INQUEST

INQUEST submission to the United Nations Special Rapporteur on Torture for their thematic report on current issues and good practices in prison management

November 2023

Introduction

1. INQUEST is the only charity in the UK providing expertise on state-related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question.

2. In order to provide an overview of the current issues in the management of prisons in England and Wales, we analyse key concerns arising from coroners' Prevention of Future Death (PFD) reports.[1] This submission also outlines broader issues identified by INQUEST through our work with bereaved families over recent years. Throughout this submission, we reference important, life-saving recommendations made by investigators and coroners to improve aspects of prison management and highlight the need to establish a better system for following up on such recommendations.

3. INQUEST's work on deaths in prison and their investigation has highlighted many other issues, not all of which will be detailed in this submission. We urge the Special Rapporteur to read INQUEST's previous reports and submissions on deaths in prison, particularly recent submissions to the UK Parliament's Justice Select Committee on mental health in prison,[2] women in prison,[3] remand prisoners[4] and Imprisonment for Public Protection Sentences,[5] our 2018 report '*Still Dying on the Inside*' on the deaths of women in prison;[6] and our 2020 report '*Deaths in prison: a national scandal*' on deaths in prison.[7]

Analysis of Prevention of Future Death reports

4. INQUEST has been monitoring deaths in prison since 2013. Our statistics show that since 2013, 3,214 people have died in prison. 29 per cent of those people died a self-

[1] PFD reports are reports written by a coroner following an inquest where the coroner has heard evidence that further avoidable deaths could happen if preventative action is not taken. The duty of coroners to issue a PFD report is outlined in the Coroners and Justice Act 2009.
[2] INQUEST submission (2021) to the Justice Select Committee Inquiry into mental health in prison https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=74dc9177-91fd-4f17-b0c0-6a3d871d1a83
[3] INQUEST submission (2021) to the Justice Select Committee Inquiry into women in prison https://committees.parliament.uk/writtenevidence/36829/pdf/
[4] INQUEST submission (2022) to the Justice Select Committee Inquiry into the role of adult custodial remand in the criminal justice system https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=fb9a23a6-e591-4887-bb1d-4bd6e6973e49
[5] INQUEST submission (2021) to the Justice Select Committee into IPP sentences https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=abc48042-55fb-494c-8ba6-cb047e44bcca
[6] INQUEST report (2018) 'Still Dying on the Inside' https://www.inquest.org.uk/still-dying-on-the-inside-report
[7] https://www.inquest.org.uk/deaths-in-prison-a-national-scandal

inflicted death.[8] 2021 saw the highest number of deaths in prison ever recorded, with 371 deaths according to Ministry of Justice figures.[9] The latest Safety in Custody statistics show that in the 12 months to September 2023, there were 304 deaths in prison. 92 of these deaths were self-inflicted, a 24% increase from the 74 self-inflicted deaths in the previous 12 months.[10]

5. Investigations into deaths in prison can, in some cases, lead to PFD reports being issued. INQUEST analysed all 39 PFD reports issued relating to deaths in prison in England and Wales in the past two years, between 31 October 2021 – 31 October 2023. INQUEST identified key cross-cutting areas of concern. We list these below in order of how much each concern was mentioned, from most to least. Many of the concerns following a death in prison reflect issues with prison management and specific areas of concern of the review, such as mental health provision and physical health.

Emergency medical response

6. Eight PFD reports highlighted failures concerning emergency medical responses in prison. Concerning CPR, some PFD's stressed the poor training of nurses, the lack of mouth protection to conduct CPR to prevent disease spreading, and a lack of guidance in the absence of qualified medical professionals. The low-level understanding of first aid across prison staff was also raised, as was misunderstanding across discipline staff concerning what constitutes a code blue/red situations (the former for breathing issues and the latter for blood and burns issues). PFD reports also highlighted poor communication between the prison and the ambulance service.

Healthcare

7. Six PFD reports noted failures in prison healthcare. Matters of concern included that healthcare was being undertaken by different healthcare providers; a lack of guidance in caring for vulnerable prisoners; no clear process for the disclosure of medical information; the lack of a safe healthcare system and a joint up system of care with the prison; poor disability awareness; and the absence of healthcare staff during the night.

8. Two PFD reports underscored issues relating to the management of medication.

Mental health

9. Failings relating to mental healthcare were mentioned in six PFD reports. Specifically, reports noted the lack of appropriate/any action despite staff being aware of a prisoner's risk of self-harm or suicide, or their history of mental health issues. PFDs also noted the poor or non-availability of consultant psychiatrists.

---

[8] INQUEST statistics (2023) Deaths in Prison statistics https://www.inquest.org.uk/deaths-in-prison

[9] INQUEST (2022) INQUEST responds to new data shows 2021 had highest number of deaths in prison ever recorded https://www.inquest.org.uk/moj-data-jan2022#:~:text=In%20the%2012%20months%20to,than%20one%20death%20a%20day.

[10] Ministry of Justice (2023) Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to September 2023 Assaults and Self-harm to June 2023 https://assets.publishing.service.gov.uk/media/653a30da80884d000df71b42/safety-in-custody-q2-2023.pdf

Another issue cited was poor communication about mental health appointments and delays in mental health assessments.

10. Five PFD reports noted issues relating to the ACCT system, the care-planning process for prisoners with a self-harm/suicide risk. Specifically, PFD's noted inconsistencies in conducting and recording observations on prisoners on an ACCT, inadequate and incomplete ACCT training for prison staff, and general failures in the use of the ACCT system.

Staffing levels

11. Four PFD reports noted low staffing levels as an issue, with one highlighting retention of experienced staff as a particular issue.

Record keeping

12. Poor and incomplete record keeping by prison staff and contracted private companies was noted in four PFDs, especially in relation to the Prison National Offender Management Information System, the main information system for offender management.

Welfare checks

13. Two PFD reports noted the inadequacy of welfare and roll checks, whilst a third highlighted that concerns from family and friends were not followed up.

Communication about being held on immigration detention

14. Two PFD reports noted poor communication with people who were to be detained under immigration powers following the completion of a custodial sentence, with one report highlighting the specific issue of information being provided in 'legal English' as opposed to 'plain English'.

Availability of drugs

15. Two PFD reports underscored the wide availability of drugs.

Post-death investigations

16. Two PFD reports noted issues that affected post-death investigations, namely that witnesses were not contacted in a timely manner and the prison failed to retain and preserve evidence.

Broader issues highlighted by deaths in prison

17. Over the past five years, INQUEST has written numerous reports and submissions of evidence which analyse the impact of failings in prison management, particularly on specific groups such as women, children and racialised groups which we note are areas of focus for the Special Rapporteur.

Mental health in prison

18. INQUEST's casework highlights repeat failures in the provision of mental health care. These include inadequate mental health assessments, with prisoners wrongly assessed as not needing further assessment; failures in the use of the ACCT system for prisoners with a risk of self-harm or suicide; a culture of neglect and disbelief in

responding to prisoners' requests for mental health support; the inappropriate use of segregation for prisoners with mental health issues; and critical delays in providing necessary medication for mental ill health.[11]

19. Tommy Nicol, who was on an IPP sentence (see paragraph 32 for more on IPP prisoners) and died in 2015, received no mental health assessment despite exhibiting psychotic symptoms before being placed in segregation. In addition, Tommy did not receive any mental health support during four days spent in segregation.[12] The PFD issued following the inquest into Tommy's death highlighted the length of time it took to transfer prisoners in acute mental health crisis to a suitable secure hospital as a matter of concern.

20. David Sparrow, 36, who died in 2019, was subject to a poor mental health assessment in prison which meant available information about his history of mental health issues was not acted on. Additionally, he did not receive his anti-psychotic medication.[13]

21. INQUEST has previously recommended that HMPPS should ensure that all prison staff receive in-depth training on how to properly identify and treat prisoners in need of mental health support and end the use of segregation for prisoners with mental ill health.[14]

Physical health

22. INQUEST's casework repeatedly exposes wide-ranging failures to provide basic medical care. Inquests regularly reveal that the standard of care is inadequate and not in line with standard provision in the community. There is often a lack of provision for people with complex physical health needs along with insufficient health screenings and incomplete care plans. Inquests regularly reveal failures to assess, monitor and review existing health conditions (for example, asthma and diabetes). Emergency responses are often inadequate and delayed.

23. Liridon Saliuka, 29, who died in 2019 at HMP Belmarsh, was a disabled man whose disabilities were dismissed by the prison and was moved out of his disabled access cell to a standard cell. The jury found that these failures, amongst others, negatively impacted on Liridon's mental health and thus constituted a contributing factor to his suicide.[15]

24. Nile Dillon, 22, who died in 2018 at HMP Stocken, had severe asthma and called for help when struggling to breathe. However, prison staff took eight minutes to enter

[11] INQUEST submission (2021) to the Justice Select Committee Inquiry into mental health in prison https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=74dc9177-91fd-4f17-b0c0-6a3d871d1a83
[12] INQUEST (2018) Inquest concludes into death of Tommy Nicol who 'lost hope' on IPP sentence https://www.inquest.org.uk/tommy-nicol-conclusion
[13] INQUEST (2020) Jury identifies multiple failings contributed to death of David Sparrow at HMP Norwich https://www.inquest.org.uk/david-sparrow-close
[14] INQUEST (2021) submission to the Justice Select Committee inquiry into mental health in prison https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=74dc9177-91fd-4f17-b0c0-6a3d871d1a83
[15] INQUEST (2022) Liridon Saliuka: Jury finds significant and multiple failings at HMP Belmarsh contributed to death https://www.inquest.org.uk/liridon-saliuka-inquest

and there was delay in alerting others and calling an ambulance. The jury found that staff missed the opportunity to call 'code blue' - which immediately calls an ambulance - as soon as it was observed that Nile was struggling to breathe.[16]

25. Furthermore, it is important to note that so-called 'natural deaths' as defined by the Ministry of Justice, are the leading cause of mortality in prison and are commonly attributed to the ageing prison population. However, INQUEST's casework has shown that many of these deaths are anything but 'natural' and often reflect serious lapses in healthcare.

26. INQUEST recommended in our 2020 report '*Deaths in prison: a national scandal*' that prison staff and healthcare staff require improved training to meet minimum human rights standards to ensure the health, well-being and safety of prisoners.[17]

Women in prison

27. INQUEST's casework on the deaths of women in person highlights poor physical and mental healthcare provision; failures in communication between healthcare, mental health staff and prison staff; poor responses to medical emergencies; poor communication; and poor drug management processes. The recent death of baby Aisha Cleary, whose mother gave birth in her prison cell alone despite requesting medical assistance, raised a fundamental question about why a vulnerable pregnant teenager was sent to prison in the first place.[18] INQUEST has repeatedly highlighted the need to redirect women away from the criminal justice system and towards treatment and support.[19]

Racialised people in prison

28. Our report, *Deaths of racialised people in prison 2015 – 2022*, concluded that the deaths of racialised people in prison are among some of the most contentious, violent and neglectful of all deaths in prison. The report identified key issues in the deaths of racialised people, including the inappropriate use of segregation, racial stereotyping, the hostile environment, the failure to respond to warning signs, the neglect of mental and physical health, and concerns about bullying and victimisation not being acted on.

29. Trevor Monerville, a 33 year old Black man, died in 2021 at HMP Lewes following an epileptic seizure. The jury concluded that staff displayed a lack of empathy and an unacceptable management of Trevor's care.[20]

---

[16] INQUEST (2021) Nile Dillon: Death of young asthmatic man at HMP Stocken examined at inquest https://www.inquest.org.uk/nile-dillon-opens
[17] INQUEST report (2020) 'Deaths in prison: A national scandal' https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=bb400a0b-3f79-44be-81b2-281def0b924b
[18] INQUEST (2023) Aisha Cleary: Inquest finds serious failings contributed to death of baby in Bronzefield prison cell
[19] INQUEST (2018) 'Still Dying on the Inside' https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=8d39dc1d-02f7-48eb-b9ac-2c063d01656a
[20] INQUEST (2023) Trevor Monerville: Inquest critical of 'unacceptable' care of epileptic man at Lewes prison https://www.inquest.org.uk/trevor-monerville-inquest

30. Annabella Landsberg, a 45 year old mixed-race Black woman, who died in 2017 at HMP Peterborough prison, was restrained by prison staff and left lying on the floor for 21 hours. Despite healthcare staff noticing this, they did not aid her, with a nurse instead throwing a cup of water over her believing her to still be faking illness.[21]

31. Our report found that self-inflicted deaths as a percentage of total deaths were highest amongst people of Eastern European nationally, Mixed Other people and White Gypsy or Irish Traveller people, respectively. In order to increase the transparency on deaths of racialised prisons, INQUEST have recommended the Ministry of Justice make public data on all types of deaths in prison and the ethnicity of those who die, as currently it is only possible to view self-inflicted deaths in prison by broad ethnicity categories.

IPP prisoners

32. Prisoners on indeterminate sentences, known as an IPP sentence, must serve a minimum 'tariff' before becoming eligible for parole. In 2021, 96% of IPP prisoners were post-tariff,[22] with the majority of unreleased IPP prisoners held for more than eight years beyond the end of their tariff.[23]

33. INQUEST has repeatedly documented the link between the IPP sentence, hopelessness, self-harm and suicide. Between 2008 and 2022, INQUEST has assisted 30 people on IPP who died in prison, with 25 of those people taking their own life.[24]

34. In September 2022, the Justice Select Committee published a report following their inquiry into IPP sentences and recommended reviewing IPP sentences, abolishing the sentence retroactively and resentencing all IPP prisoners.[25] In February 2023, the government responded and rejected these recommendations.[26]

Remand

35. As INQUEST highlighted in our submission to the Justice Select Committee, our primary concern with remand is the risk of self-inflicted death it presents to vulnerable prisoners with complex needs. Remand prisoners can be at a higher risk of self-harm or self-inflicted death because they may be entering prison for the first

---

[21] INQUEST (2019) Inquest finds serious failures at Sodexo run HMP Peterborough contributed to death of Annabella Landsberg https://www.inquest.org.uk/annabella-landsberg-conclusion

[22] Ministry of Justice (2020) Offender Management Statistics Bulletin, England and Wales https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882163/Offender_Management_Statistics_Quarterly_Q4_2019.pdf

[23] Ministry of Justice (2021) Offender management statistics quarterly: April to June 2021 https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-april-to-june-2021/offender-management-statistics-quarterly-april-to-june-2021

[24] INQUEST (2023) Powerful exhibition by families of IPP prisoners challenges continued injustice https://www.inquest.org.uk/powerful-exhibition-by-families-of-ipp-prisoners-challenges-continued-injustice#:~:text=INQUEST%20has%20repeatedly%20documented%20the,died%20took%20their%20own%20life

[25] Justice Select Committee report (2022) on IPP sentences https://committees.parliament.uk/publications/28825/documents/173974/default/

[26] House of Commons (2023) 'IPP sentences: Government and Parole Board Responses to the Committee's Third Report https://publications.parliament.uk/pa/cm5803/cmselect/cmjust/933/report.html

time and may experience complications or separations in family relationships as well as a loss of employment and accommodation. According to INQUEST's casework and monitoring of official statistics, over the five-year period from 20 April 2017 – 30 April 2022, 55% of adult remand deaths were self-inflicted, compared to 20% of non-remand deaths. INQUEST's casework also highlighted the inappropriate use of remand, especially for those with mental ill health, the overuse of remand, and racial disproportionality in the use of remand.[27]

The need for a National Oversight Mechanism

36. Every year we see countless preventable deaths occurring because of systemic failures to enact meaningful change. As evidenced in this submission, many deaths in prison reveal similar issues which contribute to an individual's death. Post-death processes should be a forum in which systemic failings can be identified, and from which essential changes can follow. However, INQUEST's work has highlighted how the possibility for prevention is undermined by the lack of a framework to monitor compliance with, and/or actions taken in response to, the findings and recommendations that emerge from post-death investigations.

37. This is why we are calling on the Government to establish a National Oversight Mechanism, which would be an independent public body responsible for collating, analysing and following-up on recommendations arising from four post-death processes: investigations; inquests; public inquiries, and official reviews. We believe a National Oversight Mechanism would provide better learning, prevention, transparency and accountability for bereaved families following a state-related death[28].

[27] INQUEST submission (2022) on remand https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=fb9a23a6-e591-4887-bb1d-4bd6e6973e49

[28] For more information see INQUEST's briefing on the case for a National Oversight Mechanism, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=b480f898-7fbd-4c9c-a948-50dd3fad3a04, June 2023