INQUEST submission to the Health and Social Care Committee
Inquiry into Healthcare in Prisons
May 2018

1. “The fact that the jury have confirmed she might still be with us if the level and nature of observations had been different is painful to hear. I am still worried for other vulnerable prisoners, who like Nicola, might not be getting the correct treatment or support. I hope that lessons have been learnt and the prison and healthcare providers put changes in place which mean that Nicola’s life has not been lost in vain. I do not want another family to have to go through what we have been through.” Christine Lawrence, mother of Nicola Jayne Lawrence.

SUMMARY

2. INQUEST welcomes the opportunity to respond to the Health and Social Care Committee Inquiry on Healthcare in Prisons.

3. In INQUEST’s view, ill-health in prison and deaths in custody should be viewed as an urgent public health issue. Deaths in prison are at the sharp end of a continuum of neglect, inadequate mental health support and systemic failures in healthcare, experienced by people with complex social, health and economic needs. Prisoners often face existing physical and mental ill-health and social inequalities that are further compounded by the prison environment.

4. This submission explores the effectiveness of prison and healthcare services in meeting the needs of prisoners with a particular focus on deaths in prison. Our evidence highlights the impact of poor prison healthcare on both physical and mental health, contributing to death. An investigation of INQUEST’s case files identifies systemic failings around communication, emergency responses, drugs and wider issues of mental ill-health and healthcare provision.

ABOUT INQUEST

5. INQUEST is the only charity providing expertise on state-related deaths and their investigation. Our specialist casework focuses on deaths in prison and other forms of detention, and mental health settings, as well as deaths where wider issues of state and corporate accountability are in question, such as Hillsborough and Grenfell Tower. Our policy and parliamentary work is grounded in the day to day experience of working with bereaved people.

6. INQUEST’s Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody. INQUEST has published numerous reports on the failure of state agencies to learn and implement lessons from deaths in custody (accessible at www.inquest.org.uk). INQUEST has recently given oral and written evidence to the Joint Committee on Human Rights (JCHR) Inquiry on Mental Health and Deaths in Prison, raising important points relevant to this Inquiry. INQUEST’s publications and Inquiry submissions consistently highlight the failure of successive governments to take seriously, and act upon, recommendations from official inquiries, post-death investigations and inquests.
DEATHS IN PRISON

7. 2016 was the deadliest year on record with a total of 354 deaths in prisons in England and Wales. The reduction to 295 in 2017 should be welcomed, but deaths are still at historically high levels with 2017 being the second deadliest year on record (see Table 1). Between 2015 and 2016, self-inflicted and ‘natural cause’ deaths rose by 36% and 39% respectively. In 2017, self-inflicted deaths fell by 43%, whereas ‘natural cause’ deaths fell by only 10%.

8. ‘Natural cause’ deaths (as defined by the Ministry of Justice) are the leading cause of mortality in prisons. In 2017, the ‘natural cause’ death rate was 2.15 deaths per 1,000 prisoners. This is often attributed to the ageing prison population. However, INQUEST’s monitoring, casework and evidence from inquests and official reports, suggests that many people are dying prematurely and unnecessarily due to inadequate healthcare provision.

![Table 1: Deaths in prison custody by apparent cause](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAoAAAAHgCAYAAAACXzraAAAgAElEQVR42mOwzR0QRoGRQfFQoGwNIBgQFfGgAIAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgAgA

9. The Ministry of Justice (MoJ) (2018b) has noted that in the 12 months to March 2018, there was “a particularly high number of deaths awaiting further classification” (57 in total). Through our monitoring work, INQUEST is aware of, and increasingly concerned about, prisoners being found ‘unresponsive in cell’, with 22 deaths so far in 2018. At present it is unclear whether these might be drug related and/or due to undiagnosed or untreated health conditions. It is concerning to note that at a time when the MoJ have been very vocal about their concerns about New Psychoactive Substances, there appears to be limited or no training for staff on how to identify risk and respond to drug related emergencies.

10. Levels of distress in prison are rising as demonstrated by the fact that in 2017 the MoJ recorded 44,651 incidents of self-harm in prison, up 11% from the previous year. The number of self-harming individuals increased by 6% to a new record high of 11,630 (MoJ 2018b).
11. It is also worth noting that between 2010/11 and 2016/17, 1,378 people died during post-release supervision in the community following a custodial sentence (MoJ, 2017). 401 deaths were recorded as self-inflicted, 554 were ‘natural causes’ and 229 await classification. According to INQUEST’s analysis of official data (MoJ, 2017), deaths recorded by the MoJ have risen by 274%, at a time when caseloads only increased by 62%. These deaths raise a number of issues around continuity of care particularly the crucial links between outside healthcare agencies and the prison at the start, during, and at the end of a prisoner’s sentence.

CASE STUDIES

12. **Michael Dean Foster** was found hanging in HMP Leicester on 19 November 2016. He was 26 years old. Upon arriving at the prison on 4 October 2016, suicide and self-harm prevention procedures were started and he was referred to the mental health team and a psychiatrist. On 14 October, the psychiatrist who believed him to be psychotic, requested an assessment to commence the process to move him to a secure hospital. Michael was still waiting for this assessment at the time of his death. In March 2018, the jury concluded at his inquest that neglect and failure to provide him with basic care contributed to his death. Nottinghamshire Healthcare NHS Foundation Trust provide healthcare in HMP Leicester.

13. **Darren McConnell** was found dead on the floor in his cell in HMP Thameside in December 2014 having received an excessive dose of methadone from healthcare staff. He was 41 years old. When Darren was admitted to the healthcare unit in the prison, the GP stipulated that staff must record his pulse and blood pressure on a half hourly basis to ensure he was alive and well. The CCTV footage showed that these observations did not take place and that staff falsified records to show that they had. The jury at the inquest in 2016 found that the quality of healthcare provided by Care UK fell well below acceptable practice and that Darren’s death was contributed to by neglect. The medical evidence suggested that if he had been observed as requested by the GP, signs of overdose could have been picked up and easily treated with a drug which was available in the prison.

14. **Nicola Jayne Lawrence** was 38 years old when she died from a combination of methadone toxicity and multi drug administration at HMP New Hall in September 2016. Nicola had complex physical and mental health needs and suffered from Multiple Sclerosis (MS). In May 2018, the jury at her inquest found the decision to prescribe methadone should have been checked with Nicola’s MS specialist and that when she was seen lying face down on the floor of her cell and snoring loudly, prison staff should have recognised this as obvious signs of methadone toxicity. Had the staff responded and administered a drug to reverse the effects of toxicity, Nicola’s life could have been saved. Evidence at the inquest showed that the staff did not have basic first aid training or training to recognise medical emergencies.
15. **Shalane Blackwood** was 29 years old when he died in HMP Nottingham from internal bleeding caused by a burst duo-denal ulcer in August 2015. He arrived from his previous prison with a history of stomach problems. His health deteriorated significantly in July 2015. He was not eating, sleeping or drinking properly and was also behaving strangely and crying out. Shalane was found with blood in his cell. Despite his poor health, he was still not taken to hospital. He was found dead the next morning. The staff giving evidence at his inquest stated that due to inadequate staffing levels sometimes the medical professionals were assessing him through a hatch behind a closed door and they accepted that when he was found with blood in his cell he should have been taken to hospital. The jury found that neglect by both prison and healthcare staff contributed to his death. Nottinghamshire Healthcare NHS Foundation Trust provide healthcare in this prison.

16. **Ashley Gill** died in HMP Liverpool after suffering a serious asthma attack in April 2015. He was 25 years old. The inquest heard that healthcare staff at HMP Forest Bank, a privately operated prison, failed to transfer information relating to Ashley’s asthma and prescribed medication when he was transferred to HMP Liverpool. In HMP Liverpool, he was not assigned a chronic disease manager due to staff shortages in the prison. He was also not prescribed his essential asthma medications after his transfer. He raised his concerns and even made a formal complaint about this prior to his death. In hearing evidence regarding failures to provide Ashley with basic healthcare, the jury concluded that neglect contributed to his death.

17. **HMP Liverpool and HMP Nottingham**: INQUEST would like to draw the Committee’s attention to a series of critical reports and warnings from coroners, inspection and monitoring bodies about specific failings in care at both HMP Liverpool and HMP & YOI Nottingham. Our analysis of recent Inspection reports reveals that in the two prisons combined, a total of 137 general recommendations were made by the Chief Inspector and only 34 had been achieved. Of 28 safety specific recommendations, only 5 were achieved and 5 partially achieved. In January 2018, the Inspector published a damning report on conditions in HMP Liverpool and issued an ‘Urgent Notification’ to the Secretary of State demanding that he intervene on the ‘fundamentally unsafe’ HMP Nottingham. In January 2018, INQUEST submitted a briefing to the Justice Committee about deaths in HMP Liverpool and HMP Nottingham. This is included as Appendix A to this submission.

18. **Care UK**: Shortcomings in healthcare is something common to both private providers and NHS trusts. However, in our casework and monitoring, INQUEST has noted a number of deaths involving private providers and in particular, that of Care UK. Care UK has been criticised over several recent deaths in prison. An inquest jury found that “neglect” contributed to the death of Dean Saunders at HMP Chelmsford after being taken into custody when he was in a severe mental health crisis (INQUEST, 2017). They said that Dean and his family were “let down by serious failings in both mental health care and the prison system” and that Care UK, “treated financial considerations as a significant reason to reduce the level of observations” of Dean, despite repeated warnings of his state of mind. An inquest into the death of Tedros Kahsay in HMP Pentonville in January 2016 criticised Care UK staff over their chaotic response when he was discovered in his cell, including their apparent inability to perform basic CPR. A report issued by the coroner after the death of Terence Adams, also in HMP Pentonville, in November 2015, identified “significant failures” by Care UK (ibid).
19. In 2016/17, the Prison and Probation Ombudsman (PPO) made 690 recommendations following investigations into deaths in custody. 22% were related to healthcare provision, 14% to emergency responses, 11% to suicide and self-harm prevention and 11% to escorts and restraints (PPO, 2017). The PPO notes that many ‘natural cause’ deaths are “largely explained by the increase in older prisoners” but emphasises that “too many” post death investigations highlight failures and delays in healthcare. These include “instances of healthcare staff failing to make urgent referrals to specialists when they had concerns that a prisoner might have cancer. Delays can prevent early diagnosis, early treatment and even result in unnecessary deaths. Similar problems arose when healthcare staff failed to review and treat abnormal blood test results” (ibid).

20. Key issues raised by the Ombudsman include:

- “sharing and management of medical records and as a consequence, prisoners did not receive appropriate treatment.”
- “...we continue to see too many seriously ill and dying prisoners with mobility issues being restrained with handcuffs and chains in hospital.”
- “we found cases where staff failed to use appropriate emergency codes, control room operators did not immediately call for an ambulance or healthcare staff responded with unsuitable or broken emergency equipment.”
- “....found instances of prison staff missing opportunities to check that a prisoner is alive and well – as they are required to do – during roll or welfare checks. These simple measures would increase the chances of prisoners receiving quick, emergency, and potentially life-saving, medical treatment.”

(PPO, 2017)

21. The Independent Advisory Panel on Deaths in Custody (IAP) (2017) conducted a review of safety in prisons, collating responses from more than 100 letters and 50 telephone calls from prisoners. The results are deeply disturbing with prisoners reporting bullying and being treated with contempt by staff. They describe ‘flippant’ attitudes of prison officers towards suicide with staff apparently ‘laughing’ and ‘goading’ prisoners to commit suicide. Prisoners spoke of a lack of support, empathy and highlighted unmet health, drug and alcohol treatment needs.

22. In responding to this Inquiry, INQUEST conducted a rapid review of casework files and associated documents to identify deaths where healthcare (physical and/or mental) had been of particular concern. Drawing on Record of Inquests, coroners’ Prevention of Future Death (PFD) reports, jury narrative conclusions and reports from the Prison and Probation Ombudsman, files were identified relating to the deaths of 33 people in prison between January 2014 and February 2018. This included an urgent Prevention of Future Death report about healthcare provision relating to a death at HMP Liverpool in February 2018. Of these deaths, 31 inquests had taken place, and two were ongoing. 29 were men, 4 women (one transwoman in a male prison); 15 deaths were non self-inflicted and 18 were self-inflicted; 6 deaths were of BAME people, and 27 were white.
23. The findings of this evidence-based review identified the impact of poor prison healthcare on both physical and mental health, in many cases resulting in findings of ‘neglect’. The documents point to systemic failings around communication, emergency responses, drugs and wider issues of mental ill-health and healthcare provision.

A summary of key issues are listed below:

24. **Healthcare:** Standard of care is inadequate and not in line with provision in the community. Inadequate staffing levels and reliance on bank or agency staff who may lack relevant training. Failure to provide basic medical care. Lack of provision for those with complex physical and/or mental health needs. Insufficient health screenings and incomplete care plans. Failure to assess, monitor and review existing health conditions, such as asthma. Cancelled and delayed appointments and systems for prioritising appointments being left to custody staff rather than clinicians.

25. **Communication:** Failures in communication between healthcare, mental health and prison staff. Inadequate recording of important medical and mental health related information. A failure to share information between: the police and the courts, different prisons when prisoners are transferred and different agencies inside and outside of the criminal justice system.

26. **Emergency responses:** Poor and inadequate training of staff in first aid skills to identify medical emergencies and attempted resuscitation. Faulty cell bells or failure to respond. Delays in calling for emergency services.

27. **Drugs:** Failures to review prescriptions and delays in accessing medication (both for physical and mental health needs). Failures of staff to understand risks of substance misuse, toxicity and withdrawal and to identify emergencies.

28. **Mental health:** Inconsistent and insufficient mental health care and assessments. Failure to share information about risk of suicide and self-harm. Inadequate understanding and application of suicide and self-harm monitoring forms and procedures used in prisons (known as ‘ACCT’).

29. These findings are supported by research on deaths in women’s prisons published in May 2018 (INQUEST, 2018). An analysis of 33 reports relating to the deaths of 25 women between 2007 and 2018, found systemic failures around self-harm and suicide management and inadequate healthcare. Other contributory factors included a lack of staff training, poor communication and poor record keeping.

**INVESTIGATIONS & ACCOUNTABILITY**

30. Findings from post-death investigations, coroners and other formal inquiries have consistently demonstrated that many deaths in prison are preventable. INQUEST has concerns about the oversight, regulation and accountability of prisons and healthcare services, both private and NHS.
31. INQUEST has published numerous reports on the failure of state agencies to learn and implement lessons from deaths in prison. Our 2012 report, ‘Learning from Death in Custody Inquests: A New Framework for Action and Accountability’ details how opportunities for learning are lost due to: the inconsistent approach by coroners to the use of their powers to report matters of concern to the relevant authorities; the lack of analysis, publication and dissemination of the reports or narrative verdicts across custodial sectors; and the lack of transparency and accountability of the agencies about action taken to rectify identified and dangerous systemic problems.

32. The Prison and Probation Ombudsman is tasked with investigating all deaths in prisons. In his latest Annual Review, Nigel Newcomen describes an “incessant growth in demand” for the Ombudsman’s services whilst experiencing budget cuts of 4.6% (PPO, 2017). INQUEST is concerned that the reduction in resources may lead to ‘natural cause’ deaths not receiving the full attention they may deserve.

33. Another concern is the PPO’s heavy reliance on clinical reviews to assess the level of care provided to the deceased and whether there were any shortcomings. The quality of reviews vary greatly, as does the level of expertise of the clinical reviewers. INQUEST has ongoing concerns about the independence and expertise of clinical reviewers who are appointed by NHS England. In our experience some appointed clinical reviewers may not always hold the appropriate, specialist or clinical expertise required.

34. Clinical reviewers will categorise deaths as ‘foreseeable’ or ‘unforeseeable’ and may influence the coroner in their decision around Article 2 and the scope of an inquest. This can also affect whether families are eligible for legal aid funding for representation at the inquest. Without full family involvement in the inquest process, the danger is that many apparent ‘natural cause’ deaths may not receive the appropriate level of scrutiny.

35. A robust, wide-ranging inquest at which families are legally represented is an opportunity to ensure proper scrutiny and uncover unsafe systems or practices and action needed to prevent future deaths. When families have access to the right legal support and advice, they are empowered to take part fully in the process to expose unsafe practices. Properly conducted inquests can help to prevent future deaths by exposing unsafe system or practices as well as making recommendations for change. Records of Inquests (ROIs), coroners’ reports to ‘Prevent Future Death’ (PFD) and narrative jury findings can provide an overview of systemic failures. PFDs are sent to relevant authorities (for example, prisons, private service providers and government ministers), and comment on action that should be taken to ‘eliminate or reduce the risk of death’.

36. The lack of a national oversight mechanism tasked with the statutory duty to collate, analyse and monitor the implementation of official recommendations relating to custodial deaths and prison safety means that opportunities to save lives are missed. This indicates an abject failure in current arrangements for the oversight and regulation of prisons and prison healthcare services to safeguard prisoners and improve their health.
CONCLUSION

37. Informed by almost forty years of working with bereaved families, INQUEST has long running concerns about the high rates of distress, self-harm and deaths in prison. This submission has drawn attention to systemic failures in healthcare provision that are directly linked to both self-inflicted and non self-inflicted deaths.

38. Evidence from INQUEST’s casework, supporting families whose relatives have died in custody, indicates that prisons are unhealthy and unsafe environments. While all deaths require better investigation, of particular concern is the lack of official attention paid to what the MoJ describe as ‘natural cause’ deaths. INQUEST’s evidence indicates that many deaths are premature, avoidable and far from ‘natural’.

39. At present, standards of healthcare in prison do not conform to the same standards of delivery and accountability as provision in the community. Poor-quality healthcare can have a devastating impact on prisoners and their families. A patient in prison has very little autonomy, control and access to medication and appointments. Prisoners are totally dependent on others for their treatment and care which puts them in a uniquely vulnerable position in comparison to other citizens.

40. Much needed and urgent improvements to prison healthcare can help to prevent deaths in custody. However, the prison environment is inherently unhealthy with limited access to fresh air and exercise, poor nutrition and unsanitary impoverished regime conditions. Prisons, at their core, are environments of toxic, high health-risk and therefore, greater attention should also be paid to the need for public health approaches to tackling ill-health in the community.

41. People entering prison experience “a higher burden of communicable and non-communicable disease, mental health and substance misuse problems than the general population” (Sturup-Toft et al, 2018). The state’s responsibility for the damaging and sometimes fatal consequences of imprisonment often starts well beyond the prison walls with failures in social, health and educational services, sentencing policies and a lack of investment in alternatives. Ill-health and deaths in prison are a public health and social justice challenge in need of urgent attention.

RECOMMENDATIONS:

42. Prison staff, including healthcare staff, require improved training to meet minimum standards to ensure the health, well-being and safety of prisoners. Enhanced training is also required to disrupt the apparent view among many prison staff that prisoners who self-harm, or who are affected by physical or mental ill-health, are manipulative attention seekers who are a disciplinary problem. There should also be improved engagement with families who may be able to provide life-saving information about physical and mental ill-health.

43. Improve standards of post-death investigations so that failures are identified and changes can be made. In particular, to ensure that so called ‘natural cause’ deaths are investigated by independent specialists.
44. **Ensure access to justice and learning for bereaved families** through the provision of non-means tested legal aid to bereaved families as recommended by two Chief Coroners and in two recent reviews by Dame Elish Angiolini QC and Bishop James Jones. There should be parity of funding at inquests between public bodies and bereaved families. This would ensure proper public scrutiny, equality of arms with state funded or corporate lawyers and would help maximise the preventative potential of coroner’s inquests so that self-harm and deaths in custody can be drastically reduced and families can be spared the trauma that many are experiencing under the current system.

45. **Create a national oversight mechanism to monitor deaths in custody and the implementation of official recommendations arising for post death investigations.** Such a body would be tasked with closely monitoring all deaths and providing detailed information on causes of death, broken down by age, ethnicity and gender. Parliamentary oversight (possibly through a select committee) should annually review and monitor prison inquest findings and coroners’ Prevention of Future Death reports to track issues and trends. The Ministry of Justice and NHS England should provide a response to the review to ensure a high-level of political focus and accountability. NHS England should also have to report yearly on issues arising from healthcare related deaths in prison. This would ensure greater transparency in terms of tracking whether action has been taken to rectify dangerous practices and systemic failings.

46. **Ensure accountability for institutional failings that lead to deaths in prison.** For example, full consideration should be given to prosecutions under the Corporate Manslaughter and Corporate Homicide Act, where ongoing failures are identified and the prison service has been forewarned (as with Liverpool and Nottingham prisons).

47. **Halt prison building, commit to an immediate reduction in the prison population and divert people away from the criminal justice system.** Criminal justice resources should be reallocated away from prisons to well-funded, well-staffed community alternatives, involving drug, alcohol and mental health services, supported by NGOs and involving the families of those accessing these services. Welfare, health and social care in the community is both a humane and sustainable response to dealing with social problems, which cannot be meaningfully addressed through the criminal justice system, as illustrated by the revolving door nature of the prison population. Instead of imprisonment, treatment and support should be the preferred option.

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REFERENCES:


INQUEST briefing note to the Justice Committee

HMP Liverpool & HMP Nottingham

23 January 2018

About INQUEST

INQUEST is the only charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. INQUEST’s specialist casework focuses on deaths in prison and other forms of detention, mental health settings, and deaths where wider issues of state and corporate accountability are in question, such as Grenfell Tower. Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people.

INQUEST’s Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody, and was until recently a member of the Independent Advisory Panel on Deaths in Custody. She was an advisor to the Harris Review into self-inflicted deaths in custody of 18-24 year olds published in 2013, and advisor to the Corston Review on women in prison published in 2007. Over almost 40 years of work on deaths in custody, INQUEST has published numerous reports, books and given evidence to many parliamentary committees.

We hope this briefing note may be of use in your important discussion of HMP Liverpool and the current crisis in prisons.

HMP Liverpool

The recent report on Liverpool prison is one of the most shocking indictments of a prison by inspectors in years. However, the inspection is only a small part of the range of damning evidence on the prison’s conditions. Institutional neglect, violence, bullying, and inhumane conditions at HMP Liverpool have been highlighted time and time again at recent inquests. The prison has had the second highest number of self-inflicted deaths of any prison in England and Wales. INQUEST has worked with many families bereaved by a death in HMP Liverpool.

As with Nottingham prison, where the Inspectorate found serious safety failures repeated from earlier inspections, previous recommendations for improving the Liverpool regime have been effectively ignored. As have the findings of inquest’s, detailed below.

We also note that despite the deaths and failures at HMP Liverpool, NHS England are cutting the healthcare budget at the prison (as reported by the BBC). Since 2011 there have been at least 17 self-inflicted deaths in the prison, many raising concerns about the level of healthcare provided. That NHS England are cutting the budget just shows the lack of priority afforded to prison healthcare. It is clear they are ignoring the warnings and increasing the risk of further deaths. Prison and health ministers must act on these risks to prisoner health and safety.

Recent deaths and inquest conclusions: neglect, bullying and failures

Recent inquest conclusions have shown evidence of systemic neglect and repeated serious failings by prison staff and managers, including failing to implement suicide and self-harm monitoring policies (known as ACCT). Inquests have also found that violence and bullying have contributed to self-inflicted deaths.
HMP Liverpool has had the second highest number of self-inflicted deaths of any prison in England and Wales in the last ten years. HMP Woodhill has had the highest number. In 2017 there were four deaths in HMP Liverpool, three self-inflicted and one awaiting classification. In the five years from January 2012 to December 2017, 31 people died in HMP Liverpool. Of these, 14 deaths were self-inflicted and two await classification.

We invite the committee to consider the outcomes of recent inquests as part of their evidence, detailed further in the following media releases.

- Carl Newman, 23, died of a self-inflicted death on 11 November 2017, just a month after the inspectors left. We await the inquest into his death.
- John Duffey died in July 2016. The inquest concluded that bullying, debt and drug abuse in HMP Liverpool exacerbated the conditions that led to the death of John Neil Duffey, (Media release, November 2017)
- Sam Molyneaux died in April 2016. The inquest concluded bullying contributed to his death, (Media release, September 2017)
- Edwin ‘Ned’ O’Donnell died in October 2016. The inquest jury found neglect contributed to his death, (Media release, July 2017)
- Ashley Gill died in April 2015. An inquest jury found that neglect contributed to his death, (Media release, September 2016)
- Lee Rushton died in January 2015. An inquest jury found neglect contributed to his death in a damning narrative conclusion, (Media release, May 2016)

HMP Nottingham

We also note our strong concern about the situation in HMP Nottingham, as highlighted by the inspectorate. Ten prisoners have died in two years, compared with four deaths in the previous 10 years.

The majority of recent deaths were of men in the first night centre or on induction. Both HM Inspectorate of Prisons and the Independent Monitoring Board had previously raised concerns about the influx of vulnerable prisoners arriving at HMP Nottingham each day, and reception staffing and procedures. Yet the situation was allowed to continue and five newly arrived prisoners died over a four-week period in Autumn 2017.

Why was this not stopped in its tracks when problems were so clear and well documented? That the inspectorate are still finding lamentable dangers and failings in care is reprehensible. This points to INQUEST’s ongoing concern about failures in the mechanisms of accountability. This is a broken prison within a broken system.

More information on this can be found in our recent press release, and this article, which INQUEST assisted with following the deaths in October.