

Vulnerable individuals or harmful institutions?

J M Moore questions whether the current review of deaths in custody goes far enough

On 29 September 2013, the day before Chris Grayling, Justice Secretary, addressed the Conservative Conference, 21 year old Steven Davidson died. Steven had hung himself in Glen Parva YO1. In his speech, Grayling made no mention of Steven's tragic death. Instead he focused on 'a justice system that doesn't properly punish' and on young prisoners 'having a lazy, easy time'. He pledged 'an end to soft justice' (Grayling, 2013). Rhetoric about 'soft justice' and prisoners having an 'easy time' do not reflect the lived reality of prisoners. Steven was not having an easy time in Glen Parva, and felt the pains of imprisonment so acutely that, unable to cope with them, he was driven to killing himself.

During 2013 more deaths of young men followed. On 12 October, 20 year old Gary Douglas in HMP Altcourse; on 10 November, 21 year old Sean Brock in HMP Woodhill; on 14 November, 23 year old Jamie Oliver in HMP Hewell and 18 year old Imran Douglas in HMP Belmarsh; on 15 November, 18 year old Reece Taylor in HMP Chelmsford, and on 15 December, Jack Davies in HMP Norwich. In January 2014 three more young men died: on 9th, Steven Trudgill, 23, in HMP Highpoint; on 10th Thomas McGovern, 21 in HMP Humber and on 24th Hayden Brown, 20, in HMP Lancaster Farm. All ten had died through 'self-inflicted hanging' (INQUEST, 2014).

On 6 February 2014, in response to public concern about deaths in custody and the campaigning work of Inquest and others, Grayling announced an independent review into 'self-inflicted' deaths of 18-24

year olds in prison to be chaired by Toby Harris. At face value this review would appear to offer the potential to improve our understanding of the deaths that occur all too regularly in prisons and potentially help avoid future ones. But is this its likely outcome? To understand the possibilities offered by the Harris review, I firstly want to explore the 1985 inquiry into six deaths at the Glenochil complex.

1985: Chiswick and the death of young men in Scotland

William Whitelaw's 'short, sharp shock' speech to the 1981 Conservative conference signalled a toughening of penal regimes. Political speeches advocating harsher conditions legitimise already severe regimes in establishments, such as Glenochil in Scotland where, just weeks after Whitelaw's speech, Edward Herron died. In the next three and a half years a further six young men killed themselves at Glenochil: Richard MacPhie, Allen Malley, Robert King, William McDonald, Angus Boyd and Derek Harris. Their ages ranged from 16 to 19. A further 25 young prisoners attempted to end their own lives (Scraton and Chadwick, 2014).

In response to these seven deaths the Scottish Office established a working party under Derek Chiswick. Its brief was clear; to focus on procedures for identifying and supervising prisoners at risk of suicide, and it was not to look at broader questions about the regime or the reasons why the young people were imprisoned. The inquiry, its 100 page report published in 1985 and its recommendations were subject to a swift and critical review by Phil Scraton and Katherine Chadwick

which has recently been republished. Their critique recognised the inherent violence of young people's imprisonment. Glenochil, they argued, had a culture of bullying and routine prisoner and staff violence where 'doing time ... is about being able to handle the extremes of the conditions created formally (institutional) and informally (cultural)' (ibid). This perspective was radically different to Chiswick's. Whilst forced by overwhelming evidence to recognise the bullying and violence endemic in Glenochil Chiswick sought to blame it on 'inmate culture'. How this bullying and violence was routinely exploited by the institution to exercise control was not recognised (Great Britain, 1985).

In the same way that responsibility for the institution's endemic violence was allocated to prisoners, the blame for suicide was placed firmly with those who killed themselves. To do this, Chiswick sought to identify the specific vulnerabilities and inadequacies of those who killed or attempted to kill themselves. Rather than examine the institutional pains the young men had been subjected to, Chiswick instead focused on the personal 'inadequacies' which had led to them not coping. Scraton and Chadwick (2014) rejected this narrative:

...people who resist such regimes or who crack-up within them are not necessarily suffering from 'broken homes' or 'personal disorders', as Chiswick would have us believe, but are responding rationally to inhuman policies and practices which are inherent in harsh regimes of detention.

(emphasis in original)

2014: Harris and a focus on vulnerability

The very fact that the government has been forced to commission Harris' review shows that the state has had to acknowledge that something has gone wrong. However, how Harris will explain that failure is still to be determined. In setting out Harris's terms of reference Grayling has,

controversially, excluded the deaths of children. This is important for a number of reasons. Firstly it indicates his desire to tightly restrict the focus of the review. Secondly, including children would have made it far more difficult to focus on 'vulnerabilities' and 'inadequacies' (what child in prison is not vulnerable?). Thirdly, given the greater legal and organisational protection offered to children in penal institutions Harris would have been unable to recommend safeguards that are already in place and have failed in the children's estate.

In seeking submissions to his review Harris has set out 38 questions he specifically wants addressed. These allow us to see the direction in which Harris is minded to lead the enquiry. What is *not* highlighted in these guidelines is of interest. None of the questions focus on what happens before prison, the journeys the young people take and the missed opportunities for alternatives to custody. There are no questions on the overall profile of young people imprisoned or anything on the cultures and functions of the institutions they are punished in.

Individual vulnerability

Harris's questions focus predominately on individual vulnerability. Questions 1 to 7 are about identifying the 'vulnerable' prisoner, whilst questions 19 to 25 focus on the management of vulnerable individuals. The clear presumption here is that vulnerability is exceptional and a failure to identify and manage it can explain deaths in custody. Vulnerability is not exceptional; it is a characteristic of an overwhelming majority of imprisoned young people. The scale of vulnerability means it makes sense to presume it rather than identify it and to develop policies that routinely treat all young prisoners as vulnerable. Questions 8 to 12 focus on 'information and effective communication'. Such a focus typically allows inquiries to present failure as temporary and a technical malfunction. They avoid hard questions about the nature of state institutions and in the case of prisons

the violence which is at the heart. They also deflect attention from the abuses which are endemic across the whole penal estate. Questions 13 to 18 again focus on administrative operations – in this case on ACCT (Assessment, Care in Custody and Teamwork) – again showing Harris's underlying assumption that deaths in custody are the result of operational malfunctions that can be corrected by better administration. Such an approach allows the underlying causes – the pains of imprisonment – to be sidestepped. Questions 26 to 31 focus on ways in which procedures following a death in custody can be improved and questions 32 to 37 address prison staff. The focus in the staffing section is exclusively on training, there are no questions on staff violence, staff bullying, or the conflicts inherent in the role of prison guards. The final question addresses the needs of young prisoners' families (Independent Review, 2014).

The report, *Fatally Flawed*, drew on INQUEST's extensive knowledge of the cases of children and young people who died in custody between 2003 and 2010 (Edmundson et al., 2012). The report highlighted the vulnerability of those who had died, the ways they had been failed by community agencies prior to their imprisonment and opportunities that had been missed to divert them away from the criminal justice system. It also exposed poor medical care, the extent of bullying, segregation and restraint and the fundamentally unsafe nature of prison environments. There is no doubt that the children and young people who have died in prisons have often been vulnerable on a number of counts. As studies of prisoners in general, women prisoners and young people have consistently shown that those who have experienced troubled childhoods, educational exclusion, sexual violence, learning difficulties, homelessness, poverty and poor mental health are massively over represented in incarcerated populations. Prison is not somewhere vulnerable people are occasionally erroneously placed. They are places that are full of damaged and vulnerable people.

Prisons are also places of punishment whose very purpose is the deliberate infliction of pain. Imposing pain on vulnerable and damaged people inevitably leads to high levels of self harm and self-inflicted deaths. The Harris review must decide if it is prepared to engage with this fundamental truth. If it's not, and its questions suggest it isn't, then like Chiswick it will move the focus away from the inherent pains of penal institutions and instead attempt to put the focus on the victims 'inadequacies' and 'failures' to cope. But improved administration, communication, systems and staff training will do nothing about the real causes of death in custody. To end the deaths of children and young people in prison we need to start with questioning their very imprisonment. By focusing on the reality of prisons it becomes obvious that the solutions are not be located inside but beyond prisons. ■

Dr J M Moore is Senior Lecturer in Criminology, University of the West of England

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