INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST submission to the Justice Select Committee Inquiry into Mental Health in Prison

June 2021

Introduction

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. For four decades, INQUEST has provided expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. INQUEST's Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody and is a member of the Independent Advisory Panel on Deaths in Custody.

2. INQUEST welcomes the Justice Committee's new inquiry into mental health in prison. We note that this follows a number of significant inquiries and reports in recent years, which in our view have achieved insufficient progress.[1] Our long-standing concerns[2] about mental health care in prisons have been put into sharp focus in this last year, with people in prison experiencing the harshest of restrictions as a result of the response to COVID-19. In this submission, we provide an overview of the failings in mental health care in prisons as evidenced by our casework with bereaved families: investigations and inquests too often highlight the inadequacy of mental health care in prisons. We highlight the deaths of four men and women whose experiences reveal a recurring pattern of failures in identifying and addressing mental health need in prison.[3]

Overview

3. The soaring rates of self-harm in women's prisons and worrying statistics on self-inflicted deaths across the prison estate during the COVID-19 pandemic reflect the continuing mental health crisis in prisons.[4]

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[1] These include inquiries by the Equality and Human Rights Commission (2015), the Joint Committee on Human Rights (2016), the Prisons and Probation Ombudsman (2016), the National Audit Office (2017) and the Harris Review on self-inflicted deaths in custody of 18-24 year olds (2015).

[2] See previous INQUEST work on the scale of mental health issues within prisons and their relation to deaths in prison: *Deaths in prison: a national scandal* (January 2020), *Still dying on the inside: examining deaths in women's prison* (June 2019 update), our submission to the Health and Social Care Committee Inquiry into Healthcare in Prisons (May 2018), our submission to the Joint Committee on Human rights inquiry into Mental Health and Deaths in Prison (March 2017) and our submission to the Harris review (2014). A look back at INQUEST's evidence shows a shameful repetition of the issues associated with providing proper mental health care in prison.

[3] This evidence submission focusses largely on deaths in prisons that have occurred within the past five years, with inquests concluding in 2020-21 (with the exception of one case in which the death occurred in 2015, with the inquest concluding in 2018).

[4] See INQUEST's response to Ministry of Justice Safety in Custody statistics, https://www.inquest.org.uk/inquest-responds-to-record-number-of-deaths-in-prison

4. However, INQUEST's casework highlights systemic failings in mental health provision in prisons that long pre-dates the COVID-19 pandemic. The most common issues found include:

    - inadequate mental health assessments with prisoners sometimes wrongly identified as not needing further assessment or assessments being carried out by junior or poorly trained members of staff;
    - systemic failures in the monitoring process for prisoners at risk of self-inflicted death and self-harm, including a lack of information sharing on an individuals' level of risk (known as ACCT). While the forthcoming update of ACCT is welcome, it is not clear what long-term impact, if any, the ACCT process has had on preventing self-harm and self-inflicted deaths in prisons[5];
    - the fundamentally inappropriate use of prison for individuals with acute and chronic mental ill health which highlights the need for far greater community mental health provision;
    - the damaging use of indeterminate Imprisonment for Public Protection (IPP) sentences;
    - the harmful use of segregation for prisoners identified with mental health issues[6];
    - critical delays in providing necessary medication for mental ill health in a timely and consistent manner; and
    - a systemic culture of neglect and disbelief in responding to prisoners' request for mental health support.[7] INQUEST have found this to be a particular problem for racialised groups in prison.

Case studies

5. We highlight below four recent cases of deaths in prisons which reflect these issues.

6. **David Sparrow** was found hanging in his cell in HMP Norwich on 4 June 2019 and died in hospital the following day. The jury at David's inquest found a series of failings in his mental health care which contributed to his death. For instance, critical information about David's mental ill health – including the fact that he was formerly detained under the Mental Health Act and that his paranoia worsened during his

[5] See INQUEST Report of the Family Listening Day for the London Clinical Network Health in Justice, https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=86ea91f9-c740-4e97-bcf2-7d047febd17e
[6] See Eric Allison's article in the Guardian on two cases of deaths in prison in segregation units, https://www.theguardian.com/commentisfree/2021/may/31/two-deaths-in-english-prisons-make-me-wonder-how-civilised-we-are-in-2021
[7] See INQUEST press release on the death of Dean Saunders in HMP Chelmsford in which the inquest jury found neglect and serious failings in health care at the prison, provided by Care UK, contributed to his death in 2016 https://www.inquest.org.uk/dean-saunders-inquest-closing

time in prison – was missed or not passed on by staff in the prison. There was also no evidence David was given his anti-psychotic medication in the week leading up to his death. Further, there was a 25-minute delay between officers noticing David's door was blocked on the day he died and raising the alarm.[8]

7. **Garry Beadle** died 11 February 2019. He was found hanging in his cell in HMP Durham and died in hospital four days later. It was known that Garry had mental ill health and was at risk of suicide and self-harm. On arrival at the prison, Garry told a senior officer that he was a suicide risk. However, this information was not passed on within the prison. The nurse involved in Garry's initial health screening had not received training on ACCT, which the inquest jury concluded possibly contributed to his death. Further, concerns about Garry's risk of suicide from a close friend were reported to Northumbria Police who then contacted HMP Durham but were never passed on to the mental health team or staff involved in Garry's ACCT review. An ACCT review on 7 February 2019 reduced Garry's level of risk from 'raised' to 'low'. Garry was found hanging in his cell at 2pm that day. There were also delays in administering Garry's anti-depression medication.

8. HMP Durham has the highest number of self-inflicted deaths of any prison in England and Wales and since Garry's death there have been a further seven self-inflicted deaths. This clearly indicates that despite ample evidence from inquests about failures to manage risk, provide adequate mental health care and prevent self-inflicted deaths, changes have not been implemented and preventable deaths have not been avoided.

9. **Serena Nicolle** died aged 52 in HMP Bronzefield on 3 September 2018. Her cause of death was determined to be from 'natural causes', with stress as a contributory factor. Serena suffered from serious physical and mental ill health and was reported to be in a highly distressed state around the time of her death. However, a full mental capacity assessment was not deemed necessary by attending staff. Serena was later admitted to prison healthcare, yet no multi-disciplinary meeting to discuss her care took place for a further three days. Tragically, during the course of that meeting, Serena was discovered unresponsive in the cell. Questions remain as to why Serena was assessed as fit to detain in prison given her severe physical and mental vulnerabilities and evidence that she was distressed in police custody and court prior to her imprisonment: these were left outside the scope of the inquest.

[8] The Prison and Probation Ombudsman (PPO) noted in their investigation into David Sparrow's death that HMP Norwich failed to implement a recommendation previously issued on ensuring obscured cell doors are promptly checked as per prison policy, https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2020/11/F3903-19-Death-of-Mr-David-Sparrow-in-hospital-Norwich-05-06-2019-SI-31-40-36.pdf

10. **Tommy Nicol**, a mixed White and Black Caribbean man, died at Watford General Hospital on 25 September 2015 after being found with a ligature around his neck in his cell at HMP The Mount three days earlier. Tommy was serving an indefinite IPP sentence and was two years over his minimum term with no immediate hope of release at the time of his death. Tommy had previously set fire to his cell and self-harmed. He was moved into a segregation unit. No mental health assessment had been carried out for Tommy and there was no input from mental health staff during his time in segregation. An expert witness at Tommy's inquest noted that Tommy was at a high level of risk of self-harm and suicide – the nature of his sentence contributed to this "more than anything else" as it made him lose hope.[9]

Conclusions and recommendations

11. Our casework makes clear that prison is an inappropriate environment for people with mental ill health and very often damages an individual's mental health further.

12. INQUEST has serious concerns regarding the extent to which the restrictions imposed on prisoners because of COVID-19 – such as widespread solitary confinement and a lack of contact with prisoners' loved ones – has exacerbated these pre-existing issues, while already stretched mental health provision is further limited. The government's early release scheme for prisoners had an extremely restricted criteria and as such its impact was negligible.[10] The opportunity to mitigate the long-lasting, harsh effects of COVID-19 restrictions and prevent deaths was lost, and the full scale of the mental health impact in prisons is only starting to show.

13. There has been wide recognition in the community about the lasting mental health impacts of the pandemic. However, the situation for prisoners is less well acknowledged. It is not clear how current policy, for example the ACCT review, will be able to tackle the scale of these concerns. The government's misguided policy of prison expansion will put further strain on the existing system.

14. We urge this Committee to question the government and HMPPS on these issues, with specific focus on the concrete actions it will take to strengthen mental health care in prisons, learn from previous failures and prevent death, as recommended below.

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[9] See also INQUEST's evidence submission to the United Nations High Commissioner for Human Rights report on "*systemic racism, violations of international human rights law against Africans and people of African descent by law enforcement agencies, especially those incidents that resulted in the death of George Floyd and other Africans and people of African descent, to contribute to accountability and redress for victims*". Page 19 of this submission reflects on the case of Sarah Reed whose mental health need was treated by staff at HMP Holloway as a disciplinary issue.

[10] See letter from Dame Anne Owers, National Chair for the Independent Monitoring Boards, to this Committee with an update on IMB findings during COVID-19, https://committees.parliament.uk/publications/1416/documents/12925/default/

- Instigate a proactive programme of mental health screening that will direct policy and resources to address the lasting impact of pandemic restrictions on prisoners.
- Ensure all prison staff receive in-depth training on how to properly identify and treat prisoners in need of mental health support.
- End the use of segregation for prisoners with mental ill health.
- Halt prison building, commit to an immediate reduction in the prison population and divert people, particularly those in need of mental health support, away from the criminal justice system, as recommended by the Bradley Report in 2009.
- Develop and fund alternatives to custody which respond to the specific mental health needs of racialised groups, women, trans and young prisoners.
- Provide automatic non-means tested funding for families' legal representation at inquests which shine a light behind closed prison walls.
- Ensure that the learning from investigations and inquests around mental health in prisons leads to concrete action, following INQUEST's proposal for a National Oversight Mechanism. As recommended by this Committee in its May 2021 report on the Coroner Service, a new body should be established to "oversee risks to public safety discovered by coroners and inquest juries and monitor and enforce action to reduce these risks".[11]

15. The issues we have outlined above are systemic and are built on a culture of neglect, denial and incompetence which have led to preventable deaths and self-harm. There is an urgent need to radically change the culture of sentencing, divert those with mental health needs away from prison and act on failings from these preventable deaths. Alongside this, it is essential that those involved in preventable deaths are held accountable if further deaths are to be avoided in the future.

[11] Justice Committee, The Coroner Service: First Report of Session 2021-22, https://committees.parliament.uk/publications/6079/documents/68260/default/