resourcing allocated to child and adolescent mental health services.

33. INQUEST (2013) Preventing the Deaths of women in prison: the need for an alternative approach [http://inquest.gn.apc.org/pdf/briefings/Oct2013\\_updated\\_INQUEST\\_Preventing\\_deaths\\_of\\_women\\_in\\_prison.pdf](http://inquest.gn.apc.org/pdf/briefings/Oct2013_updated_INQUEST_Preventing_deaths_of_women_in_prison.pdf)
34. Williams, H. (2012) Repairing Shattered Lives: Brain injury and its implications for criminal justice (p. 18) [http://www.barrowcadbury.org.uk/wp-content/uploads/2012/11/Repairing-Shattered-Lives\\_Report.pdf](http://www.barrowcadbury.org.uk/wp-content/uploads/2012/11/Repairing-Shattered-Lives_Report.pdf)

Prisons are harsh environments characterised by impoverished, punitive, isolating and controlling regimes that intensify levels of anxiety and exacerbate mental ill health. INQUEST's publication, '*Preventing the deaths of women in prison: the need for an alternative approach*', has shown that women's mental health particularly suffers from these failings<sup>33</sup>. Many young women have a complex set of needs (including acute mental health problems, histories of substance misuse problems, abuse and self-harm) yet their symptoms and distress are often managed through increased discipline and segregation leading to isolation.

The Centre for Mental Health has called for the government to facilitate a holistic care system, providing continuity in care and specialist intervention to 15-24 year olds. Further objectives also include the close collaboration of local police, health and young adult community-based or voluntary sector groups to ensure low-level offenders, with mental health, development, learning or substance misuse needs, are better supported. Lastly the report calls for training to be implemented, and provided by criminal justice agencies, to ensure police officers or sentencers understand how to best support young adults with a combination of mental health problems<sup>34</sup>.

## Prison a place of extremes – treatment during custody

This section highlights some of the key failure which typically occur during a young person's time in custody, features which arise from an analysis of INQUEST's casework. Many are endemic features of the prison system, and directly contribute to the deaths of young prisoners. INQUEST's casework has identified repeated patterns of systemic failure and poor practice, including the following:

- Lack of staff training in dealing with young adults and their complex emotional needs;
- Communication breakdown between different state agencies and prisons, within institutions and between prison and healthcare staff;
- Unchecked bullying due to a lack of protective measures and debt bondage;
- Inadequate assessment of vulnerabilities including inappropriate placement and treatment of those with mental health problems, self-harm history, drug/alcohol misuse, learning difficulties;
- Unsafe cells and dangerous access to ligature points;
- Mental health distress and associated behaviour treated as a disciplinary rather than a medical problem;
- The inappropriate and over-use of segregation; and
- The lack of family involvement in supporting vulnerable prisoners, including the long distances many prisoners are from home.

### Identifying vulnerability



“Vulnerability to suicide is neither clear-cut nor static, and the strategy of focusing on a few identified cases can reduce the attention which all prisoners require as they move in and out of coping stages... [and] to categorise selected prisoners as 'vulnerable'... implicitly categorises the rest as invulnerable”<sup>35</sup>

35. Medicott, D. (2000) "Don't Think This Stuff": An Analysis of Prisoners' Accounts of Being Suicidal in Prison (p. 10) <http://britsoccrim.org/volume3/007.pdf>

All prisoners are more or less vulnerable and prisons, by their very nature, can be places which create and exacerbate vulnerability. Whilst risk assessments may have their benefits, such an approach ultimately shifts focus from the whole system to the nature of individuals within it rather than recognising the potential impact of a closed institution on the individual. The term 'vulnerability' does not always prove useful for assessments and sentencing. For under 18s, courts are obliged to consider the “welfare of...young person” as “an offender or otherwise” under the Children and Young Persons Act 1933. For over 18s, the courts can consider “age and/or lack of maturity” as a mitigating factor in sentencing decisions, and probation pre-sentence

reports can include a specific section on the maturity of a young adult. Yet the balance between punitive and welfare approaches to youth offending have swung in favour of the former. Coles and Shaw have pointed out that:



“the discourse on the meaning of vulnerability has most often taken place in adversarial settings – in the media, in court and in Parliament and has not been conducive to calm and thoughtful development of shared understanding and meaning. This adversarial struggle to both avoid and impart blame, has undermined objective and clear thinking....”<sup>36</sup>

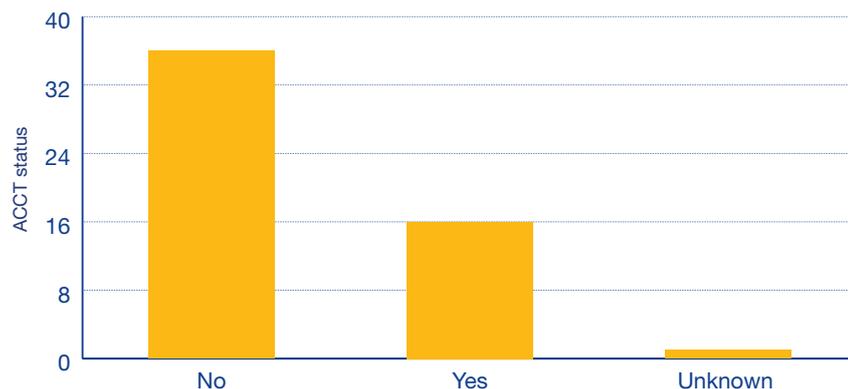
36. Coles, D. & Shaw, H. (2012) *Physical control, strip searching and segregation: observations on the deaths of children in custody*, In A. Briggs (Ed.) *Waiting to be found: Papers on children in care* London: Karnac

### **The Assessment, Care in Custody and Teamwork (ACCT) approach**

In prison the Assessment, Care in Custody and Teamwork (ACCT) is the tool used by prison staff to make decisions about prisoners’ risk. Its introduction in 2007 was accompanied by a renewed sense of hope that it would address vulnerabilities through the development of a care plan attentive to the needs of a young cohort. However, its effects and usage have been disappointing and it is frequently criticised in PPO reports, jury conclusions and coroner’s Prevention of Death reports. In our experience there is a disconnect between the stated policy and its practical implementation. Moreover the vital contribution that families can make to the care of vulnerable prisoners is often not utilised in this process.

Between 1 January 2011 and 31 December 2014, findings reveal that 36 (67%) of the 54 self-inflicted deaths were not on an ACCT at the time of their death, raising serious concerns about the identification young prisoners at risk. Problems in detection of those at risk have also been commonplace because there is no tailored assessment specific to young adults’ needs. For example, there is reliance on self-reporting and this has proved inadequate, as young adults are often reluctant to inform officers about their psychological distress for fear of being singled out. Given the endemic culture of hyper-masculinity in prisons, the ability to express emotional vulnerability becomes even harder. It may be hidden in order to ‘fit in’ and often prison staff fail to understand that young men can be both offenders and victims at the same time. This is worsened by a prison culture with limited meaningful staff prisoner interaction where staff are over reliant on forms with a tick box culture prevailing.

**ACCT status of the 54 self-inflicted deaths**





In its separate findings, the 2013 Prison and Probation Ombudsman Annual Report also stated:

“We continue to investigate deaths where reception health screening has been poor. In many cases, previous records are not examined, either because they have not arrived with the prisoner or are simply not taken into account... There is too much reliance on information from the prisoner...”<sup>37</sup>.

37. Prison and Probation Ombudsman (2013) *Annual Report 2012-2013* (p. 21) [http://www.ppo.gov.uk/docs/PPO\\_Annual\\_Report\\_2012-13.pdf](http://www.ppo.gov.uk/docs/PPO_Annual_Report_2012-13.pdf)

38. Medicott, D. (2000) *“Don't Think This Stuff”: An Analysis of Prisoners' Accounts of Being Suicidal in Prison* <http://britsoccrim.org/volume3/007.pdf>

Many young prisoners who become entangled in the prison system have been subjected to a series of violent, degrading and painful life events, but this does not necessarily lead to self-harming behaviour. INQUEST finds that vulnerability is heightened at the point of prison entry and is then exacerbated by the painful process of separation from family and friends, endemic violence, bullying and loneliness. The early days of custody are a critical time for many young prisoners, particularly if it is their first time in prison. Placement in an unfamiliar and intimidating environment can traumatise individuals, whilst also making them targets for other prisoners. Medicott has found that anxiety and grief is also compounded by the absence of communication: “all prisoners stress the scarcity of talk in prison, and those with suicidal feelings especially crave the opportunity to talk about their feelings and feel sure of being listened to.”<sup>38</sup>

What is particularly concerning is that many young prisoners are placed in adult establishments, rather than designated young adult institutions, despite concerns about their age and associated vulnerabilities. INQUEST’s casework reveals that less than half of those who died in prison were placed in adult settings (see “Young adults dying in adult institutions” in the statistics section). Their placement was a clear sign of risk assessment failures, particularly as many had only recently left childhood behind; had never lived independently outside of prison; and had a range of social and emotional challenges which complicated their transition to adulthood.



#### Samuel Gale HMP Doncaster

Samuel Gale was found hanging in his cell at HMP Doncaster on 17 May 2014. He was 18 years old. Samuel entered HMP Doncaster on 3 May 2014, his first time in custody, having been charged with a serious offence. His father had recently committed suicide, following which Samuel had taken an overdose. Court services had alerted the prison of their concerns about him, and Samuel also informed reception staff that he was feeling low and suicidal.

During an initial reception health screen Samuel’s vulnerabilities and associated risk of suicide were noted and an ACCT (Assessment, Care in Custody and Teamwork) was initiated. A mental health assessment took place the next day and despite him stating that he had suicidal thoughts and had recently begun taking anti-depressants, it was decided that he was not suffering from depression but required bereavement counselling.

Samuel revealed that he felt suicidal the night before an ACCT review took place but said he would feel better if he had his anti-depressant medication. However, this was never provided during his time in custody. Although a member of healthcare staff is required to be present at an ACCT review, none had attended.

In the run up to his death, a prison officer without the requisite seniority closed the ACCT at Samuel’s request. It is hoped the inquest will investigate the adequacy of the ACCT process and how it was managed in light of Samuel’s identified vulnerabilities.

## Violence and bullying

Prison Inspection reports have frequently raised concerns about conditions and treatment experienced by young adults in prison and the levels of bullying and violence. The Youth Justice Board have reported the ‘major challenge’ that bullying presents in the secure estate. Too many young adults are detained in brutal and brutalising environments where frustrations and distress is exacerbated by boredom, lack of access to fresh air, and long hours of inactivity and lock up. INQUEST’s casework has revealed how bullying and restraint has contributed to deaths.

## Restraint

The use of force by staff on children and young adults is a common feature of prison life. For example the Youth Justice Board, recorded an average of 538 restrictive physical interventions (RPIs) per month in 2012/13, involving an average of 366 young adults and a total of 6,455 incidents of RPI<sup>39</sup>. There has been a reported reduction in numbers. However, the number of RPIs per 100 young adults in custody has been higher for the younger age group (10-14) and for females in comparison to 15-18 year olds and males respectively<sup>40</sup>. Moreover, in certain institutions, such as Wetherby YOI, 303 incidents involving force were reported, resulting in an average of 51 per month and 20 per 100 young adults per month between October 2013 and March 2014<sup>41</sup>. On average four incidents per month involved force being used in planned interventions, as opposed to a typical response to spontaneous incidents, thus suggesting the routine nature of restraint and a waning commitment to the “best interests” of a young person or using dangerous methods as a “last resort”. The use of force against children, and its dangerous and ultimately lethal implications, came to public prominence following the deaths of 15 year old Gareth Myatt<sup>42</sup> and 14 year old Adam Rickwood, both of which occurred in secure training centres<sup>43</sup>.

However as INQUEST Co-Director, Deborah Coles, has said:

*“The government is intent on ignoring the facts and warnings from the past with plans to build Europe’s biggest children’s prison, euphemistically called ‘the secure college’. The authorisation of force ‘to ensure discipline’, and a preoccupation with the management of children is a startling prospect as we remember the deaths of [children] for trivial acts of adolescent misbehaviour”<sup>44</sup>*

Lastly the disproportionate use of physical restraints against BAME groups has been highlighted by the Young Review in 2014, which reports that Black or mixed origin prisoners are more frequently subjected to the use of force<sup>45</sup>. These findings are supported by previous findings from an HM Inspectorate of Prisons survey in 2011/12 which found that 44% of BAME young men in custody found they had been physically restrained by staff (compared with 32% of young white men).

## Bullying

The HMIP has commented on the increasing levels of violence, both prisoner-to-prisoner and prisoner-to-staff assaults. For example, in June 2014 an inspection into HMP Altcourse raised serious concerns about the prison’s ability to protect individuals from violence. The situation had become so bad that many prisoners were forcing their way into segregation to escape the violence of the ordinary cellblock. Similar findings have also been raised about HMP Wandsworth. With the influx of young offenders into this adult prison a number of allegations have been made about

39. Youth Justice Board / Ministry of Justice (2013) *Youth Justice Statistics 2012/13 England and Wales*  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_t\\_data/file/278549/youth-justice-stats-2013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_t_data/file/278549/youth-justice-stats-2013.pdf)
40. INQUEST and Prison Reform Trust (2012) *Fatally flawed: Has the state learned lessons from the deaths of children and young people in prison?*  
[http://inquest.gn.apc.org/pdf/reports/Fatally\\_Flawed.pdf](http://inquest.gn.apc.org/pdf/reports/Fatally_Flawed.pdf)
41. Youth Justice Board (2014) *Statistical Notice Minimising and Managing Physical Restraint (MMPR) Data Collection*  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_t\\_data/file/368350/minimising-and-managing-physical-restraint-data-collection.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_t_data/file/368350/minimising-and-managing-physical-restraint-data-collection.pdf)
42. Coles, D. & Shaw, H. (2012) *Physical control, strip searching and segregation: observations on the deaths of children in custody*, In A. Briggs (Ed.) *Waiting to be found: Papers on children in care* London: Karnac
43. Allison, E. & Hattenstone, S. (2014) “G4S and Serco pay out in youth restraint claims” *The Guardian*  
<http://www.theguardian.com/uk-news/2014/oct/24/g4s-serco-pay-out-100000-youth-restraint-claims-stc>
44. Children and Young People Now (2014) *Abolish child imprisonment*  
<http://www.cypnow.co.uk/>
45. The Young Review(2014) *Improving outcomes for young black and/or Muslim men in the Criminal JusticeSystem*  
[http://www.clinks.org/sites/default/files/basic/files-downloads/clinks\\_young-review\\_report\\_final-web\\_0.pdf](http://www.clinks.org/sites/default/files/basic/files-downloads/clinks_young-review_report_final-web_0.pdf)

46. Sleight, S. (2015) *Coroner to raise concerns with police*  
[http://m.yourlocalguardian.co.uk/news/11707776/Coroner\\_to\\_raise\\_concerns\\_with\\_police\\_after\\_11\\_deaths\\_last\\_year\\_at\\_Wandsworth\\_Prison/#comments-anchor](http://m.yourlocalguardian.co.uk/news/11707776/Coroner_to_raise_concerns_with_police_after_11_deaths_last_year_at_Wandsworth_Prison/#comments-anchor)
47. HMP Wandsworth (2014) *IMB Annual Report*  
<http://www.justice.gov.uk/downloads/publications/corporate-reports/imb/annual-reports-2014/Wandsworth-2013-14.pdf>

bullying and associated problems of debt bondage<sup>46</sup>. A recent Independent Monitoring Board Report questioned the care of vulnerable individuals, who formed part of a younger cohort, indicating serious dangers around the placement of this group into environments where there was no tailored support available and where vulnerabilities could be exacerbated<sup>47</sup>.



**Robert Richards**  
HMP Wandsworth

Robert Richards was 22 years old when he hung himself at Wandsworth prison on July 29, 2014. Robert suffered from frequent bullying after he inherited debts from his former cell mate and was reported to have told his family and prison officers about this. According to the family lawyer when Robert was discovered, a note was also found in his cell which indicated he couldn't go on with the bullying he was receiving.

As the largest prison in the UK, with the capacity for 1,877 prisoners, Wandsworth has become a place of serious concern. In 2014 there were 10 deaths there, with recurring problems being raised such as, the care of vulnerable prisoners in an adult regime, and to what extent a tailored support system was offered to young adults who had a range of distinct needs.

In HMYOI Glen Parva, an August 2014 inspectorate report found a regime characterised by persistent bullying and endemic violence and found that nearly half of the prisoners said they did not feel safe. This was underpinned by a 25% increase in assaults, on prisoners and staff over a one-year period, linked to a growing tolerance of violence, which the Prison Inspectorate referred to as an *"unacceptable attitude among some staff"*. The inspectors also reported that prisoners were charging 'rent' for cells and using the supply of legal highs to threaten other prisoners with debt bondage.

These findings paint a mixed picture. Growing evidence indicates staff tolerance, and even complacency about the violence taking place - seeing it as an inevitable part of prison life. Detection and support for victims of bullying requires increased staffing capacity and the ability for prison officers to develop trusting relationships with prisoners. Many young prisoners experience a constant feeling of fear and anxiety, may be traumatised because of early life events and are extremely isolated due to their very limited contact with family, staff and time outside cells.



**Jake Hardy**  
HMYOI Hindley

Jake Hardy was 17 when he hung himself in his cell at HMYOI Hindley in 2012, and died 4 days later at hospital. A vulnerable boy with a history of self-harm, Jake had repeatedly told officers he was being bullied, yet insufficient steps were taken to protect him. Prior to custody, Jake had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder, had been given a statement of special educational needs, and was under the care of the local mental health team. Hindley was informed of all of this information, as well as the fact that he had been bullied at school. It appears that Jake was allocated a Personal Officer who had very little engagement with him throughout his time in Hindley despite being aware of the bullying he was enduring.

A jury concluded that a series of 12 individual failures contributed to the death of this child in prison and that preventative measures could have saved Jake's life. In a letter to his mother he wrote *"I told the staff and they did nothing about the problems. So Mum if you are reading this I am not alive because I can't cope with people giving me shit, even the staff."* Jake's mother, spoke of her grief following the death of her son *"Every day we have to wake up to this nightmare that Jake died and some officers could have helped him."*



## Ryan Clark Wetherby YOI

Ryan Clark was aged 17 years when he was discovered hanging from the window bars in his cell at Wetherby Young Offender Institution (YOI) on 18th April 2011. Ryan is one of 33 children who have died in state custody since 1990.

Ryan had been in Leeds Social Services care from the age of 16 months and entered Wetherby as a 'looked after child'. Some 50% of the youngsters in Wetherby are looked after children. There was no consistency in Ryan's care. A number of Social Workers and Social Work students had been responsible for him throughout his time in care.

Several documents accompanied Ryan to Wetherby detailing his self-harm, concerns about him and his own fears. A prison officer in Wetherby thought he would benefit from a referral to Child and Adolescent Mental Health Services, but at no point was this ever followed through.

Ryan had an altercation with a prison officer on 3 April 2011, which appears to have arisen from a misunderstanding but resulted in an adjudication, loss of privileges and transfer to another wing where Ryan felt more vulnerable. The adjudicating Governor did not consider Ryan's explanation of events relevant or consider suspension of the punishments.

Wetherby operates a Personal Officer Scheme but at no point was one assigned to Ryan nor was there any engagement with him. This was in spite of his vulnerabilities as a looked after child, despite it being his first time in custody and despite the concerns he expressed that he was intimidated by other Trainees.

Staff saw Ryan as quiet and reclusive, whilst some Trainees gave evidence that he was being bullied and intimidated by other Trainees and in particular two who were in cells close to his. The inquest heard evidence that there was a problem with 'shout outs' at night, but the policy to limit this and the anti-bullying policy were ineffectual.

The inquest also heard that on the night of 17 April 2011 Ryan was subjected to a number of shout outs and could be heard crying. He later asked other Trainees to 'string up' with him. Ryan was discovered the following morning suspended from the window bars in his cell.

The jury was highly critical of Wetherby and their inadequate management of this vulnerable looked after child, despite policies being in place to safeguard him. The coroner made a number of recommendations following the inquest and it appears Wetherby has implemented some major changes.

Jane Held, Independent Chair of Leeds Safeguarding Board, reported that the system had failed Ryan and that he was treated as "*troublesome rather than troubled, vulnerable and an emotionally damaged young person.*"

## Segregation

The use of segregation has been widely criticised due to its overuse in prison and the severe impact it can have on young prisoners, particularly those who are already emotionally unstable. According to the HMIP, segregation is an extreme disciplinary measure which should be used only in "exceptional circumstances"<sup>48</sup>. It has been linked to heightened prisoner distress and is associated with an increased risk of self-harm. Yet establishments have continued to use segregation units to punish misbehaviour<sup>49</sup>. Moreover there is a concern that segregation has become the preferred option for young adult prisoners struggling on the normal wing because of bullying and intimidation. Analysis of casework reveals that on many occasions segregation has been used to manage mental health problems.

48. HM Chief Inspector of Prisons for England and Wales (2013) Annual Report 2012-13  
<http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hm-inspectorate-prisons-annual-report-2012-13.pdf>

49. Ibid

In its 2014 annual report, the HM Inspectorate of Prisons documented its concerns about the use of segregation for women as a method of control and punishment.



“Some of the most vulnerable women are also some of the most challenging and their care is less well developed than it would be in a men’s prison. At HMP Bronzefield we found one woman with acute needs who had been kept in segregation for over five years in conditions which, in our view, amounted to cruel, inhuman and degrading treatment.”

### Family contact

Family contact can also be fundamental to prisoners’ wellbeing. Access to family can be an important stabilising influence in an individual’s life, offering them vital support during custody and giving them a sense of hope during a time of distress. Despite evidence detailing the benefits of family support, prisoners are often sent to distant locations, away from family and community networks of support presenting financial and practical difficulties for families making visits. For those prisoners with children family interaction can play an even more crucial role.

Family members are often able to detect changes in behaviour and increased vulnerability. Yet despite this, family members have cited instances where their relative’s worrying behaviour was not brought to their attention. Families have described encountering frequent difficulties when contacting prisons to voice their concerns with prison staff, with switchboards unanswered and no designated family liaison officer to pass on information to. Even where contact has been made, there have been cases where warnings were not passed on to the relevant staff or authorities.



**Mahry Rosser**  
HMP New Hall

Mahry Rosser was 19 years old when she was found unconscious in her cell at HMP New Hall in April 2011. She used the handrail in the toilet area to tie her ligature. This was not the first time she had tied a ligature around her neck. Mahry had a long history of self harm and suicide attempts. She came from South Wales and lived there with her grandmother from the age of three. At age 16 she was detained at a secure children’s home and later was sentenced to 3 years detention for robbery. Thereafter she moved from one establishment to another. She spent time in HMP Eastwood Park, HMP Downview and HMP Peterborough prison and in 2010 she was transferred to HMP New Hall.

The Prison and Probation Ombudsman stated in their investigation report that there was a systemic failure in her care and she was transferred around the women’s estate without adequate regard for her significant needs. In particular the Ombudsman was critical about the decision to move her to HMP New Hall taking her away from her family and home area. During her time at HMP New Hall, she consistently told staff of her distress at being too far away from her family to receive visits and her wish to transfer to Eastwood Park to be closer to them. Many of her acts of self-harm were as a consequence of her continued frustrations at being far away from her family. In his assessment of Mahry’s case, Nigel Newcomen, the Prisons and Probation Ombudsman for England and Wales, said: *“Unfortunately, this report sets out a catalogue of failures which calls the whole process into question...Her needs could have been better managed by a more holistic, multi disciplinary approach...”*

### ***Failures of information flow and inadequate staff training***

INQUEST has identified significant failures in information exchange between community agencies and prisons and within prison that have undermined effective risk assessments of young prisoners. This point is crucial to preventability. In INQUEST's experience, there is a complete disconnect between multi-agencies operating in prisons and within the community. The most serious and potentially life-threatening issues include:

- Delays in the arrival of crucial documents when the prisoner is received into prison, which accompany initial screenings of risks;
- Failure in the transfer of information about a prisoner when moving between different establishments;
- The absence of documents from statutory agencies operating in the community which highlight susceptibilities to self-harm or challenges and;
- Poor communication flows within prison.



#### **Reece Taylor HMP Chelmsford**

Reece Taylor was found hanging in his cell at HMP Chelmsford on 14 November 2013. He was 18 years old at the time. It was his second time in prison. Reece lived with his parents and his four brothers and sisters. He was a devoted and protective brother towards all of his siblings.

In the days leading up to his first imprisonment, he became very upset due to an argument he had with his mother and was found sitting on a bridge threatening to jump, along with a suicide note. The police got involved, his father was contacted and he was talked down from the bridge.

On 27 July 2013, Reece started his first spell of imprisonment in Chelmsford serving a short sentence. He found it very difficult to cope in there. During this period of imprisonment he was placed on an ACCT (Assessment, Care in Custody and Teamwork) on three separate occasions and frequently self-harmed. He was eventually released to live with his family.

After another family dispute the police were called but the family did not want to press charges. They told the police how difficult Reece had found it to cope the last time he had been in prison. The family's concerns were not listened to and his parents were told that they would be charged with wasting police time if they did not press charges. Reece was taken from the house and this was the last time his family saw him.

During the last 24 hours of his life, Reece came under the care of six separate agencies. He had several interviews, at the police station, at Basildon Magistrates Court, on reception in HMP Chelmsford and again at an initial health screening at HMP Chelmsford. However 'risk alerts' were either missing or not recognised by staff. There were key issues around the communication of information because of the many parties involved, leading to a disrupted flow of information among agencies who failed to flag or register relevant facts, including the recent suicide attempt and the fact that Reece had self-harmed during his previous time in custody.

Reece spoke to a Listener twice during his first night. He told him that he felt like killing himself when he was at reception and that he wanted to speak to his mother. The next morning, two prisoners stated that Reece asked to speak to Listeners again on several occasions but was told to wait. During the lunchtime lock-up, Reece asked to speak to a Listener but an officer informed him that the only Listener on the wing was busy and he would have to wait. No other support options were suggested. Less than two hours later, Reece was found hanging by his bed sheet from the windows of his cell.

Reece's Mum said that had she been allowed to speak to him she could have reassured him and calmed him down. About six weeks after Reece Taylor died, Wayne Roe, aged 29 was found hanging within 48 hours of being imprisoned at HMP Chelmsford.

50. Justice Committee (2013) Recruitment and Training in Justice Committee Twelfth Report "Role of the Prison Officer" <http://www.publications.parliament.uk/pa/cm200809/cmselect/cmjust/361/36105.htm>

51. Prison and Probation Ombudsman (2014) Annual Report 2013-2014 [http://www.ppo.gov.uk/wp-content/uploads/2014/09/PPO-Annual-Report-2013-14\\_FINAL\\_web.pdf](http://www.ppo.gov.uk/wp-content/uploads/2014/09/PPO-Annual-Report-2013-14_FINAL_web.pdf)

The adequacy and frequency of staff training is another issue of concern. Given the complexities of working with children and young adults it is hard to understand why initial training for staff in England and Wales is only eight weeks which is shorter than other European countries: in Norway staff are given five months initial training; in Finland it is four months; more than two months in Denmark; 11 weeks in Sweden and nine weeks in Ireland<sup>50</sup>.

### ***Unsafe cells and ligature points***

Death by hanging accounts for all but one of the 54 self-inflicted deaths, of children and young adults in the four years which are the focus of this report. INQUEST's research has also shown that out of the 29 deaths that have occurred in single cell occupancy 26 were self-inflicted.

Three of the deaths were natural causes. The PPO has commented on concerns around deaths due to "natural causes" in its Annual Report, 2013-14<sup>51</sup>. According to the report, poor medical treatment had led to inadequate detection of illness and its treatment. In such circumstances, prison establishments must answer questions about whether placement on a healthcare wing or in a hospitalised environment would have been more appropriate and safer places of care.



#### **Nicholas Saunders HMP Stoke Heath**

Nicholas Saunders died on 2 April 2011 at HMP Stoke Heath. His offence related to the possession of an offensive weapon in a public place. This was his first time in prison. He was 18 years old.

Nicholas suffered from ADHD and was vulnerable from a very early age. He was in local authority care from the age of seven until he was 16 years old. Both the social services and probation services should have shared their concerns with the prison and highlighted the risk posed to him in a custodial setting but this never happened. His probation officer did recommend community disposal at his pre-sentencing review but it appears that the judge decided that prison was the right place for him.

He started his sentence in HMP Woodhill. It took a serious attempt by Nicholas to take his own life on 4 January 2011 for staff at Woodhill to realise that he was a very vulnerable young man who had to be watched very closely. He was referred to the mental health in reach team and was prescribed anti-depressants. An ACCT document was opened, closed and re-opened. There was a meaningful engagement by the Woodhill Staff which enabled them to manage his risk. They all described him as a very likable lad who was clearly vulnerable. When Nicholas became very upset after receiving a letter from his ex-girlfriend with a picture of a baby who he thought was his son, a prison officer sat with him in his cell and went through the letter with him, so putting his mind at ease.

On 15 February Nicholas was transferred to Stoke Heath. At his inquest, which took place in October 2012, the jury found that the ACCT document was never transferred from Woodhill to Stoke Heath. This resulted in all the valuable information recorded on this document about his risk management being completely lost. The inquest jury identified this as a contributory factor to his death. It also became apparent that none of the discipline staff at HMYOI Stoke Heath had any knowledge of his previous suicide attempt.

Within six weeks of arriving at Stoke Heath, Nicholas was discovered hanging in his cell from a ligature attached to a light fitting. Ten years ago, in 2005, another 18 year old prisoner Karl Lewis also used the light fittings in his cell to hang himself in Stoke Heath. HM Coroner J Ellery said in his report that consideration needed to be given to changing the light fittings to prevent ligatures being attached. Since Nicholas's death three other young men have used light fittings in their cells to hang themselves: Zac Atwell, 24, HMP Wayland (9.2.2012), John Baker Hefferman, 22, HMP Swaleside (20.2.2012) and Sean Brock, 21, (10.11.2013).

Out of all of the deaths, only one prisoner was placed in a 'high-risk' cell and two of the deaths took place in a shared cell with single occupancy, despite repeated evidence of bunk beds being used for ligature points. It is concerning that 13 locations of death were unknown at the time of writing.

For many of the families with whom INQUEST works, what is incomprehensible is the repetition of findings arising from deaths caused by unsafe cells. Inquests have revealed the use of the same ligature points (sometimes in the very same cell as those who have died before) by prisoners, even when previous findings have indicated the risks posed or a death which resulted from it. It is this seeming institutional complacency, lack of accountability and related inability to reflect *and* learn which needs to be challenged. Sadly, these occurrences demonstrate systemic and widespread failing across the prison estate. The prison system has continually failed to protect vulnerable young adults by removing potential ligature points and recording self-harm triggers.



#### Amy Friar HMP Downview

Amy Friar was 24 years old when she was found hanging in her cell at HMP Downview on 30 March 2011. She had used exposed heating pipes that ran below her cell window to tie a ligature. An inquest into her death identified serious issues in relation to suicide and self-harm procedures and especially the quality of checks on prisoners and the lack of meaningful interaction and conversation with vulnerable prisoners. However, the Coroner did not allow any questions to be left to the jury on these issues and the issues around ligature points were also not explored.

Since Amy Friar's death, there has been a further self-inflicted death in HMP Downview. Two years after Amy died, another woman, Cheryl Norrell-Goldsmith also hanged herself using the exposed pipes over her head in the toilet area of her cell. Exposed pipes being used as ligature points have been a common feature in the deaths of women in prison. Previously in 2008, West Yorkshire Coroner, David Hinchcliff had made a recommendation for boxing in pipework in order to reduce the number of ligature points in New Hall following the death of Kelly Hutchinson in 2006 who was 22 years old at the time of her death.

## New solutions to working with children and young adults in conflict with the law

52. Human Rights Review (2012) Article 2: *The right to life* [http://www.equalityhumanrights.com/sites/default/files/documents/humanrights/hrr\\_article\\_2.pdf](http://www.equalityhumanrights.com/sites/default/files/documents/humanrights/hrr_article_2.pdf)
53. Keenan v. the United Kingdom [2001] 3 EHRR 913. Para 91; Edwards v. the United Kingdom [2002] 12 BHRC 190; R.(J.L.) v. Secretary of State for Justice [2008] UKHL 68, [2008] 3 WLR 1325 at [38]; [http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-59365#{"itemid":\["001-59365"\]}](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-59365#{)
54. Table D1, Office for National Statistics (2013) *Annual Trend and Demographic Tables - Crime in England and Wales: Year Ending March 2013* London: ONS
55. Transition to Adulthood Alliance (2014) *Response by the Transition to Adulthood Alliance (T2A) to the Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 year olds* (p. 1-9) <http://www.t2a.org.uk/wp-content/uploads/2014/07/Response-by-the-Transition-to-Adulthood-Alliance-to-IAPFINAL.pdf>
56. Transition to Adulthood Alliance (2009) *Universities of Crime Young people, the Criminal Justice System and Social Policy* (p. 5) [http://www.t2a.org.uk/wp-content/uploads/2011/09/T2A-Universities\\_of\\_Crime.pdf](http://www.t2a.org.uk/wp-content/uploads/2011/09/T2A-Universities_of_Crime.pdf)

Political will and the investment and allocation of resources towards community based alternatives which are needed to divert individuals away from the criminal justice system, are lacking. Moreover, sentencing decisions and policy choices, which fail to recognise the risks posed by imprisoning a vulnerable group, are compromising the obligation of care under Article 2 of the European Convention on Human Rights<sup>52</sup>. Evidence of neglect and misconduct, for example, directly contravene a series of human rights obligations such as the positive duty of care which requires institutions to take appropriate measures to safeguard lives. This duty includes deaths which are ‘self-inflicted’, ‘homicides’ and ‘natural causes’, and becomes greater for individuals under the care of the state<sup>53</sup>.

### ***Diverting young adults from prison***

The most effective suicide prevention measure is to stop the overuse of prison. Whilst more crimes are likely to be committed by young adults (making up more than a quarter of all crime<sup>54</sup>) they are also more likely to be victims of crime, their behaviours criminalised and they are very likely to grow out of those behaviours. This begs the question about how necessary incarceration is for a number of young adults. As T2A research shows emphasis must be placed on desistance<sup>55</sup>. Community diversionary strategies can play a key part in dissuading young adults from continuing criminal behaviour, and thus generating benefits for the wider public. Punitive responses can be disastrous because they entrench criminal behaviour further and may do nothing to address the social problems that have contributed to their criminalisation.



“Young adults caught up in the Criminal Justice System spend their ‘age of possibilities’ with very limited options and even more limited support. At an age when young adults develop their identity, their aspirations and their ambitions in life, young adults in the Criminal Justice System are immersed in a culture and a community of offending, cut off from the opportunities that could help them move on. Contrasted with the experience of the increasing numbers of young adults entering higher education, the common description of prisons as ‘universities of crime’ is more appropriate than ever”<sup>56</sup>

# From women's centres to youth centres

INQUEST believes tackling the issues behind young adults' interaction with the criminal justice system requires a holistic and sustained approach, which identifies and challenges the interconnected issues. Many of the deaths reflect the inequality and injustices that characterise these young lives.



“As Coles has argued in relation to deaths of women in prison a radical reallocation and redirection of criminal justice resources is needed”<sup>57</sup>.

57. Coles, D. (2012) *Deaths of Women in Prison: the Human Rights Issues Arising In Malloch*, M. & McIvor, G.(Ed.) Women, Punishment and Social Justice: Human Rights and Penal Practices

58. Corston, J. (2007) *A review of women with particular vulnerabilities in the Criminal Justice system*  
<http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>

59. Corston, J. (2007) *A review of women with particular vulnerabilities in the Criminal Justice system* (p. 10)  
<http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf>

In a review of women's imprisonment conducted by Baroness Jean Corston in 2007, an important recommendation was the extension of therapeutic work with the mapping of women's centres across the country<sup>58</sup>. These centres would be based on existing successful initiatives, whereby by voluntary and statutory sectors would operate in the community and would better cater to the needs of female offenders. Accordingly the “*aim of the centres is to develop an integrated approach to routing women to appropriate services to meet their needs at various stages of their offending history, from prevention and diversion to resettlement into the community at the end of sentence*”<sup>59</sup>.

INQUEST believes a similar model could be adopted for young adults. Multi-agency collaboration would better support a range of complex needs which provide the social context for looking at young adults who end up in the criminal justice system. These include: addiction, homelessness, mental health problems or histories of abuse. This would allow young adults to receive appropriate care, develop trusting relationships with staff members, and remain close to family and friends – all of which are known to offer greater stability and reduce offending.

A report by Rob Allen (2013) for T2A (*Young Adults in Custody: A Way Forward*) highlights some alternative models of secure settings for young adults up to their mid-20s). T2A has strongly advocated that it is essential that young adults receive distinct provision in custody, and are not mixed in with the adult estate. At the end of 2013 the government proposed ending the current limited distinct provision for 18-20s, which was widely opposed, including by the Youth Justice Board, and this plan has since been cancelled. The findings of this report strongly endorse a model of distinct provision for young adult prisoners, and strongly oppose the notion of mixing young adults across the adult prison estate.

T2A research also calls for the reconfiguration of priorities and resources, and a ‘whole pathway’ approach to interventions for young adults throughout the criminal justice process (ref. *T2A Pathways from Crime* 2012). This requires effort in the areas which stabilise an individual's life: employment, housing, good health and well-being. Fragmentation and a lack of permanence cannot be addressed by a prison sentence

60. All Party Parliamentary Group for Children (2010) *Children and Young People in the Youth Justice System: Report of seminars organised by the All Party Parliamentary Group for Children 2009/10* (p. 9)  
[http://www.ncb.org.uk/media/153014/youth\\_justice.pdf](http://www.ncb.org.uk/media/153014/youth_justice.pdf)

61. Ministry of Justice (2013) *Costs per place and costs per prisoner, National Offender Management Service Annual Report and Accounts 2012-13*:  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/251272/prison-costs-summary-12-13.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251272/prison-costs-summary-12-13.pdf)

62. Ministry of Justice (2014) *Proven re-offending statistics quarterly July 2011 to June 2012*  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/192631/proven-reoffending-jul-10-jun-11.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192631/proven-reoffending-jul-10-jun-11.pdf)

63. Coles, D. & Shaw, H. (2012) *Learning from Deaths in Custody Inquests: A New Framework for Action and Accountability* London: INQUEST

64. Ibid

and criminal justice agencies are limited in what they can achieve. The real work occurs in the community – both in terms of prevention and rehabilitation. In the words of the All Party Parliamentary Group for Children “*prison is poor value for money; community sentences with early intervention, family therapy and multi-focused therapy are best value.*”<sup>60</sup>

INQUEST knows of a number of excellent charities doing very innovative work with marginalised young adults at risk of engagement with the criminal justice system. Many of these offer gender specific and culturally diverse services ranging from theatre and arts projects, education and training and mental health support. This youth work model which is both creative and inspiring, needs to be better supported, developed and resourced.

The economics of incarceration are yet another damning indictment of prison effectiveness. According to the Ministry of Justice’s (MoJ) own reports, the average annual cost per prisoner in a male closed YOI is £41,818 for ages 18-21 and £100,388 for ages 15-17.<sup>61</sup> This level of ineffective spending is even more startling when considered with MoJ findings that “58 per cent of young adults (18-20 year olds) released from custody in the first quarter of 2008 were reconvicted within a year.”<sup>62</sup>

## Accountability and the prevention of future deaths



“For thirty years INQUEST has monitored inquests into deaths in custody. One of the striking features of this work has been our repeated experience of attending inquest after inquest where the same issues are identified... Deaths in custody represent the extreme end of a continuum of near deaths and injuries and a proactive post-inquest strategy in response to verdicts and reports can not only avert deaths but also risks to custodial health and safety generally.”<sup>63</sup>

There is an overwhelming case for the creation of an effective mechanism in the form of a central oversight body. This body would be tasked with the duty to collate, analyse critically and constantly audit across the relevant sectors, and report publicly on the accumulated learning from inquest outcomes and those recommendations from PPO investigations, HMIP/IMB recommendations pertinent to custodial health and safety.

The repetition of deaths results from on-going shortcomings in the Prison Service. Time and again, local prison policies have been exposed as woefully inadequate, with frequent examples of dangerous cells and poor risk assessments identified, yet no changes are made and the culture of complacency continues unchallenged.<sup>64</sup>

One telling statistic demonstrates this: there has only ever been one single Censure brought against the Prison Service following a death in custody – and the results were both disappointing and symptomatic of longstanding impunity. This Censure was linked to the death of a prisoner on 26 September 2006 at HMP Bullingdon, whereby the Health and Safety Executive (HSE) formally reprimanded the Prison Service for allowing so-called ‘safer cells’ to be modified to include shower rails with ligature points.

The prisoner concerned was Danny Rooney who was at imminent risk of death by hanging, having been found with a makeshift noose which he had tried to hang himself with. Based on this knowledge, duty officers did not refer him to the care of the prison healthcare team, and instead officers’ response was simply to put him in a ‘safer cell’. This cell had shower rails installed which created dangerous ligature points, and around 40 minutes after being placed there, Danny was found hanging from the rail fittings.

The Censure was secured following a 3-year battle fought by the family and their lawyers, requiring a painful recollection of events during an inquest and civil claim - both of which were fought hard by the prison service. Despite the eventual guilty plea by the Prison Service, the Censure was the only sanction available to the HSE at the time of the proceedings, which meant that even after misconduct was acknowledged, there was still no mechanism for holding the institution accountable.

***Narrative verdicts and Preventing Further Deaths (PFD) report***

A crucial part of INQUEST’s work is to bring about accountability, both as an absolute requirement for bereaved families seeking answers about how their relative died and to prevent another death from happening. PFD reports, previously known as Rule 43s, are especially important as they afford new powers to Coroners to highlight prison failures to the relevant authorities and are able to recommend institutional change.

INQUEST has studied a small sample of 52 narrative verdicts and PFDs from its casework, covering an annual review of failings between 2007-13. In this sample the most frequent issues raised were mental health awareness, ACCT training and communication failures. These failures have been illustrated by the case studies cited

Narrative verdicts and Preventing Further Deaths reasons (2007-13)	
Mental Health Awareness/ Training	(8) 15%
ACCT Awareness/Training/Implementation	(9) 17%
Inadequate/ Missing Information on Records	(5) 10%
Reliance on Prisoner self-reporting	(1)
Communication/Information Sharing	(12) 23%
Systemic Failures	(2)
Lack of Appropriate Care	(5) 10%
Other Training	(9) 17%

65. Ministry of Justice (2013)  
*Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*  
[http://webcache.googleusercontent.com/search?q=cache:bUJ\\_YW9W5uoJ:https://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc+%&cd=1&hl=en&ct=clnk&gl=uk](http://webcache.googleusercontent.com/search?q=cache:bUJ_YW9W5uoJ:https://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-64-2011-safer-custody.doc+%&cd=1&hl=en&ct=clnk&gl=uk)

66. Coles, D. & Shaw, H. (2012)  
*Learning from Deaths in Custody Inquests: A New Framework for Action and Accountability* London: INQUEST

67. Ibid

in this report. Communication and information sharing was stressed every year bar one, and ACCT failures were highlighted 5 years out of the 7 years covered. For example in the cases of 15 year old Alex Kelly and 18 year old Reece Taylor, there was clear evidence of poor mental health training (including the management of self-harm behaviour), and information breakdown between different statutory bodies and organisations, both inside and outside prison establishments.

The repeated failures demonstrate an inability to learn, and undermine a fundamental duty of care to prisoners as set out by the National Offender Management Service framework for delivering safer custody procedure<sup>65</sup>.

In September 2012 INQUEST published a widely praised report: '*Learning from Death in Custody Inquests*'<sup>66</sup>. The report was a critical review of narrative verdicts and Coroners' rule 43 reports returned at inquests and made recommendations about what changes needed to be made to ensure accountability by learning from previous systemic failures. The report argued that the absence of a mechanism to capture and act upon the rich seam of data available from well-conducted and costly inquests leads to unnecessary further loss of life. The most troubling aspect of INQUEST's work is the failure of state bodies and agencies to act on the compelling evidence from numerous PPO investigations, inquests findings, and Coroners' reports resulting in the increasing number of preventable deaths. The inquests and investigations into the deaths of children and young adults should be a forum through which lessons can be learned. However, lessons are far too frequently lost, they are analysed poorly or ignored; misunderstood or misconstrued; dissipated or dismissed.<sup>67</sup>

While the Coronial service can and does make a vital contribution to the prevention of deaths its input is being undermined, as there are no established mechanisms for monitoring compliance, and/or action taken in response to failings identified in narrative verdicts/findings or in response to PFD reports. Jury findings are not collated and published and whilst Coroners' reports are now published on the judiciary website there is no audit of progress or follow up to ascertain the impact of these reports at a local and national level.

There is an urgent need for a stronger focus on the implementation of PFD reports and a need to monitor progress more consistently, particularly for those prisons with extremely poor standards. There must also be a willingness to enforce existing legislation such as the Corporate Manslaughter and Corporate Homicide Act, which came into force in September 2011.

Overall, deaths cannot be considered in isolation from one another as this doesn't allow for an overview of systemic factors, contributing to a pattern of deaths. The findings of previous inquests or inquiries into deaths involving similar factors or within the same institution are very often not considered. The restricted remit of the inquest also means that it does not enable an in-depth analysis of sentencing policy and allocation. Therefore, a key concern for families – why the young adults were imprisoned in the first place – is outside the scope of the inquest and further frustrates the learning process.

# Post-death family liaison and legal representation for families

Following a custodial death, INQUEST has observed poor implementation of family liaison common standards and principles. Problems have arisen where no family liaison officer has contacted the family, and where timely dissemination of information regarding the family’s rights to help and support during the inquest process has been lacking. Families have also reported no or very little access to information about their entitlements to financial compensation for funeral costs and independent advice about a death in custody. This is in spite of clearly set out guidelines by the Independent Advisory Panel, which have been accepted by a range of custodial organisations, investigatory bodies and the Department of Health. Good practice is where all the agencies involved with a family post death ensure the prompt provision of advice and support to a bereaved family<sup>68</sup>.

The current inquest process is beset with practical problems including lengthy delays, which are distressing, and interrupt the grieving process for families. The Independent Advisory Panel on Deaths in Custody has gathered data from Coroners which showed that, between August 2010 and January 2011, approximately 25 per cent of deaths in custody inquests were taking more than two years to complete. The reasons given by Coroners for the delays included outstanding investigations by other bodies such as the PPO and lack of available resources. Whilst there has been an improvement in the timeliness of PPO investigations, delays frustrate the learning process. The table below is a small sample of the time taken between a young prisoner’s death and inquest start date.

First Name	Date of death	Date inquest started
Greg Revell	11/06/2014	14/04/2015 - 10 months
Reece Taylor	15/11/2013	08/12/14 - 13 months
Connor Smith	02/01/2013	8/12/14 - 23 months
Joseph Corcoran	15/09/2012	27/9/2013 - 11 months
Edward Tula	16/06/2012	21/11/2013 - 17 months
Kieron Dowdall	27/01/2012	25/2/2014 - 24 months
Christopher Neale	19/11/2011	24/04/2013 - 17 months
Kyal Gaffney	09/11/2011	11/03/2013 - 16 months
Alex Kelly	26/01/2012	10/11/2014 - 34 months
Ryan Clark	18/04/2011	20/01/14 - 34 months
Jake Hardy	24/01/2012	24/02/2014 - 25 months

Bereaved families have a vital role to play in ensuring inquests do not merely sanction the official version of events. Indeed, they and their legal representatives have been instrumental in exposing “systemic and practice problems that have contributed to deaths. Many of the changes to...training and guidance, changes to the law... increases in information entering the public domain...and public awareness of the issues have been a direct consequence of the deceased’s family’s participation in the inquest proceedings and lobbying...for change.”<sup>69</sup>

68. For a comprehensive set of guidelines on good practice regarding post death family liaison, please consult INQUEST’s recommendations in section “Notification of the Death” in *Unlocking the Truth: Coles, D. & Shaw, H. (2007) Unlocking the truth: families’ experiences of the investigation of deaths in custody London: INQUEST*

69. Coles, D. & Shaw, H. (2007) *Unlocking the truth: families’ experiences of the investigation of deaths in custody London: INQUEST*

70. Ibid

71. See answers to parliamentary questions from Jeremy Corbyn MP, House of Commons, 18 January 2011

Skilled advocacy for the family aids the inquisitorial process and can contribute to the writing of Coroner reports to prevent future deaths. As Coles and Shaw have explained in 2007, families:

*“hope their questions will be answered and their concerns addressed. Instead they can be left feeling that they have been further damaged by the investigation and inquest which in turn exacerbates their anger and grief.”<sup>70</sup>*

It is essential, therefore, that families are supported to participate at every stage in the investigation and inquest process as fully and as openly as possible. Families should automatically be eligible for non-means tested public funding to cover the costs of legal advice and representation and subsistence costs for the inquest hearings. Yet this right of access is often denied to families. Karen Gammon, the mother of the recently deceased Amy Friar, referred to her troubles in seeking legal representation:

*“This inquest has been a very difficult experience, made harder by the lack of financial assistance from Legal Aid, and initially the prison HMP Downview, which meant that I was not able to attend and hear all the evidence.*

Lawyers instructed on behalf of a prison, the Prison Service and other public bodies whose conduct may be subject to scrutiny during the inquest are paid for from public funds. For example, the Ministry of Justice incurred legal representation costs of £2.7 million in relation to inquests into deaths in prison. In contrast, the entire amount spent on the exceptional legal aid budget (i.e. for all cases covered by that scheme and not just family representation at death in prison custody inquests) in the same period was £1.6 million.<sup>71</sup> This translates into a significant inequality between bereaved families and the public institutions which may have failed the children and young adults in their care. NHS commissioning of prison healthcare and other services and the increasing involvement of the private sector has added to the number of legal teams that are often present at these inquests.

70. Coles, D. & Shaw, H. (2007) *Unlocking the truth: families' experiences of the investigation of deaths in custody London: INQUEST*

71. See answers to parliamentary questions from Jeremy Corbyn MP, House of Commons, 18 January 2011

# Recommendations

## *New responses to children and young adults in conflict with the law*

- 1 Prisons should be used only as a last resort for those who present a significant risk to others.
- 2 In the event that prison is deemed necessary, there should be investment in local and smaller prison units, designed and designated specifically for the young adult age group, with an emphasis on therapeutic environments, interventions and increased staff who are adequately trained and want to work with young prisoners. (Grendon Underwood prison provides a clear example of this process, taking violent men and changing them through a combination of therapy and highly motivated staff).
- 3 Most young adults will 'grow out of crime' if given opportunities and support to turn their lives around. The temporary nature of this stage of life should be taken into account in criminal justice responses, as should research that has highlighted the criminalising effect of imprisonment on this age group
- 4 There should be a reallocation of resources away from imprisonment towards crime prevention, looking at the areas which destabilise an individual's life: social care, education, healthcare and housing.
- 5 Community schemes are best placed to deal with low-risk to minor offences. Individuals with mental health problems, learning difficulties and drug/alcohol addiction should be diverted away from the criminal justice system and given access to treatment and rehabilitation support.

## *Identifying vulnerability*

- 1 A review of the ACCT scheme is needed, focusing on a specific assessment and identification of young adults's vulnerabilities, and their difficulties in communicating emotional instability.
- 2 Staff should be trained to recognise crucial factors linked to vulnerability and use this expertise during assessments. Factors include: first time in custody, recent conviction, transfer to adult prison, previous history of self-harm, poor mental health or earlier experiences of trauma.
- 3 Consistent processes for regular monitoring and reviews of bullying should be implemented, and staff capacity increased to support prisoner and staff relationships, with a particular emphasis on the personal officer scheme. Regular staff meetings must be held to ensure the necessary flow of information concerning prisoner risks.
- 4 Given the high number of deaths in the first days of custody a structured induction programme, with thorough screening of risks and access to easy-to-understand support services, should be provided.

### ***Knowledge and resources***

- 1 Sentencers should be fully informed about the range of community provisions available for young adults and must not impose prison sentences because of a lack of appropriate facilities or provision.
- 2 Probation pre-sentence reports for 18-25 year olds should always include a specific section on a young adult's maturity.
- 3 Multi-disciplinary agencies in prisons and the community have a duty to share information about a young person's vulnerability with one another.
- 4 A national database that all prisons can access should be set up to counter delays in documents and incomplete information arriving with prisoners.
- 5 The Prison Service must learn from other criminal justice systems, and develop sufficient resources and capacity to train prison staff about working with young offenders.

### ***Post-death family involvement***

- 1 There should be agreed protocols and standards about notification of death across the Prison service such as, prompt notification of death to family, access to appropriate support mechanisms made available by staff, and a Family Support Worker from the Coroner Service.
- 2 The Coroner Service should ensure bereaved families are referred to appropriate legal, social and health service providers.
- 3 Families bereaved by a death in custody should automatically qualify for non-means tested public funding to enable their legal representation at inquests.
- 4 Inquests should be closely monitored to account for any unnecessary delays, which increase the distress of family relatives. Rushed inquests, particularly those relating to natural causes deaths, also need to be monitored as they may ignore a number of failings which contributed to a death.

### ***Accountability, policy and institutional learning***

- 1 There is an overwhelming case for the creation of a central oversight body. This body would be tasked with the duty to collate, analyse critically and constantly audit across the relevant sectors, and report publicly on the accumulated learning from inquest outcomes and those recommendations from PPO investigations, and HMIP/IMB recommendations pertinent to custodial health and safety.
- 2 All Coroners' Prevention of Future Death reports and juries' narrative verdicts should be publicly accessible through a national custody death database and analysed, audited and followed up, and brought to the attention of Parliament to ensure responses from relevant Ministers.
- 3 Legislation such as the Corporate Manslaughter and Corporate Homicide Act should be better employed to enforce institutional change and accountability, by addressing negligent acts leading to a prison death.
- 4 Learning from the restorative justice model could be developed to create a new mechanism to ensure learning, providing a suitable and mediated framework for dialogue between bereaved families and members of the Prison Service.

## Conclusion

The countless stories of young adults who took their lives in prison show that such deaths are not isolated cases but part of a deeply worrying pattern. Time and again systems set up to safeguard children and young adults fail miserably. There have been an array of critical outcomes from the investigation and inquest processes into these deaths that demonstrate where the proper protective measures and institutional culture that should protect young adults from human rights abuses have repeatedly failed. Prison is an ineffective and expensive intervention that does not work, as demonstrated by the high reconviction rates. It fails both victims and communities. The prison system is a repository for some of the most disadvantaged groups in society and failed education, social care and healthcare policies. There needs to be a radical re-think of how we treat young adults in conflict with the law. To ignore this serious human rights issue means the tragic loss of young lives will continue to put to shame our prison system and society.



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“Jake was too vulnerable and should never have gone to a place like Hindley to start with. I kept my son safe for 17 years yet Hindley couldn’t keep him safe for two months.”

**Liz Hardy, mother of 17 year old Jake Hardy who died at HMYOI Hindley (2012)**

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# STOLEN LIVES AND MISSED OPPORTUNITIES

## The deaths of young adults and children in prison

Between 1 January 2011 and 31 December 2014, 65 young adults and children died in prison whilst in the care of the state. Of this number, 62 were young adults aged 18-24 years and three were children under 18 (one 15-year-old and two 17-year-olds). This report analyses those deaths drawing upon the evidence-base accumulated through INQUEST's specialist casework with bereaved families and associated policy work over the last 30 years. Moreover it supports the independent review into self-inflicted deaths in National Offender Management Service (NOMS) custody of 18-24 year-olds. This review is chaired by Lord Harris and seeks to make recommendations which will reduce the risk of future self-inflicted deaths in custody.

This report exposes a litany of systemic neglect, institutional complacency and short-sighted policies which have contributed to the deaths of young adults and children.



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