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TRUTH, JUSTICE & ACCOUNTABILITY

Deaths of people following release from prison

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About INQUEST

INQUEST is an independent charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes death in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question. This includes work around the Hillsborough football disaster and the Grenfell Tower fire.

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Foreword

For almost four decades, INQUEST have provided expertise on contentious state related deaths. Due to the efforts of bereaved families, their lawyers and INQUEST, there has been growing visibility and awareness about preventable deaths in prison. Whilst not perfect, there are clear systems in place for the investigation and monitoring of deaths, overseen by government and Parliament. In contrast, almost no official attention is paid to those deaths which occur after someone leaves prison.

INQUEST has become increasingly concerned about the rising numbers of deaths of people on post custody supervision. In 2018/19, ten people died each week following release from prison. Every two days, someone took their own life. In the same year, one woman died every week, and half of these deaths were self-inflicted.

Deaths have been rising for a number of years, coinciding with the introduction of the Offender Rehabilitation Act in 2014. These increases have outstripped a rise in caseload and reflect the catastrophic impact of changes to the probation service. Women under probation supervision appear to be at significantly greater risk of taking their own lives.

The figures are deeply disturbing and require urgent scrutiny, due to the current lack of independent investigation into these deaths. Without this, we cannot fully understand what is happening or how it could be addressed. What is clear however is that people are being released into failing support systems, poverty, homelessness and an absence of services for mental health and addictions. This is state abandonment.

In the context of the major changes to the probation policy landscape, there is an urgent need to establish the reasons for these deaths and how to prevent them in future. The Ministry of Justice are currently reviewing probation policy and services. It is essential that as part of this process, serious attention is given to the recommendations of this report.

The silence, inaction and institutional indifference surrounding deaths of people following release from prison must end. Any incoming government must guarantee immediate action to ensure greater scrutiny, learning and action to prevent the deaths of people following release from prison.

Deborah Coles, Executive Director of INQUEST

Introduction

Through an analysis of official data published by the Ministry of Justice this report provides an overview of what is known about the deaths of people on post custody supervision following release from prison. It highlights the lack of visibility and policy attention given to this growing problem and calls for immediate action to ensure greater scrutiny, learning and prevention.

This report builds on academic research (Gelsthorpe et al., 2012; Phillips et al., 2016, 2017, 2018) and analysis of official data. Between 2010/11 and 2018/19, a total of 2,297 people died whilst under post-release supervision by probation services in the community following a custodial sentence (MoJ, 2019a). A significant rise in the number of deaths has occurred against a backdrop of major reforms to probation services and alongside rising levels of deaths, self-harm and violence within the prison system.

Following the introduction of the Offender Rehabilitation Act in 2014, between 2014/15 and 2018/19, the numbers of people dying each year whilst under post-release supervision increased. The rise in the number of deaths far outstripped increases in caseload. Despite this, these deaths have largely been ignored and hidden from view and do not receive the same level of scrutiny, concern or investigation currently received by deaths in custody.

The deaths of people on post custody supervision raises serious questions about the impact of imprisonment on the welfare of prisoners, and the suitability of transition arrangements as they leave custody. For example, continuity of care and probation support alongside links between outside healthcare and mental health agencies and prisoners at the start, during, and at the end of a prisoner's sentence. Such concerns have been raised by other organisations such as HM Inspectorate of Probation in their inspections into Through the Gate (2016) provision as well as post-sentence supervision (2019).

Following written and oral submissions from INQUEST and Dr Jake Phillips, the Health and Social Care Committee's final report (2018) of an inquiry into prison healthcare acknowledged that too many people are dying after release from prison and more should be done to monitor what is happening and seek to find ways to reduce the risks. The Advisory Council on Misuse of Drugs (2019) has highlighted the 'first few weeks immediately following release to the community [are] the highest risk period' and urged the government to improve the support provided to opioid, non-opioid and abstinent drug users when they are released.

The data

Probation Instruction 01/2014 governs what happens when someone dies under probation supervision. This requires an internal review to be undertaken by the responsible officer's first line manager when a death occurs. All deaths must be recorded but a more thorough review is carried out if the cause of death is linked to one the following risk factors:

- drug or alcohol misuse
- risk-taking behaviour
- violence
- known physical condition
- self-inflicted injury

However, the internal review simply asks if the specified factor/s had been identified and what action was taken to encourage and facilitate the person under supervision to address the issue/s. The review also asks whether there were any additional opportunities to encourage the individual to address the issue/s. There is no process in place for an investigative approach. Previous research by Gelsthorpe et al (2012) found these forms were only cursorily filled in.

Since 2010/11 the Ministry of Justice has collated data gathered from these forms and since 2016 it has published an annual report on the numbers of people who die whilst under probation supervision in the community (Ministry of Justice, 2019a). *Deaths of Offenders Under Supervision* includes figures of the deaths of people on post custody supervision, i.e. they were being supervised by probation agencies after release from prison.

Forms completed by probation providers collect data on the age, gender and ethnicity of the people who die. Offence type, date of death and, where relevant, release from prison is also recorded. Offender managers complete the forms prior to an inquest and update them as new information comes to light. However, research (Phillips et al, 2016) has highlighted gaps in the data with many cases having missing information. In 2018/19, 25% of deaths were recorded as 'unclassified' (MoJ, 2019a). Moreover, it would appear that data on the cause of death does not generally get updated following an inquest.

The Ministry of Justice data is collated and published annually which is problematic in terms of identifying any worrying trends as they emerge within a 12-month period.

General picture and key trends

The detrimental effect of imprisonment on prisoners' physical and mental health is well documented (Haney, 2012). Mortality rates of people inside the prison system are significantly higher than the general population (Fazel et al., 2017), both for self-inflicted deaths and non-self-inflicted deaths.

The number of people dying after release from prison increased between 2010/11 and 2018/19. There was a slight reduction in the mortality rate in 2017/18 - but this proved to be a one-year dip as the rate increased again in 2018/19 (see Appendix on page 14).

The Ministry of Justice (2019a) puts the increase in the number of deaths down to an increase in the caseload. However, we can see from official figures that the numbers of deaths have far outstripped the increase in caseload. Table 1 shows that the number of people dying per annum after leaving prison increased from 110 to 515 between 2010/11 and 2018/19, whilst Figure 1 shows that the rate of people dying on the post-release supervision caseload increased significantly between 2010/11 and 2018/19. **At a time when the caseload doubled, almost five times more people died.**

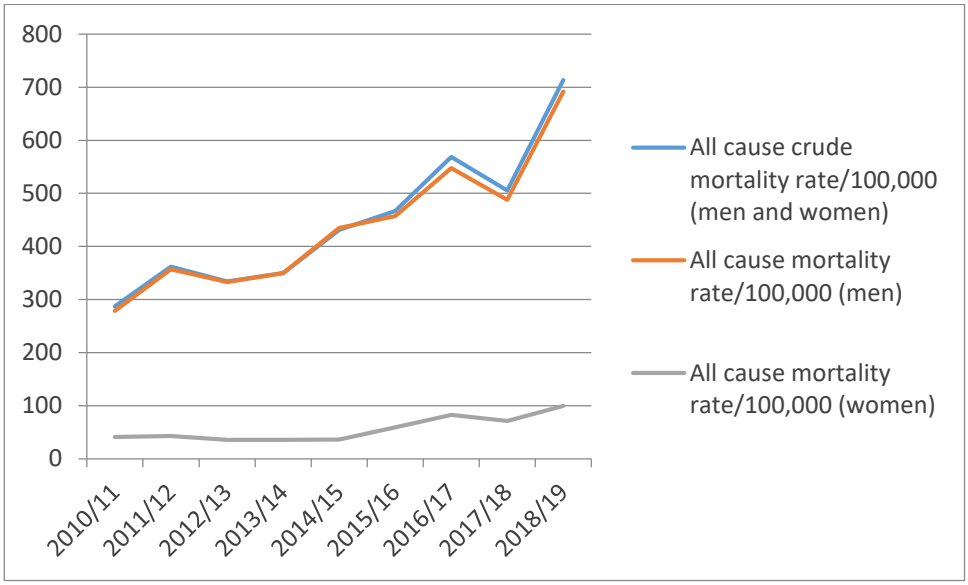
Table 1: Deaths, 2010/2011 to 2018/19 (Ministry of Justice, 2019)

Year	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Deaths of people under post-custody supervision	110	147	140	136	171	301	403	374	515
Self-inflicted deaths, post-custody supervision	24	30	43	40	50	97	124	101	153
Post-custody caseload	38325	40649	41882	38852	39669	64441	70872	74043	72185

It is notable that the number of deaths started to increase more rapidly immediately after the implementation of Transforming Rehabilitation (TR) and the Offender Rehabilitation Act 2014. The Offender Rehabilitation Act 2014 (ORA) expanded probation supervision to include those who are sentenced to a custodial sentence of less than one year. This change will not only have increased the caseload but will also have changed the nature of the cases by including people released from short prison sentences. This group are more likely to lead chaotic lives and face particular vulnerabilities. This will have had an impact on the mortality rate.

That said, concerns have been raised about the quality of 'through the gate' provision, which was intended specifically to improve the level of support provided to people prior to and after leaving prison. Thus, the trends for deaths which occur after leaving prison are particularly notable in light of problems that emerged amid the upheaval within probation services following TR, which also outsourced around 70% of the probation caseload to the private sector.

Figure 1: Crude mortality rates (per 100,000) for people being supervised by probation after release from prison (Ministry of Justice, 2019a)

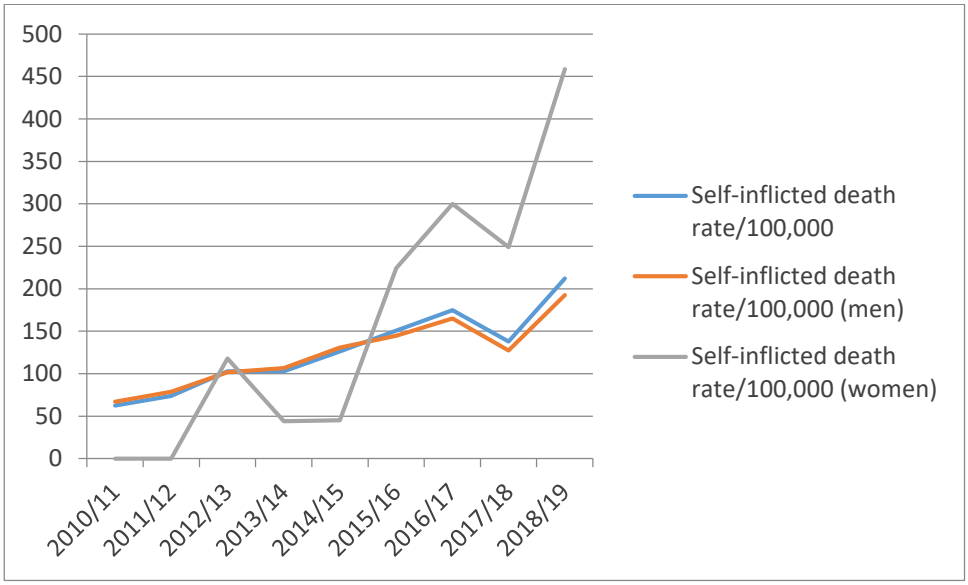


Self-inflicted deaths

Between 2010/11 and 2018/19, 662 people died a self-inflicted death after leaving prison (MoJ, 2019a). Disproportionately this increase is in the number of self-inflicted deaths amongst people on post-release supervision.

The number of people dying a self-inflicted death increased by more than a factor of 6 whilst the caseload doubled. Figure 2 shows that the self-inflicted death rate amongst people on post-release supervision has been increasing since 2010 (despite a small drop in 2017/18). Changes and improvements to recording have also had an impact. However, an almost five-fold increase in all deaths, and a six-fold increase in the number of self-inflicted deaths amongst people on post custody supervision cannot be explained by better recording practices. It is also important to note that this is against a backdrop whereby the suicide rate in the general population had, until 2018, been stable or decreasing since 2013 (the suicide rate for 2018 was significantly higher than that in 2017 and represented the first increase since 2013).

Figure 2: Rate of self-inflicted deaths by people under post-release supervision (Ministry of Justice, 2019a)



The rate of self-inflicted deaths amongst people leaving prison is considerably higher than the general population and others in the criminal justice population. The self-inflicted death rate amongst people leaving prison in 2018/19 was 212/100,000 whilst for people serving community orders and suspended sentence orders (i.e. who are under supervision but have not served a custodial sentence) the rate is 132/100,000. The rate for prisoners is 83/100,000 (Fazel et al., 2017) and the suicide rate amongst the general population is 13.6/100,000.

People on post-release supervision appear to be particularly at risk of dying from a self-inflicted death when compared to other groups. The self-inflicted death rate is fifteen times higher than that of the general population.

Women's deaths

Between 2010/11 and 2018/19, 211 women died whilst on post custody supervision and 165 (78%) of these deaths happened in the last four years (MoJ, 2019a). In 2018/19, of those deaths for which the apparent cause has been recorded (38 deaths out of 52), 63% were self-inflicted.

The comparatively low number of women on probation who die means statistical analysis needs to be treated with care. In spite of this, the indicative figures suggest that the mortality rate is alarmingly high. They show that there was a self-inflicted death rate of 459/100,000 amongst women on post-release supervision during 2018/19. The suicide rate among women in the general population is 4.6/100,000.

Table 2: Deaths of women during post-release supervision, by apparent cause, England & Wales (Ministry of Justice 2019a)

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total	**10**	**11**	**9**	**8**	**8**	**29**	**44**	**40**	**52**
Self-inflicted	0	0	3	1	1	11	16	14	24
Natural Causes	8	4	5	3	4	4	12	12	12
Homicide	0	0	1	0	0	1	2	0	1
Accident	1	3	0	0	0	2	2	1	0
Other	0	1	0	1	0	1	0	1	1
Unclassified	1	3	0	3	3	10	12	12	14

Women are disproportionately affected by the process of criminal justice supervision and are at greater risk self-harm and of dying by self-inflicted deaths in custodial settings (MoJ, 2019b). INQUEST's 2018 report, *Still Dying on the Inside* reframes deaths in custody as a form of violence against women, given many women's experiences of domestic violence, abuse and trauma. The report identifies serious safety failures inside prisons around self-harm and suicide management and inadequate healthcare provision and calls for an urgent review of deaths of women following release from custody.

In the general population men are more likely to die by suicide than women. However, when we look to people in the criminal justice system - whether in prison or under probation supervision - women are at a higher risk of a self-inflicted death than men.

Scrutiny

There is a distinct and dangerous lack of oversight when it comes to investigating and learning from these deaths. This is exacerbated by the lack of any formal oversight from bodies such as the Prison and Probation Ombudsman (PPO) and Her Majesty's Inspectorate of Probation.

In 2018/19, the PPO commenced investigations into 334 deaths, 96% of which were of people in prison (PPO, 2019). The only deaths of people under probation supervision that were investigated by the PPO were the deaths of 12 residents in probation approved premises, some of whom will have been on post-custody supervision. It is worth remembering that there were 515 deaths of people on post-custody supervision in 2018/19 which serves to illustrate the lack of oversight in this area.

The Chief Inspector of Prison, when inspecting prisons, explores levels of safety and establishes how many deaths have taken place at the prison and whether arising recommendations have been implemented. When a death happens in police custody or a self-inflicted death happens within two days following release, the Independent Office for Police Conduct will also investigate. In the case of deaths of people after release from prison and under supervision of the probation services, there is nowhere near the same level of scrutiny.

For deaths in state detention that are self-inflicted, violent or if the cause was unclear, then an Article 2 inquest will take place (often with a jury) to establish the circumstances of the death. In addition to presiding over the inquest, the coroner has the power to issue a 'Prevention of Future Death' (PFD) report to relevant agencies, highlighting any failures and asking for them to be addressed.

There is a case to be made that post-release deaths may engage Article 2 of the Human Rights Act, even where the deceased was not resident in an approved premises, and thus require an independent investigation (Phillips et al., 2019). Whilst there may be an inquest into the death of a person under probation supervision, the lack of any national reporting makes them difficult to identify. A search of the Chief Coroner's website which hosts Prevention of Future Death reports revealed just five reports that included probation providers as recipients of the coroners' concerns. INQUEST's casework has only identified a small number of cases. However, from the official data, it is clear that many people are dying.

Given the scale of the problem, it is concerning that such a small number of inquests appear to be making recommendations involving probation providers. A lack of accurate and timely recording and reporting of such deaths make the identification and thus investigation of the deaths difficult.

Discussion

In summary, the data shows that:

1. **Deaths are rising.** The number of deaths of people after they leave prison (in absolute terms and relative to the caseload), has been increasing for a number of years. The number of deaths that occur after leaving prison has increased much faster than the caseload and the number of self-inflicted deaths have increased even faster still.

   Against a backdrop of declining suicides in the general population and when examined in the context of the changing probation landscape and changes to probation provision, there is an urgent need to establish why this has happened and how to prevent deaths.

2. **Women are at significantly greater risk.** Mirroring the situation in prison, women under probation supervision appear to be at significantly greater risk of taking their own lives when compared to women in the general population.

However, the data tells us very little about *why* the mortality rate is so high, why it is increasing and why women seem to be at greater risk of self-inflicted deaths. It has already been noted that self-inflicted deaths are correlated with levels of inequality and we know that people in prison and on probation are likely to have experienced a range of inequalities in the run up to contact with the criminal justice system. Thus, one might argue that contact with the criminal justice system and the structural violence that this inevitably involves might explain the high self-inflicted death rate amongst all groups of people on probation.

The risks factors for self-inflicted deaths amongst the criminal justice caseload include mental ill health, and drug and alcohol use and specific aspects of probation supervision can increase the risk of suicide further. MacKenzie-Cartwright and Borrill (2018) and Borrill et al (2017) have shown, for example, that difficulties relating to the probation sentence, the impact of legal proceedings and changes in supervision are all potentially linked with subsequent suicide and suicide attempts. However, there has, to date, been no systematic investigation of self-inflicted deaths amongst people under probation supervision. This is partly because, unlike deaths in custody, deaths in the community are not investigated, even though the Prisons and Probation Ombudsman has the power to do so. Such investigations would enable systematic lesson learning to take place and would allow for the development of policies to further reduce these deaths. Not all deaths could, or necessarily should, be investigated. Rather, deaths that occur within a certain period of leaving prison, (for example, within 28 days), should be subject to a more thorough investigation than the very basic internal review that currently takes place.

There is an urgent need to examine the significantly elevated risk of suicide amongst women on the probation caseload. The Female Offender Strategy, published by the Government in 2018, could have provided an opportunity to tackle this by improving support for women as they leave custody. However, concerns have been raised about the feasibility of the strategy, especially as the amount of money originally earmarked has been cut from £30million to just £5million (Booth et al., 2018). Even though there is scope for more learning in this area – through academic research and formal investigations – we already know what can help to reduce these deaths: divert women away from the criminal justice system and improve community-based, gender specific provision for women, for example through Women's Centres.

Ultimately, this analysis serves to reinforce the point that people on probation are at significant risk of a premature death, whether that is self-inflicted or otherwise. Yet, these deaths are not afforded the level of attention and concern we see in custodial settings. There is a clearer duty of care for people in a custodial setting. However, we must remember that every suicide is preventable, as are many non-self-inflicted deaths.

Prompted by evidence submitted to the Health and Social Care Committee in 2018 by INQUEST (2018) and Dr Jake Phillips (2018), there was finally some form official acknowledgement that this is an issue which needs addressing. The Committee (2018) recommended:

> *"that the Government undertake a thorough investigation of deaths during post-release supervision in the community, including the reasons for the rise in death rate that has been described. We further recommend that the Government clarify where responsibility for oversight of such deaths should lie and set out a plan to reduce this death rate."*

Moreover, the Government, in its response, agreed to conduct 'a national review of deaths under post-release supervision with the aim of identifying what further actions may be appropriate to prevent such deaths' (Department of Health, 2019). However, no further information has been provided by the government on how and when this review will be conducted.

Recommendations

People in the criminal justice system are amongst the most powerless and disadvantaged people in society, with high incidence of mental ill-health, chronic health conditions and poverty (Sirdifield et al., 2019). Research (Haney, 2012) has demonstrated that imprisonment has adverse effects on people's lives even once they have left custody. Thus there is a strong likelihood that a period of imprisonment, and therefore the actions of the state, are highly relevant to understanding and preventing these deaths.

Immediate action is required to ensure greater scrutiny, learning and prevention of deaths of people following release from custody. INQUEST recommend the following actions;

1. **National review:** The government should proceed with its national review of deaths of people on post-release supervision in the community following a custodial sentence to establish the scale, nature and cause of the problem. Such a review should also include an audit of what information and support is available to bereaved families.

2. **Data:** More detailed data - including ethnicity and time elapsed between release and death - should be made available. There should also be more accurate recording of data by probation providers and a greater commitment to updating records as and when more information becomes available (such as following inquests). There should also be regular reporting to the relevant Minister and Parliament alongside the publication of an annual report.

3. **Investigations:** Deaths of people on post custody supervision should be investigated by an independent body such as the Prison and Probation Ombudsman, with adequate resources allocated to allow this to happen. There needs to be a threshold for this with a range of factors taken into account. This might be based on the 'time since release', or where drug use is involved, where the deceased had previous mental ill health or attempts at suicide as these are strong predictors of a self-inflicted death. We would also urge the government to arrange for all women's deaths to be investigated.

4. **Improve scrutiny and learning.** The Government needs to confirm oversight at a local and national level. There is also much potential for probation providers to do more in the way of monitoring, reviewing and learning when people in their care die. HMI Probation should consider monitoring deaths as part of its inspection and research activities in a similar vein to that of the Chief Inspector of Prisons.

Appendix

Table 3: Deaths of men and women during post-release supervision, by apparent cause, England & Wales (Ministry of Justice 2019a)

	2010/11	2011/12	2012/13	2013/14	2014/15			2015/16			2016/17			2017/18			2018/19		
					NPS	CRCs	Total	NPS	CRCs	Total	NPS	CRCs	Total	NPS	CRCs	Total	NPS	CRCs	Total
Total	**110**	**147**	**140**	**136**	**93**	**78**	**171**	**154**	**147**	**301**	**185**	**218**	**403**	**153**	**221**	**374**	**238**	**277**	**515**
Self-inflicted	24	30	43	40	17	33	50	36	61	97	45	79	124	35	66	101	50	103	153
Natural causes	49	58	60	61	48	27	75	75	35	110	93	57	150	61	69	130	103	68	171
Homicide	9	7	5	5	2	1	3	5	6	11	10	7	17	1	9	10	11	11	22
Accident	7	17	9	11	7	7	14	12	13	25	6	11	17	5	28	33	11	17	28
Other	2	9	10	4	0	2	2	1	4	5	2	5	7	1	2	3	6	5	11
Unclassified	19	26	13	15	19	8	27	25	28	53	29	59	88	50	47	97	57	73	130

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