INQUEST

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Report of the Family Listening Events organised for the Harris Review into Self-Inflicted Deaths in Custody of 18-24 year olds

January 2015

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1. Introduction

Following the establishment of the Independent Review into self –inflicted deaths of 18-24 year olds in National Offenders Management Service (NOMS) Custody, the organisation INQUEST successfully tendered to provide opportunities for bereaved families to give personal testimony to members of the Review panel. The contract was formally awarded to INQUEST in September and two facilitated events were held in October and November 2014. This report distils the themes that emerged based on the discussions and includes comments and recommendations from families.

INQUEST made the bid for this work with the Harris Review because of its extensive experience in working alongside bereaved families following deaths in custody. For over thirty years INQUEST has provided assistance to thousands of individual families following deaths in custody to enable them to engage with the investigation and inquest process, analysed the issues emerging from the inquests and brought them to the attention of policy makers, practitioners and politicians and worked for improvements to the treatment of bereaved people and the investigation and inquest process.

1.1 External Consultant and Report Writer

The report was written for INQUEST by an independent consultant Chris Tully, who assisted in previous design and facilitation of Listening Day events for the Independent Advisory Panel on Deaths in Custody, which included report writing, research and analysis. He also held a similar brief with the Independent Police Complaints Commission as part of its review into working with families bereaved following contact with the police. He has 27 years experiences of training development and delivery for voluntary and community based organisations working with young people. He has also conducted monitoring and evaluation, example projects for Women in Prison evaluating its Women Prisoner Advice and Information Service (WPAIS) and prior to that, its Move Out Move On employment and training programme for women offenders. He also works as a trainer and a Transformative Mediator with skills in neighbourhood disputes and conflict resolution.

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2. Background

2.1 About INQUEST

Based in London INQUEST is a small charity that has a proven track record in delivering a free in-depth specialist casework service to bereaved families following deaths in all forms of state custody or detention or involving state agents in England and Wales. INQUEST also works on other cases that involve multi agency failings and/or engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability. The issues from its evidence based casework and the collective experience of bereaved people informs its strategic policy, research and legal work. INQUEST also involves bereaved families in its policy and campaigning work for change.

Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; holds those responsible to account and disseminates the lessons learned from the investigation process in order to prevent further deaths occuring.

INQUEST also provides the *Inquest Handbook: a guide for bereaved families, friends and their advisors* free to *any* bereaved family.

It works in partnership with members of the INQUEST Lawyers Group who support and advance the work of INQUEST by providing preparation and legal representation bereaved people; promoting and developing knowledge and expertise in the law and practice of inquests and working for law reform.

INQUEST has made important contributions to reform, including the establishment of independent investigation processes following deaths in police and prison custody in 2004, the Corporate Manslaughter and Corporate Homicide Act 2007 and the Coroners and Justice Act 2009. It has generated cross-party parliamentary interest and debate about deaths in state detention and is represented on the Ministerial Council on Deaths in Custody. INQUEST publications include: briefings on individual cases and on thematic issues arising; *Inquest Law*, the journal of the INQUEST Lawyers Group; and number of extensive reports: *In the Care of the State? Child Deaths in Penal Custody in England and Wales* (2005); *Unlocking the Truth – Families' Experience of the Investigation of Deaths in Custody* (2007), *Dying on the Inside – Examining Women's Deaths in Prison* (2008*), Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?* (2012), *Learning from Deaths in Custody: A New Framework for Action and Accountability* (2012) and *Deaths in mental health detention: an investigation framework fit for purpose? (2015 forthcoming).*

2.2 INQUEST's work on deaths of children and young people in custody

Following the inquest into the 2002 death of 16 year old Joseph Scholes in Stoke Heath YOI, the coroner recommended a public inquiry to address the wider policy issues that could not be explored at the inquest. INQUEST and Nacro called for a public inquiry supported by other penal reform groups, parliamentarians and the Joint Committee on Human Rights. However, it was rejected by the government in 2006.

INQUEST's casework and related policy work continued to draw attention to the issue and INQUEST was commissioned by the Prison Reform Trust as part of its work on a 'Strategy to Reduce Child and Youth Imprisonment' to produce a report on the deaths of young people

in prison. The resulting report *Fatally Flawed: has the state learned lessons from the deaths of children and young people in prison*, was published in 2012. The report drew on INQUEST's extensive casework on the 143 deaths of children and young people (aged 24 years old or younger) between 2003 and 2010[1]. It has been submitted as evidence to the Harris Review.

Fatally Flawed concluded that there needed to be an overhaul of the use of imprisonment for vulnerable children and young people and included in its recommendations a suggestion that: *"an Independent Review should be established, with the proper involvement of families, to examine the wider systemic and policy issues underlying the deaths of children and young people in prison."*

In January 2014 INQUEST published a call for a review highlighting the continuing pattern of deaths and the limits of the current system in understanding and preventing them. *The deaths of children and young people in custody: the need for an independent review*[2] that was backed by a wide range of leading organisations working in the criminal justice and children's rights fields[3]. It highlighted that 18-24 year olds who have died in custody had commonly experienced multiple disadvantage and typically had complex needs such as histories of substance misuse, mental health difficulties, learning disabilities and self-harm. It outlined how there is a *pattern* of deaths with worryingly familiar themes

Expressions of concern were also made by the parliamentary Justice Committee[4] and other bodies and key public figures including the Children's Commissioner and Deputy Children's Commissioner for England.

2.3 Facilitating family engagement with inquiries, reviews and consultations

INQUEST has successfully organised a range of events to faciliatate bereaved family engagement with a range of reviews and consultations. It has developed and refined its method of working with families and developed a model that provides a safe and supportive environment in which families can share their experiences of deaths in custody and detention within a structured, thematic framework. In 1998 INQUEST organised a meeting with the then Chief Inspector of Prisons (now Lord) David Ramsbotham during his thematic review of suicides in prison. We facilitated an afternoon meeting with ten family members. In 1999, he said in his report:

> *We had a most moving and informative meeting with the relatives of nine prisoners who died in prison, whose courage in coming to meet with us I recognise and admire*.

[1] The full report can be found here: www.inquest.org.uk/publications/books/fatally-flawed.

[2] Available here http://inquest.gn.apc.org/pdf/briefings/INQUEST_Briefing_on_deaths_of_children_and_young_people_in_prison_JAN_2014.pdf

[3] See *Young people are still dying in prison* Letter to the Editor, Daily Telegraph, 5 February 2014: http://www.telegraph.co.uk/comment/letters/10617755/Young-people-are-still-dying-in-prison.html

[4] Justice Select Committee, *Youth Justice: Seventh Report of Session 2012-13*. Full report from: www.publications.parliament.uk/pa/cm201213/cmselect/cmjust/339/33902.htm

INQUEST also arranged for families to meet the team who conducted the Home Office fundamental review of coroner services in 2002, and with peers and MPs from the Joint Committee on Human Rights during their inquiry into deaths in custody in 2004:

> *We also held a private meeting with members of the families of people who had died in custody. They provided us with compelling evidence of failings throughout our systems of detention, and of the grievous personal consequences of those failings. The family members with whom we met, primarily parents whose sons and daughters had died, told us of their belief that the state had failed them in its duty of care.* (*Deaths in Custody: Third Report of Session 2004-05 Vol I*, 2004, para 6, p8.)

More recently in 2007/8 we organised a similar event for Baroness Jean Corston during her review of women with particular vulnerabilities in the criminal justice system. She said in her report:

> *During my review, INQUEST arranged for me to meet a group of families bereaved by a death in custody and I met others individually on separate occasions. I am particularly grateful to these families for sharing their sad and personal stories with me. I greatly admire their courage and was struck time and again by their overwhelming concern that others should not suffer as they had done."* (*Corston Review*, 2006).

In March 2010 and in September 2011 we organised two successful family listening days for the members of the Independent Advisory Panel on Deaths in Custody (IAP) and the reports of the events are published on the IAP website[5] The first focused on deaths in prison and police custody or following contact with the police and the second on deaths of detained patients in mental health settings.

In March 2013 we organised similar events for the Chair, Dame Anne Owers and senior members of the Independent Police Complaints Commission as part of their review of their work in investigating deaths. Their final report[6], published in March 2014 makes considerable reference to the importance of the family listening events in informing their recommendations for change.

INQUEST's model of facilitated Family Listening Days enables effective and meaningful dialogue between families and those working in a range of official capacities. The effectiveness of the model is dependent on the relationship of trust between the families and those facilitating who have a unique understanding of the complexity for bereaved families in dealing with traumatic bereavement and the inquest process in the context of a death in custody. It is also important that facilitators also have detailed knowledge of the changes to policy and practice made over a number of decades. Families also express a

[5] Family Listening Day reports 2010 and 2011 http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2010/09/IAP-Family-Listening-Day-Report-Aug-2010.pdf and http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2012/02/IAP-Listening-Day-Report.pdf.

[6] Review of the IPCC's work in investigating deaths – Final Report March 2014 https://www.ipcc.gov.uk/sites/default/files/Documents/deaths_review/Review_of_the_IPCCs_work_in_investigating_deaths_2014.pdf.

consistent message; for there to be learning from the death of their relative and for action to be taken so that others do not suffer in the same way. INQUEST's commitment to placing the family voice at the heart of its work also recognises the important insight families can offer. The aim of the model is to both enable dialogue between bereaved families and officials but also to produce reports that can be used by organisations to improve their practices and the way they engage with bereaved people.

2.4 Approach and methodology

Following discussions with the Harris Review secretariat it was agreed, that two Family Listening events would be organised – one open and one closed for those who wanted confidentiality.

INQUEST identified the cases that were relevant to the time period and remit of the review from its statistical database. It then cross referenced this with its case database to identify those cases where families or their representatives had contacted the organisation for assistance. Invitations were extended to the families of 44 young people who had died. INQUEST suggested, and the Harris Review panel agreed, that hearing from at least one family of a child who had died in custody would add to the panel's understanding and knowledge of the concerns and views of families of young people. For this reason, the second hearing day included one session with family members of a child aged 17.

They were invited by a letter(see Appendix 1) from INQUEST's Co-Directors, that included direct quotes from Lord Harris about the importance of the Review and explained that it would *"focus on issues that include, but are not limited to, vulnerability; contact with family; staff training; staff-prisoner relationships; information sharing; whether things should have been done to divert vulnerable young people from the criminal justice system; and whether appropriate lessons have been learned from previous deaths"*. Those families that responded and were in a position to attend were a representative sample of those with whom we work in terms of race, gender, geographical representation across England and Wales and who were at different stages of the investigation and inquest process.

Extensive follow-up was conducted by caseworkers to answer family queries and to encourage them to contribute to the review. The trust families have in the organisation meant that we were able to reassure families about the importance of their contribution to the review. Caseworkers also contacted family legal representatives to inform them about the invitation so that they could also answer family queries and likewise encourage them to attend. Those families who were unable to attend as they could not arrange time off from work or cover other commitments were encouraged to submit written comments. In order to try and contact those with whom INQUEST had no contact, assistance was sought from the Prison's and Probation Ombudsman. However due to the tight time frame and complexity of the task they did not have the resources to assist.

Two events were scheduled, the first of which took place at the National Council for Voluntary Organisations (NCVO) in London on the 16th October 2014, the second at the same venue on the 27th November 2014. It was important that the events took place at a venue that was neutral and that was easily accessible to those travelling in to London.

The days were designed with reference to the Review's Call for Submissions and a structure created to maximise input from families.[7] The overall structure was based on the family experience of each individual young person's chronological journey into custody, their experience of custody, and the experience that followed the death. We also built in sufficient time enabling Panel members to have informal conversations with family members over coffee, lunch and tea. INQUEST produced a short, confidential note for Panel members on the circumstances of the families' relative's death prior to the meetings and a briefing on the design and structure of the days that suggested that their role would be primarily to listen and ask clarifying or follow up questions during the sessions.
Written submissions were also received by INQUEST from families who were unable to attend the events and/or providing additional comment. Hard copies of these submissions can be provided by INQUEST if required by the review team.

2.5 Post event analysis and structure of report

Following the events, INQUEST staff and the consultant analysed the notes taken on the day and the written contributions submitted by families to identify emerging themes. These themes were then cross referenced with the questions as outlined in the Review's Call for Submissions (http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/05/Call-for-Submissions-Final.pdf). The report then set the family evidence in the context of both the requirements of the Harris Review and with findings from previous INQUEST research and analysis (see Family Recommendations for reference) and caseworker feedback.

[7] See appendix 1

3. Provision of Support prior to contact with the Criminal Justice System

3.1 Early support and intervention issues

Families described the problems of accessing appropriate and co-ordinated support for their relatives, in some cases stretching back years. It became clear that for those with pre-existing mental health problems, or learning difficulties, diagnosis proved difficult as did finding the appropriate support once a diagnosis had been made.

"There was nothing, no help for (him). The only help we received was from an Educational Psychologist. He tried to get him moved from the school. He tried to get him help. He couldn't get anything. Nobody else did anything. I contacted the social services. I knew he had problems from the word go. When he left school there was nothing. Social services were rubbish. They said 'watch your back'. I was working so many hours every day. I had 3 or 4 jobs on the go. I also stayed at home with him and looked after him full-time. I was looking after him on my own with no help. I am just so angry. How could social services tell me to 'watch my back'"!

Failings in early interventions created an environment in which untreated problems in childhood contributed to further difficulties in adolescence and young adulthood.

A family member recounted their powerlessness to access the support needed for their son. He had a long history of problematic behaviour; in school, in forming relationships and in learning. He was assessed by a psychiatrist aged seven, was self-harming at nine and by his mid-teens was known to police.

"*Police, doctors and psychiatrists all knew about these day to day incidents, but still the help was not there. On many occasions he used to hold his head and cry for help because he knew he could not control what he would do to himself".*

Another family member felt support from school was lacking,

"(He) was permanently expelled from school in Year 2. He never got a statement (confirming special educational needs). He came back to school, and got through primary school with a teaching assistant. The school never said that they wanted (him) to see a counsellor or to get a statement".

3.2 Mental health provision

Families felt that there should be a greater provision of mental health places in specialist centres geared towards working with young people. There were consistent calls for increased funding, more bed spaces, specialist mental health trained staff and for these services to be established as an alternative to prison.

"He fell through a big hole and was sent to prison because of a lack of mental health places".

Another family saw the problem as a financial one,

"A fundamental weakness of funding is the lack of residential psychiatric treatment. We begged for help".

"Young boys need intensive treatment for mental health problems".

The lack of bed spaces in residential alternatives to prison also meant families were faced with long delays for help and provision in places often miles from home. One parent thought her son might get a place in a unit which was over 150 miles from the family home and had *"considered moving so I could visit him".*

3.3 Support from other agencies prior to contact with the Criminal Justice System

There were some families who had sought or received support from agencies over a sustained period of time. For others their requirements were more pressing closer to the time immediately preceding detention and the custodial sentence. Families discussed the absence of support, or reluctance on the part of health/social/educational professionals to make what they felt would have been the appropriate interventions.

"Before his time in prison there was no support for him from social services. He was left alone".

This included agencies that have a direct link with the criminal justice system,

"(His) probation officer had trouble getting his clients [access to] services. Mental health self-referral forms make it difficult to access services. They are worse than being referred by a doctor. When I took (him) to his GP, the GP said he was not going to refer (him) to mental health services as 'you don't want that on your record', and that he was just going to give (him) anti-depressants".

In another example the family had taken their relative to see a psychiatrist who diagnosed *"attention seeking (sic) disorder".* They felt this was patronizing.

The provision of community based child and adolescent mental health services was seen as particularly lacking, and crisis teams seen as being poor. Crisis teams were described as "*a waste of the NHS 's money"* whilst another person claimed,

"*NHS mental health services need a kick up the arse".*

One family described how their relative had a long history of mental health problems, including a diagnosis of ADHD,

"*a disease a lot of people don't recognise. We were told it was a case of bad parenting".*

Families experienced inconsistent care, and a perceived desire by professionals to diagnose recovery when the families could see their relatives were still in crisis, which resulted in young people ending up in custody with limited access to alternatives.

Other families described similar problems with social services. In one case the family's relative had been run over by a police car resulting in severe frontal lobe damage - a serious brain injury. Before that he had been identified as suffering from ADHD but had not had the assessments that they believed he should have had. After the brain injury their relative became aggressive, experienced mood swings and was unable to cope with his feelings. He was eventually placed into social services care. After his initial arrest he received no more help from the social services, despite his parent's pleas for help. In that time social services took no heed of his parent's warnings that he could be a danger to himself and other people. He then murdered someone while he was in social services care.

"If he'd had some input from social services it would have helped".

Some families talked about the change in available services after their child reached 18.

"Child and Adolescent Mental Health Services (CAMHS) were brilliant with him but eventually he lost all support".

A number of families recognised one agency as being effective with regard to the care and attention paid to their relatives. The Youth Offending Team (YOT) staff were commended by a number of people who felt they demonstrated a commitment and care lacking from others. They were variously described as "*brilliant"* and *"good because they kept me informed*".

"*I had a good experience with the Youth Offending Team also. There was an excellent support worker who was the only one who was aware of (his) mental health issues. She pushed for him to get support and said she was worried about him".*

Another described the differences between the YOT and other involved agencies.

"The Youth Offending Team was brilliant. When he was in prison the Youth Offending Team worker used to call me every time she was going to prison for a visit so that I can also go with her, so I used to get an extra visit on top of my ordinary visit. She was really nice and supportive. Probation services on the other hand were awful. When I phoned them for some information about my son they told me that he had to give his consent before I could speak to them so he did send his consent but even after that they were not supportive at all".

The reasons for this more successful way of working were identified by families.

"The difference is that Youth Offending Team workers are trained to work with young people. They care about young people and get on their level".

Families felt these skills were absent from staff from other agencies. There was an acknowledgement however that information held by the YOTs was not shared as effectively

as it might be, and that on occasion the YOTs encountered difficulties in accessing information once a young person was in prison.

3.4 Court Process and Sentencing

There was a consistent view expressed by families that procedures around sentencing were inadequate. Examples were given of poor information sharing.

"The night before (he) was taken to the magistrates court the police who knew him well were so concerned about his unusual behaviour they took him overnight to the Accident and Emergency Unit. I don't believe any of this was taken into consideration by the court or passed on to the prison staff".

Another family member raised the same issue,

"*(he) was seen by a psychiatric nurse prior to being sent back to prison, at the magistrates' court at the request of his solicitor. He recommended and wrote that should (he) be returned to custody there was a high risk of self-harm or suicide attempt. This document did not go with (him) to the prison. It was faxed 24 hours later, filed without being acted upon and thus another opportunity to keep our son safe was missed. I am not convinced that anyone was or is held responsible at the Magistrates Court level for ensuring these important pieces of information are communicated".*

There was a perception that courts failed to recognise the specific vulnerabilities of young people or to understand their mental health needs. In some cases families had tried to pass on information to the court clerks, legal representatives and to the judge, but they did not believe their concerns had been listened to. This raised questions for many of the families over the suitability of prison for 18-24 year olds who have vulnerabilities and why there weren't suitable alternatives to prison.

"The judges shouldn't be judging these people as they judge others, because of their particular vulnerabilities. There should be something like a special secure unit".

One family summed up the need to support vulnerable young people in a way that was sensitive to the needs of the individual, rather than presuming a one size fits all prison system was effective.

"*A different type of custody is needed. On one occasion (he) told me how much he wished he could stay at a halfway house near (the family home). There was a curfew around 8 p.m. He knew they would check him for alcohol or drug use. He found these boundaries helpful. Unfortunately he could only stay there for 6 weeks".*

Families described how they had little confidence in the appropriateness of the courts' ability to recognise vulnerability, and how they often failed to consider information from the families and other agencies when deciding on sentences.

A family described their experience, which they felt demonstrated poor administration and a lack of attention to the individual.

"In court the solicitor was reading my son's previous convictions out, (they were the records of her son's older brother). The prosecution read out the wrong records. They put this in the (news)paper. I tried to say that it wasn't (his) record. The judge told me to sit down and said to the prosecution 'don't worry, mistakes happen.' The paper only printed a small apology after I told them about the mistake".

The contrast in the sentencing process for those under the age of 18 was described. One family noticed the greater attention given to the particular needs and vulnerabilities of their child when faced with the court process.

"I had to go into the cells to calm (him) down. He had no idea what was happening. His YOT worker did a pre-sentence report and contacted CAMHS. They said that he would not be able to answer questions and would not be able to understand the court process. His YOT worker also noted that he was very vulnerable".

More time was taken to explain what was going on, and greater care taken to provide a continuity of legal representation. This was in contrast to their experience post 18, when the same vulnerabilities and mental health issues existed, but the process seemed much more confusing and fragmented.

3.5 Assessing vulnerability and information sharing between police and prison

For some families the reliance on a "pro forma" approach to assessing vulnerability was perceived to be failing those entering custody. It was felt the absence of the "human touch" meant issues were not picked up and staff were not using their training or intuition, instead relying on a "tick box" approach to assessing risk.

"The staff receiving (him) into the prison appeared to be unskilled and untrained to assess the people before them. They rely on computer programmes to reach a conclusion but don't necessarily use their eyes to notice scars from self-harm on a young man's arms".

Families also described how they were unable to pass on their concerns regarding their relatives to the authorities. They spoke of "*trying and trying, but they wouldn't listen*" and their fears that without support or input from families it would be a difficult task for the prison service to look after the young people effectively.

"(He) should never have been sent to prison, he was mentally unwell and needed help, not locking up. I knew he would continue to self-harm and I knew I wouldn't be able to help him. He had a long list of previous self-harm. Everybody knew what he was like yet he was sent to a prison with staff looking after him that had no training to deal with someone like (him) and many others with mental health (problems)".

For others, their relatives' vulnerabilities had been assessed and recognised, but the relevant information was either incorrectly noted, or not passed on.

"When he was arrested the police realised that (he) had mental problems and required an Appropriate Adult. During his stay in the police cell he was self-harming and having checks at 20 minute intervals. This information was not indicated on the Prisoner Escort Record (PER)".

One family knew that the assessment process had identified a mental health issue, but it was unclear whether this information was shared with others within the criminal justice system.

"*The fact that he had changed neurologically after the accident wasn't taken into account. The police didn't identify him as having mental health issues, but two days later the Youth Offending Team worker assessed him as possibly having bipolar disorder".*

Another family described how their relative's mental health was also poor prior to going to prison for a second time, and although this information was available to the prison, it did nothing to trigger the appropriate care and supervision to ensure his well-being and safety.

"When going into (the prison), he had a file - a prisoner escort form - saying that he was a self- harmer. He also came into prison with ligature marks round his neck. (The prison) had all of (his) details, including a big file with a sticker on it which said he was a self-harmer".

3.6 Information vacuum for families

Families spoke about an absence of information regarding where their relatives' were being held, and complained of delays in being told of arrest and detention. Families described the uncertainty, confusion and hopelessness of not knowing what was happening to their relatives,

"nobody told us where he was. We were not allowed to contact him initially. We were not informed about anything".

"No family liaison was really made after he was initially arrested (12.30pm) with his Mam and Dad until very late into the night when two police officers drove to their house to explain that their son had been arrested".

"At the police station, (he) was crying, screaming and saying he was going to kill himself. The police strapped him up and left him alone. They didn't contact us (his family) - they said that this was because he was over 18. They didn't give him medication, or a Doctor or nurse".

"I and his parents were really concerned about how (he) was during his period of time in police cells Friday to Monday. After what had happened we imagined him traumatised, in shock and alone and there was no way of being able to support him. The officer in charge refused to let us see or speak to him".

Concerns were expressed about not knowing how the "*system works*". Families with no previous experience of the criminal justice system were unsure how to arrange visits, what items could and couldn't be brought to their relatives, and were very unclear who to talk to if they wanted to pass on information or raise concerns,

"*no information was given at the court, no contact details or procedures etc. We had to find out contact information for the prison, which invariably led to being passed from pillar to post as every telephone number we tried, gave us a new one to ring".*

4. Experiences in custody

4.1 Adequacy of prisons dealing with the vulnerabilities of young people

Families believed there was a palpable failure on the part of prisons to cope with vulnerable young people. These failings were identified as twofold: firstly, the inability of staff to deal with young people, with observations suggesting prison officers could not work on "*young people's level"* and the need for specialist prison officer training for work with young people "*like you would have to be a youth worker";* secondly, the inadequacy of provision for people entering prison with mental health issues. There was less discussion, for example, about dealing with drug and/or alcohol addictions (although one family's experience was specifically about drug treatment in prison – see below) than there was about the treatment of mental health problems, learning disabilities and other medical conditions.

According to the families there are a number of contributory factors impacting on the effectiveness of the care shown to their relatives whilst in prison, and these will be explored in this section. Families described the prisons' failings in recognising mental health conditions, failing to treat them effectively, employing staff who could not recognise the signs and symptoms or were not trained effectively to do so. One family explained the impact.

"My son, who suffered from Attention Deficit Hyperactivity Disorder (ADHD), hung himself in desperation to get some attention. During the period after his death, I was able to read various documents and reports from the NHS Mental Health team and the Prison, and subsequently the Coroner's Inquest. It became very clear that these people knew nothing about ADHD. In fact ADHD was not considered a risk. All of my son's medical records were sent to the prison, it was clear that he had ADHD and that he had been treated with Ritalin and Concerta (ADHD medication) for many years. Consequently, whilst on remand he repeatedly asked to be given Concerta. This drug calms and slows somebody with ADHD, thus controlling the impulsive and disinhibited behaviour, morbid ideology and attention seeking behaviour".

Others described the medication their relatives relied on being administered at the wrong time of the day, thus negating its effectiveness, and information regarding medication not following prisoners through the system. The absence of suitably qualified health staff was also identified as problematic.

One family spoke about the prison's failure to recognise the impact of drug withdrawal and the risks this posed. Their relative had been addicted to heroin and following his entry into prison had alerted the prison to this. Although he was placed on an ACCT he was allocated a cell on his own. He was not given methadone to help with the withdrawal symptoms and insufficient checks were carried out.

"These are not hardened criminals these are vulnerable young men, doing petty crimes, stealing alcohol to get a fix. Is this (prison) the best place for him when he is an addict? Lots of judgements were made which was awful because it is shit scary coming off that stuff".

It was also his first experience of being in prison and coupled with the failure to treat his drug addiction, he told an officer that he would take his own life. This threat was apparently not taken seriously and he was found by an officer later that night, hanging in his cell. The officer subsequently called a code blue, but did not attempt to move him and instead left, locking the cell behind him. The family could still not understand why the officer *"did not cut him down"?*

4.2 Information sharing

Families discussed difficulties with information sharing, both inflows and outflows i.e. information obtained from families and what to do if families had concerns they wanted to pass on, or who and how to contact relevant people within the prisons. As was noted previously (Section 2.4) there were also concerns raised regarding information sharing between agencies. Families complained that key mental health reports, educational, psychology reports etc. had simply not been shared, or had been but were not acted on**.**

4.2.1 Information sharing between families and the prisons

As with pre-sentencing families felt there was a lack of guidance and information on how to negotiate the prison "*experience*". This initially centred on practicalities like visiting, bringing in belongings etc.

"*There's no consistency when speaking to staff, each one gave different information or did not know procedures for how to arrange visits, what we could take in on the first visit etc. After several phone calls on that first day I came to the conclusion that either staff 'could not care less' or the organisation of the establishment was a 'shambles'. I hoped I was wrong but unfortunately time proved me correct on both accounts".*

Some families perceived staff to be obstructive and one family complained about,

"*not getting any information about how to contact the prison to arrange a visit. I found a number on the internet but was told by the 'stroppy' woman that I had to call back later because they were only open for one hour to book visits. No-one said anything about arranging visits".*

Families talked about inconsistency, procedural failings and what they experienced as a lack of care and understanding. What appeared to upset families most was knowing how vulnerable their relatives were and feeling that they had no effective way of informing the authorities how issues might be best addressed.

"*Once you land in prison, that's the end of it, nobody listens to the families"*

"*When you ring them up with concerns they don't care. Prison officers talk to you like you're rubbish, say 'OK, we'll write this down', but they don't".*

The importance of telephone communication was also highlighted, but the process for using phone cards was not always explained to prisoners or the families. It was recognised that for vulnerable young people, contact with family and their pre-existing support networks was absolutely vital. In some cases young people were denied the opportunity to make these calls, or simply didn't know how the process worked. One family explained the difficulties their son had with understanding money and budgeting.

"All the young people are given a phone card of £7.50 for the week. (He) didn't know how to manage money. He was given the card on Friday, by Sunday it was all used up. He then had no way of contacting (me) until his credit was topped up again".

This then limited his access to his family and their support. Another family made the point that as parents who had been primary carers they knew their relative better than anyone, and their insights could ultimately save lives.

"They should have carried out regular mental health checks. My son was fine when he got there but then he had problems with his girlfriend etc. and he became really depressed but no one noticed. If someone just phoned me and told me that they were concerned as he was giving all his clothes away, I would have gone there; I would have told them to watch him carefully. I knew how important his clothes were for him. There was no communication between us and the prison".

Families also described being angry that information regarding self-harm or suicide attempts were routinely kept from them. The first acknowledgement was often after the death of their relative.

"*I was thinking he was getting the help he needed. I didn't know he was suffering in prison as no-one told me. I thought they'd take care of him".*

4.2.2 Examples of good practice

There were some examples of good practice in effective information sharing which highlighted the importance successful information flows had on families' perceptions of care and empathy. Families felt more in control when assurances were given, and individuals took the time to speak to them in person. A lack of information caused anxiety and confusion, so the opposite appears true. In the simplest terms, having calls returned, or a

system for communicating information regarding health and well being operating effectively makes a difference to family perceptions of the prison system.

However, families identified that this good practice appeared to be as a result of individual acts of kindness rather than a systematic approach to communication and information sharing.

"(His) welfare officer was excellent and offered a lot of support at first when in the hospital wing. However once moved from there no-one else bothered and no procedures [were] in place so that if we had any concerns we could speak to someone. However this one welfare officer should be recognised for his diligence and care as he was an example as to how things should be".

"There were a couple of concerned phone calls made by myself and his Mam and Dad a few weeks before he died; these were responded to and they called us back to let us know action had been taken".

Families also felt that having an opportunity to discuss their concerns in person provided assurances,

"I met with the safer custody officer the day after (his) remand began in (prison), he also talked to (his) Mum and Dad - this conversation took place at the end of visiting time face to face. This was a good thing and assured us that someone realised the extent of (his) difficult feelings."

4.3 Administration of Assessment, Care in Custody and Teamwork (ACCT)

An ACCT (Assessment, Care in Custody and Teamwork) plan is the form opened by staff in prison when a prisoner is identified as at risk of suicide or self-harm. It was introduced during 2005 and 2006 and its forerunner was a form called the F2052SH. ACCT is intended to be a 'care-planning system' to enable staff within the establishment to work together in order to:

- help defuse a potentially suicidal crisis and/or
- help individuals with long-term needs (such as those with a pattern of repetitive self harm) to better manage and reduce their distress.[8]

Families discussed the merits and implementation of ACCT, and a picture of inconsistent administration emerged. Concerns for families included; assessment of need when opening an ACCT, family involvement in any subsequent reviews, the lack of opportunity to feed family concerns into the process and failures to take appropriate action once an ACCT was active. Families also raised concerns regarding how effectively information was gathered and shared with others e.g. medical staff, other prison officers on the wing etc.

[8] PSI 18/2005 'Introducing ACCT (Assessment, Care in Custody & Teamwork) – the replacement for the F2052SH (Risk of Self Harm); see also guidance on ACCT at http://pso.hmprisonservice.gov.uk/pso2700/PSO%202700_-_front_index_and_PSO_itself.htm

"We weren't given information about how we can raise any concerns we might have. His file went into the prison with him. Despite this, the prison still said he didn't need to be put on ACCT or go into a safe cell. (He) wasn't on an ACCT at any point in the prison. (He) should have been in a safe cell under constant observation. I blame the nurse - she assessed him, said he was OK to go in a cell on his own even though she had a big file in front of her saying he was a self-harmer".

Another identified problems with mental health conditions that were simply not picked up at the point of assessment,

"The Prison and NHS Mental Health team do not understand the behaviours of ADHD. (He) would constantly tell them that he was OK and he was not thinking of self-harming. How many prisoners actually give notice that they will self-harm? He would give the appearance that he was happy when he was on a high and then write a desperate statement on a complaints form when he was on a low. His letters home were very turbulent with various statements of his thoughts. But because he was not at risk, nor was an ACCT ever raised, nobody was alerted to his tormented state of mind".

Another family described how information that should have accompanied their relative on being transferred from a YOI to prison, relating to his previous health records and age vulnerability did not trigger the opening of an ACCT, which they felt it should have.

"He was supposed to be taken back to a Young Offender Institution but because he had turned 18, and the law had changed, he was taken to prison. He was lost for 3 days. We and his key worker didn't know where he was. When (he) was lost in the system no one contacted us. In Belmarsh they didn't open up an ACCT for (him) which they should have done because of his age and brain injury".

None of the families were invited to a review following the ACCT becoming active. The families saw this as a major failing, not least because in many cases they were their relatives' primary carers and had unique insights into best care options. Similarly it was felt there was a lack of information as to what an ACCT was, and how it worked. One family member described receiving no information at all, and having to find out how the ACCT worked on the internet.

Once an ACCT was active, families felt there was a lack of information sharing between staff, and the plans themselves were poorly administered.

"Responsibility - staff need to be responsible for their actions, or to be more precise lack of actions - checks need to be in place to ensure current procedures are followed i.e. Careplans adhered to, ACCTs are taken seriously i.e. correct number of officers who are trained and from the right disciplines i.e. knows prisoner, (is from healthcare etc.).

There was a feeling that staff failed to follow up what should have been standard practice,

"These procedures are in place to protect people but are not being followed so until staff adhere to what is already in place things will not improve. Again a simple process of checks

and balances [needs to be] set up to ensure current procedures are followed and if not staff will be held responsible."

Another family member identified the importance of empathetic staff responses to an ACCT,

"An ACCT needs to be opened for all prisoners and needs family involvement; but an ACCT also relies on well trained officers who care about the welfare of young prisoners".

The implementation of ACCTs was also questioned, with suggestions that greater rigour be applied to observations and monitoring of vulnerable young people,

"Why put someone on 15 minutes watch? If you know that someone you are looking after is a poor coper than you can't say: 'See you in 15 minutes' as it takes 5 minutes to form a ligature and take your own life. They should either watch constantly or every 5 minutes if someone is that vulnerable. I know he had to be watched every hour, every minute. You had to watch him all the time. If you watch someone every 5 minutes you might be able to save their lives. 15 minutes is too long".

Families thought that, *"an ACCT should be opened for all the young people entering prison and there should be a full assessment of people entering custody for the first time".* But for many families, an ACCT was seen as more than a series of tick boxes to be completed in order to comply with "regulations", and for it to be properly effective it had to be part of an on-going, active and shared process. As one family member said,

"He was on an ACCT but no one joined up the dots with him".

Another summed up her feelings in this way.

"Suicide is a serious intention with serious repercussions not just for the individuals but their family and friends. It is also indicative of poor mental health. Therefore appropriate interventions and treatments should be made easily accessible to all prison inmates. Training needs to take into account that people who intend to commit suicide might not actually at that point in time be willing to report this as they may not want to be stopped from taking their own life. Suicidal feelings don't disappear overnight - suicidal feelings are themselves traumatic - they may ease off and the ACCT procedures should reflect this. It is always with caution (as life is very valuable) that should be the way ACCTS are closed".

4.4 Staffing issues

Some prison staff and officers in particular, were criticised by the families. It was recognised that staffing numbers and the impact of cuts were in some part responsible for the poor relationships between some staff and prisoners, but families identified deeper issues that impacted on the well-being of the young people in custody.

At its worst, families described a culture in some prisons in which bullying was commonplace and that they believed staff encouraged or ignored bullying to make their own jobs easier.

"*In prison they're doing a 'divide and conquer' thing. They encourage violence. 6 lads that were bullying (him) were co-defendants. If I was a prison officer I would have split them up. (He) was so scared he didn't want to get his food. If you grass them up you get bullied more. Prison officers should be trained in how to deal with bullying".*

"They're being treated like animals in there, so when they come out they're going to treat people like that. A report into (the prison) said they were using too much force on boys - pushing and hitting them unnecessarily".
Another family explained that because of their son's profound communication problems no-one bothered to take the time to understand him and staff were involved in the bullying he received.

"He got bullied by prison officers as well as other prisoners. He [The prisoner next door to him] was a good lad. He was friends with him and looked after him. Most importantly he could understand him. If he could do it why [was] nobody else able to do it"?

For others it was simply a symptom of the prison culture.

"Staff seemed to be both incompetent in doing their job to protect the young people in prison but also there seemed to be a "don't care culture" operating in prisons".

"I do not feel that what (he) experienced in custody was a single, one off failure to involve the appropriate professionals in ACCT reviews. What I believe strongly is that the system itself is heavily bureaucratic and inhumane. This is compounded by the culture rife amongst prison officers that subjugates those under their care as unworthy of life, support and respect. As a visitor to (prison) I witnessed prison officers discussing how it wouldn't matter what happened if things kicked off in the visitor rooms as there was plenty more scum and families where they came from".

Families believed there was a lack of compassion and care amongst some staff, and they were either unaware or unable to identify vulnerable young people in their midst. For some this was down to poor information sharing from other agencies.

"It was also very clear that the prison staff are working blind and do not know if they have vulnerable people in their care. This is because NHS mental health teams do not share their information".

Another family agreed,

"*prison officers are not psychiatrists and too much emphasis is placed on their views which can be stereotypical e.g. persons who intend to commit suicide are withdrawn and unkempt when often the reverse is true".*

One parent recognised the pressure the prison was under to simply cope with young people whose needs were complex and profound.

"They also said that they couldn't manage the risk he posed himself. There is a damn problem there as, on the one hand, they are saying that there is a risk and on the other hand they are saying that they can't help him so he is dumped there with no help".

The failure to recognise these needs can be devastating.

"Prison officers are not trained to work with kids – if someone had called me – if they had let him have his phone call to me on that last night (they forgot to unlock him to make the call) then he would still be alive now".

4.4.1 Training

Families were quick to recognise the importance of regular, appropriate and professional training and how that could help develop good practice,

"with the right training there is no reason why prison officers cannot pick up on the vulnerability if they just do a good basic job".

They elaborated on the theme of effective training development,

"There should be better training and regular training. They should be able to pick up on things and changes in the behaviour. Personal officers should have regular contact with the prisoners. They shouldn't just listen to what that person is saying. It would help if there is one person responsible in the prison for reporting back to the family on a weekly basis how that young person is doing. As family members we know that person better than anyone. They should listen to us more and get us more involved".

Another family was critical of the emergency response from staff and it was established that the training regime had not altered since their relative's death.

"There was no healthcare in prison at night time. Officers had no first aid training. At the inquest, two years after (his) death they still hadn't received their first aid training".

The relationship between staff and prisoners was also a point of concern. Families wanted staff behaviour that mirrored that of youth workers rather than based on fear or "*bullying*" and assumptions that young people were trying to "*play the system*". Families believed prison officers should be people in whom prisoners could confide and develop relationships based on confidence and respect and who could provide vulnerable young people with support and a listening ear.

"Young people need to have positive relationships with prison officers and need to be supported".

Crucially the absence of opportunity to discuss feelings and anxieties was identified as vital in another case.

"There should be better access to listeners. My son asked to speak to a listener during the first night he was there. In the morning when he asked to speak to a listener again they told him that there was no one available for him. So he felt really low and needed to speak to someone and there was no one available for him to talk to. He then went and hanged himself".

Although specialist training in working with young people was identified as key, another family believed the lack of diversity of the services that dealt with vulnerable young people also needed to be addressed and thought this may encourage better relationships.

"The ambulance, police and prison service is not racially representative. It needs to be more diverse, the staff should be more representative".

4.5 Prison "culture"

Following on from the families' observations regarding staffing was a broader theme of what one described as the "*culture of prisons*". Concerns raised included distance from home, the nature of the regime and conditions and its impact on the young people.

"*They shouldn't be locked up in a cell for 23 hours a day. He started to withdraw and wasn't eating. He stopped going out on association".*

For some this manifested itself as an environment where weakness or vulnerability was frowned upon, and as a result key moments of crisis were missed or ignored.

"*On the day he died he was screaming to be put into a cell that was on constant watch, the prison officer ignored him and wrote it on his ACCT plan and placed it outside his cell. He also informed an inmate that he had a noose in his cell and the inmate acted and told a prison officer who said 'he'll have to wait, we're busy'. This was one of many times he was ignored. The Chaplain of the prison released a statement and described the terrible care and lack of communication between prison officers within the prison. Sadly this happens way too often".*

This failure to recognise young people in crisis seems to further inhibit opportunities for help or care as the young people believed admissions of vulnerability was a weakness and this was not the way to "*survive*" in prison.

"*For our boy he was finding it hard to cope emotionally in prison. (He) had a history of self-harm yet prison officers thought he was okay because he did not say anything. He was a boy who didn't want to look weak in front of others, so he wouldn't have told the officers".*

Another family identified a similar theme.

"There is also culture within the prisons amongst young men. You are not supposed to show your feelings or ask for help. You don't become a man overnight. One minute you are under 18 and you are a child and next minute they say that you are a man".

Families described the period around the transition from childhood to adulthood to be particularly problematic, and for some the chronological age bore no resemblance to emotional ability to cope with an environment that placed far greater emphasis on punishment rather than support, rehabilitation or care. One family highlighted the difficulty of being open about vulnerabilities or problems when in prison. There is a perception of a "macho" culture and the acceptance of weakness is discouraged. When prisoners were feeling isolated or alone,

"the prisons answer to this is that prisoners can make phone calls to outside. BUT if a prisoner is not comfortable being in prison, they are not going to disclose how they feel from a public phone. Also they have to be seen by other prisoners to be hard not soft. This is something the prison staff do not understand. The prisons need to improve staff-prisoner relationships and to be trained in recognising unusual symptoms, and reporting and documenting them".

4.6 Safer cells and acting on previous recommendations

The use of safe cells, and the failure to address the issue of cell safety was also a prominent theme as were concerns about the number of young people who had been placed in cells in which ligature points had not been risk assessed, or the risk of self-harm had been ignored or underestimated. Families were also angered by the subsequent discovery (following investigation by the Prison and Probation Ombudsman (PPO) or during the inquest) that suicides had previously taken place in the same cells.

There was concern about cells with bunk beds being used for single occupancy by vulnerable young people.

"*My son was in a cell with a bunk bed which he used to tie a ligature. He should not have been in this cell. Every time I asked them about why he was placed there, I received a different answer".*

The family suggested the prison was being evasive in their response and this was down to placing its need to satisfy administrative requirements, before the needs of a grieving family.

"I think they just did not want to get the family involved, asking questions etc. before they got their story right and ticked all their boxes".

For one family the failure to assess risks had terrible repercussions. Whilst in prison their son asked to speak to the Samaritans and he was escorted to the listener suite. He had taken a ligature with him and was neither searched nor supervised for over 50 minutes. He was subsequently found hanging from exposed pipework in the listener suite. The family believed their son would be safe in prison,

"*you trust the prison to take over your role".*

Another family questioned why those tasked with making the decisions to allocate cells were not held responsible.

"My son was put in a double cell with bunk beds. One person made that mistake and my son died. If this happened with a nurse in an NHS setting, she would have been disciplined or struck off, why does the same not apply in prisons"?

Of particular concern was the knowledge that recommendations from previous deaths had not been acted on. Families were horrified to discover that cells in which suicides had already taken place were still being used, unaltered, for their own relatives.

"Our son hanged himself in a cell in which some weeks earlier another young man had died using the same method from bunk beds. Previously the Prison Ombudsman had recommended that should inmates be occupying a cell on their own then bunk beds should be removed from these cells. When the Ombudsman followed up his recommendation he found that it had not been acted upon. Had the bunk beds been removed from single cell occupancy when recommended by the Ombudsman our son may still be alive. The Governor in charge of the prison at the time of (his) death did not attend the inquest. Why was this I wonder"?

There was a consensus of opinion that the issue of safe cells and their use was something the prison authorities needed to address as a matter of urgency to prevent future loss of life. In particular families made reference to air vents, bunk beds, cell bars and light fittings as potential ligature points.

"There needs to be attention paid to unsafe cells where ligature points have been used for hangings".

"Cells could be much safer. If they don't have the opportunity then they would not be able to do it".

4.7 Institutional insensitivity to bereavement

Some families experienced the actions of those who were present as their relatives were dying or on life support as profound institutional insensitivity. Some families were able to see their relatives in hospital immediately prior to death. There were a range of similar stories of the prison authorities' lack of sensitivity to the needs of the families and a lack of recognition that their procedures had distressing impacts.

"When we attended the hospital the governor was there and the prison FLO. It was so disgusting, so degrading, they had him chained to the bed as if he was going to spring up and run away. He was cuffed to the bed first time round but then they removed them. The officers however remained. One officer was sitting at the bottom of the bed and another was waiting outside. Governor spoke to us in a very matter of fact way. He didn't offer his condolences or said he was sorry or anything".

Another family described their experience,

"When we went to see my son in hospital he still had two prison officers standing at the foot of his bed. It was obvious that he was unconscious and could not escape. Even when the life support was switched off and he died, they still didn't leave the room, there was no consideration given to our privacy".

For one family the prison's failure to make contact with them after their relative was found hanging had dreadful consequences.

"(He) was taken to hospital. I could have gone to the hospital to see him. But they didn't phone me straight away (at 4am) but only at 8am the following morning. He was still alive when he went to hospital. I could have been with him when he had his last moments. They said they called me late because they weren't sure it was (him) as prisoners move cells. The day after he died I got a letter from him saying 'come visit me, here's a VO'. But the prison forgot to put the VO in with the letter".

The family experience at the point of death created an atmosphere of mistrust and suspicion at a time of great distress.

5. Post bereavement

Families described the lack of a co-ordinated response from the Prison Service following a death. There appeared to be no standard approach to informing families of the death of their relatives including; which personnel pass on information, details of how the death had occurred, when the death occurred or who to contact for further information.

Families also highlighted a perceived lack of care and compassion on the part of the prisons, linked to what they described as an institutional defensiveness in the immediate aftermath of their relatives' deaths. Families were in shock and disbelief and many reported how hard it was to take in information, natural emotional responses that were compounded by the lack of accurate information and not knowing who they could turn to for support.

5.1 Informing families

Families described how the initial response of the prison set the tone for future interactions.

"When we were told they gave us very little information and the officers also withheld information about how he was found. They had no need to do this as the information didn't impact on the cause of death but it did make me feel like I couldn't trust the prison about everything they were telling us about his death".

Families felt the prisons could be defensive in the way they communicated with them.

"My experience when my 18 year old died a year ago was that it was very hard to get any info or even confirmation of his death (which I heard from a third party) and I felt the prison service were obstructive and unhelpful".

Another explained how brief and cursory the initial information was,

"the governor rang us to tell us he has done it. We all went down there. He had written to the prisoner next door to him. He said that he was feeling down. He was missing his family and that he was going to hang himself and that he had ten minutes to stop him. There is a CCTV of this and the officer standing outside the cell to suggest that he read the note but he denied this at the inquest. Nothing was done about it and he was found hanging shortly after".

There was also evidence given of differing responses to informing the families. Some received phone calls requesting they visit a hospital, others were informed by the police whilst some were visited by a variety of officials.

"The assistant governor of the prison, family liaison officer, vicar and 2 local policemen came to my house to tell me he had died. They said he didn't have a cellmate. I said - you know his history, why was he on his own in a cell with bunk beds? The assistant governor clammed up. Initially the assistant governor said that he hung himself off the bunk beds. But later he said he did it off the window grill".

One family described how the process involved delay, misinformation and no opportunity to obtain further information as it was the weekend.

"When they first told us about the death it was on a Friday. We were in shock. They told us that our son was found hanging and left us a number for us to ring for more information. We tried ringing this number all weekend but we couldn't get through to anyone. That weekend, I was convinced that my son was murdered as we had no information from the prison and his death came totally out of the blue. It was only on Monday when we were able to get through to the prison we were able to find out more about the details, about how he gave away all his belongings etc. before he was found. We went to see his cell; it was undisturbed when we saw it. He left a message on the wall before he did it so we were able to see that. We had asked before if he left a letter for his family or a message but they said he didn't so we were surprised to see what he had written on the wall of his cell. Why did they not tell us about this note when we specifically asked for it"?

Families wanted a standardised process, delivered with compassion that provided clear information as to what to expect next. They wanted that process to acknowledge the devastating impact of finding out your relative had died and the need to afford them proper respect and dignity.

"The problem is there is no standard practice – sometimes you get a good officer who can be helpful but this is not enforced across the system".

Families complained of a cursory and callous handover of belongings, sometimes in bin liners. There was a perception from a number of families that the prisons lack empathy when dealing with families' grief and bereavement, and that any person dealing with a family in such circumstances should be trained properly.

"*I asked the chaplain - doesn't it make sense for a young person in a big prison, with vulnerabilities and a long sentence, to be given proper care? The chaplain said 'no because only a small percentage of people like that do anything as a result'. This showed a lack of compassion".*

Families felt the prisons could do a lot more to acknowledge their loss and grief.

5.2 Lack of information

Almost without exception families felt they were given little or no information about what to expect in the days and weeks immediately following a death. This included information on when they could see the body of their relative, the process of post mortems or their rights to a second post mortem and the investigation and the inquest. (Section 5. Investigations and the inquest will look at legal representation, securing legal aid etc. in more detail). Families described "*feeling abandoned*" after finding out their relative had died, had no idea who to turn to or what they needed to do in the aftermath of a death.

"*We didn't have anyone to speak to, we felt lost and confused".*

"*I was given some information a month later, but none before this. This information was from the Prisons and Probation Ombudsman, not the prison. They told us about INQUEST who put us in touch with lawyers".*

Families described receiving no information about how their relative's body might be when first viewed.

"They met us in the car park, took us to a room. They didn't say what he would look like - didn't prepare us".

Another family described the impact of seeing their relative, and how they were prevented from touching him.

"We didn't get to touch (him) either. This really got me. He was in the coroner's morgue with ligature marks around his neck and burn marks around his chest. The Prisons and Probation Ombudsman was very critical of this. He said that no one checked him that night when they should have done. By the time they found him he had rigor in place and had burn marks on his chest from having been in the same position for so long".

Procedural information was also seen as lacking, and in particular relating to the families' rights regarding post mortems.

"We asked to go to the post mortem. They said that it would cost us £250 and to send the GP. Then I found out that we could send a family member. I rang up the police officer he said 'well, you wouldn't have gone anyway would you?'".

"The prison governor told us where the body would be. We were told who the coroner would be. But the coroner didn't tell us that we could have a second post mortem, and we weren't given any information about INQUEST".

Families felt that the lack of standard procedures, and the delays or absence in providing information needed to be addressed.

"There should be a law that prison authorities, when they tell you your child is dead, that they tell you there will be an inquest and you are entitled to your own solicitor. They didn't tell us either of these things - or that the prison authorities would have their own solicitor".

5.3 Role of Family Liaison Officers (FLOs)

There were mixed sentiments expressed regarding the role of Family Liaison Officers (FLOs). The role of the FLO was not clear, nor was it properly explained to them. If families sought support and information, they often felt let down with the service provided, complaining that *"we were given no information by the family liaison officer".* Others talked of FLOs who had promised to be in touch, only to hear nothing more from them, or delays of days and/or weeks between contacts.

There were also complaints of administrative failings,

"the family liaison officer said 'contact me at any time'. We phoned the family liaison officer after (his) death and they [the prison] said they don't know who he is".

Another family spoke of their FLO being new to the post and their inexperience preventied any meaningful intervention on behalf of the family.

"They rang up the voicemail and left their name, but no contact number. In the end I was giving him support. His head was all over the place".

In keeping with previous descriptions of other staff roles within the prison system there were individuals who stood out: one FLO being described as,

"*really lovely when we went to identify the body".*

And another person described,

"one prison officer who was good and I talked to the governor about making this person an FLO".

5.4 Institutional defensiveness

Families spoke about how following a death they wanted answers to their questions, and openness about what had happened. Instead they described how they felt they encountered institutional defensiveness and insensitivity to their grief.

""From the first contact onwards, you know that you can't trust them. Before my son died in prison, I had complete trust in the system but not anymore. As soon as I was told about my son dying, I phoned the prison and told them that I was coming and that I wanted to speak to the governor and see the cell. They even lied about where my son was found hanging, first it was the window then it was the bed. I knew that I had to fight them to get to the truth. I requested all the paperwork went through everything myself".

""When families request information it should be forthcoming and honest - this however will never happen as the establishment would not want to be seen in a detrimental way and open themselves up to criticism so become defensive and close ranks which makes things worse because families feel as if they are ignored at a time when they need help and support and simply want the truth".

Another family described their anger at having had their request to see the cell, in which their relative died, denied.

"Even now I haven't had an opportunity to view the cell where he died (which I requested)."

Families also reported little or no contact from the prisons by way of apology or condolence. Some described brief and procedural letters which could have been pro-formas. One family described their reaction to a letter received.

"After the inquest we received a one line letter from him (the governor) saying he was sorry for our loss. We received this one month after the inquest where the jury found that 'neglect' contributed to (his) death. I was disgusted. It was an insult, a waste of paper"!

6. Investigations and the inquest

Families described how problems encountered in the immediate aftermath of a death set the tone for their experience of the subsequent investigation and inquest process. Families pinpointed a number of key themes; the lack of information available as to what the process involved, the delays in completing investigations and the start of the inquest itself, the complexities of applying for legal aid to fund their legal representation, and the importance of being properly legally represented.

6.1 Lack of information

Families explained how there was little or no information made available to them regarding investigations and the inquest. PPO investigators appeared not to know about the

complexities of accessing legal aid, and in one case failed to explain what the purpose of the inquest was. Families felt alone and "*powerless"* and described how hard it was to negotiate the process without information, support and guidance. In this information vacuum, families described how it was INQUEST who provided them with the specialist advice and support needed.

"I really don't know what I would have done it wasn't for INQUEST. They were an amazing source of support for me. I remember I broke down over the phone to her and told her that I couldn't carry on anymore and that it was all too much. She then put me in touch with my solicitor. She was brilliant. You couldn't fault her in anyway. We wouldn't have got anywhere if it wasn't for INQUEST. There was no one else there to help us. Even now, I know that they are at the end of a telephone line even if I just want to talk".

Another described the support from INQUEST.

"INQUEST got us a solicitor, without them we wouldn't know where to go. It was our son's solicitor who gave us the details of INQUEST. Prison did not give us any information about the investigation and inquest process. They gave us a leaflet about local counselling and I threw it in the bin".

Those that had not been given information, or been in contact with INQUEST, made it clear that the earlier information and support is available, the more manageable the process.

Families described finding out about INQUEST through the internet, word of mouth or via the PPO or the Coroner. Families suggested there should be an established process for informing them of their rights including the right to legal advice and support and how this should not be left to chance or good fortune. It was also suggested that the PPO should be trained in these issues before any investigator could conduct investigations.

6.2 Delays

A further pressing concern for families was the delay in conducting investigations and holding inquests. People described "*putting their lives on hold"* and the huge emotional toll of waiting for things to happen. The longevity of the process meant families had not "*grieved for my son"* because it was impossible to do so until some form of closure had been reached.

Others talked about "*living in a bubble"* where all you do is "*function and focus on dates".*
For those currently involved in the process the endless changing of dates and the uncertainty that caused was an issue for urgent consideration.

"*They keep giving you dates, and then you build yourself up and concentrate on that one, and then it's changed. You want answers but you don't want shortcuts either, it takes a very long time".*

The notion of postponed grief was also important for families. Placing things on hold during the process is very difficult as one person explained,

"All decision making is taken out of our hands after the death, just like the decision to imprison him".

Families were clear that by delaying the process they were unable to grieve and were constantly reliving the bereavement and its aftermath and that it was important to understand the impact this had on other family members and in particular on children.

6.3 Legal Aid and the importance of legal representation

Families agreed that having legal representation was absolutely vital as they needed help with this complex process. However information about their right to this was not routinely provided by the investigators, or the prisons. Some felt it should be a legal requirement to do so. It was also pointed out that no-one tells you that the prisons and other agencies will have "*lots of lawyers"* and the process feels unfair and stacked in favour of them.
Families felt legal representation and the need for legal aid was vital for the inquest process (often described by the Ministry of Justice as 'informal proceedings'). One described being,

"too emotionally involved to represent yourself at the inquest".

Securing legal aid was also described as difficult, embarrassing and complex.

"Our solicitor was brilliant but legal aid is a nightmare. They go into all your bank accounts and it's such a long process. We couldn't have done it without a lawyer".

"In the run up to the inquest I had to secure legal aid funding which was really hard as I was already struggling with (his) death. INQUEST staff were such a support, I really don't know what I would have done without their help. They helped me track down a legal aid solicitor and gave me all the information I needed about the inquest process".

In another case a family described the embarrassment of their (new) son in law having all his financial statements "*trawled"* through. Awaiting decisions on eligibility was also a cause for concern,

"Funding was a big problem. They refused at first and I had to appeal. Eventually it was granted but I didn't know right up to the last minute".

Families felt without legal representation it was difficult to establish the truth.

"Initially the prison tried to delete the CCTV of (his) death and this only became apparent when our lawyers requested a copy and realised that this was attempted. One week before the start of the inquest the prison eventually disclosed the full CCTV".

For those that had completed their inquest, there were mixed feelings about its impact. For some the process was traumatic and people described having to relive the bereavement all over again. For others the experience felt demeaning.

"I felt insulted at the inquest. Some of the comments they made were awful! A week before the inquest they tried to argue that (his) offence had to be disclosed. Information that he gave to the chaplain, they also said they were going to disclose this but we managed to stop this. The prison governor came to my daughter's home after the funeral but she had just moved there and was decorating so the wall paper was stripped etc. She did not know that her brother would die did she, so she did not have time to make her house look nice for the funeral visitors. The governor than commented in his statement that the family house was unkempt- he was passing judgement on our family! It was disgusting".

Another echoed this experience and was upset by the efforts of the prison's legal representative to blame her for what had happened. She described feeling intimidated by the lawyers on entering the room,

"They tried to make out that I was a bad mother, especially (counsel for prison) who asked me why I didn't do more as a mother. She tried to make it sound like it was my fault. I kept him alive for 17 years, they only had him for 56 days and couldn't keep him safe. All my lad wanted was help. The prison officers were intimidating too, kept saying they couldn't remember".

Some felt the inquest to be a waste of time because the truth was never going to come out. There was a sense of injustice and the process being on the side of the prisons. This was developed with accounts of unsuitable venues and a lack of respect for the families' feelings.

In one case the coroner,

"refused to make recommendations because the prison had told him it had already made changes, although we never found out what they were".

Another family were waiting to find a venue for the pre inquest review (PIR) and heard,

"the government lawyers joking with the coroner, 'could we have it in a country club because they do nice meals'".

For others the inquest was a real opportunity to find out what had happened and to seek what they described as "*justice*". What defined a successful inquest appeared to rest with the thoroughness of the inquest findings and coroner's recommendations. Families stressed the importance of *"other families not going through what we have"* and for this reason, above all others, they were adamant that any recommendations made by the process should carry weight.

"*Having seen the PPO and coroners make 'recommendations' that are time and time again not implemented, I feel hopeless, particularly when I see increased numbers of prison*

suicides. If people actually followed policy, implemented changes and learnt from practice there might be some hope that these appalling statistics of deaths in custody of young men might be reversed. This might have to include a culture change where the deaths of these young men are seen as unacceptable tragedies amongst prison officers, Governors, the government and the general public".

Where information had been passed to families informing them about changes that had been made in response to the self-inflicted death of their relative this was particularly welcomed. One family described how they found comfort in knowing that ligature points have been removed. One family member described the value of knowing that,

"*two suicides had been prevented in the prison where my son died because of changes made after his death".*

Another took similar comfort.

"I waited three years for someone to tell me he didn't die for nothing".

7. Family recommendations

The following family recommendations are based on the evidence heard at the Listening Days and made in written submissions. They also reflect the collective experience of those in contact with the organisation as expressed to caseworkers. They are also consistent with recommendations from INQUEST's previous publications (see section 2.1 & 2.2). INQUEST would reiterate that many of the issues identified have been consistently raised by families, during investigations and inquests and in our previous publications. Indeed, some of these concerns have been reflected in changes to policies and procedures but there remains a gap between policy and practice. As reflected in the recommendations relating to after the investigation and inquest (7.5) changes to the mechanisms for ensuring meaningful learning after deaths would be one of the most important outcomes from this process.

Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?[9] utilised INQUEST's unique statistical data set and evidence from families to examine the circumstances of these deaths and their subsequent investigation. The key themes to emerge relate to those contained within this report; the imprisonment of some of the most disadvantaged young people, with problems around mental health, self-harm, alcohol and drugs, significant interaction with agencies prior to entering prison, communication problems between agencies and the prisons, failure to divert vulnerable young people out of the criminal justice system, unsafe environments and cells, poor medical care and limited therapeutic services, exposure to bullying and treatment including segregation and restraint and evidence of inadequate institutional responses to the deaths of children and young people in prison.[10]

[9] Written by INQUEST and published in 2012 in conjunction with Prison Reform Trust
[10] Fatally Flawed – Summary pp1

7.1 Before entering prison

- More emphasis on early interventions to address children's and young people's problems (see pp12)
- A more phased transition from CAMHS to adult mental health services (see pp14)
- Better diagnosis and recognition of mental health illness, and an end to inconsistent care and treatment (see pp14)
- Better provision of consistent high quality community based mental health care (see pp14)
- Effective alternatives to custody for children and young people (see pp16)
- More effective communication between the police and families at the point of arrest (see pp17)
- Better provision of information to families about the procedures and expectations at the point of arrest (see pp18)
- More effective information sharing between agencies, and between agencies and families (see pp17)
- More rigorous checks on transfer information from police to prison custody (PER) forms (see pp17)
- Better information sharing at the point of sentencing (e.g. visiting rights, contact details of a designated staff member, telephone options etc.) (see pp16)
- Greater emphasis placed on family involvement and a recognition that consultation with families could improve care options and assessment of the needs of young people facing prison and can contribute to their safety and well being (see pp17)

7.2 In prison

- Greater emphasis placed on "getting to know" the young person when assessing their needs, vulnerabilities and risk of self- harm - "relationship building" (see pp18)
- Information sharing between staff and between prisons needs to be improved, including medical records and PER when transferred (see pp19)
- Seeking the involvement of families, particularly when primary carers, when assessing risk and vulnerability needs to be urgently considered and improved (see pp20)
- Review the ACCT system: in particular addressing when does an ACCT become active, managing reviews and family involvement in reviews (see pp21)
- Consideration to be given to whether or not an ACCT should be activated for every young person entering prison, and especially for those in prison for the first time (see pp22)
- Improved staff training; around the use and administration of an ACCT, first aid and emergency response and working with those with mental health problems (see pp22)
- Specialist training for all staff working with young people – consider the youth worker model (see pp25)
- Staff training on the problems of bullying – both by other prisoners and staff (see pp23)

- Greater opportunities for young people to contact family members and other support networks when in prison – particular emphasis was placed on the "lifeline" of telephone calls (see pp20)
- Greater consideration given to safe cells, their use and provision (see pp27)
- Review protocols re security and prison officer roles for dying prisoners or those on life support (see pp28)

7.3 Post bereavement

- A standardised approach to informing families of a death (see pp29)
- Staff to be properly trained to work with families following a death (see pp30)
- The prisons to demonstrate greater sensitivity and recognition of the pain of bereavement (see pp33)
- Better trained FLOs who are clear about their role (see pp32)
- More effective communication with families regarding information on what to expect in the immediate aftermath of a death; including visiting the scene of death, what to expect when seeing the body of the relative, information about investigations and the inquest (see pp31)
- Greater sensitivity in handling the possessions of the deceased relative (see pp30)
- Families should be given early information about where to go for independent advice and guidance on the process (see pp32)

7.4 Investigations and the inquest

- More effectively trained PPO investigators – families required more information on their rights, legal representation, legal aid, and the inquest (see pp34)
- Regular and timely updates to families on progress with the investigation and inquest process (see pp33)
- An end to unnecessary delays in the investigation and inquest process (see pp34)
- A simplified legal aid process, or an end to means testing for legal aid altogether allowing families parity of public funding for legal representation when faced with lawyers for prisons and other agencies (see pp35)
- An end to attempts by legal teams to portray parents as "poor" or "inadequate" or failing their children (see pp35)

7.5 After the investigation and inquest

- Prisons that have been required to make changes should be compelled to do so (see pp36)
- Accountability for individual members of staff that had failed to take appropriate action to keep their relatives safe (see pp28)
- Governors had to become more accountable for their actions as they have overall control for the running of the prison. "The buck stops here". (see pp28)

- A legally binding recommendation system when coroners and the PPO have suggested improvements and made it clear that systemic failings have resulted in a death (see pp36)
- Families should be notified of action taken in response to the outcomes of the investigation and inquest process. (see pp36)

Final Family Comments

"We pray that your review will have some impact on the way our young men are treated in the future. They are mostly ill and victims of their earlier life's experiences. We all let them down at some level".

"I believe these young boys/men are cast as tearaways when really all they need is help".

"We should be trying to make them better and bring them back into society. What does it make us if we just discard them onto the scrap heap"?

"I am glad that we were invited to this event. I appreciate being here and I think my boy would have liked me being here as well. It is a shame that we did not get this when he was alive".

Appendix 1

Invitation letter to families

Dear [ ]

Re: Family Listening Event for the Harris Review

Thursday 16 October 2014

11am - 4pm

NCVO - Regent's Wharf, 8 All Saints Street, London, N1 9RL.

(The venue is close to Kings Cross and Euston stations)

We would like to invite you to a family listening event, which INQUEST has been invited to host on behalf of Lord Toby Harris.

Lord Harris is the Chair of the 'The Independent Review on Self-Inflicted Deaths in Custody of 18-24 years olds', which was set up in response to concerns about self inflicted deaths of 18-24 year olds in NOMS custody. He was invited to lead the Review by the Minister for Prisons.

The purpose of the Review is to make recommendations that are aimed at reducing the risk of future self inflicted deaths in custody. The review will examine evidence from a broad range of sources, including family members and key stakeholders. The views and experiences of the bereaved family members are a fundamental component of the evidence that the panel want to consider.

Lord Harris has said of the Review that:

"*This would be a once in a generation opportunity to improve the care of some of the most vulnerable people in custody*".

He went on to say

"*I am determined that this review will pull together the key learning from these deaths so that we can help ensure that 18-24 year olds, and indeed vulnerable people in all age groups, including children, do not continue to die when they are under the protection of the state*".

The Review is focusing on issues that include, but are not limited to, vulnerability; contact with family; staff training; staff-prisoner relationships; information sharing; whether things should have been done to divert vulnerable young people from the criminal justice system; and whether appropriate lessons have been learned from previous deaths.

This listening event is an opportunity for you to share your experiences with Lord Harris and the Review panel members. The panel know that hearing directly from family members will give them crucial insight into issues that could help prevent future deaths and welcome suggestions for changes that you think could make a difference.

INQUEST will write a report for the Review based on the discussions, issues and suggestions that emerge during the listening day. This will form part of the evidence for the Review. All the discussion is, however, confidential and your input will remain anonymous. If, for whatever reason, you would prefer that the issues you raise are not included in the report, then please let us know.

If you are unable to attend but would like to contribute you can send a contribution to us either by post of by email to inquest@inquest.org.uk, or to the Harris Review email address at HarrisReview@justice.gsi.gov.uk.

To make sure as many families as possible can come to the event attendance is restricted to two members of each family. Please let us know if you will be able to attend by phoning us on 020 7263 1111 or emailing inquest@inquest.org.uk and provide the information requested in the reply slip.

Reasonable travel expenses will be covered and refreshments will be provided including lunch.

You can find out more about the review here http://iapdeathsincustody.independent.gov.uk/harris-review.

We look forward to hearing from you.

Appendix 2

Structure of the event 16th October

Agenda

The event will be chaired by Helen Shaw, co-director INQUEST

10.30 Tea and Coffee

11.00 Introduction Lord Toby Harris

Outline of the day Helen Shaw

Introduction of Panel Members

Questions

11.30 Small group discussions: journey into custody and family liaison whilst in custody

12.40 Feedback from groups

13.00 Lunch

13.45 Small group discussions: Information, advice and family liaison after the death of your relative and suggestions for improvements

15.00 Tea and Coffee

15.15 Feedback from groups

Final discussion

Closing remarks Lord Toby Harris

16.00 Close

The day was designed to create an environment where it was possible for bereaved families to share information about sensitive and distressing experiences in the hope that there will be changes in the future. Some of the families had been through the whole investigation process and some were still at the beginning of the process and were at different levels of their experience of traumatic grief. The structure of the day created a framework that assisted families to share their experiences in a manner that maintained their dignity.

The issues that could be addressed at the event went beyond many of the issues that are addressed during the investigation and inquest and so it was a unique opportunity for families to speak about different aspects of their experiences. Three small groups were

formed and panel members were allocated to one of the groups in the morning and swapped in the afternoon so they had an opportunity to hear from as many family members as possible.

In the morning the facilitated small groups focussed on the journey into custody and family liaison whilst in custody. The role of the facilitators was to enable the families to share relevant experiences. The facilitators also had these prompt questions to help keep the discussion focussed

- What access to support services were there i.e. education, drug support services, social services, probation services
- Was alternative community based sentencing explored before a custodial sentence was given
- What advice was given on accessing legal representation
- Definition of vulnerabilities and information sharing (between institutions – both within and outside prison)
- How adequate was the prison in dealing with the vulnerabilities of your relative?
- Were families able to contact the prison, make visits and informed of self-harming incidents (prison officers bound by confidentiality?)
- Were there sufficient communication inflows and outflows i.e. information obtained from families and were families informed of prison transfers (i.e. what to do if family had concerns/who to contact and how to contact them?)
- Were any family members invited to ACCT review or contacted by prison to raise any concerns when ACCT procedures were put in place?
- Were opportunities provided for additional contact with family where YP was identified as particularly vulnerable?

Each group was asked to bring back four key points from their discussion to share with the whole group in the feedback session. The aim of this was to keep the focus of the whole group discussion and feedback on the themes the review is keen to address.

In the afternoon the small groups reconvened and the focus was on information, advice and family liaison after the death and suggestions for improvements. The facilitators were guided by the following prompt questions:

- What procedures were followed after a death – any recording of the scene; was there an opportunity for families to visit the prison where loved one died and see cell as it was when young person died (or was it cleaned up)?
- How was their experience of family liaison immediately after the death and through the process including at inquest hearing?
- What was family's experience when young person moved from child estate to over 18 estate?
- What concerns raised by young person of how they were being treated in custody by staff and other prisoners?
- If you could name one thing which would prevent deaths in the future what would that be?

Again the groups were asked to identify four key points to share with the whole group in the feedback session. There was a final feedback session and a final plenary which was an opportunity to share any final thoughts and reflections and to hear some final words from Lord Harris.

The same prompt questions were used as a guide for the facilitated conversations with the panel at the session on 26th November.

Appendix 3

Participants

Family members
Details of family members who attended these events has been redacted for the purposes of publication only

Harris Review panel members (http://iapdeathsincustody.independent.gov.uk/harris-review/)
Lord Toby Harris
Deborah Coles
Stephen Cragg QC
Professor Philip Leach
Matilda MacAttram
Dr Dinesh Maganty
Professor Richard Sheppard
Professor Graham Towl
Dr Meng Aw Yong

Harris Review Secretariat
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Selen Cavcav
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Anastasia Solopova
Rob Styles
Chris Tully