HOUSE OF LORDS

Library Note

Harris Review on Self-inflicted Deaths in Custody of 18–24 year olds, *Changing Prisons, Saving Lives*

On 6 February 2014, the then Lord Chancellor and Secretary of State for Justice, Chris Grayling (Conservative), announced the establishment of an independent review into the self-inflicted deaths of 18 to 24 year olds in custody. Lord Harris of Haringey (Labour) was appointed to lead the review—thenceforth known as the Harris Review (the Review). Lord Harris also chairs the Independent Advisory Panel on Deaths in Custody (IAP). The IAP forms the second tier of the Ministerial Advisory Council on Deaths in Custody.

The Review's terms of reference stated that:

- The review should take into account deaths of young adults aged 18–24 in prisons and Young Offender Institutions in England and Wales.
- The review should examine cases since the roll out of ACCT [Assessment, Care in Custody and Teamwork] was completed on 1 April 2007.
- The review should identify whether appropriate lessons have been learned from those deaths and if not, what lessons should be learned/what actions should be taken to prevent further deaths.

The Review was tasked with focusing on vulnerability; information sharing; safety; staff prisoner relationships; family contact; and staff training. It was also required to take into account the views of stakeholders such as prison reform bodies, the Probation Ombudsman; young adults in custody; practitioners; and the affected families. The Review published its report *Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18–24 year olds*, on 1 July 2015. The Government has said that it would respond to the report in the autumn.

This Library Note provides a brief summary of the Review's main findings, presents some statistics on self-inflicted deaths in custody and provides references for further reading on this subject.

Charley Coleman
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Relevant Documents

Title	Date	Referenced in Library Note as	QR Code*
Harris Review, *Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18–24 year olds*, Cm 9087	1 July 2015	The Review	

* QR Codes are graphical representations of hyperlinks which can be read by barcode or QR code scanning applications on smartphones and tablets which are equipped with a camera. The links are read automatically by the device and will download the relevant PDF of the report.

1. Harris Review

The Harris Review examined the lives of the 87 young people who suffered self-inflicted deaths between April 2007 and December 2013.[1] For the purposes of the criminal justice system a distinction is made between young adult offenders aged between 18 and 20 and adult offenders aged over 21.[2] However, for the purposes of the Review 'young adult' was used to describe individuals aged 18 to 24.[3] The Harris Review describes 'self-inflicted death' as an:

> […] inclusive term used to describe the death of a prisoner who has apparently taken his or her own life irrespective of intent. This not only includes suicides but also accidental deaths as a result of the person's own actions. This classification is used because it is not always known whether a person intended to commit suicide.[4]

The Review was asked to look back to April 2007, following the full rollout of the Assessment, Care in Custody and Teamwork (ACCT) procedures. ACCT is part of the National Offender Management Service's (NOMS) suicide prevention strategy and is outlined in Prison Service Instruction (PSI) 64/2011, *Management of Prisoners at Risk of Harm to Self, to Others and From Others (Safer Custody)*.[5] NOMS describes it as "a prisoner-centred, flexible care-planning system which, when used effectively, can reduce risk".[6] ACCT involves the completion of a 'Concern and Keep Safe Form', which then triggers subsequent steps to help ensure prisoner safety including the completion of an 'Immediate Action Plan'.[7] The Government has said that NOMS is currently undertaking a review of ACCT that "will consider issues around the delivery of ACCT and compliance with its principles [and] which will report in October 2015".[8]

The Review used a range of evidence sources and methodologies including, but not limited to:

- The examination of case material on the lives of the 87 young people—four children and 83 young adults—who suffered self-inflicted deaths between April 2007 and December 2013.
- Written evidence submitted by 54 organisations and individuals.
- The holding of family hearings to hear from bereaved family and friends.
- Working with the Ministry of Justice and NOMs to analyse the available statistical data on self-inflicted death in custody.

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[1] This included four children and 83 young adults aged from 18 to 24.
[2] Harris Review, *Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18–24 year olds*, 1 July 2015, Cm 9087, p 24.
[3] ibid, p 8.
[4] ibid, p 282.
[5] NOMS is an executive agency of the Ministry of Justice. It manages public sector prisons in England and Wales through HM Prison Service and the delivery of probation services in England and Wales through the National Probation Service; NOMS, 'About Us—What We Do', accessed 20 October 2015.
[6] ibid.
[7] A flow diagram summarising ACCT can be found on page 10 of the Prisons and Probation Ombudsman's (PPO) *Learning from PPO Investigations: Self-inflicted Deaths of Prisoners on ACCT* (April 2014).
[8] Government Response, September 2015, Cm 9129, p 13, to House of Commons Justice Committee, *Prisons: Planning and Policies*, 18 March 2015, HC 309 of session 2014–15.

- The commissioning of qualitative research into the perceptions of staff in prisons and YOIs.

A full discussion of all of the methodologies and evidence sources can be found in Appendix 3 of the Report.

2. Recommendations

In addition to recommendations aimed specifically at reducing the number of self-inflicted deaths amongst 18 to 24 year olds the Review also made a number of more general recommendations about prisons.

Overall, the Review made a total of 108 recommendations in seven categories. These are divided into three levels: fundamental, primary and secondary. The table below provides a summary breakdown:

Category	**Number of Recommendations By Level**		
	Fundamental	Primary	Secondary
1. The Purpose of Prison:	1	5	8
2. Leadership and Ownership of Prisoner Safety and Rehabilitation:	-	7	7
3. The Vulnerability of Young Adults in Custody:	-	4	8
4. Diverting the Vulnerable from Prison—			
On Diversion:	-	2	5
On Family Support:	-	1	8
On Peer Support:	-	-	3
5. Managing Vulnerability, Health and Mental Health:	-	9	17
6. After a Self-inflicted Death:	-	3	1
7. The Role of Inspection, Monitoring and Investigation Bodies:	-	2	17
Total:	1	33	74

This section provides a brief summary of a selection of the primary recommendations of the Harris Review. For full details of all of the primary recommendations, and for the secondary recommendations, please see the Recommendations section of the Harris Review report.[9]

The Review's fundamental recommendation was that the Ministry of Justice should devise and publish a new statement which reiterates that the primary goal of prison should be rehabilitation. The Review argued that this should state that the purpose of prison is to:

> […] hold safely and securely those people sent there by the courts, either because they have been sentenced to imprisonment or because they have been remanded in custody while awaiting trial or sentencing. A prison should provide to those in custody a regime

[9] Harris Review, *Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18–24 year olds*, 1 July 2015, Cm 9087, pp 201–18.

> whose primary goal is rehabilitation. The penalty of imprisonment is the removal of liberty; all persons deprived of their liberty shall be treated with respect for their human rights (including the European Convention on Human Rights) and their individual protected characteristics (as defined by the Equality Act 2010). Restrictions placed on persons deprived of their liberty shall be the minimum necessary and proportionate to the legitimate objective for which those restrictions are imposed. Life in prison should approximate as closely as possible the positive aspects of life in the community.[10]

Alongside the recommendation outlined above the Review also recommended that young adults in custody be allowed to spend a "reasonable part of the day" outside of their cells, ie eight hours or more, engaged in varied activities of a purposeful nature.[11] The Review argued that this was in accordance with the European Convention on Prevention of Torture.[12]

Further, the Review argued that "elementary" action was needed to reduce the risk of self-inflicted death in custody of 18 to 24 year olds, and that this required cross-organisational cultural change in the approach taken towards the rehabilitation and management of offenders in custody.[13] It found this to be a particular issue in the sharing of physical and mental health information:

> […] whether it is between Departments, between prison and YOI establishments, or between individuals within an establishment, information is falling through gaps and lives are being put at risk as a result.[14]

Additionally, as part of this more open ethos, in cases of self-inflicted death NOMS should have a 'duty of candour' towards those bodies which have a role in the post death processes, such as the coroner and the Prisons and Probations Ombudsman (PPO).[15]

2.1 The Custody and Rehabilitation Officer and the Safety and Vulnerability, Risk Assessment and Support Process

Alongside its recommendations on improved information sharing, the Review also argues for the creation of a new officer post—the Custody and Rehabilitation Officer (CARO)—and a new process to assess and support vulnerable individuals held in custody.

The CARO would be a new specialist role created to work specifically with all young adults in custody. The post-holder would have a caseload of no more than fifteen or twenty prisoners to allow for the development of close and effective relationships between the CARO and each prisoner. The role would be specialist and skilled, and require competencies at least equivalent to that of a professional youth worker or qualified social worker. The Review recommended that the training of CAROs begin within 12 months of the report's publication.[16]

As part of their duties the Review recommended that CAROs be responsible for the development of a new Safety and Vulnerability, Risk Assessment and Support (SAVRAS) process for their prisoners. SAVRAS would be developed as a comprehensive, multi-

[10] ibid, p 202.
[11] ibid, p 54.
[12] ibid.
[13] ibid, p 201.
[14] ibid, p 13.
[15] ibid, p 166.
[16] ibid, p 76.

disciplinary, and holistic needs assessment which would be undertaken within 48 hours of a prisoner's arrival in custody. This would facilitate the development of a young adult prisoner's Individual Custody Plan (ICP). The Review stated that SAVRAS would not be a replacement for the initial reception screening which prisoners receive, and that it would be:

> […] in addition to any urgent risk assessments which need to be put in place as soon as a young person arrives in prison (the SAVRAS will be opened from the first instance to manage this information), including the Offender Assessment System.[17] The SAVRAS process should be integral to how the needs of a young adult are assessed and acted upon.[18]

The Review argued that elements of current ACCT procedures designed to protect and safeguard someone at risk of self-harm or suicide should be incorporated into the proposed SAVRAS process. All prison staff who have contact with prisoners should receive regular mandatory training in regard to SAVRAS and also to enable them to recognise, and address, prisoners' vulnerabilities and mental health needs. The Review argued that such increased professionalisation should be reflected in the remuneration of staff,[19] and that the management of young adults was distinct from the management of the older prison population and training must reflect this.[20]

2.2 Further Recommendations in Summary

Additionally, the Review made a wide range of further observations and recommendations, including but not limited to:

- The Review concluded that all young adults in custody are vulnerable.
- Families should be included as a central part of a young person's care and management whilst in custody, when appropriate. They should also have the right to non-means tested public funding for legal representation at an inquest. This cost should be borne by NOMS.
- Her Majesty's Inspectorate of Prisons (HMIP) should set up a thematic review on 'Safer Cells'.[21] This should include an analysis of what the right number of safer cells is for each prison and young offender's institution.
- Following each self-inflicted death in custody, the Minister for Prisons should personally phone the family of the deceased to express their condolences on behalf of the State, and commit to a full and thorough investigation.

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[17] The Offender Assessment System is a system for both prisons and probation, providing a framework for assessing the likelihood of reoffending and the risk of harm to others.
[18] Harris Review, *Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18–24 year olds*, 1 July 2015, Cm 9087, p 147.
[19] ibid, p 77.
[20] ibid.
[21] The Ministry of Justice National Offender Management Service (NOMS) explains that: "Safer Cells are designed to make the act of suicide or self-harm by ligaturing as difficult as possible. It is achieved chiefly by reducing known ligature points as far as is possible and by installing specialist 'anti-ligature' furniture and fittings as an integral part of the cell fabric. Cells are either designated 'normal accommodation' or 'Safer Cell'". NOMS, *Quick-time Learning Bulletin: Safer Cells*, December 2010.

- The Review argued that operational staffing levels in prisons are not adequate, and that benchmarking levels need to be reviewed.

- The Review concluded that there should be a legal recognition that maturity and chronological age are not synonymous. Consideration should be given to maturity when making sentencing decisions and when a custodial sentence must be given. The Ministry of Justice should work to achieve this and report on progress within one year of the publication of the Review.

- Local Authorities should act as 'corporate parents' to all young people in NOMS custody, not just care leavers.

- As part of its secondary recommendations under this heading the Review argued that if Youth Offending Teams (YOTs) and other key actors believed that due to an individual's lack of maturity they should stay in the under-18 estate upon reaching 18 provision should be made for them to do so.

- Prison should be considered a last resort and should not be used as a default solution. The Review asserted that diversion to healthcare services, social care and other alternatives to custodial sentences can be a route to meeting the complex needs of young people, and also better serve society and the victims of crime. Consequently, judges involved in sentencing decisions should be trained to recognise the specific vulnerabilities of young people. Under circumstances where a young adult must be committed to custodial remand due to a lack of provision for alternative accommodation to which they can be remanded, the relevant local authority should meet this need, or pay the costs of the custody provided by NOMS.

- The Review recommended that its suggested approach of the ICP, SAVRAS and CARO be considered for older adult prisoners.

In order to achieve the recommendations outlined in the report, the Review stated that additional resources would be required. However, it also argued that such investment could be delivered through savings from earlier intervention and diversion from the criminal justice system. The Review urged the Government to detail how it would meet these extra resources in its response.

3. Responses

On 18 March 2015, the House of Commons Justice Committee published its report *Prisons: Planning and Policies*.[22] This was debated in Westminster Hall on 15 October 2015.[23] During that debate, the chair of the Committee, Robert Neill (Conservative MP for Bromley and Chislehurst) spoke with reference to the Harris Review saying that:

> We have seen, for example, the inspection report on Her Majesty's young offenders institution at Cookham Wood: 36 percent of boys are locked up during the core day. As the report by Lord Harris of Haringey legitimately and properly highlights, these are young and often vulnerable people. They have to be punished; they have to be detained.

[22] House of Commons Justice Committee, *Prisons: Planning and Policies*, 18 March 2015, HC 309 of session 2014–15; Government Response, September 2015, Cm 9129.
[23] HC *Hansard*, 15 October 2015, cols 187–206WH.

> That is right to reflect what they have done, but it is very hard to do the rehabilitative work with lock-up for that amount of time. We ought to address that as a matter of urgency.[24]

The Labour Shadow Minister for Justice, Jenny Chapman, expressed concern about "[the] 43 suicides and five homicides in prisons in the past six months".[25] She also said that—in relation to policies such as those that help to maintain family links and prepare prisoners for employment—we:

> […] must assess the effectiveness of such interventions and focus funding on those proven to be most effective. It is incredibly frustrating to find that the work that does happen is so patchy and is not enough to have a significant impact on reoffending figures, which is probably because the methods are very inconsistent and delivery sometimes lacks quality. Access to courses, as we know, is extremely limited, and understaffing leads to offenders spending time idle and to missed opportunities to put right bad attitudes.[26]

Robert Neill asked the Parliamentary Under-Secretary of State for Justice, Andrew Selous, when the Government would be responding to the Review.[27] Mr. Selous stated that the Government would respond in the autumn, and in regard to prison reform he said that:

> It is true that our thinking on the issue is emerging and developing; […] it is clear that our current system fails to rehabilitate offenders and ensure that criminals are prevented from reoffending. Our prisons must offer offenders the opportunity to get the skills and qualifications that they need to turn their lives around, particularly qualifications that have value in the labour market and are respected by employers.[28]

Later in the debate, Mr Selous added that:

> In September, we announced a departmental review of the youth justice system, led by Charlie Taylor, the former chief executive of the National College of Teaching and Leadership. I recognise the importance of clear responsibility for the young adult offender group. We have therefore appointed a deputy director of custody for young people, within NOMS, as senior lead on operational policy on young adults. We are also working to improve the evidence base around what works best with young adult offenders. That includes developing and testing a tool to screen for emotional and social maturity, which should help us to understand need better and better tailor services and interventions for young adult offenders in prison or in the community.[29]

Speaking to the Harris Review, the Minister said that:

> It is too simplistic to attribute self-inflicted death or self-harm to staffing reductions or benchmarking. Deaths have occurred in contractor prisons, which have not been

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[24] ibid, col 191WH.
[25] ibid, col 196WH.
[26] ibid.
[27] ibid, col 202WH.
[28] ibid, col 199WH.
[29] ibid, col 202WH. The Government's review into the youth justice system was announced by the Secretary of State for Justice, Michael Gove, on 11 September 2015 (HC *Hansard*, cols 23–4WS). The terms of reference are available on GOV.UK.

> subject to reductions, as well as public sector prisons. All prisons are required to have procedures in place to identify, manage and support people who are at risk of harm to themselves. NOMS has put in place additional resources to undertake this safer custody work. NOMS is also reviewing the operation of the case management process for prisoners assessed as being at risk—procedures for assessment, care in custody and teamwork, known as ACCT. It is considering the recommendations of the Harris review into deaths of young adults in custody, about which the Chair of the Justice Committee rightly asked.[30]

External Organisations

A number of interested organisations have responded to the Harris Review into Self-inflicted Deaths in Custody of 18–24 year olds, some of which will have made submissions to the Review whilst it was gathering evidence.

The Director of the Prison Reform Trust, Juliet Lyon stated that:

> The stark recommendation for the Minister to telephone families when a loved one has died in custody will come as a shock but it may well be that only when this conversation takes place that change will result and true accountability be achieved.[31]

The Prison Reform Trust also agreed with the Review's statement that prison should be seen as a last resort.[32]

Frances Crook, chief executive of Howard League for Penal Reform, described the report as "magisterial" in its overview of the "failings in the system", writing that:

> The challenge has been placed before government, judges, magistrates, prisons, the Crown Prosecution Service and police. Everyone has to play their part in building the change that will save lives.[33]

The Youth Justice Board welcomed the publication of the Review, saying that:

> Although focused on the young adults' secure estate, the Review's findings powerfully advocate the benefits of a multi-agency and holistic approach to address the needs of those in the criminal justice system; to reduce the use of custodial sentences; and to rehabilitate those who are serving them. This same approach—used by the YJB for the last 15 years—has been key to our success in reducing the numbers of young people in custody, and of first time entrants into the youth justice system, to their lowest ever levels.[34]

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[30] ibid, col 203WH.
[31] Prison Reform Trust, 'The Harris Review: Deaths of Young People in Custody 'A Failure by the State'', 1 July 2015.
[32] ibid and Harris Review, *Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18–24 year olds*, 1 July 2015, Cm 9087, p 12.
[33] Howard League for Penal Reform, 'The Harris Review', 1 July 2015.
[34] Youth Justice Board, 'YJB Response to Harris Review', 1 July 2015.

The Youth Justice Board described the recommendations as "well-informed" and that it would carefully consider where and how it could apply them to the care of children and young people in custody.[35]

Speaking to the British Psychological Society regarding the Harris Review, former Chief Psychologist at the Ministry of Justice and Professor of forensic psychology at the University of Durham—and member of IAP—Graham Towl, said that:

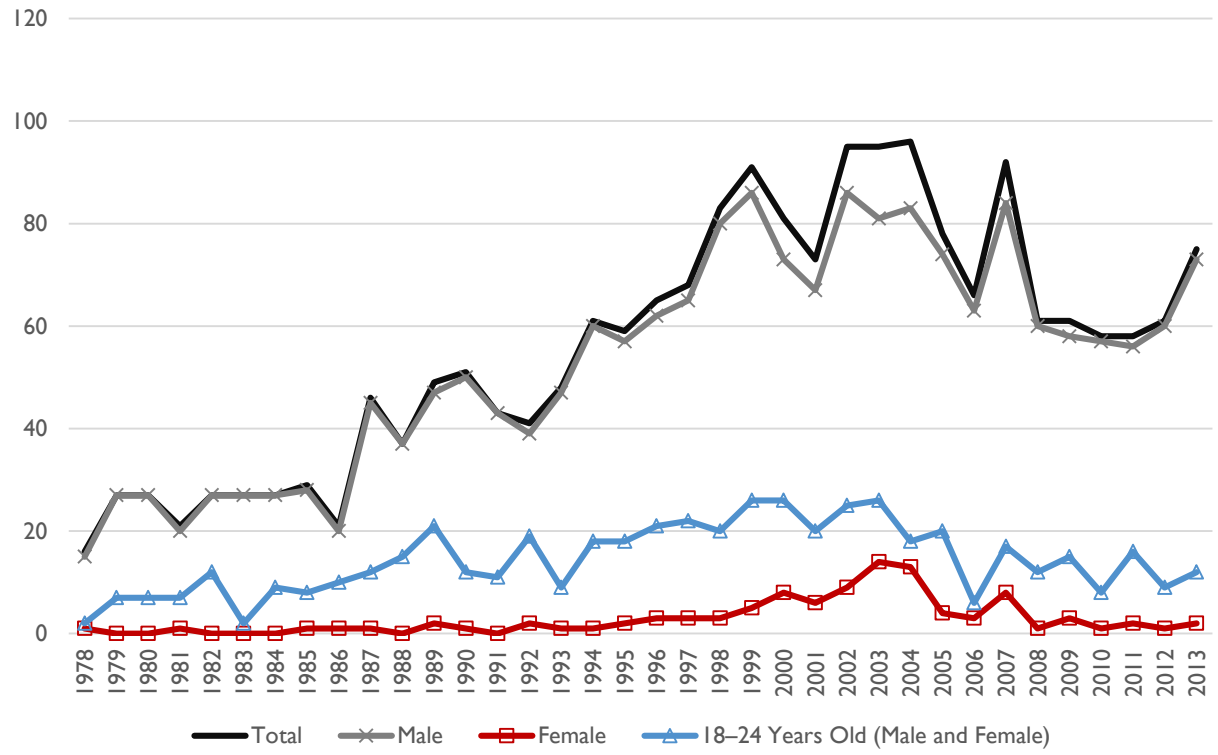
> In public health terms prisoners are a vulnerable group on a range of measures with high needs for psychological support. I would encourage the National Offender Management Service to build on previous and existing work and employ a broader range of applied psychologists to deliver services reflecting the full range of the needs of members of the public who happen to be prisoner[s].[36]

4. Statistics

As part of the Harris Review's collection of evidence, analysts at the Ministry of Justice and NOMS were commissioned to undertake an analysis of self-inflicted deaths in England and Wales between 1978 and March 2014. These statistics were published alongside the Report.[37]

A selection of data from the report has been presented below.

Chart 1: Number of Self-Inflicted Deaths by Gender, England and Wales, 1978–2013[38]



[35] ibid.
[36] British Psychological Society, 'No holds Barred in Harris Review', 6 July 2015.
[37] Ministry of Justice, *Quantitative Analysis of Self-inflicted Deaths in Prison Custody*, 1 July 2015.
[38] ibid, data tables 3.1 and 3.2.

Chart 1 shows that there has been a trend of increasing total numbers of self-inflicted deaths since 1978. The large difference between males and females reflects the much larger male prison population. Total deaths amongst 18 to 24 year olds has remained relatively constant. It should be noted that Chart 1 does not take account of any changes in the prison population over this time period.

The Prisons and Probation Ombudsman (PPO) publishes data on its investigations into self-inflicted deaths. On 10 March 2015, the PPO published *Learning from PPO Investigations: Self-inflicted deaths of prisoners—2013/14*. This includes the numbers of deaths and provides an analysis of various factors, including sentence length and type of crime.

5. Other Reports and Further Reading

As part of its evidence gathering the Harris Review consulted a number of reports, policy documents and PSIs out of committee, rather than for the purpose of a specific agenda item. These 97 documents are listed in Appendix 8 of the Report. Copies of the evidence submitted by the external organisations and individuals, and other research considered by the Review can be found here:

- Independent Advisory Panel on Deaths in Custody, The Harris Review, 'Submissions, Research and Evidence', accessed 21 October 2015

The Prisons and Probation Ombudsman has published several relevant reports in its *Learning Lessons* series.[39] These include the following:

- PPO, *Learning from PPO Investigations: Self-inflicted Deaths Under ACCT*, April 2014
- PPO, *Learning Lessons Bulletin: Fatal Incident Investigations Issue 8: Segregation*, June 2015

The PPO has also published its submission to the NOMS review of the ACCT, available here:

- PPO, *Submission to National Offender Management Service (NOMS) Review of Compliance and Delivery of the Assessment, Care in Custody and Teamwork (ACCT) process (August 2015)*, 6 August 2015

Further Reading

- Graham Towl and Tammi Walker, 'Prisoner Suicide', British Psychological Society, 6 July 2015
- House of Commons Justice Committee, *Prisons: Planning and Policies*, 18 March 2015, HC 309 of session 2014–15; Government Response, September 2015, Cm 9129.
- House of Commons Library, *Prison Population: Social Indicators Page*, 18 August 2015, SN02620
- House of Commons Library, *Probation Reforms 2014*, 9 September 2014, SN06974

[39] PPO, 'Learning Lessons Reports', accessed 22 October 2015.

- House of Commons Library, *Prisoners: Incentives and Earned Privileges Scheme*, 31 July 2014, SN06942
- House of Commons Library, *Debate Pack: Safety in Prisons*, 15 June 2015, CD 0013
- Debate on 'Safety in Prisons', HC *Hansard*, 17 June 2015, cols 81–105WH
- Debate on 'Prisons: Planning and Policies', HC *Hansard*, 15 October 2015, cols 187–206WH