Submission to The Chief Inspector of Prisons’ Thematic Review into Suicide and Self-Harm In Prison

“The grim toll of despair reflected in the unacceptably high number of prison deaths begs questions as to whether suicide prevention and the health care of prisoners are given any priority at all. We must question the ability of the Prison Service to implement their suicide prevention strategy in a political context where the emphasis is on punishment, harsh and impoverished regimes in which security and control take precedence over humanity and care.

It must be a priority to address not just the fundamental failings highlighted by this death toll, but the secretive and unaccountable system of investigation that allows so many prisoners to die in similar circumstances and lessons not to be learnt.”

INQUEST, July 1998
INQUEST’s Submission to The Chief Inspector of Prisons’ Thematic Review into Suicide and Self-Harm In Prison

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1. WHAT IS INQUEST?

1.1 INQUEST is in a unique position as a non-governmental organisation which works directly with the families of those who die in custody. It was set up in 1981 following a number of deaths in controversial circumstances in prison and police custody. It monitors all deaths in custody - in police custody, prisons, immigration detention centres as well as the inquiries held into them. INQUEST provides an independent, free legal and advice service to the bereaved on inquest procedures and their rights in the Coroner’s court. It aims to raise public awareness about controversial deaths, and campaigns for the necessary changes to improve the investigative process, increase accountability of state officials, and avert further deaths. Until April 1998 INQUEST provided this service with no more than three paid staff.

2. BACKGROUND

2.1 In preparing material for this submission the depressing message conveyed by Coles and Ward in ‘Failure stories: Prison suicides and how not to prevent them’ (1994) remains ever too present.
"It is difficult to convey, without multiplying case histories *ad nauseum*, the exasperation we feel as inquest after inquest, year after year, reveals the same failures of communication, the same almost wilful blindness to prisoners’ distress. Of course this is not true in every case: there are many deaths where everyone concerned seems to have acted quite reasonably within the constraints of the system and where any suspicions the family might have could probably be defused by greater openness in advance of the inquest. But it is true in too many cases, and the lessons of these cases do not seem to be learned"

2.2 INQUEST made a detailed submission to the Tumim inquiry in 1990 (*Appendix 1*) and met one of the then Inspectors. We were keen highlight the emphasis of previous inquires on the psychiatric focus of the 1984 report and wanted to stress the significance played by the process of imprisonment itself in self-inflicted deaths and that the reaction of ordinary prisoners to overcrowded, brutal, depressing and unproductive regimes was a contributory factor to the taking of their own lives. We welcomed the shift of the Tumim inquiry’s focus and recognition of the social dimension to self-harm and self-inflicted deaths - a perspective developed at INQUEST by staff attendance at inquests. We particularly welcomed the report’s attention, given for the first time, to the families of those who died in custody, and the recommendations made.

2.3 Sadly, it is the nature of suicide prevention that its failures are easier to identify than its successes. It is a depressing reality that little of the philosophy within the Tumim report has been translated into action. The report marked an important break from a purely medical understanding of suicide in prison, acknowledging that the environment played a significant role in a prisoner’s state of mind. Tumim set out a realistic programme of short-term reforms, many of which were reiterated in the Woolf report. The fate of Tumim’s report like so many official inquiries that get close to identifying the real problems, is that their recommendations may not even be accepted in principle, or where they are, there is a failure to translate them into practice.

3. OBSERVATIONS SINCE 1990

3.1 As a result of the spiralling number of prison deaths and our role in assisting bereaved families and lobbying for practical change to regimes, we have attended numerous inquests and assisted lawyers in their preparation. Our service offered to families is complemented by our monitoring and research role. We have worked closely with the families of 147 out of 477 prisoners who died as a result of self-inflicted injuries.

3.2 For the purposes of this report we not only relied on our own files and experience but also contacted 80 families for comments on their experience (*Appendix 2*). We also organised for relatives from seven families who had lost a loved one as a result of self-inflicted death to meet members of the Inspectorate. Our views are informed by INQUEST’s direct experience over the past 17 years with a particular focus on the period 1990 to date.

3.3 In this submission our primary focus is on the way deaths in prison are investigated and the treatment of bereaved families. We address the fragmented nature of the investigation and the polarisation which occurs between the prison service and bereaved relatives as a result of the secrecy surrounding the investigations. We will also address the contradictions of a prison system which while not responding to the individual needs of prisoners focuses primarily at inquests on the individual pathology of the deceased. We also highlight our concerns about the types of deaths which occur and patterns which have emerged.

3.4 There has been a steadily rising number of deaths in prison (*see fig. 1*) and indeed much warranted attention has been focused on the very serious problem of self inflicted deaths within prison. There are, however a significant number of non-self inflicted deaths which merit greater scrutiny than they are presently given. Indeed the present unhelpful Prison Service classification
of non-self-inflicted deaths as by natural causes fails to acknowledge that some of the deaths raise serious questions about the adequacy of health care, particularly of vulnerable prisoners such as those with mental health or drug problems, and the effects of the use of control and restraint.

Deaths in Prison (England and Wales)
Totals (to July 1998):

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<tbody>
<tr>
<td>Self-inflicted</td>
<td>51</td>
<td>40</td>
<td>39</td>
<td>47</td>
<td>59</td>
<td>60</td>
<td>64</td>
<td>71</td>
<td>47</td>
</tr>
<tr>
<td>(of which on Remand/Unconvicted)</td>
<td>N/A</td>
<td>N/A</td>
<td>23</td>
<td>24</td>
<td>22</td>
<td>33</td>
<td>31</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Non Self-inflicted</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>7</td>
<td>9</td>
<td>55</td>
<td>41</td>
<td>27</td>
<td></td>
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<tr>
<td>Control &amp; Restraint</td>
<td>N/A</td>
<td>N/A</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Homicide (NSI)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Youth (SI)</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>3</td>
<td>12</td>
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<td>14</td>
<td>18</td>
<td>8</td>
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<td>Youth (NSI)</td>
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<td>2</td>
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<td>3</td>
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<td>1</td>
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<tr>
<td>Women (SI)</td>
<td>N/A</td>
<td>N/A</td>
<td>3</td>
<td>1</td>
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<td>Women (NSI)</td>
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N/A=Not available
Homicide, Women & Youth (21 & under) figures are also included in the S.I./N.S.I totals. Figures pre-1996 are those INQUEST monitored as Home Office statistics were not made available.

Source: INQUEST monitoring (1990-8)

3.5 While the remit of the review is self inflicted deaths INQUEST believes that amongst these other deaths there are a significant number that give cause for serious concern and raise the same issues regarding the treatment of families and the investigation of the death

4. TREATMENT OF BEREAVED FAMILIES

4.1 We welcome the review’s focus, in one of its three central aims, on “the next of kin of prisoners who appear to have committed suicide”.

4.2 Our submission to Judge Tumim’s review and meeting with one of the Inspectorate in 1990 resulted in the adoption of our recommendation that ‘the next of kin should enter the inquest system with the same amount of information as the prison service’. Clear recommendations were made acknowledging the ‘little thought’ given to the next of kin and the difficulties they encountered in trying to obtain information.

“At the earliest opportunity the next of kin must be given details of what happened to the deceased. While we recognize potential problems in respect of the sub-judice rule, the air of secrecy and lack of cooperation which has surrounded some cases only adds to the sense of loss. These circumstances often provide a point on which to focus anguish, desperation and all manner of prejudices if not handled carefully. Where the next of kin feel they are in need of outside help from solicitors then those acting on their behalf should be given access to, or copies of, papers and, if necessary, allowed to visit the actual scene of death.” 5.09, Tumim Report.

It is an indictment of the Prison service and illustrative of the low priority afforded the families of those who die that, eight years on, there is still resistance to implementing these recommendations.

4.3 Thoughtless and insensitive and treatment of many bereaved families remains a prevalent feature following a death in prison. Some small steps have been taken to improve the information made available to bereaved families as a result of INQUEST’s lobbying. Current
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policy of the Prison Service Suicide Awareness Support Unit (SASU) is to ask Governors to inform families of the support available from INQUEST after a death and to pass on to the family a leaflet prepared by INQUEST and its family support group Death On Remand (DOR). This, however, is done at the discretion of individual Governors. The number of families who are actually given access to this information is not known and recent contact with bereaved families suggests that this is not happening in many cases.

4.4 In April this year (1998) a bereaved father telephoned us after the inquest into the death of his son in HMP Cardiff to say he was deeply unhappy with the whole process and that he had not been given any information about INQUEST or DOR. He felt the inquest had been a cover-up, he had not been represented and was furious to have only been informed of his rights and of our existence when in his words it was ‘too late’. The mother of Elliot Mitchell who died in HMP Reading knew about INQUEST from reading The Voice newspaper. But the mother of Ben Mills who also died in the same institution and whose inquest took place on the same day was given no information and was deeply unhappy about the speed of her son’s inquest and that she had no-one to represent her.

4.5 There are now an increasing number of families who have been given our leaflet and have contacted both INQUEST and DOR as a result. They have all found that contact really helpful and supportive.

4.6 Before we reached the above agreement with SASU in 1996 we had made direct approaches to the institutions involved in collaboration with DOR which elicited the following responses:

- “Having sought advice from head office I have to advise you that we are not in a position to pass on any information…” HMP Bristol
- “Such letters as we often receive in these circumstances can cause distress to the families involved…” HMP Dorchester
- “Our rule is to be there when needed but not to be invasive…” HMP Liverpool
- “In view of the circumstances of the death and the time which has passed since the death, I doubt whether it would now be appropriate to pass on your details…” (the prisoner had been dead for less than two months) HMP Manchester
- “I have not been able to forward your letter to the family and have therefore disposed of it accordingly…” HMP Shrewsbury

This small selection epitomises the difficulties families face and the hostility towards an organisation which seeks to ensure that at least the bereaved have some support and legal representation if they so choose. Some families have been invited into the prison to view the scene of the death and meet staff. However families’ frequent complaint is the lack of sensitivity shown to them and the refusal of staff to answer any questions. The experience of one mother following her daughter’s death typifies our concerns:

“After the initial phone call form the Governor of Risley, which I must admit appeared sympathetic, the only contact after that was when my daughters or I contacted Risley. They just didn’t understand that when you’ve just been told that your beloved child has committed suicide in a prison cell that you’re not likely to take in this information that they are throwing at you over the phone. She couldn’t get off quick enough because she honestly gave me the impression that she was embarrassed. So of course once it hits you properly and you start thinking half straight: you need to ask questions and you desperately want some answers.

I rang the prison back a couple of hours after I had spoken to the Governor to ask my questions and I seemed to hit a wall of silence and I’m told my questions cannot be answered because there’s going to be an inquest. I was made to feel a nuisance because I needed to ask these questions, as time goes by you start to get angry and frustrated and then you probably do become a nuisance and because I kept asking for some answers to my questions they terminated my calls. So then you become suspicious. What are they trying to hide? Why all the secrecy this was my child I have a right to know! This is how you
4.7 Despite the Director General’s acknowledgement of the need for greater openness we remain disturbed by the slow progress towards that aim and the common experience of both families and solicitors is that the secrecy in the investigative process remains the norm. Access to proper information and advice is crucial in ensuring that people are informed of their rights at what is no doubt a deeply difficult time in their lives and where no other help and support is offered. Finding out the truth about how someone died is a fundamental human right and plays an essential part in coming to terms with the bereavement.

4.8 The correspondence from bereaved families contained in Appendix 2 is a powerful condemnation of the way in which the Prison Service and Home Office deal with bereaved families and of the investigative process. It is, at best inadequate and at worst, callous in the extreme. Families frequently comment on the double pain they experience by the death itself, which is then compounded by the secrecy and silence they encounter at each stage.

4.9 This experience underlines our view that the many within the Prison Service do not regard the public investigation of prison deaths as an opportunity to establish the truth and learn any lessons but rather see it as a potentially hostile forum if the bereaved are legally represented.

5. THE INVESTIGATION OF PRISON DEATHS – THE INQUEST

5.1 In this section we look at the failure of the investigation of deaths in prison to address the key problems and address the fragmented nature of the investigation and the polarisation which occurs between the prison service and bereaved relatives as a result of the secrecy surrounding the investigations. It is our view that greater openness in the investigation of prison deaths would allow a more honest dialogue about the systemic problems the deaths reveal and about what needs to change to prevent this relentless and repetitious death toll from continuing unchecked.

5.2 INQUEST has long-standing criticisms of the way in which deaths in prison are investigated. There is the inherent problem of investigating a death in a closed institution. In prison, after any death there is an internal investigation followed by an inquest held with a jury. The Coroner relies on the prison investigation to shape the inquest and to a large extent to decide which witnesses should be called to give evidence and what questions should be asked. The internal inquiry is carried out in secret and never disclosed to the family or the public. Tumim recommended that it should be carried out by a Governor from a different establishment but as these reports are never disclosed it is not possible for us to monitor how often this is the case. At various times in the last four years there have been comments made by the Prison Service that they are considering disclosing the reports and still the immense secrecy remains. It is not possible to judge how thorough the inquiries are and what impact they have internally. The excuse of security issues being a barrier to disclosure simply does not stand up as there are ways of ensuring security is not compromised. The inquiry report should be made public to the family and their lawyers and other parties in advance of the inquest. It should then be reviewed at conclusion of the inquest and a report conclusion issued to family and Prison Service detailing any action to be taken.

5.3 The narrow remit of the inquest and the Coroners responsibility to establish ‘who’ the deceased was, and ‘where’ and ‘when’ and ‘how’ they died, prohibits a thorough examination of the circumstances leading up to death in most cases. The inquest’s focus on ‘how’ being the means by which the person came to their death i.e. the medical cause of death means many issues are not addressed. In the absence of an independent body to investigate prison deaths, INQUEST has called for the extension of the Prisons Ombudsman’s remit so he can take complaints from a third party, the bereaved family, in this exceptional situation (See Section 6).

5.4 However as Coles and Ward (1998) have argued, the inquest provides a forum in which the case constructed by the prison service can be challenged by the family of the deceased or by
officers or prison personnel who may be subject to criticism. The inquest of someone who died in prison must be held in front of a jury (Coroners Act 1988 s.8 3a). They argue that the jury ‘introduces an important element of independence and public participation into the proceedings,’ however limited their function may be. This is particularly vital in cases involving the possibility of gross negligence, the limits of which are matters of moral judgement that a jury is pre-eminently qualified to decide.

5.5 The inquest is ‘inquisitorial’ and supposed to be based on a co-operative relationship between the coroner and investigators. However there is often suspicion from the deceased’s family because of the secrecy involved, about the nature of the death and a lack of trust in those conducting the investigation which also is felt towards the Coroner. There is often conflict between the family’s interpretation of evidence and that of the Prison Service. In our view, the dynamic set up by this process creates conflict, suspicion, defensiveness and a failure to learn lessons for the future. As Coles and Ward (1998) have argued in cases where the inquest works ‘at all effectively to investigate contentious events it relies heavily on the adversarial system - the questioning of witnesses on behalf of those with the strongest interest in challenging what they say. It is very rare indeed for a coroner, in the absence of legal representation, to conduct the kind of searching questioning that occurs when interested parties are represented’.

5.6 The family’s experience of an inquest makes a nonsense of any idea that the coroner is presiding over a non adversarial court when one of the parties is the Home Office in who’s custody the person died and another the bereaved family. While this in itself does not preclude a non-adversarial situation what does is the imbalance of power and resources between these two parties. The Home Office, from the time of death, is in possession of all the facts. They have all of the documentation of events prior to and following the death and any witnesses to events immediately prior to or after the death are prison staff or prisoners. The family, on the other hand, have little if any information, have no control over documentation and no witnesses.

5.7 The only thing that the family is usually entitled to is a copy of the autopsy report. The disclosure of any other factual information or documentary evidence is entirely at the discretion of the Home office and it is never the case that the family or its legal representatives are provided with the same documentation as the Home Office. These practices ensure the proceedings take on an adversarial nature because one side is in possession of all the information and the other side has to fight to obtain any. That fight is further loaded against the family by the fact that the Home Office employs solicitors and barristers at tax-payers expense to prepare and represent the Prison service at the inquest. In some cases these lawyers are actively engaged in attempting to narrow the remit of the inquest or limit the choice of verdicts available to the jury, the cases of Katherine Wood and Alton Manning being two recent examples.

5.8 In stark contrast there is the bereaved family. The inquest is the only opportunity that the family has to try and find out the circumstances of the death. Following the death they will have been given little if any information from the prison. In short a brick wall goes up between the prison and the family. The coroner’s court often assists in this wall of silence. Families can wait months, sometimes years, for the inquest to be held. Few are told of their rights to be represented.

5.9 And what of these rights? A grieving and distraught parent has the right to attend the inquest, without having had any access to the documentation or witness statements, nor with any in-depth understanding of prison guidelines, particularly where there are issues about care of the suicidal or at-risk prisoner. They have the right to ask questions of the witnesses without any understanding of the system of the court and what questions should be asked. Across the court they face a professional barrister or barristers representing the Prison service and other parties such as the prison doctor or individual officers who are as prepared and experienced as they are not. Most families would not or could not face the trauma of representing themselves and would choose to be represented. Many do not get that choice because they are not informed of their right to be represented. Others are denied this because they find that there is no legal aid for representation at inquest and cannot afford the legal costs.
5.10 Since the beginning of the 1990s it is unusual to attend an inquest where the prison service and the Prison Officers' Association are not represented. As the Prison Service became increasingly sensitive to public concern it would use considerable public resources to defend itself from any criticism. Indeed this was crystallized in the Circular Instruction 52(1990) Deaths In Custody – Follow Up Action which made clear that legal representation should be sought where criticism was likely or pressure groups involved.

5.11 The low priority given to the treatment of families by the Prison Service can be seen by its failure to implement any of the recommendations of the Tumim report in this area to date and to update the circular instruction on follow up to deaths. INQUEST has consulted SASU on this and provided comments to new drafts currently being considered.

5.12 Important details about prison deaths have been brought to light by lawyers representing the bereaved, which we believe would not have been explored had the family relied on the Coroner to protect their interests. In the case of the death in hospital of a 21 year old young man six months after attempting to hang himself in HMP Dover, the terrible bullying to which he was subjected only came to light because of the tenacity and the experience of the lawyer. At the inquest prison officers gave examples of the bullying such as the young man having toothpaste put in his shoes and other such harassment, when in fact he had been the subject of serious sexual advances and threats of violence.

5.13 Many Coroners do not have the detailed knowledge of the way prisons work and the structural framework in which they operate to enable them to question witnesses as fully as is necessary and do not regard it as their duty to do so. Frequently lawyers acting for the prison service urge the Coroner to restrict the questions lawyers for the bereaved can ask. At an inquest into the death of a young woman drug user who hanged herself in HMP Risley in 1996, the Coroner argued that all he was there to do was investigate the medical cause of death and (supported by the Prison Service lawyer) would not allow any questions to be asked about the support mechanisms available at weekends for vulnerable prisoners. The young woman in question was a heroin dependent who died after 48 hours in HMP Risley having been locked in her cell for 23 hours a day over a weekend and having received no medical attention, despite having been sent to prison by the Courts for her own safety. In fact there would have possibly been grounds for Judicial Review of the Coroner’s ruling, but often families are not in a psychological or financial position to pursue such action.

5.14 As we have already outlined, we remain sceptical about the current arrangement we have with the Prison Service whereby the establishment concerned is asked by SASU to pass on information to the deceased’s family. This relies on the institution concerned, which may be subject to criticism, passing on the information after a death which will result in the bereaved family being competent advised and represented. All the families we have advised have said that a direct approach from INQUEST offering our help would have been very welcome and not seen as intrusive at all. The most effective arrangement would be where the Prison Service pass next of kin details to our organisation so that a personal and direct approach can be made (Appendix 3). The services that INQUEST and DOR offer are professional, caring and confidential, and much needed by families. If families have our details and choose not to contact us, that is their choice and the Prison Service and its Governors should not be denying them that choice by vetoing any of our attempts at communication.

5.15 There are a number of difficulties in the way of effective legal representation. Firstly, not every prisoner who dies has a family; there is no-one who qualifies as a 'properly interested party' under the Coroner’s Rules. There is no Legal Aid despite the public funding of lawyers for the Prison Service. The only real chance of adequate professional representation is through INQUEST. We have access via our Lawyers Group to a number of solicitors and barristers who themselves are appalled at the situation that families find themselves in and are prepared to do reduced fee or pro bono work in the interests of justice. However these lawyers will never have the resources and knowledge afforded to those acting for the Home Office. Even where lawyers can be found with sufficient experience and knowledge to represent a family for free or for a reduced fee, it may be necessary to pay for other expert reports. It is also a matter of real
concern that the demand for lawyers often exceeds the number we have available, particularly where an inquest lasts more than one day. It is manifestly wrong that a family has to rely on free representation when the other interested parties have access to considerable public, professional or union resources.

5.16 What is never acknowledged by the Prison Service is how the work of INQUEST and DOR can actually assist the Prison service by providing a sympathetic ear and practical support to a newly bereaved family in considerable distress. The opportunity for a family to spend the time they need talking to one of our staff who can answer all their questions about the investigation process can allay suspicions people may have about the reasons why they are not being given all the answers they want immediately. It can help them to focus their anger and most importantly can empower them in the process. The emotional support and empathy offered by DOR has been of tremendous help to many families. It is so often the case that a clear explanation of what is going to happen, that the same process occurs after each death, and that they are not alone in feeling angry and bewildered, can stop people imagining that the Prison Service are being particularly secretive in their case.

5.17 The distress and mistrust is compounded by the lack of full disclosure of information. There is provision for the Treasury Solicitors to disclose certain information (Appendix 4) but it is usually due to the tenacity of knowledgeable lawyers that this information is available before the inquest and even then disclosure is limited. As Coles and Ward (1998) have argued, the lawyers for the family 'have no way of knowing whether all witnesses have been called' and indeed whether all the information given in evidence is the full story.

5.18 The family has no right to call their own witnesses at an inquest: they can only bring them to the attention of the Coroner. Following prison deaths prisoners have expressed fears to us about the possible consequences of speaking out and about talking to prison staff. They have also spoken of wanting to give evidence to the inquest but not being given access to the investigators (letters to INQUEST 1990 - 97). It is also frequently the case that prisoners who have witnessed the events leading to a death are frequently moved to another establishment. It has required lawyers with considerable experience of the prison system to track them down and suggest they be called to give evidence.

5.19 The Coroner begins the questioning and will often lead the witness through the evidence he has before him. The lawyers for the Prison Service who are in possession of all relevant documentary evidence can then cross examine anyone whose evidence is unfavourable to the Service on any discrepancy between their written evidence and what they say in court. They are also fully prepared on what will be said, whereas the family's lawyers are not. This only adds to the adversarial tenor of the inquest. It can also considerably lengthen the inquest and heighten the family's sense of distrust of the process. Lawyers are forced to ask the same questions of each witness and to pursue what can appear to the Coroner, who is in possession of much greater information, many irrelevant lines of questioning because of the lack of prior disclosure. Coroners frequently display irritation with lawyers for family's asking what they consider to be repetitious questions – the family then feel that the Coroner is not being impartial in his/her deliberations.

5.20 At the end of the inquest the Coroner sums up the evidence to the jury and directs them on a choice of verdicts. Unlike a trial, no legal representative is able to address the jury on the facts, only the Coroner. It is clear that some Coroners are more objective than others, but even with the best Coroners their summing up is an interpretation of the evidence. The jury is subject to immense restriction. Changes to the Coroners rules over recent years have severely restricted the range of critical verdicts that can be reached and have abolished the right of juries to add riders. As Ryan (1996) has said, “the legitimising stamp of the jury is required by the state, but definite limits must be set on its powers to criticise and initiate”. They must not deliver a verdict that could appear to determine any question of criminal responsibility by a named person, or civil liability (Coroners Rules 1988, r. 42). The only way the jury can hint at its views is through a carefully worded statement of the circumstances of the death, as in the case of Daniel Barry who died in HMYOI Feltham where the jury gave a detailed description as to how he died. (Appendix
5) We have attended numerous inquests where juries have attempted to bring back verdicts critical of the treatment and care of the deceased but have been forced to change them because of legal restrictions placed upon them.

5.21 Additional problems are raised by the great disparity between different Coroners in the thoroughness of their inquiries and conduct of the inquest. In general, in London and in some of the other large metropolitan centres, it is usual that an inquest into a death in prison would last between 2 and 5 days. However, three recent examples from many which have been brought to our attention are:

a) an inquest into a death in HMP Cardiff which took two and a half hours;

b) an inquest into the death of Ben Mills in HMP Reading which lasted a little under two hours, followed by an inquest into the death of Elliot Mitchell who died in the same institution, which took a day and a half. (The family of Ben Mills were unrepresented and that of Elliot Mitchell were represented by an INQUEST lawyer. Both families had not received information about INQUEST from the prison);

c) at the inquests into the deaths in 1996 of Nicholas Mitchell and Neil Page in HMP Dorchester a proposal by the Coroner that he intended to get through six jury inquests in one day.

5.22 As we have argued elsewhere (Coles and Shaw 1996), we also have concerns about policy and procedural failings in both the investigative mechanisms employed after such deaths and in the process for holding those responsible to account. This concern is both at the seeming unwillingness to take action against those whose acts or omissions have contributed to or caused deaths, and at the failure of those who have responsibility for policy and procedural decisions to ensure similar deaths do not occur in the future.

5.23 No mechanism exists to ensure a more integrated and public inquiry after an inquest or a series of inquests which raise particular concerns, such as the series of self inflicted deaths in HMP Brixton in the late 1980s - early 1990s (INQUEST Annual Report 1990-91); the deaths of four young men in Feltham Young Offender institution (1992/3); the series of methadone related deaths in HMP Brixton in the early 1990s (INQUEST Annual Report 1995 - 1996); the deaths of three black men involving the use of Control and Restraint techniques in late 1995 (Coles and Shaw 1996 and Appendix 6) or the death of Claire Bosely (Appendix 7) which raised serious concerns about the ability of the Prison Service to adequately implement its suicide prevention strategy.

5.24 Whilst it is the case that under Rule 43 of the Coroner’s Rules “the Coroner who believes action can be taken to prevent the recurrence of fatalities similar to that of the inquest may announce at the inquest he is reporting the matter in writing to the person or authorities who may have the power to take such action” (Coroners Rules 1984 r.43), there is no guarantee that these will be acted upon and they are not legally binding. Many Coroners do not make recommendations or make public what they will be recommending and where they do there is no way of monitoring the response of the Prison Service. Even where the recommendations are made in public, the lack of a public procedure for monitoring the response can make the process seem meaningless and can lead to a view that such recommendations are ignored. A public procedure which is so distorted by selective release of information and which relies on another procedure at its conclusion which then exits the public domain, perpetuates the culture of secrecy surrounding these deaths. What would reassure many bereaved families and would increase confidence in the procedures would be a response from the Prison Service detailing what action has been taken in the aftermath of a death. We take a cynical view of the tendency of the Prison Service to send a press officer to the conclusion of an inquest that has attracted media interest to issue a statement saying lessons have been learnt and procedures have changed. It lacks substance, details are never given and of course it cannot reflect any of the evidence that has emerged from the inquest. Statements are never given to the family or their lawyer and viewed by us as nothing more than a public relations exercise. The only time that families hear about any follow up action after an inquest is where INQUEST, either through personal correspondence or via an MP, elicits a response from the Prison Service or Prisons Minister.
5.25 Greater openness and more sensitive treatment of families should be of paramount importance to the Prison Service. The current system breeds suspicion of malpractice at every stage. Even if that is not the case how can families and the wider public be sure that the truth has been established, that lessons will be learnt and that policy changes so often mentioned after inquests are actually made and implemented? Outside the inquest there is limited opportunity to explore issues in any other official forum.

6. THE OMBUDSMEN

6.1 Indeed families and their advisors have been forced to ask the Parliamentary Ombudsman to intervene in light of the restriction on the Prison Ombudsman which does not allow him to take complaints from a third party. Following a meeting with Sir Peter Woodhead, the current Prisons Ombudsman, he agreed to raise his concerns about extending his remit with the then Prisons Minister Joyce Quin. His current remit only allows him to investigate complaints from prisoners and once a prisoner is dead he cannot look at the case and is therefore not in a position to take complaints from the families of those who die in prison.

6.2 Given the narrow remit of the inquest and its focus on the medical cause of death, many of the wider issues cannot be addressed. In the absence of any independent investigation into prison deaths INQUEST called for the Prison Ombudsman's remit to be extended. This would allow a more thorough and open investigation into all the circumstances of a death and would address the concerns of families so often overlooked.

6.3 Sir Peter Woodhead made the following comments on BBC Radio 4’s Face the Facts programme in late 1997:

“I am here to make sure that justice, openness and fairness prevail throughout the Prison Service. I’ve been approached by not only the families but by some of the campaigning groups that are acting on behalf of the families and this needs to be discussed I think with ministers and with the Prison Service and I’m sure that we can at least consider whether we can do rather better than we’re doing at the moment because I think something needs to be done for the sake of the families.”

The reports of the Ombudsman, like that of the Chief Inspector, are open to public scrutiny and also the Government are obliged to respond to them.

7. LESSONS TO BE LEARNED

7.1 As we have argued elsewhere (Coles and Shaw 1996), we also have concerns about policy and procedural failings both in the investigative mechanisms employed after such deaths occur and in the process for holding those responsible to account. This concern is both at the seeming unwillingness to take action against those whose acts or omissions have contributed to or caused deaths, an at the failure of those who have responsibility for policy and procedural decisions to ensure similar deaths do not occur in the future.

7.2 In monitoring inquests and supporting families for 17 years INQUEST has been able to document disturbing patterns revealed by the repetitious nature of many of the deaths (Coles and Ward 1994).

7.3 Suicide Prevention Guidelines and implementation. The problem of inadequate training in and implementation of guidelines on suicide prevention is still evident as shown by our case studies and by our attendance at inquests. It is the very nature of suicide prevention that its failings are easier to identify than its successes. However, too many inquests reveal a wholesale lack of
understanding of the guidelines. There has been a lamentable failure by penal policy makers to address the relentless repetition of deaths. So many recommendations have been made at inquests, so many inquiries held, instructions drafted and excellent paper policies developed which are rendered effectively meaningless without the will to address the root of the problem.

7.4 In 1995, the Prison Service issued guidelines relating to prisoners considered to be a suicide risk (Caring for the Suicidal in Custody: Guidelines to Policy and Procedures, HM Prison Service 1995) but the guidelines provide advice only and are not enforceable. The understanding and implementation of these guidelines is patchy and uneven. At the inquest into the death of 20 year old Stuart Moffat in HMYOI Glen Parva in 1997, a Governor admitted that 40% of staff had received no training on suicide awareness and prevention. This is in an establishment that has had an appalling history of suicides and self-inflicted deaths. At various inquests we have heard evidence which revealed a contemptuous disregard for such guidelines from prison staff. The view has been expressed that these are merely guidelines and nothing compels staff to follow them.

7.5 There are no guidelines on the 15-minute watch, which is an integral part of the suicide prevention strategy. The Prison Service should issue instructions and guidelines on what ‘15-minute watch’ means and advice on good practice. A feature in so many of the self-inflicted deaths is the routine way in which vulnerable prisoners are subjected to isolation and surveillance. Signs of distress and mental health problems are described as ‘manipulative behavior’ or regarded as a disciplinary problem and dealt with as such rather than by some intervention as part of the suicide prevention strategy.

7.6 Family Involvement. Another area where families are so badly treated and which breaches clearly laid down guidelines is the lack of involvement of families with at-risk prisoners. The guidance given in Instruction to Governors 1/1994 states “The care of prisoners who are at risk of suicide and self harm is one of the Prison Service’s most vital tasks. Following an incident of self-harm or attempted suicide, after consultation with the prisoner the nominated next of kin will be notified except where clinically contra-indicated or, if aged 18 or over the prisoner does not consent.” Frequently in attending inquests we learn of families who have not been told acts of self-harm or attempted suicides. Anne Holmes, whose son Matthew died in HMP Belmarsh after three previous attempts, said:

“I can walk down there (Belmarsh) from my front door in ten minutes. There’s no way if I’d known that my son was in such dire straits down there that he’d be dead today because I could have done something about it.”

Other families complain of the difficulties they have in trying to get prison staff to take their concerns seriously. There is no central recording of families’ concerns, no nominated staff member to speak to and they are frequently passed from pillar to post within the prison. INQUEST/DOR always advise families to follow up phone calls with a letter.

7.7 Emerging Patterns. In focussing our attention in this submission on the investigation process and on the treatment of families we have not detailed our concerns about the patterns which have emerged in relation to the circumstances of the deaths. However we would highlight the following areas:

- the rise in the number of youth deaths and in particular of remand prisoners;
- particular issues arising from the deaths of women in custody;
- the link between prison deaths and inadequate or inappropriate health care;
- the increasing number of drug related self-inflicted deaths in prison of prisoners who are not given treatment and support for drug withdrawal;
- the problems of imprisoning those with mental health problems;
- the stereotyping of black people with mental health problems;
- the use of control and isolation for disturbed and vulnerable prisoners;
- the use of prison for those with serious mental health problems has also raised the questionable use of prison as a ‘place of safety’;
• the number of self-inflicted deaths which occur within Health Care Centres (Fig. 2).

**Location of Self-Inflicted Deaths in Prison 1997-8**

<table>
<thead>
<tr>
<th>Location</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Centre, Double Cell</td>
<td>1</td>
</tr>
<tr>
<td>Health Care Centre, Single Cell</td>
<td>23</td>
</tr>
<tr>
<td>Health Care Centre, Ward</td>
<td>2</td>
</tr>
<tr>
<td>Normal, Double Cell</td>
<td>22</td>
</tr>
<tr>
<td>Normal, Single Cell</td>
<td>46</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>Outside Hospital</td>
<td>1</td>
</tr>
<tr>
<td>Segregation</td>
<td>9</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
</tr>
<tr>
<td>Vulnerable Prisoners Unit, Double Cell</td>
<td>4</td>
</tr>
<tr>
<td>Vulnerable Prisoners Unit, Single Cell</td>
<td>2</td>
</tr>
</tbody>
</table>


7.8 Many of the self-inflicted deaths which occur are clearly preventable. We are not aware that there is any mechanism even within particular establishments to alert staff to particular problems or bad practice which has been a contributory factor in a death which has emerged as the result of an inquest. It is frustrating in the extreme to then attend an inquest into a second death in the same establishment where the same mistakes have been made. There certainly seems to be no way of ensuring the relevant information which should result in changes of practice which have been found to have played a part in a death is made available across the Prison Service.

8. CONCLUSION

8.1 The current methods for investigating prison deaths do not allow for a thorough, full and fearless inquiry; encourage suspicion and defensiveness; do not allow for discussion of the wider policy issues; do not allow for accountability of those responsible for policy and do not enable and honest an open approach to ensuring changes are made to prevent future deaths in similar circumstances.

8.2 We maintain that until there is reform of the inquest system and a change in penal policy deaths will continue to occur. Until bereaved families are treated with greater respect and there is an acknowledgement that a proper, open examination of all the facts surrounding a death is in the interests of all involved there will not be an adequate focus on policy change to prevent more and more deaths occurring in the future. Greater openness and transparency in the process will reduce the current adversarial nature of the investigations. What must occur is a change in attitude and culture - towards prisoners within the institutions and towards families. Far too often at inquests evidence is heard which displays a contempt for the vulnerability of prisoners and an assumption that distressed behaviour is manipulative and should be treated as a discipline problem - an attitude which is a barrier to ensuring such prisoners receive the help they need. Families are too often perceived by the Prison and the Coroner as motivated by the need to blame and to obtain compensation. Time and time again bereaved families tell us that what they want is for the inquest to result in changes which will ensure another family does not have to endure the same distressing experience. It is correct that where there has been wrongdoing or mistakes have been made families want an admission and more often than not an apology - not so they can pursue the Prison Service through the civil courts (an option which is not open to many of them because of the nature of the law) but for reasons of decency and humanity.

8.3 The defensiveness displayed at inquests and the automatic closing of ranks in the face of any
possible criticism does not inspire public confidence in the current investigations. In fact the opposite is the case and people suspect that there is something to hide. Greater openness can only be positive for all concerned.

8.4 The increase in the use of prison will further damage the ability of the Prison Service to care for those in its custody. It is clear from our case work that a reduction in the number of deaths will only occur with a drastic reduction in the prison population, more humane, healthy and constructive regimes for those who remain and the introduction of radical alternatives to custody.
REFERENCES


HM Prison Service (1995) Caring for the suicidal in custody: guide to policy and procedures


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