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Non-natural deaths following prison and police custody

Data and practice issues

Jake Phillips, Loraine Gelsthorpe, Nicola Padfield and Sarah Buckingham

Sheffield Hallam University
University of Cambridge

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Post: Research Team
Equality and Human Rights Commission
Arndale House
The Arndale Centre
Manchester M4 3AQ

Email: research@equalityhumanrights.com
Telephone: 0161 829 8100
Website: www.equalityhumanrights.com

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Executive summary

The deaths of people in the immediate aftermath of state detention have received considerably less attention than the deaths of those who die in custody. This research was commissioned by the Equality and Human Rights Commission (EHRC) in October 2015 with the aim of contributing to the understanding of the size and extent of the problem.

In order to do this, we reviewed the existing literature and investigated relevant legal and policy frameworks. We then analysed a number of data sources:

- National Offender Management Service (NOMS) data collected under PI 01/2014. This Probation Instruction requires probation providers to report on deaths that occur amongst people under probation supervision. Chapter Four explains the difficulty of analysis, but of the 3,196 deaths of people under supervision over a five-year period, we can only be confident that 66 died within 28 days of release from prison. It would appear that the period of greatest risk is the seven or eight days following release, and that drug-related deaths of those convicted of acquisitive offences occur most frequently.
- The Prison and Probation Ombudsman (PPO) provided data on 13 cases of deaths of those who had been released to Approved Premises within the previous 28 days (all men). These reports revealed the problems associated with the management of offenders abusing both prescribed and illegal drugs; the challenges experienced by staff; failures in communication; and the difficulty of ensuring a smooth transition from custody to Approved Premises.
- Independent Police Complaints Commission (IPCC) data revealed 289 referrals by police to the IPCC of apparent suicide within two days of police contact (again, over a five-year period). Of those, 11 were investigated by the IPCC. The remaining referrals may have not required investigation, may have been investigated by the police or other independent body or investigations were ongoing. We were also given summaries of 30 other referrals, six from each year which were chosen at random. Of the 41 reports, 38 concerned men and 3 women. Mirroring one of the key observations in the IPCC's

Annual Report (2016b), an arrest for a sex offence featured prominently, and we consider the impact of shame.

We were also able to carry out a few interviews/focus groups with a small selection of key stakeholders: four members of staff in two prisons, a coroner, a psychiatrist and some police officers (two focus groups, one interview). A key finding, however, was the difficulty we had in identifying those who were prepared to discuss the subject: there seemed to be a reluctance to come forward.

Conclusions

While some critical observations are embedded within the body of the main report, we group our main conclusions under four headings: The Size of the Problem, Policy and Practice, The Human Rights Framework, and Culture, Communication and the Need for an Ethic of Care. We discuss in turn:

- limitations of current recording practices
- key observations from the data
- the need for greater awareness and better training for frontline staff in police services and prisons
- the need to recognise the trauma of arrest and detention for individuals suspected of or charged with sex offences in particular (but also all offences) which raises broader issues of anonymity for suspects until or unless they are convicted
- obligations under the Human Rights Framework in terms of appropriate risk assessment and communication between agencies, and
- the need for the operational policies and practices of organisations to express competence, confidence and ‘care’ for offenders through consistent and continuous monitoring as well as forward thinking to anticipate vulnerability and preparation for support.

Recommendations

We recommend that:

- The Home Office should give further consideration as to whether responsibility for health and mental care in police stations should be allocated

to the NHS. As a minimum requirement, custody health care staff should have prompt access to NHS records in order to provide the best care and support.

- An inter-agency summit should be convened to explore how these 'hidden' deaths can be better exposed, and how the data can be made more reliable and comprehensible. Following the obligations set out in the Equality Act 2010, in future data collection and analysis should include reference to protected characteristics such as gender (where this does not compromise anonymity for those concerned), in order to monitor progress and identify any problems.
- More training be provided to support police custody staff in the identification and treatment of suspects who may be traumatised by the fact of arrest and investigation, and of others with mental health issues. Notwithstanding the progress made by the Mental Health Crisis Care Concordat around improving liaison between the police and mental health services, there is a need for police custody staff to understand the responsibilities of different agencies who work with people with mental health issues. The College of Policing is currently in the process of rolling out training and we would encourage prioritisation of this by individual police forces.
- More training be provided for all probation and Community Rehabilitation Company (CRC) staff (including those who work in Approved Premises) particularly in relation to inter-agency co-operation when working with those at risk of abusing illegal and prescription drugs.
- Criminal justice agencies review how far relevant policy documentation is immediately accessible and comprehensible for staff. This includes providing a 'checklist' of actions for dealing with people at crucially vulnerable moments in their lives.
- There should be an obligation on the appropriate authorities to carry out effective risk assessments before release from prison and police custody and to disseminate information to all relevant agencies to provide appropriate safeguards and support. These obligations should be monitored within a framework of accountability.
- All apparent suicides within two days of release from police custody should be referred by the police to the IPCC, to assess whether or not to carry out an Article 2 compliant investigation.

All non-natural deaths within two weeks of release from prison should be referred to the Prison and Probation Ombudsman to assess whether or not to carry out an Article 2 compliant investigation.

1 | Introduction

The deaths of people who are under the control of the state, or in situations where the state might be responsible or even culpable, have come under increasing scrutiny in recent years. There have been several reviews and inquiries. For example, in July 2015 the Home Office commissioned an independent review of deaths in police custody (chaired by Dame Elish Angiolini). In terms of recent research, in early 2015 the Equality and Human Rights Commission published a review on *Preventing Deaths in Detention of Adults with Mental Health Conditions* (EHRC, 2015). The *Report on the Independent Review into Death in Custody of 18-24 year olds* (the Harris Review), also reported in 2015, while in 2012 Gelsthorpe et al. conducted research on behalf of the Howard League for Penal Reform on deaths that occurred under probation supervision. This increasing concern, particularly about suicide while under state control or care, stems partly from an increase in the number of people who die when in police and prison custody (IPCC, 2015a; Ministry of Justice, 2016). However, the people who die *following* state detention have received considerably less attention than those who die in custody. This can be attributed to several factors: relevant organisations may not even know when someone has died following custody; even when they do, it is not always clear whether the death is related to the recent spell in custody; and there remains some ambiguity over whose responsibility it is to investigate such deaths. This is an important, but hitherto neglected subject.

This report analyses data and practice issues in relation to non-natural deaths in England and Wales following police and prison custody with a particular focus on human rights and improving policy and practice. The research underpinning this report therefore aimed to contribute to understanding:

- the size of the issue – the numbers/locations and any other available information relating to apparent suicides and non-natural deaths of individuals within two days of release from police custody or 28 days after release from prison, and

- the numbers of people from groups with protected characteristics, with particular attention to mental health, and steps taken to provide appropriate support to them.

The research was also designed to help identify:

- Key themes and trends, for example types of offences, length of prison sentence or licence conditions, geographical clusters.
- Issues relating to ongoing processes and responsibilities, including how risk assessments are done, what relevant manuals indicate and any indication of the stage and form of mental health risk assessment that is required. This also included examining which (if any) organisations are responsible for assessing if an individual is at risk of taking their own life; ensuring this information gets handed on to relevant agencies upon release from detention; and providing information about support services to the person being released from detention.
- Any possible solutions which would improve the available data, and reduce the numbers of deaths.

1.1 Methodology

The research involved a review of extant research, quantitative analysis of data collected by the Independent Police Complaints Commission (IPCC), the National Offender Management Service (NOMS) and the Prisons and Probation Ombudsman (PPO), and five interviews and three focus groups with 15 relevant 'stakeholders' such as frontline staff.

Our initial remit was non-natural deaths that occur within two days of someone being released from police custody and within 28 days of leaving prison custody. The two day period for police custody is in line with IPCC guidance; the IPCC collect data on apparent suicides within two days, but only for this period. The 28 day period was selected as an appropriate timescale for the research in discussion with the EHRC and reflected responses from stakeholders to its *Preventing Deaths in Detention* review. When we discuss deaths following police detention our focus is apparent suicide, while our discussion of deaths post prison custody is broader and includes all non-natural deaths. This is a product of the data that were available to us and which we describe below.

In Chapter 2, we review existing research on deaths after prison and police custody and other criminal justice deaths. In Chapters 3, 4 and 5, we outline the legal and policy framework in England and Wales surrounding the investigation of deaths following police and prison detention. We offer an analysis of three sets of data. The first was provided by the IPCC and comprises reports and summaries concerning cases of people who have died from an apparent suicide following police detention as requested on our behalf by the EHRC. The second was provided by the NOMS and concerns people who have died under supervision in the community, including those on licence to the National Probation Service and Community Rehabilitation Companies after custody. The third was provided by the PPO. In addition, we provide an analysis of data that were generated through focus groups and interviews with custody sergeants, prison staff and a few other 'stakeholders'. In our concluding Chapter 6, we draw attention to the limitations of the existing data, as well as to a number of pertinent good practice issues, and outline our recommendations.

2 | Review of previous research

2.1 Deaths after prison custody

We began our study by conducting a thorough literature search and review using the following databases: Medline, PsycIFNO, Google Scholar, and Google, which enabled us to cover a range of potentially relevant academic disciplines from public health to criminology. Our literature searching will only have uncovered published literature and so we do not draw on so-called 'grey' literature (that which has not been formally published). We used the following search terms: former, ex, post, prison, police, probation, custody, detention, state supervision, community sentence, homicide, suicide and non-natural deaths.

Much of the research that we have identified is focused on the experiences of people leaving prison rather than police custody or those who are under supervision following custody. Much of the research is quantitative in nature. It comprises systematic reviews and meta-analyses which have combined large datasets in order to calculate the mortality rates of people leaving prison along with analysis of the main correlates and causes (such as drug overdose or mental health disorders). Much of this literature is published in health journals, whilst articles in the criminological literature are primarily qualitative in nature.

We have identified little research which presents data generated with people who have attempted suicide (in an Australian context: Segrave and Carlton, 2011; Carlton and Segrave, 2013; in an English and Welsh context, Forrester and Slade, 2014; Hawton et al., 2014; Byng et al., 2015). Yet such research sheds considerable light on the factors which are important when it comes to identifying and preventing potential suicides. Moreover, no research has been conducted with family members of people who have died following prison custody. Families and partners are likely to have views which may be helpful in identifying the ways in which criminal justice institutions can prevent future deaths. This is similar to the way that the views of families are collected by the Prisons and Probation Ombudsman when people have died in custody.

There is considerable evidence to suggest that people who have recently left prison are at a much higher risk of death than the general population. In the USA, Binswanger et al. (2007) found that the mortality rate in a cohort of people who had left prison over a period of 1.9 years was 777 deaths per 100,000 which was 3.5 times higher than that of other residents in Washington State. This risk was highest in the first two weeks after release, with the risk of death, when compared to the general population, being 12.7 times higher. Whilst this research used American data, similar research in England and Wales by Farrell and Marsden (2008) showed that male prisoners are 29 times more likely to die in the first week after release when compared to the general population. The majority of these deaths are attributed to substance abuse, suicide or as a consequence of mental health issues.

Substance use disorder

Substance use disorder (now measured by differing levels of severity) is a key explanatory factor. The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), defines both alcohol and drugs as part of this umbrella categorization. Injecting drug users are at the highest risk of drug-related deaths after leaving custody and such deaths tend to occur as a result of overdose. In a meta-analysis of drug-related deaths, Merrall et al. (2010) found that the relative risk of dying post-custody in the UK was up to 8 times higher in the first two weeks after release when compared to non-drug using ex-prisoners. This risk reduced over subsequent weeks but, importantly, remained high for four weeks after release. In Sweden, Hakansson and Berglund (2013: 502) found that the 'single substance associated with death was heroin'. Such drug-related deaths after custody stem from individuals having lower tolerance levels, as well as from a possible tendency for celebration post-release. Added to this are risks around individuals not knowing the purity of the drug they are using which may be exacerbated by having spent time away from drugs in the community. It is difficult to discern, based on the various meta-analyses and other research, whether drug-related deaths are purposeful (suicide) or accidental overdoses.

Several strategies have been identified to reduce the number of drug-related deaths post-custody. For example, in the UK, Møller et al. (2010) highlight pre-release counselling, post-release follow-up and failure to identify those at risk. Gisev et al. (2015) found that opioid substitution therapy (OST) in Australia reduced the risk of mortality post-release, particularly in the first four weeks, although this reduction was small. Degenhardt et al. (2014) in New South Wales, and Huang et al. (2011) in Taiwan, highlight the importance of a seamless transition between OST in prison and

in the community. This is because those who were fully retained in treatment had a much lower crude mortality rate than those who were not retained in treatment upon release. This suggests that good communication between the prison and community treatment programmes is paramount in preventing such deaths. But OST is not a panacea for preventing these deaths. Huang et al. (2011) analysed the effectiveness of OST but the population in their study had also been provided with an educative and harm reduction programme which included needle-exchange, HIV testing, counselling and education about the risks of opiate injection upon release which increased the likelihood of people staying in treatment. The Patel Report (Department of Health, 2010), a UK government-sponsored report on reducing drug-related crime and rehabilitating offenders led by Professor Lord Patel, chair of the independent Prison Drug Treatment Strategy Review Group, highlighted the need for an integrated care pathway and emphasised the need for support upon release from incarceration. The recovery process can be promoted from the beginning of incarceration with support networks of mutual aid (e.g., Narcotics Anonymous, SMART recovery), peer support, and families and community services contributing toward these achievable goals. Upon release, 'assertive linkage' to these networks is critical for continuity of positive health outcomes (Department of Health, 2010: 133). The clear message from the Patel Report is how post-release (i.e., employment, education) financial support and community integration are essential to achieving successful outcomes for individuals post-custody (see also Denton et al., 2015).

Many prisoners who use drugs also experience mental health issues. People with mental health issues are over-represented in prison with 25% of women and 15% of men in prison reporting symptoms indicative of psychosis (Light et al., 2013) (compared to a rate of 4% amongst the general public (Wiles et al., 2006)). Moreover, 58% of women and 35% of men entering prison say that they had emotional wellbeing or mental health issues (HM Chief Inspector of Prisons, 2015). In terms of substance use, two-thirds (64%) of prisoners report having used drugs in the four weeks before custody and half of women (49%) and 29% of men in prison report needing help with a drug problem when entering prison (Light et al., 2013). While prisons attempt to address people's mental health issues as well as substance use, there is arguably too great a focus on the individual rather than their context (Rhodes, 2002). Any attempt to reduce deaths following prison custody should focus not only on treating mental health and substance use disorders, but also on the social context into which prisoners are released. Yet, as the EHRC inquiry into *Preventing Deaths in Detention of Adults with Mental Health Conditions* found, risk

assessments are often lacking: more rigorous risk assessment might help to prevent such deaths (EHRC, 2015).

It is certainly widely recognised that the quality of mental health provision in prison is very uneven (Brooker et al., 2002; Edgar and Rickford, 2009; Bradley, 2009; Royal College of Nursing et al., 2010; Crichton and Nathan, 2015).

Suicide

In 2014, 6,122 suicides of people aged 10 and over were registered in the UK and the UK suicide rate was 10.8 deaths per 100,000. The male suicide rate was more than three times higher than the female rate, with 16.8 male deaths per 100,000 compared to 5.2 female deaths (Office for National Statistics (ONS), 2016). The male suicide rate in the UK decreased in 2014 from 17.8 to 16.8 deaths per 100,000 population; while the female suicide rate increased from 4.8 to 5.2 deaths per 100,000 population. The highest suicide rate in the UK in 2014 was among men aged 45 to 59, at 23.9 deaths per 100,000, slightly lower than the record high seen in 2013. This age group also had the highest rate among women, at 7.3 deaths per 100,000 population (ONS, 2016).

Importantly, in 2012, the Department of Health published a cross-governmental report in which it outlined four strategies for reducing suicide. People who have been recently released from prison come within the Government's priority target group of 'people in contact with the criminal justice system' (Department of Health, 2012: 13). However, it should be noted that the report makes no mention of those who have been released from prison, or who were under the supervision of probation services.[1] Rather, when it comes to the issue of suicide and criminal justice the focus is wholly on people in prison. This is reflective of the neglect of the high risk population released from custody.

Research in the UK shows that the most common cause of non-natural death amongst people who have recently been released from prison is apparent suicide (Binswanger et al., 2011). In their research on suicide in recently released prisoners in England and Wales, Pratt et al. (2006) found that 382 suicides occurred amongst 244,988 individuals within one year of release from prison, which equated to 156 suicides per 100,000 person-years. 79 of the suicides (21%) occurred within the first month following release. In all age categories, the suicide rate of newly released former prisoners was higher than for the general population. Moreover, as mentioned

[1] At the time, the supervision of offenders in the community was managed by local Probation Trusts (known as 'services').

above, it is sometimes difficult to distinguish between an accidental drug overdose and a suicide so the figures may have been an underestimate.

In an international context, Hakansson and Berglund (2013) found that in a cohort of 4,081 people who had been released from prison in Sweden, 10% (n=16) of the deaths that occurred were due to apparent suicide. Despite this, very little research exists into the prevalence and correlates of suicide post-custody. Zlodre and Fazel (2012) found that, in their cohort of 400,000 people who had been released from prison across a range of countries, 8% of deaths were as a result of suicide.

Suicide *can be* closely linked to mental illness although this obviously does not apply to all suicides. According to the National Confidential Inquiry (2015: 19), 28% of suicides in England in 2003-13 were of people who had been in contact with mental health services in the 12 months prior to death, although this cannot be read as a direct correlation with mental health. In the USA, Zlodre and Fazel (2012) found that higher standardized mortality ratios were reported in mentally disordered offender populations. In a systematic review of research into suicide amongst recently released prisoners in the UK, Jones and Maynard (2013: 26) found that the risk of suicide amongst the cohort was 7.76 times higher than in the general population and argue that 'the mental health problems faced by prisoners will inevitably play a part in the increased risk of suicide'. In acknowledging the role of mental illness in the increased risk of suicide amongst recently released prisoners in Sweden, Haglund et al. (2014) identify the prevalence of psychiatric risk factors that are associated with suicide following release from prison. In addition to the influence of substance misuse, as identified above, they argue that prior suicidal behaviour is a 'moderately strong independent risk factor' which underlines the importance of identifying such incidents when it comes to prevention.

Haglund et al. (2014) highlight the important link between substance misuse and mental illness. In addition to mental health issues, other factors such as structural inequalities, negative life events and a difficulty in coping with the transition to the community can increase a person's risk of suicide (Jones and Maynard, 2013). In her study of suicide in prison conducted in the 1990s, Liebling (1995) found that those who had attempted suicide tended to have experienced serious disadvantage, violence and more difficult family histories, as well as more contact with the criminal justice system and other care services. Importantly, Liebling also revealed a difference in the way in which suicide attempters and other prisoners described their experiences of prison and argued that a connection could be made between suicide attempters and those who seemed less able to cope with imprisonment.

As there is a link between people's experiences within prison and life after custody (Haney, 2001), it is important to bear in mind that people's risk of suicide is likely to have been affected, to some degree, by their experience whilst in custody. Among their sample of multiple suicide attempters post-release, Byng et al. (2015) found that despair and hopelessness, as well as possible post-traumatic stress disorder and depression, were common themes. Those who had attempted suicide on one occasion exhibited lower levels of distress, and higher levels of self-esteem than those who had attempted suicide on multiple occasions. Byng et al. (2015) argue that those who had attempted suicide multiple times had 'restricted agency' – little control over their lives – which was arguably related to past trauma and constraining social structures. They go on to suggest that we should understand suicidal behaviour in terms of individual patterns of 'agency' (capacity for action and control over one's life) as well as risk profiles as exemplified by many of the epidemiological studies referred to above. Most of those with one-off or no previous attempts portrayed themselves as having more mastery, whereas one-off attempters described using particularly violent means. Iterational agency, the selective reactivation of past patterns of behaviour, appeared to dominate in individuals who were choosing between further suicide attempts and substance use. Projective agency, having a more future orientation, appeared more prominent in some single attempters and in those individuals with plans to escape crime and social exclusion. Indeed, their findings suggest that interventions should be focused on a holistic treatment of mental health problems, including attempts to address structural obstacles to mental health (e.g. homelessness and unemployment), as well as on consideration of different types of agency and therefore where someone might be on the pathway to suicide.

Gender, age and offence type

In addition to considering the cause of death, we can also look at the ways in which people who share characteristics are at risk of dying following custody. Across drug-related deaths and suicide, older prisoners (those aged 50 and over) appear to be at greater risk (Forsyth et al., 2014 in Australia; Hakansson and Berglund, 2013 in Sweden; Pratt et al., 2006 in England and Wales). Whilst this might be surprising because 'aggressive impulse traits, an important risk factor in suicide, can become less severe in offenders of older age', it could be put down to the increased challenges of reintegration that older people face upon release (Pratt et al., 2006: 122).

Pratt et al. (2006) found that the risk of suicide is higher amongst women than amongst men when compared with the general population. Women in prison are 69 times more likely to die than females in the general population (NHS Confederation, 2012: 2). Women are 36 times more likely to die by suicide within one year of release from prison than females in the general population (Pratt et al., 2006). Based on work in HMP Holloway, England, Petrillo has suggested that in part, this may be explained by the interrelated nature of many problems which women in contact with the criminal justice system face: 'mental health problems are often part of a complex pastiche of environmental, social and emotional challenges that weave the fabric of their [women's] lives' (Petrillo, 2016: 134). However, several studies have been unable to report on gender differences due to low sample sizes. This situation makes the epidemiological studies primarily referred to above problematic when it comes to analysing the deaths of women after a period of detention because it 'obscure[s] the gendered links among physical and sexual abuse, drugs, and crime…thereby placing female offenders at risk for neglect… in an otherwise seemingly objective method of assessment' (Davidson and Chesney-Lind, 2009: 240). This is important to bear in mind for this report, because the number of deaths of women is considerably lower than that of men, making meaningful analysis difficult.

One way around this would be to follow the approach forced by withdrawal of state controlled data (see Segrave and Carlton, 2011; Carlton and Segrave, 2013), in which a feminist model of research was adopted. This method did not rely on data that had been collected by the state and therefore, arguably, for the purposes of the state. Rather they collected data from women themselves. The assumption underpinning the research is that data collected by the state might be biased, although this is clearly debateable: such data may be objective in the same way that other data may be objective. Nevertheless, Carlton and Segrave (2016) suggest that such an approach emphasises 'lived experiences' beyond political agendas, individualisation, pathology and offending and they go on to make a case that to see imprisonment and release as separate entities undermines the 'reality that the vast majority of women experience serial imprisonment' and deprivations (2016: 282). Thus, periods of imprisonment and release represent different extremes of deprivation rather than opportunities for 'a new life'. The culture of prior incarceration is continued with post-prison support that adopts similar language and does not acknowledge the threatening social system to which women frequently return. While government sometimes perceives prisons as a secure and protective environment, away from the damaging effects of domestic violence, sexual abuse, rape, and alcohol and drug misuse (see Carlton and Segrave, 2016) it is increasingly

recognised that this is not the reality. There is very little research literature that suggests that incarceration is wholly beneficial, thus pathways for true 'recovery' are therefore restricted and imprisonment potentially leads to feelings of hopelessness and despair. There is some recognition of the reality in official documentation and political rhetoric, although the extent to which governments have addressed this situation is variable.

In terms of type of offence, Woodall et al. (2013), in a UK context, highlight the particular challenges faced by convicted sex offenders in transitioning successfully to the community and the shame and stigma attached to this particular offending. However, there is very little other research which considers offence type and risk of death post detention.

2.2 Deaths after police custody

There has been even less research on deaths that occur following police custody. The Independent Police Complaints Commission (IPCC) publishes an annual report on *Deaths During or Following Police Contact* (IPCC, 2016b).[2] The IPCC categorises deaths according to the circumstances of the death (for example, a death that occurs in custody, or one that occurs as a result of a road traffic accident following a pursuit of a vehicle). For the purposes of this report, we are primarily interested in the category 'Apparent suicides following police custody' (there is a separate category of 'deaths in or following police custody'). There were 60 apparent suicides following police custody in 2015-16 within two days; of these, 56 were men and four were women. The average age of those who died was 43 (with the most common age group being 41-50). The youngest person was 16. Most of those who died as the result of apparent suicide were White (58) and two were Asian. The number of apparent suicides in 2015-16 is slightly lower than in the previous year (2014-15) when the number was 70, however, the IPCC stress that 'Reporting of these deaths relies on police forces making the link between an apparent suicide and a recent period of custody. The overall increase in these deaths may therefore be influenced by improved identification and referral of such cases.' (IPCC, 2016b: 15). Moreover, the figure of 60 is the fourth highest recorded over the 12 year period since 2004-05.

[2] This is published data, distinct from the data we obtained for analysis: see Chapter 5.

Suicide

Of the 60 apparent suicides, 18 apparent suicides occurred on the day of release from police custody, 24 occurred one day after release and 16 occurred two days after release in 2015-16. (There were also two cases where the apparent suicide took place longer than two days after release from custody: one was 5 days and the other 27 days after release). More than half (33) of the people who died by suicide following police detention had known mental health concerns. One had been detained under section 136 of the Mental Health Act 1983. Other mental health concerns included depression, schizophrenia, post-traumatic stress disorder, or previous thoughts or incidents of suicide attempts or self-harm. There was an indication that 28 people may have been intoxicated with drugs and/or alcohol at the time of the arrest, or it featured in their lifestyle (21 – alcohol and 14 – drugs).

Interestingly, most people had been arrested for sexual offences (22) and of these, 17 were in connection with sexual offences or indecent images of children. Other common reasons for detention included: violence related (non-sexual or murder) (7); criminal damage (5); driving offences, including drink driving (5); failure to appear in court / breach of bail / breach of other court orders (4); theft / burglary / shoplifting (4); and harassment / threatening behaviour (4). In some cases there were multiple offences (for example, the two men arrested for sexual offences were also arrested for possession of drugs).

Notwithstanding the fact that there is limited research, we can see similarities between those who die by suicide as well as other non-natural causes following prison custody: mental health and substance use appear to be important factors, for example. Additionally, there appears to be a link between the reason for detention and a risk of suicide. One possibility here concerns the impact of shame on the suspected offender, which is likely to be affected by the action taken prior to release (i.e. whether or not the suspect was charged). As already indicated, there are several possible causes of suicide in addition to mental health conditions such as depression. While mental health is still clearly relevant here because a significant number of people who are detained in police stations present with mental health concerns, we also need to consider other causes. Other risk factors relating to prison custody include: single status, loss of a child, unemployment, past abuse, physical disability, family history of suicide, previous deliberate self-harm and the full range of mental health conditions (Byng et al., 2015: 937). Thus it may be that some of these factors are relevant to suicide after police custody. There is clearly scope for more research on these people and the circumstances of their deaths.

2.3 Other research on criminal justice deaths

Our literature review would not be complete without reference to what is already known about those who have died from unnatural causes whilst under 'supervision'. Supervision, of course, can include both community sentences and supervision following custody. An early study by Pritchard et al. in England and Wales (1997), which examined suicide and violent death in a six-year cohort of male probationers compared with the general population (1990-95), found that males (aged 17-54) had twice the death rate and nine times the suicide rate of the general population. Sattar (2001) noted that deaths among people under supervision tended to occur soon after they were released from prison. Within her sample of 1,267 deaths in the community (drawn from data collected in England and Wales in 1996-97), a quarter of all deaths noted occurred within four weeks of release from prison, over half occurred within 12 weeks of release, and within 24 weeks of release just under three-quarters of all deaths had occurred. Accidents (as they were classified in the analysis) accounted for the largest proportion of deaths of supervisees in the community, perhaps the reason behind there being five times the number of deaths in the community when compared to deaths in prison. That said, the mortality rate for the supervisees was four times higher than that for the male general population rate. Sattar (2001) noted that drugs and alcohol played a larger part in the deaths of those under community supervision than for those in prison. A further analysis of deaths under supervision by Mills (2004) highlighted the fact that many people who have offended, drug-misusers in particular, lead lives which place them at high risk of harm. Continuing the same theme of a vulnerable population of offenders under supervision, Solomon and Silvestri (2008) found that the rate of suicide of those under probation supervision was nine times higher than in the general population and higher than in prison. Indeed, Singleton et al. (2003), Canton (2008), and Brooker et al. (2009) have all noted that those under probation supervision (including those on supervision following prison custody) have poor physical and mental health and have chaotic lifestyles.

These latter observations have been confirmed in more recent research by Brooker and Sirdifield (2013) and Denney et al. (2014) in a pilot study and review (respectively) of an appropriate methodology to survey the prevalence of mental illness amongst those under supervision. They also consider the manner in which offenders with mental illnesses serving community sentences are identified and treated by probation staff in the community. King et al. (2015) found that 13% of suicides in the general population were, or had recently been, under supervision by

the criminal justice system. The researchers report a 'significantly elevated suicide risk among individuals who had: received a police caution, recently been released from prison, recently completed a supervised community sentence, served other community disposals, been remanded as a suspect on police bail and dealt with no further action' (King et al., 2015: 175). Interestingly, they found that 'individuals serving a community sentence under the supervision of the Probation Service had a relatively low risk' of suicide. Thus, it might be feasible to suggest that the new supervisory requirements introduced by the Offender Rehabilitation Act 2014 may reduce the risk of suicide amongst those recently released from prison because they will now receive probation supervision.[3] (Although we might imagine that much depends on the frequency and quality of contact.) King et al.'s findings were not statistically significant but they point to potential for probation supervision to serve as a protective factor and 'as a crucial source of support for vulnerable offenders' (2015: 176).

During 2010, the Howard League for Penal Reform obtained information regarding the number of adults who had died under probation supervision by writing to all Probation Trusts in England and Wales (as they were then known). Subsequent requests to the Probation Trusts and Ministry of Justice produced some supplementary material in the form of information relating to recording procedures. The present authors (Gelsthorpe et al., 2012) analysed these data alongside management information. The resulting report looked at a four-year period, 2006-07, 2007-08, 2008-09, and 2009-10, highlighting that there was a death rate of 5.1 per 1,000 people under supervision in 2009-10, for instance, twice as high as the rate of deaths in custody (Gelsthorpe et al., 2012). In this same period of analysis, 151 people under post-release supervision died (a rate of 0.43 per cent) compared with 0.33 per cent of the total number of people under community supervision[4] although this was not tested for statistical significance.

There are considerable uncertainties regarding the quality of the data provided. This meant that we could not test for statistical significance and that the figures are

[3] The Offender Rehabilitation Act 2014 came into full force on 1 February 2015. At the heart of the legislation is the extension of supervision to approximately 45,000 additional offenders a year who are released from short prison sentences of less than 12 months. This means that any person whose offence was committed on or after 1 February 2015, who is sentenced to a custodial term of more than one day, and is 18 years old or over when released, will now receive supervision in the community. The Act also amends licence conditions for those serving sentences of 12-24 months in order to ensure that they do not receive shorter periods of supervision than those serving sentences of less than one year.

[4] This includes supervision whilst on a Community Order and whilst on licence.

indicative only. Nevertheless, we identified some interesting proportions when looking at those who had died under community supervision (including post-custody supervision):

- Natural causes: men are equally as likely to die as women
- Suicide: men are more likely than women to complete suicide
- Drug use Disorder: men are more likely than women to die from a drug overdose
- Alcohol use Disorder: women are more likely than men to die from alcohol misuse
- Unlawful killing: men are more likely than women to be unlawfully killed
- Misadventure/accident: men are more likely than women to die from an accident
- People aged 25 to 49 were over-represented; they accounted for 59 per cent of those under supervision, but 64 per cent of all deaths over the four periods under examination.
- People aged 50 and above were also over-represented, accounting for 5 per cent of people under supervision (4% male, 1% female), but 21 per cent of deaths (16% male, 5% female) over the four periods under examination.
- Women aged 36-49 accounted for 45 per cent of all deaths of women during the four periods under examination.

Needless to say, our conclusion included recommendations for clearer:

- procedures to collect data and we highlighted the fact that the data sets were too limited to identify commonalities or differences with regards to age, gender, or ethnicity
- distinctions between those on supervision under licence (post-release supervision) and those on community orders
- distinctions between those on supervision under licence who are still in the community and those who had been recalled to prison or arrested for allegations of further offending, and
- explanations about the length of time that people were on supervision, and the quality/depth of that supervision.

We urged the need for further attention to deaths of those under supervision in the community (including those released from prison custody and under licence), and the need for staff training in relation to the need to create an ethics of care in regard

to this vulnerable group of people. The report also made a number of administrative recommendations to facilitate access and analysis of relevant data.

There has been a lack of progress in recent years in regard to what we know about people who are under supervision (including those released from prison) or otherwise released from police custody. Whilst there has been gathering momentum in relation to concerns about deaths in police custody and prison custody, relatively little attention has been paid to those under supervision or leaving custody.

3 | Legal and policy framework

3.1 Introduction

The legal and policy frameworks surrounding deaths following prison and police custody are very different. We look at both in turn. We conclude by underlining the fact that it is clear even from the legal and policy frameworks that non-natural deaths post-custody are difficult to identify, and subject to much less clarity in terms of investigation, reporting and accountability.

3.2 Preventing, reporting and investigating deaths that occur following release from prison

As noted in section 1.1, for the purposes of this research, it was agreed with the EHRC that a relevant death was one that occurs within 28 days of leaving prison custody. They are difficult to identify. Most people leave prison on licence, some on the direction of the Parole Board and most under the Governor's authority. Others may have been remanded in custody pre-trial, and may be released on the direction of a court (for example, following the grant of bail, or after an acquittal). Until recently, only those serving more than 12 months were released on licence (subject to conditions),[5] but the Offender Rehabilitation Act (ORA) 2014 introduced mandatory supervision upon release for all sentenced prisoners. Mandatory supervision means, on paper at least, that the collection of data on people who leave prison and subsequently die should be more easily identifiable by the National Probation Service (NPS) and the Community Rehabilitation Companies (CRCs). These bodies now supervise those considered to be less 'risky' or who have committed less serious offences. However, the fragmentation that has been

[5] The rules have changed regularly over the decades. The Labour Government proposed 'custody plus' for all offenders in the Criminal Justice Act 2003, but by 2005 it was recognised that the costs of providing supervision to everyone leaving prison could not be met. The idea of supervision for all was revisited by the Coalition Government in 2010 – and the Offender Rehabilitation Act 2014 is the outcome of that.

introduced through the process of privatisation of probation services may make things less clear (Padfield, 2016).[6]

There are many risk assessment tools employed within prisons and probation, most obviously the Offender Assessment System (OASys) and Assessment, Care in Custody and Teamwork (ACCT). Whilst primarily focused on the risk of reoffending and risk of harm to others, OASys includes a section on risk of harm to self. ACCT is used to identify and manage prisoners who are at risk of self-harm or suicide within the prison although we should acknowledge that problems exist with ACCT (EHRC, 2015). When someone is released, relevant risk assessments should be shared with the relevant probation provider (either the NPS or CRC) who are then responsible for managing any risk of self-harm in conjunction with other organisations, through, for example Multi Agency Public Protection Arrangements (MAPPA).[7]

In addition, healthcare providers in the prison have a responsibility to ensure that community-based healthcare providers are aware of any health issues that the prisoner faces. At the moment, prison healthcare providers can make referrals to relevant community organisations and services such as GPs, Mental Health teams or drug teams. In July 2016, Public Health England introduced a new IT system variously referred to as the Health and Justice Information Service (HJIS) or System Two. This will mean that NHS staff in prison should be able to connect directly to the NHS 'spine' (a collection of national applications, services and directories which enable the exchange of information across health services). In turn, this means they should be able to identify prisoners' health needs upon induction and input data which can be used by all NHS providers in the community upon release. Prison-based NHS staff should also be able to register prisoners with a GP whilst in prison so that prisoners' needs and treatments should be much more easily shared between prison and the community. It is hoped that the HJIS will provide a useful infrastructure for the sharing of information although there is a concern that the Health and Justice Performance Indicators do not put sufficient emphasis on mental health related indicators (EHRC, 2016).

[6] A number of recent official reports also identify challenges facing the new system: see National Audit Office (2016) and Public Accounts Committee of the House of Commons (2016), whose summary states: 'The criminal justice system is close to breaking point. Lack of shared accountability and resource pressures mean that costs are being shunted from one part of the system to another and the system suffers from too many delays and inefficiencies. … The system is already overstretched and we consider that the Ministry of Justice has exhausted the scope to make more cuts without further detriment to performance….'; see also HM Inspectorate of Probation (2016).

[7] These arrangements were introduced in the Criminal Justice and Court Services Act 2000 to encourage more 'joined-up' work with 'dangerous' offenders. They require local criminal justice agencies and other bodies dealing with offenders to work in partnership.

Probation Instruction 01/2014 instructs all probation services (the NPS and CRCs) to record every death of people on the probation caseload. For each death that occurs, offender managers complete an Internal Review Form which details the circumstances of the death and action that was taken to prevent the death and identifies lessons that can be learned to prevent future deaths of a similar nature. The NPS Local Delivery Unit or local CRC are required to submit an annual report detailing the numbers of deaths that occur under probation supervision, along with a Learning Point Summary. Following this submission, a national report should be published by NOMS each year. This report should summarise the information submitted by the NPS and CRCs, providing a statistical analysis of deaths and a summary of the qualitative learning points from the internal reviews. In turn, this report is to be disseminated to managers and frontline staff, although whether this happens is currently unknown.

It remains to be seen whether or not the post-ORA 2014 framework makes the collection of quantitative data more accurate, and enables better identification of all deaths that occur after prison custody. There is a risk that information may be more difficult to gather because of the number of separate providers of probation and supervision services. Those released from prison with no supervision (those released on bail or following an acquittal) may be particularly vulnerable. There is no body that is statutorily mandated to record or to investigate such deaths.

The Prison and Probation Ombudsman (PPO)

The PPO carries out an investigation into all deaths of prisoners, young people in detention, approved premises' residents (including voluntary residents) and immigration detainees due to any cause. It has discretionary powers to investigate deaths of recently released prisoners or detainees. The only other investigations carried out appear to be deaths in court premises – deaths of those in the community are not investigated, partly because the PPO is rarely informed of such a death but also due to a lack of resources.

The aims of the Ombudsman's investigations are to:

- establish the circumstances and events surrounding the death, especially regarding the management of the individual by the relevant authority or authorities, but including relevant outside factors
- examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence

- examine, in conjunction with the NHS where appropriate, relevant health issues and assess clinical care
- provide explanations and insight for the bereaved relatives, and
- assist the Coroner's inquest to fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights ('the right to life'), by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

We report in Chapter 4 on our analysis of the relevant reports.

3.3 Preventing, reporting and investigating deaths that occur following police custody

The College of Policing's Detention and Custody Authorised Professional Practice (APP) provides information on how to prevent the deaths of prisoners post release. Whilst the APP is not a statutory instrument, it 'is the official and most up-to-date source of policing practice' (College of Policing, 2015). Two sections of the APP are relevant. The first concerns deaths in custody, including medical interventions which should take place during a major incident in a custody suite and the requirements to inform the IPCC as well as carry out investigations. The second relevant section falls under the heading Risk Assessment, in particular Section 4 'Release from Custody'. The APP document states that a pre-release risk assessment must be carried out prior to release, emphasising that this should be an integral part of ongoing risk assessment during the period of detention: the custody officer 'should not leave this until the point of release. Instead, it should be an ongoing process throughout detention and be concluded at the point of release' (College of Policing, 2015).

The APP policy suggests that custody officers should be open to referring detainees to relevant local services such as social care, health care and hostels/refuges. It states that 'forces should ensure custody officers have access to available referral agencies and written material which may help a detainee self-refer to agencies if they choose to do so at a later point'. Importantly, it notes that 'it is the responsibility of force custody leads to make strategic links with partners to ensure that appropriate local service options are available'. In addition to referring detainees to relevant services, or providing them with the information for future self-referral, custody officers can also put bail conditions in place to protect the welfare of the

detainee. If the detainee has been charged, s/he may be detained under s. 38 of the Police and Criminal Evidence Act (PACE) 1984 if there are reasonable grounds to believe detention is necessary for his/her own protection. If the detainee has not been charged, custody officers can also use a range of powers including s. 136 of the Mental Health Act 1983, ss. 4B and 5 of the Mental Capacity Act 2005 or a police protection order (in the case of children) under s. 46 of the Children Act 1989. Moreover, as the College of Policing (2015) indicates, one of the obligations under the European Convention of Human Rights is 'to take feasible operational steps (within the lawful power of the officer) to avert any real or immediate risk of death of which the officer is aware or should have been aware'. There are, therefore, powers in place which can be used by the police to prevent someone who is at serious risk of dying being released into the community without sufficient support.

The procedures for investigating a death that occurs in police custody are relatively straightforward. If a death occurs, the local force's Professional Standards Department (PSD) informs the IPCC immediately. The IPCC then considers the circumstances of the case. It decides whether an investigation is necessary and, if so, whether it should be investigated by the IPCC or the local police force which can, in turn, be supervised or managed by the IPCC. Where the IPCC makes recommendations following an investigation, the 'appropriate authority must respond to those recommendations indicating where it accepts them and where it does not, what action it will take as a result and its rationale for those decisions' (IPCC, 2015b 87).

Where a death occurs following direct or indirect contact with the police and there is an indication of a causal link, it must be referred to the IPCC. Moreover, the IPCC advises that all apparent suicides that occur within two days of police contact should be referred to themselves (IPCC, 2015b). Where a death occurs, the professional standards department (PSD) must inform the IPCC 'without delay and in any event not later than the end of the day following the day on which the matter first comes to the attention of the appropriate authority' (Police (Complaints and Misconduct) Regulations 2012). However, it is difficult to understand the number of such deaths and to make judgments and learn lessons from any death that occurs due to a range of possible factors. Firstly, a local police force may not be notified of an apparent suicide and so may be unable to make a link between police contact and the death (IPCC, 2014a: 11); secondly, the criteria for making such decisions 'may fluctuate over time, for example in response to current public and community concerns, which means that trend analysis would not be meaningful' (IPCC, 2016b: 5). That said, each year, the IPCC publishes data on the numbers and details of all apparent

suicides that occurred within two days of leaving police custody, and we draw on these data below.

Coroners' Reports to Prevent Future Deaths

The rules on coroners' inquests were substantially reformed by the Coroners and Justice Act 2009. When a death occurs in custody, the inquest will always involve a jury. With deaths following custody, a jury inquest is less likely but the death will still be investigated. Where the coroner believes that action should be taken to prevent future deaths, he or she is under a duty to make reports to a person, organisation, local authority or government department or agency.[8] This statutory duty strengthens the earlier position when coroners could produce reports (then known as Rule 43 reports).[9] In the last year alone, there were 504 Prevention of Future Death Reports and over 1,000 Reports have been uploaded onto the Internet since 25 July 2013.[10] Of these, 71 are listed under the heading 'state custody related deaths'. These all appear to relate to deaths in custody (the choice of the title custody 'related' deaths is interesting), and further informal exploration with the Chief Coroner uncovered no other reports more relevant to this study. The Chief Coroner said in his Annual Report 2014-15:

> Coroners do not have the luxury […] as in some parts of the common law world […] of researchers to assist them in this task. Hence the law requires coroners to make recommendations of a general nature, such as 'I recommend that you review this procedure' or 'that policy' but not 'I recommend that your policy should be altered from X to Y'. Nevertheless coroner reports are a valuable tool to prevent future deaths and the regular publication of reports on the public judiciary website is a purposeful reminder of the importance of this public work. The Chief Coroner selects certain reports to pursue. Examples in the last year include ambulance attendance times, deaths in custody and child deaths. (Chief Coroner, 2015: 25)

Further research should certainly explore whether and how these reports are a 'useful tool' in addition to, or alongside, PPO reports. Our research has informally uncovered significant concern amongst coroners about the lack of care and support for people released from custody who then take their own life. Further analysis could, for example, seek to assess whether issues raised in coroners' reports are acted

[8] See paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009.
[9] See Regulations 28 and 29 of Coroners (Investigations) Regulations 2013.
[10] See https://www.judiciary.gov.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/

upon. This would indicate whether the same issues regularly arise and are not adequately addressed.

3.4 Conclusion

There are important questions concerning how relevant organisations identify and define a ‘relevant’ death. Deaths in custody are subject to statutory investigation whilst non-natural deaths following detention are not. This is especially pertinent when we consider the evidence from the research that has been conducted in this area and the high levels of mortality and vulnerability which people face upon leaving state detention.

4 | Deaths after prison custody

4.1 Introduction

In this chapter we provide an overview and analysis of data that were collected and collated by the National Offender Management Service (NOMS) as part of the procedures in PI 01/2014 regarding the requirements for probation providers to report on deaths that occur amongst people who are under probation supervision. We also draw on several conversations that we had with relevant stakeholders: prison staff, a coroner, and a Public Health England staff member with responsibility for health and justice commissioning.

4.2 NOMS data on deaths under supervision

The data described and analysed below were collected by Probation Trusts prior to 2014, and by the National Probation Service (NPS) and Community Rehabilitation Companies (CRCs) since 2014. The dataset was provided by NOMS and includes the details of all known deaths amongst people who were under probation supervision between 2010 and 2015. This includes those who were being supervised as part of a community order, suspended sentence order or period of licence. The dataset includes information on the cause of death, age of person, gender, main offence type, sentence type and requirements (if relevant) as well as, in some cases, a brief narrative of the circumstances leading up to the death.

The way that deaths of offenders under probation supervision was recorded changed in 2014 with the publication of Probation Instruction 01/2014 and so we need to be careful about identifying trends across that time period. Moreover, this change in procedure coincided with the reorganisation of probation services to create the NPS and CRCs. The last two years have witnessed considerable pressure and change. The Planning and Analysis Group within the Ministry of Justice have indicated that the combination of changes may well have led to some underreporting. However, they informed us that the data had gone through a process of ‘cleaning’ which

involved following cases up with probation providers to glean further indicative information. Categorisation of deaths whilst under supervision is, in any case, difficult to achieve, since it is the Coroners' Reports which will record the most accurate information. Even where an inquest takes place, there may be no indication that the person was under supervision and so no information would be forwarded to the probation provider. In some cases there is evidence that an inquest verdict has been recorded, but we do not know whether a gap in the inquest column means there was no inquest, or whether the verdict was not ascertained by NOMS. As discussed above, there is no statutory investigation of deaths under supervision. Thus, the cause of death may not be accurate; in some cases the categorisation may amount to a best guess by the supervising officer. Indeed, as we describe below, there are some inconsistencies in the dataset we were provided with. Moreover, there were some important gaps with, for example, 'Sentence Category' being unknown in 12% of cases.

In spite of the concerns raised above, the data do provide us with some information about the number of people who have died within 28 days of leaving custody allowing us to address the question of the extent of the problem.

There were 3,196 deaths of people under probation supervision between 2010 and 2015. Of those 3,196 deaths, 646 were of people on licence from prison. This group of prisoners has been excluded because they have not technically been released and therefore would be subject to a PPO investigation. 79 of those 646 did not have a 'release from prison' date recorded so we could not ascertain if they had died within 28 days of release. Of those who had a release date and date of death, 97 deaths occurred within 28 days of release. 25 of those were natural which possibly means that 72 people died of non-natural causes within 28 days of release over the five-year period. However, six of those were accidental and unrelated to the offence, offending or legal status (for example, a road traffic accident). This leaves us with a total of 66 deaths relevant to our purpose.

Table 4.1 shows the number of non-natural deaths that occurred within 28 days of release, broken down by year. There appears to be an increase in numbers over this period. However, as mentioned above, we must bear in mind the changes in reporting methods in 2014 and the structural reform which the probation service has undergone. Moreover, it may be possible to attribute, at least partially, any increase to greater awareness of the need to understand these deaths better.

Table 4.1 Number of non-natural deaths that occurred within 28 days of release by year

2010-11	2011-12	2012-13	2013-14	2014-15	**Total**
6	12	9	14	25	66

Table 4.2 shows the cause of death, where it is known, amongst the 66 relevant deaths. It is unsurprising, considering what we know from the literature, that drug overdose is the most common cause of death. That said, we should bear in mind the difficulty in distinguishing between an intentional and accidental drug overdose.

Table 4.2 Number of non-natural deaths that occurred within 28 days of release by cause of death

Accidental	1
Homicide: Stabbing	1
Other: Non-natural alcohol/drug related	1
Self-inflicted: Drug overdose	44
Self-inflicted: Hanging	1
Self-inflicted: Other	3
Unclassified	15
Total	**66**

Table 4.3 shows that deaths most frequently occur amongst those aged 25-35 and 36-49.

Table 4.3 Number of non-natural deaths that occurred within 28 days of release by age

18-24	7
25-35	33
36-49	24
50-65	1
65+	1
Total	**66**

Table 4.4 shows that more men died than women. Women make up 5% of the prison population and 3% of relevant deaths; but the figures are so small that we cannot discern anything statistically significant from this disparity.

Table 4.4 Number of non-natural deaths that occurred within 28 days of release by gender

Female	2
Male	64
Total	**66**

In looking at the offence type (Table 4.5), we can see that acquisitive crimes such as burglary, robbery and theft feature highly. Given the high rate of drug overdose as a cause of death this is unsurprising, as much acquisitive crime is committed in order to fund substance use. We note that one person who had been convicted of a sexual offence died within 28 days of release and that he died by suicide. In light of what we know about the risk of suicide following release from police custody following an arrest for sexual offences (see below), this figure is perhaps low. Although outside the remit of this research because the deaths occurred beyond 28 days, the data show that 63 people died after being released from prison following a sentence for a sex offence (regardless of the timeframe). Of those 63, five died by suicide.

Table 4.5 Number of non-natural deaths that occurred within 28 days of release by offence category

Burglary	19
Criminal damage	1
Other summary offence	3
Other indictable offence	7
Robbery	6
Sexual offence	1
Theft and handling	10
Violence against the person	14
Other	5
Total	**66**

The literature review revealed an increased period of risk of death in the immediate period after release from custody. As we can see from Figures 4.1 and 4.2, this is borne out in these data. The number of people who die within the seven or eight days of leaving prison is considerably higher than those who die in subsequent weeks. Given the rate of drug-related deaths that occur, and what we know about the risk of overdose and relapse upon release from prison, this is, perhaps, unsurprising. The focus of this study is therefore on this critical period.

Figure 4.1 Number of deaths that occurred by number of days after release

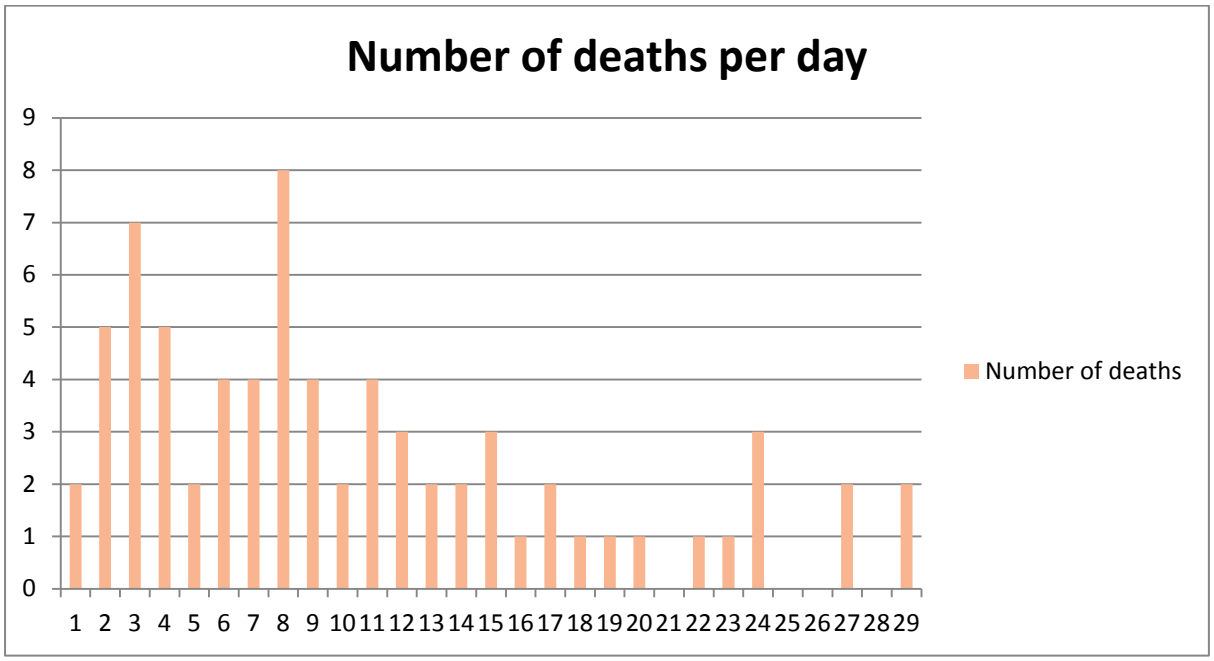
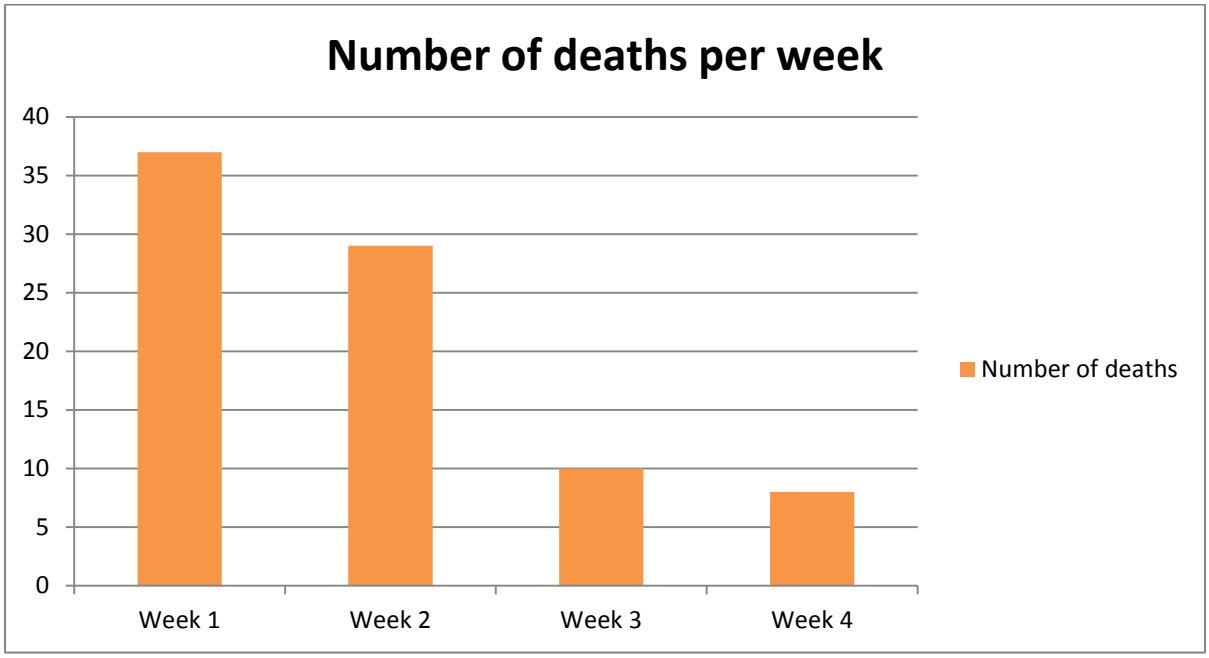


Figure 4.2 Number of deaths that occurred by number of weeks after release



4.3 PPO investigations into deaths in Approved Premises

In order to shed further light on the relevant best practice issues, we also spoke to six key 'stakeholders' and analysed the PPO investigations which were conducted into the deaths that occurred in Approved Premises (APs) within 28 days of release.

We are grateful to the PPO for guidance on which of their investigations related to those who had been released from prison within the previous 28 days. They highlighted 13 cases between 2010 and 2015, all of which we studied with care. We also read many other reports of deaths in APs: there are many similarities between those who die shortly after release and other cases. Those who have recently been released from prison appear often to have more uncertain lives: time in prison had further disrupted difficult lives. All 13 were male, and were aged between 32 and 67. Two had been recently released from prison on bail, but the majority had been released on licence from prison sentences, which had varied considerably in length. One had been recalled to prison and then re-released.

In several cases, the PPO concluded that nothing could have been done to prevent the death. But a close reading of the detailed narratives underlines the fact that previous drug users who have recently been released from prison are at high risk of relapse and of drug overdoses. Many of these people had chaotic lives, exacerbated by complex prison histories. The majority had known addictions to alcohol and/or

drugs, and several had serious mental health needs. It is these health and addiction needs/problems which led them to be identified as 'risky' individuals who are required to live in APs, for the protection of the public.

The reports illustrate certain key themes:[11]

(i) The problems associated with drug-related deaths, including the practical management of offenders who hoard prescribed medication, and the combined effect of prescribed medication and illicit drug use. Clearly it is not easy to have the confidence to remove even prescribed medication from new residents, who do not wish to have it removed. The PPO puts it this way (in case 4):

> I am concerned about the *staff reticence* and *apparent lack of confidence* in applying the suicide prevention measures, as well as the absence of documentary evidence regarding the rationale for their decisions. ….. I therefore repeat a recommendation regarding the review of training and support for staff in these procedures (italics added).

(ii) The shortage of drug treatment programmes in prison and in APs, which is closely related to the first point. The reports illustrate the extraordinary challenges facing prison and probation staff in deciding whose treatment to prioritise. In some cases the Ombudsman expresses 'surprise' e.g. 'I am surprised that he was not regarded as a priority by the CARATs teams in either prison' (case 1).[12]

(iii) The acute difficulties surrounding staffing shortages. Weekend cover is often minimal and junior staff are reluctant to call managers. The PPO frequently comments on staffing levels. We are concerned that this is an area which is not being dealt with effectively.

(iv) The crucial failures, in relation to decision making and then acting upon those decisions, as well as good collaborative working. There was evidence of last minute decisions (one man was only told the night before release that he was not to be released to his home area as had previously been agreed). The PPO identifies problems with record keeping, and with the sharing of information of risks and need both between prisons, and between prison and probation. Some of the 'stories' are truly shocking – a hostel which had no idea of someone's

[11] Some of these themes are identified in a PPO *Learning Lessons Bulletin* published in September 2012: see http://www.ppo.gov.uk/wp-content/uploads/2014/07/LLB_FII_01_Learning_from_approved_premises_final_web.pdf
[12] CARAT stands for Counselling, Assessment, Referral, Advice and Throughcare.

physical disabilities until he arrived, for example. The problem is not limited to information-sharing between staff: in one case, the man's family had tried several times to ring the probation office, but there had been no reply. Maintaining effective lines of communication with the family is not easy, before or after deaths. Although the NPS has a duty to offer to contribute to funeral expenses, the PPO regularly critically observes that there had been no such offer.

(v) The mismatch between policies and what staff actually know or do. Rules can say, 'call an ambulance' in certain situations, but staff do not necessarily do this. This merits further exploration, perhaps through the lens of staff culture which might shed light on why guidance is not always followed.

Perhaps the overwhelming conclusion is the importance of creating a smoother transition from prison to APs. There is obviously a huge need for a high level of liaison between the offender, the offender's Offender Manager (OM),[13] the releasing prison and the AP. We return later to two recommendations which flow from this:

(i) The role of the OM supporting an offender throughout the many different stages of a sentence.

(ii) The status of APs within the prison/probation process. Is it time to redesignate APs as 'open prisons', so that offenders are more fully aware that they have not 'really' been released into the community? The regime in APs can feel much more restrictive than that in, say, an open prison (see also Padfield, 2013). While we strongly support gradual release, it is clear that APs pose challenging and difficult staging posts in an offender's rehabilitative journey.

Interviews

Interviews were conducted with four members of staff in two prisons, as well as with a coroner and a psychiatrist with extensive experience of mental health issues related to imprisonment. We were granted approval by NOMS to conduct the research in prisons and probation and we negotiated access to four prisons and one division of the National Probation Service. Interestingly, no probation practitioners volunteered to take part and we managed to recruit participants from just two of the four prisons. Nevertheless, the conversations we had were incredibly useful although we cannot possibly generalise from such a small sample.

[13] I.e. the supervising (probation) officer.

One participant was a drugs worker in a prison, a second was a mental health worker and a third was the head of safer custody. We also interviewed a family liaison officer who was responsible for informing family members of any deaths that occurred in and following custody. Due to the small sample size, and to maintain confidentiality, we do not attribute the comments to specific participants but outline several key themes.

The most prominent theme to arise from all the interviews was the prevalence of drug-related issues and subsequent deaths. There was a perception that drug users were at the highest risk of dying soon after release. It is interesting to note that this perception is borne out in the data above. Suggestions for improving the problem of drug-related death included better relapse prevention strategies whilst in prison and better co-ordination with primary and secondary care providers in the community so that the process of receiving prescriptions is seamless. One participant suggested that GPs were likely to increase people's doses of opioid substitution therapy because they were less well trained to work with people who were addicted to opioids and that everyone should be treated by specialist services. Another option for preventing drug-related deaths was the increased provision of Naloxone which can reverse the effect of opioids.

Interestingly, the focus on drug-related deaths led participants to suggest that the problem of post-custody deaths was largely out of their control. That said, our participants discussed the importance of communication between the prison and services in the community, regardless of the cause of death. While no participants identified specific problems, there was a clear understanding that good communication was critical in preventing deaths and other harms upon release. Prison staff were of the opinion that communication between their prison(s) and relevant health and probation providers were very good. However, they also acknowledged that this was contingent upon good working relationships between specific people rather than the product of good systems. For example, one participant had worked in the community prior to working in the prison and thus had very good connections with local community-based providers. This made it easier for him to refer and track people upon release. There was a general consensus that the new Health and Justice Information System will be very useful.[14]

[14] The Health and Justice Information Services (HJIS) team is supporting NHS England to deliver its new health IT system for the English Health and Justice Service's residential detention settings including prisons, young offender institutes, secure training centres, secure children's homes and immigration removal centres. It aims to provide a fully functional primary healthcare system across the entire estate and to facilitate the integration of information systems across justice services and link to the wider NHS. See: http://systems.hscic.gov.uk/healthandjustice.

In terms of mental health issues, a potential factor in suicides post-release, participants suggested that prisons were seeing an increase in the number of people who had mental health illnesses. This was attributed to several possibilities: 1) better identification of mental health illness; 2) an increase in the number of people with mental health issues in the general population; and 3) an increase in the prevalence of new psychoactive substances (also erroneously known as 'legal highs') which were seen to be having a serious impact on all aspects of prison life.

Prison staff were unable to say how many people had died following release from prison. This was because there were no formal channels by which they could find out. The most common way of ascertaining that someone had died was 'on the grapevine' (i.e. finding out from a prisoner). The participants all said that it would be useful for them to have a better knowledge about how many people died upon release, although they also expressed concern about the resources needed to act on the knowledge gained. This suggests a role for a body with investigatory powers such as the PPO. Moreover, participants in the prisons were unsure about what 'counts' as a death post-custody. This suggests a need for a more precise definition of a post-custody death which, in turn, might make identifying lines of accountability clearer.

4.4 Conclusion

The data that NOMS collates with regard to deaths under supervision have important limitations for an understanding of the extent of deaths after prison custody. A key issue is that prior to the implementation of the Offender Rehabilitation Act 2014, people who had been sentenced to less than 12 months' imprisonment were not classed as being under supervision upon release and so are absent from the data. Secondly, probation providers have changed over the last two years, with the division between the National Probation Service and Community Rehabilitation Companies. This structural reform may well have affected the recording of such data and might explain the number of gaps that exist in the data. As a consequence, none of the data have provided any statistically significant findings and any conclusions are indicative only.

This said, we can see that amongst people convicted of acquisitive offences, drug-related deaths occur the most frequently. The period of greatest risk of death is the seven or eight days following release. The implication is that more might be done to

prepare drug-using prisoners for release. This could include the provision of Naloxone to reduce the risk of people dying from a drug overdose such as that trialled in Scotland with positive results (NHS Scotland, 2015). There is more to be done in terms of deepening understanding and, crucially, learning from the deaths that occur after release from prison, although we need to be careful about placing yet more demands on a prison and post-prison system that is working with limited resources.

5 | Deaths after police detention

5.1 IPCC data on deaths after police detention

In this chapter we focus on details gathered from IPCC investigations and monitoring of apparent suicides following police contact. In addition to the IPCC report on deaths following police contact (see page 19) we were provided with additional data by the IPCC for the purposes of this research. Between 2010 and 2015, 289 referrals were made by local police authorities to the IPCC because an apparent suicide had occurred within two days of police contact. Of the 289 referrals, the IPCC had completed 11 investigations at the time of us being provided with the data (more are underway, others may have been investigated by the local police force and others were deemed not to require investigation).

We were also provided with two published and two unpublished full reports as well as anonymised summaries of cases relating to the 11 investigations. The summaries provided details of the alleged offence and key risk factors, as well as the outcome of the investigation and any recommendations or learning points. We discuss these investigations below.

The IPCC also supplied a summary of 30 referrals comprising six cases from each year (2010-15) across their different modes of investigation (i.e. managed, supervised, or local). A referral contains the information which is initially provided to the IPCC by a police force when they become aware of death. The information is therefore necessarily limited and has not been subject to investigation. These summaries were chosen at random by a policy officer at the IPCC. The summaries were brief and outline the nature of the offence for which the detainee had been arrested or detained, whether an appropriate risk assessment had been carried out and the risks that were identified, as well as details of the death itself.

Thus, we have been able to base the following analysis on 41 cases of apparent suicide following police detention. As a consequence, none of the findings are statistically significant and are indicative only.

Detainees' characteristics

Of the 41 reports, summaries and referrals we looked at, 38 concerned men and 3 women. That there are more men than women is to be expected due to the significantly higher number of men who are in contact with the criminal justice system. We were not provided with either the age or ethnicity of the people referred to the IPCC.

Offence type

The most common offence for which people had been detained was sex offences (*n*=11) followed by driving offences (*n*=7). Table 5.1 shows the breakdown of offences for which people had been detained.

Table 5.1 Breakdown of referrals and investigations by detention reason

Reason for detention	Referrals	Investigations	Total
Sex offences	7	4	11
Driving offence	5	2	7
Assault	4	1	5
Theft (incl. burglary and shoplifting)	3	1	4
Criminal damage	2	0	2
Robbery	0	1	1
Indecent assault[15]	1	0	1
Drunk and disorderly	1	0	1
Breach of bail conditions	1	0	1
Wasting police time	0	1	1
Possession of Class 'A' drugs with intent to supply	1	0	1
S.136 MHA	3	1	4
Breach of the peace	2	0	2
Total	**30**	**11**	**41**

[15] This was a historic case. The offence of Indecent Assault was abolished by the Sex Offences Act 2003 and was replaced by sexual assault.

Table 5.2 shows reason for detention using IPCC published data.

Table 5.2 Breakdown of apparent suicides by reason for detention

Reason for detention	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	**Total**	**%**
Sexual offences	17	16	9	18	13	33	22	**128**	32
Violence related (non-sexual or murder)	13	10	5	17	25	6	7	**83**	21
Breach of peace / criminal damage	4	5	7	4	9	6	9	**44**	11
Driving	5	1	5	8	9	5	5	**38**	10
Drug / alcohol-related (excluding drink driving)	3	2	2	2	4	5	3	**21**	5
Theft / burglary / shoplifting	2	2	4	5	3	0	4	**20**	5
Detained under the Mental Health Act	3	5	4	7	3	5	1	**28**	7
Failure to appear in court / breach of bail / breach of other court orders	0	1	1	2	0	7	4	**15**	4
Other	7	4	2	1	2	2	5	**23**	6
Total	**54**	**46**	**39**	**64**	**68**	**69**	**60**	**400**	**100**

Source: IPCC (2016b) and data compiled from earlier IPPC reports available at: https://www.ipcc.gov.uk/page/deaths-during-or-following-police-contact. The categories have changed slightly over this period and some earlier data have been subject to later revision.

Before we consider how the reason for detention might affect the risk of subsequently completing suicide, we should further explain Table 5.1. Four people (three referrals and one investigation) had been detained under s. 136 of the Mental Health Act 1983. Of those, all bar one had been detained in a police station. We should also note that it is sometimes difficult to identify the index offence (i.e. the

offence which is recorded in the data) and disentangling mental health issues from the effect of being detained is similarly problematic. For example, one referral was made to the IPCC because a report had been received from ambulance control about a suicidal male who, it transpired, was on bail for burglary and on a curfew which he had breached. In a separate case, the detainee, who had contacted the police on several occasions informing them that she was self-harming was detained for wasting police time and subsequently took her own life. Despite the nature of her calls to the police, there had been no evidence that she was going to complete suicide.

The information in Table 5.1 suggests that an arrest for a sexual offence appears to be a factor in the likelihood of an individual subsequently dying by suicide. However, the majority of people who are arrested for such offences do not complete suicide. Its presence at the top of Table 5.1 nevertheless suggests that there may be an issue linked to the offence. Sexual offences, especially in relation to children, are particularly taboo and lead many offenders to feel high levels of shame and experience high levels of social exclusion (Levenson et al., 2007). Sex offenders, whether in prison or in the community, are at risk of what Proeve and Howells (2002: 657) describe as shame emanating from ‘consciousness of scrutiny by others'. A person’s level of social integration has long been identified as a factor in the risk of completing suicide. Hastings et al. (2002: 67) argue that although guilt is correlated with suicidal behaviour, it is actually the separate emotion of shame which is ‘more likely to result in suicidality than feelings of guilt’. In respect of drink-driving, the second most frequent offence for which detainees were arrested, the story is slightly different. While drink-driving is less obviously an offence for which suspects or offenders are likely to feel ‘shame’ there has been, over the last two or three decades, considerable attention paid to the use of shame in reducing the number of people who die as a result of drink-driving (Grasmick et al., 1993). Thus, we might speculate that this form of shame, albeit socially constructed, may be linked to the relatively high frequency of people that are arrested for drink-driving who then kill themselves.

Findings from the investigations and referrals

We must be careful about attributing deaths by suicide to the reason for detention. Alcohol and/or drugs were present in 14 of the referral summaries, and 5 of the investigations. As stated above, four detainees who subsequently died by suicide had been detained under s. 136 of the Mental Health Act (MHA) 1983. However, mental health issues were prevalent throughout the sample of referrals and

investigations. Excluding those who had been detained under s. 136 of the MHA 1983, eight of the referrals included a warning marker about self-harm or suicide and seven investigations also flagged up a history of self-harm or suicide attempts. These warning markers varied from suicide attempts that had occurred 15 years previously, to the use of generic words such as 'depression' and 'feeling unwell' and so the acuteness and imminence of perceived mental health related risks varied considerably. That said, people who died by suicide following police detention displayed many of the risk factors that have been identified already in the research discussed above in relation to police and prison detention, namely mental health issues and drug use.

In addition to providing details of the events which led up to an apparent suicide following police detention, the investigation reports and summaries also provided us with information about learning that was identified, as well as recommendations that were made following an investigation.[16] In nine of the investigations we looked at, the officers involved had no case to answer for misconduct, gross misconduct or a breach of professional standards. In the remaining two investigations, custody officers were found to have a case to answer for misconduct. In the first, this revolved around the review of custody records during shift change overs and the fact that custody officers had relied upon a verbal handover rather than a review of the written records. This meant that opportunities to identify the need for a mental health assessment were missed. One finding was that a pre-release risk assessment had not been carried out, which, again, meant that opportunities to identify mental health problems were missed. In the second case, concerns were raised about the reliance on verbal handovers (as opposed to the incoming custody sergeant reviewing the written custody record, in accordance with APP[17] and ACPO guidance). The investigation highlighted a tension between 'the requirement for Inspector's PACE (Police and Criminal Evidence) reviews and the resources available' both of which we discuss in more detail below.

In four investigations, no recommendations or learning were identified. The following section highlights the most common learning points and recommendations that were made following the remaining seven investigations. These can be summarised under three headings: record keeping and communication; the use of technology; and dealing with detainees with mental health problems.

[16] Note that this analysis excludes the referral summaries which did not include learning points or recommendations that arose from the investigation.
[17] See page 28.

Record keeping and communication

Issues around custody records were raised in five of the eleven investigations. The main concerns were that records were generic and not specific. For example, in one case, concerns were raised about cell checks not being recorded adequately. The second issue arises from the way in which insufficient attention is paid to custody records during shift handovers with officers relying, instead, upon verbal handovers. A clear theme to emerge from the investigations is that custody sergeants beginning a shift should read custody records rather than relying solely on verbal handovers. This issue also arose in the EHRC's *Preventing Deaths in Detention* inquiry (EHRC, 2015: 13). A separate but related issue revolves around communication with other agencies. In one case (IPCC, 2014b), it became apparent that the prison had not been aware of the detainees' suicidal thoughts and that this was because an intact Prisoner Escort Form (PER) had not been delivered to the prison. Immediately following the investigation, the IPCC published a learning the lessons report which has led to the PER form being improved (IPCC, 2014b: 4). Interestingly, one of the interviews conducted with custody sergeants (discussed below) raised a similar issue. In another case, it was found that the records made by the Forensic Medical Examiner had not been entered on the custody record.

Concerns were also expressed about the use of the pre-release risk assessment. For example, in one case the investigation raised questions about a detainee being described as 'having depression' which was vague and meant that there was a missed opportunity for appropriate referral upon release. In a separate case, it was unclear whether the pre-release risk assessment had to be conducted and the investigation recommended clarification around this. We do not know when this case occurred and so it is possible that this has been addressed through APP and the requirement to undertake a pre-release risk assessment as discussed above.

The use of technology

The use of technology was raised in several ways in the lessons learned and recommendations following investigations. Firstly, three of the investigations uncovered evidence that IT equipment, predominantly CCTV, had malfunctioned or was not linked to the main CCTV system. For example, in one case, the CCTV in one room of the custody suite had to be turned on manually – whilst this did not play a role in the subsequent suicide, it made the investigation difficult. In a separate case, CCTV was relied upon for cell checks to too great an extent, which meant that written records were not maintained and were not meaningful – this then introduces

the risk of exacerbating the issues around record keeping and communication highlighted above.

Dealing with detainees with mental health problems

In light of the prevalence of mental health problems that are present in this population, as identified above, it is perhaps unsurprising that issues concerning the way in which custody staff deal with detainees with mental health issues were raised. One recommendation to emerge from the investigations is that it is necessary to ensure that staff understand the responsibilities of different people when working with people with mental health problems. It is likely that this issue will be addressed when the new APP mental health module is published by the College of Policing. One case highlighted the need for better mental health awareness and training amongst custody staff. It was clear, from reading the investigations and summaries, that where a detainee had mental health problems, the potential for tensions arose. These tensions manifest in different ways. Firstly, there is the possibility that mental health workers are asked to provide police staff with information on how to deal with detainees with mental health problems, but that there is ambiguity about whether they are equipped to do this. Secondly, cases which involved people with mental health issues highlighted the tension between the different roles of the custody sergeant who is responsible for dealing with both the criminal side of detention and the welfare of the detainee.

5.2 Practice issues

The previous section analysed the data that the IPCC provided us following a request by the EHRC. The small sample size means that it is difficult to generalise about the true number of people who die from non-natural causes, in particular apparent suicides, following a period in police detention. In spite of this, the recommendations that were made following investigations suggest several areas for improvement.

In order to shed more light on the way in which custody staff work to prevent the deaths of people following a period of police detention, as well as to identify areas for improvement, we carried out two focus groups and one interview with serving custody sergeants. The first focus group started with three participants, before two more participants joined us for 45 minutes. It lasted for one hour and 50 minutes. The second focus group was conducted via a conference call and involved two

participants. In addition, we conducted a separate interview with a custody sergeant who had been unable to make the initial focus group. Finally, we discussed deaths after police detention with the same coroner and psychiatrist that we mentioned above. Although this is a very small sample, the themes which emerged from the interviews reflect many of the issues raised in the investigations.

We should note that all participants were recruited via an email sent out on our behalf by the Police Federation[18] and that the sample was self-selecting. Those who chose to respond might have particularly strong opinions on matters. Crucially, all of those with whom we spoke had experienced, in some form, an investigation into a death that had occurred following custody. The following section highlights the main themes to come out of these discussions.

Policing on the street

Whilst diverting people from custody is not the main focus of this research, it became clear that participants believed that one way to reduce the number of people who die following custody was to reduce the number of people who come into custody in the first place. As a result, participants discussed liaison and diversion and street triage – the process whereby mental health professionals provide immediate advice to police officers who are dealing with someone with mental health problems so that people can be referred to appropriate treatment providers rather than being detained. Participants spoke highly of these developments and how such initiatives made it easier for police staff to identify people who should not be going to a police station. They were positive about the move away from seeing police stations as a place of safety for people detained under s. 136 of the Mental Health Act. That said, they were concerned about the lack of resources in the community and offered numerous examples of how cuts to community services were making it difficult for the police truly to divert people from custody. They all agreed that police cars are increasingly being used to transport people who need medical attention and were concerned that '*it is only a matter of time before someone dies in the back of a police car'*. Participants acknowledged that the police were getting better at identifying mental health issues, but less good at, or severely constrained when, addressing those issues.

[18] The Police Federation of England and Wales (PFEW) is the staff association for police constables, sergeants and inspectors (including chief inspectors).

In the custody suite

Just as the treatment of people in custody suites affects the likelihood of a death occurring in custody, what happens in custody suites can also have an impact on whether a death is likely to occur upon release. Participants spoke of the move to having healthcare professionals (HCPs) in custody suites, either stationed there during the day or on call 24/7. However, they were concerned that this was only the case for physical health practitioners and not for mental health practitioners. The issue of access to mental health practitioners was also raised when we spoke to a representative of one police force, who said that this was a priority for the local police force. However, as with concerns raised around liaison and diversion, participants were concerned about what to do if a risk was identified. One example given concerned a female detainee who said that she was going to complete suicide if released. The custody sergeant sent her to hospital for a mental health assessment. However, she was assessed as not being suicidal and was returned to custody whereupon she began to say that she would complete suicide if released. The custody sergeant ended up '*taking a gamble*' and released her, making *'sure to keep all paperwork*'. They discussed how issues such as personality disorders or mental health issues were seen as a '*get out clause*' for primary healthcare providers, who were seen to be too keen to refer people on to a different provider, and conveyed a sense of unfairness because '*we are not trained*' in areas such as mental health.

One major issue that needs especially highlighting is the problem of not allowing access to NHS IT systems from police stations. This is important because people do not know/or cannot remember what legal drugs they are on, because they might be:

- under the influence of alcohol
- in withdrawal from alcohol during detention
- under the influence of illegal drugs
- in withdrawal from illegal drugs during detention, or
- in withdrawal from legal medication.

The effects of SSRIs (Selective Serotonin Reuptake Inhibitors which are widely used types of antidepressant medication) have recently been linked to elevated levels of suicide, especially in over extended use. Consequently, withdrawal (discontinuation syndrome) is especially dangerous and can happen very quickly. This can occur during, or after, a period of detention. The police officers interviewed highlighted the huge difficulty of not being linked into the NHS 'spine'. They also reiterated how the cases of people arrested and detained they dealt with were far more complex and

difficult than a few years ago, although the number of people detained within the custody suites had fallen.

The introduction of larger custody suites was also flagged up as an area of concern and is related to the developments around access to the NHS spine and healthcare commissioning. When there are complex cases in large suites, a custody sergeant (who may be the only one on duty) may decide to close the suite when it is only partially full to enable them to focus on these. One problem that was highlighted was that these subjective decisions could be overridden and criticised by senior police officers who were not present at the time that the decision was made. Regarding complex cases, one officer observed that although overall numbers had fallen for those using the custody suites, the ones that did were presenting with far more complex needs than in the past.

Participants discussed the health assessment and how it would be very important and beneficial for HCPs to have access to detainees' health records. This, they said, would overcome the problem of having to rely on detainees' accounts, which could sometimes be vague. They suggested that this was a particular problem with foreign nationals. We discussed, above, the new Health and Justice Information Service which was implemented by NHS England in prisons in July 2016. Initially, the intention had been to transfer the responsibility for commissioning healthcare in police stations to the NHS but this was dropped in December 2015. Police and Crime Commissioners have held onto this commissioning responsibility (Forrester et al., 2016). In turn, this has meant that the implementation of System Two (see page 26) was not extended to police stations. We would strongly recommend that these decisions are reconsidered in light of this research.

There was a long discussion about the difficulties of being a custody sergeant in the first focus group. Participants offered various suggestions on how to lighten the load of the custody sergeant. They argued that this was important because a lack of resources inhibited them from making good risk assessments upon reception into custody and upon release, and also commented that the role was 'high risk' and bore a lot of responsibility. Most of the suggestions revolved around resources. However, there was an emotional element to the work that was important. Participants suggested that the stress that custody sergeants experience affects their ability to look after the welfare of detainees, identify risks, and deal with them appropriately upon release, as well as manage any subsequent investigation effectively. They argued that stress can exacerbate the risks that are inherent in holding people in detention, especially those with pre-identified vulnerabilities or protected

characteristics. It was felt that there was a clear tension between the responsibilities of the custody sergeant, which should be addressed in order to improve the accuracy of any risk assessments that are undertaken in the custody suite.

Participants also discussed variations in practice. As was identified in one of the IPCC investigations, standards around conducting pre-release risk assessments, for example, vary across forces. Some participants suggested that APP should be a statutory tool in order to standardise practice in dealing with detention and custody issues.

Risk assessment and release

The previous section on the IPCC investigations raised several concerns about the risk assessments that are undertaken in custody suites. Participants in our research raised similar concerns. They discussed the problems of conducting risk assessments in the public space of a booking-in desk because '*people are unlikely to declare issues'*. All participants supported the idea of a dual risk assessment process, whereby the custody sergeant would conduct an initial risk assessment but then all detainees would see an HCP in a confidential room where, it was believed, they were more likely to speak openly. They indicated that this should be done with all detainees regardless of the outcome of the initial risk assessment and that it would represent a good use of resources in those areas where HCPs are permanently stationed in custody suites.

Participants were aware that they were significantly less well trained than other professionals to work with people with mental health conditions. In the words of one participant, '*None of us know enough about mental health*', reinforcing the argument that mental health practitioners should have a more consistent presence in custody suites. The issues of insufficient and inadequate training for custody sergeants were discussed, with concerns raised about three mandatory training days per year being insufficient.

Custody sergeants must conduct a pre-release risk assessment. Some of the issues around this have been raised above. Participants made three main comments about this risk assessment. Firstly, risk assessment tools vary in terms of their adequacy. They consider the more recent 'Niche' tool[19] to be much more comprehensive. Secondly, they have limited capacity to act on any warning flags that emerge through the risk assessment process. They described how they would give leaflets to

[19] See http://nicherms.com/products/rms_overview.php for more on this system.

detainees but have little time to do anything else. Importantly, they do not see this as their role. Rather, they argue that they are happy to refer detainees on to relevant services but cannot do one-to-one work such as taking people to access services and that this should be done by other agencies. There was general resentment that the police are asked to go beyond their remit: '*the police should learn to say "No"*'. Thirdly, they expressed concern about the focus placed on whether a risk assessment has been carried out, rather than on whether the risk assessment is effective in identifying need.

Participants highlighted that the red flag warning markers used on the Police National Computer for previously detained individuals are frequently out of date. It was therefore difficult to discern what was relevant and what was not. This feeds into the discussion, below, about a culture of blame that appeared to exist. For example, one participant described how a detainee had said he was going to a family member's house, was adamant that he was okay and so was released. However, the detainee subsequently attempted to walk home and ended up being run over in a road traffic accident. According to the participant this case is now the subject of an IPCC investigation. Participants also described how the police have to make sure that people get home safely but that beyond this, others should be responsible for the individuals concerned. There was a strong feeling that the police cannot be held responsible for people's actions. From this, it is clear that there is potential for more referrals of people who are released from police detention.

A culture of blame and IPCC investigations

Participants described how they had become risk averse by providing examples of practice which are little more than back covering, i.e., '*as a measure of self-protection.*' One example given was of putting everyone on a 30-minute observation visit whilst in custody so that there was no differentiation between levels of severity resulting in '*the ones who really need help will get diluted'.* Similarly to the recommendations made in the IPCC investigations, participants discussed the inadequacies of IT systems and how they are not always fit for purpose. However, the emphasis was on the functioning technology, and in particular CCTV, which was considered more important in terms of accountability and back covering than for the detainee's welfare per se. One case was mentioned where a young person had been on holiday with his family and was caught in possession of cannabis and charged, but a mistake with paperwork had occurred. He was subsequently wrongly issued with a further summons at his home address and killed himself as an apparent

response to this error. It was suggested that this would not have occurred if efficient IT systems had been in place.

Some participants in the discussions seemed defensive. It appeared that the focus was on reducing the risk of having to go through an investigation, rather than a concern for the deceased. This comment is not intended to be critical of police officers. Rather, it may be a product of the scrutiny which the police experience. Participants said that the word 'complaints' in the Independent Police Complaints Commission immediately implied blame whereas most investigations resemble an inquiry. They argued that this meant that whenever a death or serious injury occurred, the '*barriers go up straight away*'. This defensiveness may also come from the way in which such investigations are carried out. One participant described a qualitative difference between investigations into deaths in custody, as opposed to those following custody. She said that the latter tended to result in the custody sergeant feeling like a 'bystander' when a death occurs after detention, whilst a death in detention was more 'direct'. She found this problematic and more '*blaming'*.

Defining, identifying and investigating deaths following custody

Despite there being clear guidance (IPCC, 2016a) about when an apparent suicide should be referred to the IPCC, there was some confusion amongst participants about the different categories of death and the requirements to refer cases. For example, one participant described a case in which a detainee was released, took a drug overdose within 24 hours and died a week later. This case was subject to an investigation despite the death falling outside the two-day window. The participant described this as 'arbitrary'. This suggests a need for some training around the categories of death following police detention. We return to this issue in the concluding chapter. It was also suggested that a follow-up contact with someone (a prison officer or probation officer or community rehabilitation company worker, for example) at around 24-hours post-release would be '*really beneficial',* though clearly there would be huge resource implications in establishing such practice.

We asked participants how they found out that someone had died. They said that it is often only identified if someone makes the connection, which is not always possible. Participants agreed that any official figures would significantly understate the reality. They informed us that they sometimes only find out if a family member makes a complaint to the IPCC. In terms of the process of understanding what went wrong, they raised concerns about delays caused as a result of the coroner's

process, as well as problems in identifying the cause of death, which made it difficult to learn lessons about what might be done better.

In relation to learning from IPCC investigations, participants were concerned that insufficient attention was being paid to what could have been done better; there could be greater emphasis on lessons learned rather than accusations of misconduct. Again, this is related to the perceived culture of blame when it comes to this issue. Participants were also concerned that learning from investigations was not always systematic. Participants were all involved in the Police Federation and so made sure that they read information relating to deaths in custody or after custody, as well as policy developments, but this appeared to be down to the individual officer rather than a systematic process.

The human cost of police detention

We asked participants why people might complete suicide after a period of police detention. Participants were clear that, in many respects, it is very difficult to identify those who are at risk. In the words of one interviewee, '*these are the silent ones who make no fuss*'. Participants discussed the reasons for people completing suicide after being detained. Notwithstanding the fact that their views may not have reflected full knowledge of relevant factors, the general consensus within the small group of participants was that this stemmed from people's vulnerability. This was in a context of cuts to public services, a sense of shame, the impact of arrest on detainees' employment and the notion that, especially in the context of an arrest for a sex offence, detainees felt they had 'nothing left to lose'. That said, participants also discussed examples of people who had been arrested for seemingly petty offences such as shoplifting and expressed the view that caution is needed before placing all the attention on those arrested for sex offences.

5.3 Conclusion

We were unable to access data which would have given us a more accurate picture of the number of people who die from an apparent suicide following police custody. It may not be possible to ascertain the true figure from current records, given both quality and procedural issues, although in theory it should be possible to match all deaths against police custody records. Nevertheless, we have been able to shed some light on this important issue.

Firstly, the referrals, summaries and investigation reports provided by the IPCC showed that amongst those who subsequently kill themselves after release a significant proportion had been arrested for a sex offence. The numbers are small, but it may be that these people are more at risk of suicide because of a sense of shame and alienation. The custody sergeants we spoke to appeared to reflect this view although they also highlighted the fact that internalised shame can span the seriousness of offences from shoplifting to sex offences. Secondly, an analysis of the recommendations within the reports highlighted the importance of good training and support for custody staff (especially around mental health awareness), the appropriate use of technology, as well as the importance of good record keeping and communication. Finally, our interview and focus groups with custody sergeants have raised several operational practice issues.

Ultimately, though, our sense is that many of the issues which play a role in deaths in custody feature highly when it comes to preventing the deaths of people upon release. Specifically, good risk assessment and onward communication with relevant services are crucial.

6 | Conclusions

Size of the problem

A key aim of this research was to identify the number, locations and other data relating to apparent suicides and non-natural deaths of individuals within two days of release from police custody or 28 days after release from prison. No firm conclusion can be reached on the numbers: deaths of offenders in the community are less likely to be reported back to the relevant agencies than those in custody. From the NOMS data on deaths in the community post-prison, we were able to identify 66 non-natural deaths within 28 days of release over a five-year period. But even when relevant deaths are identified, the published data are very limited; even the unpublished (NOMS) data are unreliable or unrevealing. For example, the NOMS data do not record the protected characteristics of those who die, so no evaluation can be made between protected characteristics under the Equality Act 2010. The IPCC data (on deaths post-police custody) reveal 60 apparent suicides in 2015-16, which perhaps casts doubt on the reliability of the NOMS (post-prison) data, given the contrast to the overall number of deaths. Those who die post-prison may not be suffering the same ‘shock’ as those who were arrested. Indeed, some of those who complete suicide following police detention may require the intensity of support required by those with reactive depressions. The IPCC figure may reflect improved identification and referral practices given that it is so much higher than the figure produced by NOMS. But overall, the reliability of data is determined by police forces and other criminal justice agencies making a link between an apparent suicide and a recent period of custody or detention. Thus the findings should be viewed as indicative only and not statistically significant.

In relation to offences, it would appear that sex offences feature highly in relation to those who die post-police detention. Of the 13 PPO deaths in Approved Premises, there was no pattern to be observed in relation to offence or sentence length. There was no specific data available in relation to licence conditions or evidence of geographical clustering.

Policy and practice

Policy in this area can be unclear. Although IPCC and PPO reports make recommendations for future good practice, it is difficult to capture evidence of what is learnt from these reports or evidence of policy or practice changes. In relation to ongoing processes and responsibilities, there are clearly problems with communication between agencies. There is some evidence of poor practice in relation to the physically disabled as well as those experiencing mental ill-health. This is particularly problematic when people are released from prison: even where there has been good treatment in prisons, the relevant agencies may not be informed of key concerns when the prisoner is released. This is perhaps particularly surprising when they are released to Approved Premises. There are significant failures in communication in relation to the need for further support from drug support agencies for those leaving prison. There are also significant failures of communication between the police and mental health agencies. However, from a police perspective it appears that an even greater challenge is recognising mental health concerns and the impact of being accused of, or charged with, sexual offences. This conclusion leads to the usual call for better training in mental health awareness, and knowing whom to contact in community support services.

There are bigger issues, too. End to end sentence management does not yet work; and an offender's progression through the prison estate to the community (and sometimes back, when recalled) is difficult to navigate. In the context of police procedures, we also question whether suspects should be given greater anonymity until or unless they are convicted.

The Human Rights Framework

The Equality Act 2010 requires public bodies to consider how their decisions and policies affect people with different protected characteristics – but this cannot be achieved without data. We are also mindful of duties under the Human Rights Act 1998. The EHRC's Report on *Preventing Deaths in Detention of Adults with Mental Health Conditions* (2015: 30-31) usefully reminds us that Article 2 of the Human Rights Act imposes two positive obligations:

1. An obligation to protect individuals in state detention whose life is at risk, whether from the acts of others or from suicide.

2. An obligation to effectively investigate any death for which the State may have some degree of responsibility. This will include deaths from non-natural causes of individuals in state detention.[20]

The first obligation comprises:

a. A duty to put in place appropriate systems designed to protect lives (the 'systems' duty), and

b. A duty to take reasonable steps to protect individuals from a real and immediate risk to life which the institution is or should be aware of (the 'operational' duty).

We suggest that these obligations are explicitly extended to those who die under supervision in the community and to those released from police custody. The police and prison authorities would then be obliged to carry out an effective risk assessment before release, but must also disseminate those assessments to relevant agencies which should provide safeguards and support on release. Of course, as the EHRC makes clear, when determining what actions are proportionate, it is necessary for agencies to consider a number of factors. These include the seriousness of the risk, the steps that could reasonably be taken to reduce or eliminate the risk and the relative ease or difficulty of taking those steps. Sufficiently trained staff are required to identify risk and to determine the appropriate measures and systems that should be put in place.

If the obligation to have an effective investigation was extended to all deaths which arise within a short time of release, it might identify systemic or training defects, defects in planning or management, and defects in instructions to staff. As it is, it is not possible to say that effective investigations are carried out on all relevant cases, and this therefore limits learning and the sharing of lessons regarding what is unacceptable and what is good practice.

The IPCC, NOMS and PPO are not the only agents of accountability (political and legal). We have, for example, as part of this research initiated debate with individual coroners who were prepared to share 'stories' of deaths post-prison and post-police custody. It seems timely to encourage the Chief Coroner or the Coroners Society to seek to analyse the evidence of both inquests and the reports which coroners may

[20] These obligations are also subject to the obligation under Article 14 of the ECHR that the State must ensure that there is no discrimination in the enjoyment of these Article 2 rights. This means that public authorities must not treat individuals differently on any grounds such as their race, language, religion, political or other beliefs, sex, disability, age, sexual orientation, transgender status, or any other personal status, unless this can be justified objectively.

submit at the end of inquests.[21] A much clearer statement of accountability – who is responsible for investigating these deaths, and how the different accountability mechanisms inter-relate – is also necessary.

Culture, communication and the need for an ethic of care

At the heart of the concern about deaths following detention or custody are the questions of 'who cares?' and 'how can care be put into practice?' As already noted from the discussions with key 'stakeholders', it is clear that there is a need for better training and support for police, prison and probation staff, equipping them to discern mental health issues and vulnerability whether this be in relation to risk of suicide or in relation to the need for ongoing support post-custody. In police stations, police need better training in understanding mental health, which may enhance their ability to make appropriate referrals. Mental health practitioners should be more visible and accessible in custody suites in order that more effective assessments can be made at the point of release. Criminal justice agencies need a better understanding of their organisational cultures and gaps between 'policies on the wall' and the reality of everyday practice in order to ensure that staff have both confidence and competence to deliver good practice and help prevent deaths after custody.

The production of a checklist of actions to take when someone is preparing for release or being prepared for release would be helpful and a low cost initiative. Understanding that being charged with a sexual offence (or any other offence for that matter) may be traumatic and lead individuals to feel suicidal might involve a shift in organisational culture insofar as 'offenders' can also be vulnerable. Nevertheless, issuing those being released from detention with a card which identifies support agencies (including the Samaritans) would be a small step forward. Working with NPS or CRC liaison staff to notify Approved Premises or other agencies, and make post-prison release appointments for ongoing drug or alcohol support, would also signal 'care' to individuals.

Beyond this, and in the light of the fact that deaths after detention or custody receive relatively little public attention, we might argue that the establishment of continuous and comprehensive monitoring of data (including good record keeping) rather than one-off pieces of research (such as this) would also make a 'value' statement and register 'care'.

[21] See pages 30-31.

If these conclusions seem modest, it is because the data are weak. If one thing stands out from this research, it is that it is not clear who should care. We might conclude that these deaths do not appear to matter. We need to understand much about the culture of organisations carrying out government policy. Future research should obviously include quantitative data collection and analysis, but also qualitative interviews with stakeholders, though as this small piece of research has shown, people may be reluctant to speak out on this seemingly 'invisible' problem.

Recommendations

- The Home Office should give further consideration as to whether responsibility for health and mental care in police stations should be allocated to the NHS. As a minimum requirement, custody health care staff should have prompt access to NHS records in order to provide the best care and support.
- An inter-agency summit should be convened to explore how these 'hidden' deaths can be better exposed, and how the data can be made more reliable and comprehensible. Following the obligations set out in the Equality Act 2010, in future data collection and analysis should include reference to protected characteristics such as gender (where this does not compromise anonymity for those concerned), in order to monitor progress and identify any problems.
- More training be provided to support police custody staff in the identification and treatment of suspects who may be traumatised by the fact of arrest and investigation, and of others with mental health issues. Notwithstanding the progress made by the Mental Health Crisis Care Concordat around improving liaison between the police and mental health services, there is a need for police custody staff to understand the responsibilities of different agencies who work with people with mental health problems. The College of Policing is currently in the process of rolling out training and we would encourage prioritisation of this by individual police forces.
- More training be provided for all probation and CRC staff (including those who work in Approved Premises) particularly in relation to inter-agency co-operation when working with those at risk of abusing illegal and prescription drugs.
- Criminal justice agencies review how far relevant policy documentation is immediately accessible and comprehensible for staff. This includes providing

a ‘checklist’ of actions for dealing with people at crucially vulnerable moments in their lives.

There should be an obligation on the appropriate authorities to carry out effective risk assessments before release from prison and police custody and to disseminate information to all relevant agencies to provide appropriate safeguards and support. These obligations should be monitored within a framework of accountability.

- All apparent suicides within two days of release from police custody should be referred by the police to the IPCC, to assess whether or not to carry out an Article 2 compliant investigation.
- All non-natural deaths within two weeks of release from prison should be referred to the Prison and Probation Ombudsman to assess whether or not to carry out an Article 2 compliant investigation.

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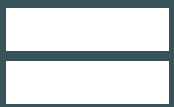

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