‘Reducing, not displacing risk’: Report from a seminar on working together to prevent non-natural deaths after custody

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Introduction

This report sets out the findings of an expert seminar[1] on preventing deaths after custody, where staff from agencies across the criminal justice field[2] in England and Wales shared their knowledge and experience. The report examines how relevant agencies can work better together to reduce the risk of non-natural deaths.

The aim of the seminar was to take forward findings from research on post-custody deaths by **Jake Phillips** at Sheffield Hallam University and **Loraine Gelsthorpe** and **Nicola Padfield** at the University of Cambridge. The research was published by the Equality and Human Rights Commission (the Commission) in December 2016.

Seminar participants identified a range of areas where policies or working practices should change across England and Wales. They suggested ways that **risks of non-natural deaths after custody could be reduced** through better joint working. The key themes and conclusions below reflect points raised by participants, rather than the views of the Commission, Sheffield Hallam University or the University of Cambridge.

Managing vulnerability

'If individuals are unable to access appropriate services when they leave custody, the risk of self-harm and suicide is not reduced, just displaced to the community'.

When arriving at and leaving police custody, risk assessments which gather information about an individual's vulnerability (including their mental health and risk of suicide) may be conducted in **public spaces in police stations**. This does not guarantee privacy and it is not an effective way to assess risk, as people may be reluctant to share relevant personal information.

Due to healthcare commissioning arrangements in England and Wales, there is a disparity between different custodial settings. For example, in police custody, nurses and paramedics may now perform functions that were previously delivered by doctors. This might reduce the standard of mental health care, as paramedics, for example, may not be **trained in mental health issues**. In contrast, healthcare in

[1] March 2017.
[2] Independent Police Complaints Commission, HM Inspector of Prisons, HM Inspector of Probation, College of Policing, Prisons and Probation Ombudsman (the Ombudsman), Inquest, HM Prisons and Probation Service, Independent Advisory Group on deaths in custody.

prisons is delivered by the NHS and there is a principle of parity of care between prisons and the community.

Police custody staff often need to make judgements about people's risk of self-harm or suicide. However, their lack of clinical training might mean they place too much weight on how individuals present themselves.

Police officers often have experience of dealing with people with mental health conditions, but they are not medically trained. Police forces have made good progress in preventing non-natural deaths in police custody. However, in practice people may not be able to access support when they leave custody as many services (including mental health) have faced significant cuts in recent years. Without a joined up approach towards managing risk after custody, the risk of self-harm and suicide is not reduced, just displaced to the community.

Many good policies are in place for the care and management of offenders - both during and after custody - including people with mental health conditions. However, there is a need for those policies to be put into practice **across all agencies**.

A useful example of joined-up working is the new requirement on local authorities and health bodies in England and Wales to include nearby **prisons in their suicide prevention plans**. This is a sensible and welcome move.

Data and information sharing

'Information systems can also be different within services, for example, between the National Probation Service and Community Rehabilitation Companies'.

The **data that exists** for deaths *after* custody in England and Wales is less comprehensive than the information available for deaths *in* custody. If this information is not collected, important lessons about preventing deaths cannot be learned.

At present, the Coroner's Office in England and Wales may not be aware that someone has recently been in prison or police custody. It would be helpful if a question about recent custody were added to the '**sudden and unexpected death**' form, which is used by the police.

Health records are crucial for staff assessing self-harm or suicide risks for individuals leaving custody. However, many healthcare staff are unsure about when they can share information. Staff may be concerned about **breaching confidentiality or**

data protection requirements. This issue is exacerbated when people interact with many different agencies. Healthcare staff working with the police would benefit from training and/or clear guidance to improve their confidence on this important issue.

To avoid duplication and improve data collection, improvements could be made to a range of forms. For example, the different forms used by approved premises in England and Wales to inform the Prison and Probation Ombudsman (PPO) and HM Prison and Probation Service (HMPPS) about deaths under supervision could be merged. Further information could also be added to it, such as the prison release date.

Although the integration of health records in custodial and non-custodial settings is a positive step, some information systems are not transferable between agencies. For example, two important forms used by prisons in England and Wales are still paper-based: Assessment, Care in Custody & Teamwork (ACCT) forms and Person Escort Records (PERs). This means that information cannot easily be shared when people leave prison, such as with Approved Premises or probation services. As a result, vital information about a person's suicide risk, self-harming or substance abuse may not be available.

Police services hold a lot of data, but it is not all on the Police National Computer. This means information can be missed, such as whether someone was taken to a place of safety by the police[3]. Leicestershire Police have a '**vulnerability database**' which they use to protect people with vulnerabilities in Leicester. This approach could be rolled out across other police forces.

Information systems can also be **different within services** in England and Wales, such as those used by the National Probation Service and Community Rehabilitation Companies.

Better transitions

'There is a need for the 'sending' organisation to have more responsibility for communicating relevant information'.

The required timeframes for charge or release mean that individuals often have **limited notice before leaving** police custody. This is also the case for people

[3] Under s136 of the Mental Health Act 1983.

leaving prison, and individuals may have limited financial resources. Some people do have effective resettlement plans, while others are merely signposted to services.

Prisoners need to be better **prepared for release** and given more training on thinking for themselves. These skills have considerable implications for how they can integrate back into the community and access the support that they need.

The police can escort people with mental health conditions off the streets to a place of safety and arrange for them to be assessed. However - despite a need for this service - they do not usually take **people from Approved Premises,** as they are not public places. This can be a considerable barrier to people getting the right diagnosis and support for mental health conditions.

Many people become **homeless when they leave prison,** as only a small proportion of ex-offenders go to Approved Premises. Even if people are advised of their release date with significant notice, they cannot be declared homeless until they actually leave custody. This can lead to a delay in them being housed and increase the risk of them rough sleeping. This can have considerable implications for a person's mental and physical health, their drug and alcohol use and their risk of suicide. It may also make it more difficult for people to register with a GP.

Services 'receiving' prisoners – such as Approved Premises - often **struggle to access crucial information** about people's needs and their risk of self-harm or suicide. There is a need for the 'sending' organisation to take more responsibility for communicating relevant information. This model has long been used in health settings.

Services in the community

'An important factor in some deaths is that many services in the community no longer exist or have limited availability'.

High proportions of people who die after police custody have experience of substance abuse or mental health issues. An important factor in some deaths is that many services in the community **no longer exist** or have limited availability. Examples of this include social housing, mental health services and drug or alcohol support. As a result, prison and probation staff may struggle to have anywhere to refer people to.

The **quality of services** has also been affected. For example, in terms of the vital services that do still exist, participants stated that few are available outside of normal (week day) working hours. Furthermore, recent changes to probation provision may mean that individuals are more likely to see different people whenever they interact with a service.

There are limited **Approved Premises for women** in England and Wales, so women leaving prison may be located far from home. This limits their support structure and contact with family and friends, which may undermine their well-being.

Improving communication

The NHS 'duty of candour' aims to ensure that health providers are open and transparent with service users (and those who act on their behalf). It includes specific requirements when things go wrong with care and treatment. While the duty is a positive development**, it does not apply to healthcare in police custody** in England and Wales, as it is not commissioned by the NHS.

High levels of **shame attached to sex offences** can increase the risk of self-harm or suicide for people leaving police custody. This is highly relevant when decisions are made about release on police bail. Individuals may also lose support from family or friends due to the nature of the charges they face. Lessons could be learned from other countries to mitigate against this risk. For example, specialist helplines for sex offenders are available in some European countries.

Conclusions

Participants suggested that the following changes be made to policies or practices, to reduce the risk of non-natural deaths after custody in England and Wales.

1. Prisons should focus more on **protecting and promoting the well-being** of individuals leaving custody. The risks of self-harm and suicide need to be reduced, not just transferred to the community or to other agencies.
2. Police forces are now better at referring people to support services on release. However, many of those services are **no longer available**. There is a therefore a need for more joined-up working in order to reduce risk.

3. Healthcare in police custody should be commissioned by the NHS. This would ensure that there is **parity of care** with services in the community. It would also mean that the duty of candour applies to staff in that setting.
4. There is a need for **better organisational learning** across the criminal justice sector. Individual staff and agencies are unlikely to learn lessons – and reduce deaths after custody - if a culture of blame exists.
5. Families can play a vital role in supporting people leaving custody, which can reduce the risk of non-natural deaths. If individuals **do not have family support**, they need to be able to access other means of support. These could be provided by mentors or probation agencies.
6. The available data for post-custody deaths is less comprehensive than the information available for custodial deaths. Changes are also needed to the way **data is stored and shared** - within and between - agencies. This would improve data collection and make communication more effective between agencies.
7. It would be beneficial if the Coroner's Office could publish thematic reports to capture and disseminate lessons learned. Their reports on the '**Prevention of Future Deaths'** should also be better disseminated and their recommendations implemented by key agencies.
8. Due to the specific circumstances that healthcare staff face in the criminal justice sector, a new nursing specialism could be developed. '**Forensic nurses'** could receive a range of training in health, mental health, and drug and alcohol care.
9. There is a need for more records need to be in electronic form, as paper-based information is not fit for purpose. Information relating to people's vulnerability post-custody needs to be **readily available** to other agencies. This will also be useful when prisoners move around the prison estate.
10. Where there is a risk of self-harm or suicide, health staff must be able to confidently **share relevant information confidently** with other agencies, while meeting data protection requirements.

Further information

Equality and Human Rights Commission, Sheffield Hallam University, the University of Cambridge. Research Report 106: Non-natural deaths following prison and police custody.

Equality and Human Rights Commission. Preventing Deaths in Detention of Adults with Mental Health Conditions: Progress review.

Equality and Human Rights Commission. Preventing Deaths in Detention of Adults with Mental Health Conditions.