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Care Leavers and the Criminal Justice System

Twenty suicides of care experienced people in custody:

A scoping review of the Ombudsman's fatal incident reports for care experienced people who died in custodial settings between 2004 and 2020.

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Introduction

This article presents a review of the Prison and Probation Ombudsman's (PPO) reports into fatal incidents from 2004- 2020. The review focuses on the reports of people who died in custody due to suicide and specifically those that had a care experience. Data shows that there continues to be a high number of suicides in the prison system[1]. The reasons for people completing suicide are often complex and nuanced with each person's loss of life having an individual context. However, statistics show there is an over representation of people with mental health and substance abuse difficulties in custody and when this is combined with the stress of life in prisons it presents an environment where suicide is prevalent[2].

Former looked after children in England's prison and secure estate are commonly known as 'care leavers' or 'care experienced people'. There have been some discrepancies in the identification of this group and what constitutes as a care leaver or care experienced person within the prison population. Accordingly, this often makes it difficult to identify what could be argued as one of the most disadvantaged and vulnerable groups within the criminal justice system. In this article we define a care leaver as a person under the age of 25 who is eligible to support provisions under the Leaving Care Act 2000. A care experienced person is someone who has been in local authority care irrespective of their age and statutory rights[3].

It is well documented that people with a care experience are over-represented in the adult prison system and the secure estate for children and young people[4]. It is important to highlight that most care leavers do not commit crime and that there are many amazingly resilient care experienced people who are prominent in sport, the media, politics, academia, and other institutions[5]. It is also important to highlight that there have been advances in supporting this group in custody. For example, HMPPS have worked with Barnados to develop a toolkit for prison staff to best support care leavers[6]. However, this is not a static accomplishment and there are many areas where their support and care are lacking, and they remain vulnerable to poor outcomes on leaving care and challenges across their life course.

There is a growing body of research that explores looked after children's experiences in the criminal justice system[7]. The focus has often been on the reasons why care leavers enter custody[8]. There have been some studies and reports that explore the deaths of young people in custodial settings[9] [10]. The data on care

1. Skinner, G.C. and Farrington, D.P., 2020. A systematic review and meta-analysis of offending versus suicide in community (non-psychiatric and non-prison) samples. *Aggression and violent behavior*, 52, p.101421.
2. Sirdifield, C., Gojkovic, D., Brooker, C. and Ferriter, M., 2009. A systematic review of research on the epidemiology of mental health disorders in prison populations: a summary of findings. *The Journal of Forensic Psychiatry & Psychology*, 20(S1), pp.S78-S101.
3. Her Majesty's Prison and Probation Service, 2019. Strategy for care experienced people, London: HMPPS.
4. Taylor, C., 2003. Justice for looked after children? *Probation Journal*, 50(3), pp.239-251.
5. Rogers, J., 2017. 'Different' and 'Devalued': managing the stigma of foster-care with the benefit of peer support. *British Journal of Social Work*, 47(4), pp.1078-1093.
6. Barnados, 2019. *Toolkit for supporting Care Leavers in Custody*. London: Barnados
7. Schofield, G., Ward, E., Biggart, L., Scaife, V., Dodsworth, J., Larsson, B., Haynes, A. and Stone, N., 2014. *Looked after children and offending: Reducing risk and promoting resilience*. London: BAAF.
8. Carr, N. and McAlister, S., 2016. The double-bind: Looked after children, care leavers and criminal justice. *Young people transitioning from out-of-home care*, pp.3-21.
9. Gooch, K., 2016. A childhood cut short: child deaths in penal custody and the pains of child imprisonment. *The Howard Journal of Crime and Justice*, 55(3), pp.278-294.
10. Youth Justice Board., 2014. *Deaths of children in custody: action taken, lessons learnt*. Available at: https://www.gov.uk/government/publications/yjb-plan-to-prevent-deaths-of-children-in-custody [Accessed 24 June 2021]

experienced people often features in these studies, generally as a small part of a broader investigation. This provides some valuable data, for example, a report by Inquest[11] found that in 30 per cent of the deaths of young adults in prison between 2011 and 2014 the person had experience of public care.

To the best of our knowledge, at the time of writing there have not been any studies that have focused on the specific issue of the deaths of care experienced people. This is a potentially significant gap in the literature as it has been reported that people leaving care are four to five times more likely to complete suicide than their peers[12]. This paper is an exploratory study that attempts to start addressing this gap by reviewing the fatal incident reports that cover deaths in custodial settings. The findings that follow, show between 2004 and 2020 there have been at least twenty people with a care experience that have died in prison due to suicide. In the analysis of the reports we identified four key findings; 1) that the people who died often had well documented histories of mental health difficulties and had expressed suicide ideation; 2) Many had experienced a significant transition prior to dying, for example, a move of prison, wing or a recent sentence; 3) This was often compounded with the person experiencing relationship difficulties in the lead up to their death, either with peers in prison or family and friends in the community; 4) in the reports there was little to no mention of the people receiving support from social work services.

A key purpose of these reports into deaths in custody is to offer lessons for policy and practice so that improvements can be made, and loss of life can be reduced.

Method

Since 2004, whenever a person dies in a custodial setting the PPO undertakes an investigation and publishes a fatal incident report. The investigation includes meeting with family and staff and reviewing the case files and paperwork. This process was established after Article 2 of the European Convention on Human Rights called for independent investigations into all deaths caused by the state, either through failure to protect or using force. The PPO undertakes independent investigations into all deaths of prisoners and detainees held in: Prisons; Young Offender Institutions; Secure Training Centres; Immigration Removal Centres; Probation Approved Premises and Court Cells. A key purpose of these reports into deaths in custody is to offer lessons for policy and practice so that improvements can be made, and loss of life can be reduced.

This paper presents a review of the PPO reports and it was guided by the following two overarching research questions.

1) What is the scale of suicide amongst care experienced people in UK custodial facilities? How many of the PPO self-inflicted fatal incident reports relate to care experienced people?
2) What are the common themes across these reports shared by care experienced people who have completed suicide in custody?

To determine which reports to include in our sample we undertook an initial search that included all the age ranges on the website. It became apparent that the reference to whether the person was ever in care reduced significantly across the older age ranges. This may of course be due to the older people not having a care experience. However, given the over-representation of care experienced people in custody we feel that care status was just not documented or felt relevant to consider. We feel this is a logical explanation given they are further away from their care experience and when they are over the age of twenty-five, they become ineligible for leaving care services. Accordingly, at this point, we chose to focus on the reports for people closer to a care experience and included the three PPO website age ranges under thirty. We selected all the reports for the deaths that were classified as self-inflicted in the age range; under 18; 18-21; 22-30. These reports dated from 2004 to 2020 and there was a total of 419 reports into self-inflicted deaths across these age ranges.

There is no systematic method of recording whether the person had a care experience in these

11. Inquest, 2015. Stolen lives and missed opportunities. Available at: https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=9fe9a856-04f5-4332-8d96-1d5538a4ff66 [Accessed 26 October 2021]
12. House of Commons Education Committee (2016). *The Mental Health and Well-being of Looked After Children: Fourth Report of Session 2015-16*. p.4. Available online: https://publications.parliament.uk/pa/cm201516/cmselect/cmeduc/481/481.pdf [Accessed 26 June 2021].

reports. Over the years the reports have adopted a variety of formats written by different authors. Therefore, we developed a range of search terms to try to identify investigations that related to care experienced people. A wide range of terms were used to ensure reports were considered even if their terminology varied. The terms used were as follows; Care; Care Experience; Care Leaver; Foster Care; Residential Care; Children's Home; Adoption; Social Services; Social Worker; Personal Advisor; Looked After. We then read through the reports where these terms were found to ascertain if there was information confirming if the person had an experience of care.

The reports were analysed by two researchers, both registered social workers with practice experience of supporting children looked after by the state. One of the researchers is a social work academic with a research background that explores issues relating to public care. One of the researchers works in practice development and training, they also have the lived experience of growing up in care and serving custodial sentences in several prisons. We acknowledge that this qualitative analysis of the reports is interpretive and recognise our positions and experiences shape the interpretation. Therefore, we adopt a reflexive approach highlighting our position and the strengths this brings with our insider knowledge but also trying to avoid making assumptions and to represent the data with our positionality declared. We undertook a form of thematic analysis[13], reading through the reports developing codes and then choosing emergent themes that we felt encapsulated the key issues for policy and practice. In relation to ethics this is an analysis of publicly available documents. Some of the more recent reports included the person's names. however, we have chosen not to use any names for consistency and to respect confidentiality of the person, their family, and friends.

Findings

The scale of suicide amongst care experienced people in custody.

In total there were 419 reports on the PPO website that document the self-inflicted deaths of people in custody under the age of 30. We searched all 419 of these reports and found reference to a person's care experience in 20 reports. This accounts for 5 per cent of the reports. Considering that 24 per cent of the people in the prison population is thought to have had a care experience this overall number in relative terms presents as low. This may be due to a lack of systematic recording of care status particularly in the reports in the older age ranges, which maybe because it is outside the PPO's terms of reference for their investigations. However, data shows that younger people, who are by virtue closer to their care experience are more likely to have their care status recorded in the report. For example, between the age range of 18-21 over 8 per cent of the people in the reports had a care experience. Furthermore, the 8 children (under 18's) who completed suicide in custody since 2004 we found reference to a care experience in 6 of the cases. This represents 75 per cent of the children in the PPO reports who died in custody.

Table 2: Distribution of PPO reports across the age ranges and numbers of people with a care experience.

PPO Website Age Ranges	Overall number of PPO reports on self-inflicted deaths	References to experience of care in PPO reports
Under 18's	8	6
18-21	94	9
22-30	317	5
Totals	419	20

Documented histories of mental health challenges, and risks of self-harm and suicide ideation.

It is well documented that care experienced people are vulnerable to mental health difficulties[14]. The impact of adverse childhood experiences and often the social impacts of inequality and poverty lead to people having to cope with significant trauma[15]. These vulnerabilities were reflected in the circumstances of all the 20 people in these reports. Across the reports there were many references to mental health and people who were receiving support from mental health services both prior to entering prison and whilst they were in custody. For

13. Braun, V. and Clarke, V., 2014. What can "thematic analysis" offer health and wellbeing researchers?.
14. Smith, N., 2017. *Neglected Minds; A report on mental health support for young people leaving care*. Ilford: Barnados.
15. Fox, B.H., Perez, N., Cass, E., Baglivio, M.T. and Epps, N., 2015. Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child abuse & neglect*, 46, pp.163-173.

example, in the report into the death of a 15-year-old boy at HMYOI Lancaster Farms, there was reference to support he was receiving prior to entering prison from a Child and Adult Mental Health Service (CAMHS). In 2010 a man, who was an immigration detainee, died whilst in custody at HMP Glen Parva. He had a history of self-harm and was placed in secure units during his adolescence. Just prior to his death he was referred for a mental health assessment to review his need for his medication.

The PPO reports highlighted many of the people having had significant histories of mental health, self-harm incidents and suicide attempts both prior to entering prison and some whilst in prison. However, in practice these histories were often poorly documented in any prison recordings. A common theme across the reports was the Assessment, Care in Custody and Teamwork (ACCT) documents that outline the monitoring of risks were often found to be lacking and, in several cases, these crucial ACCT reports were missing. For example, in the lead up to the death of an 18-year-old man in Aylesbury neither his medication chart, the ACCT document, nor a supply of his anti-depressants, were transferred when he moved from Woodhill.

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The data also shows the importance of assessing risks when a person has a previous history of self-harm and suicide ideation, staff need to remain vigilant to the risks, even if things seem settled. In several cases there was a calm before the storm; people presented as being settled and had run of the mill conversations with staff and peers. This was evident in the report about a 19-year-old man who was found dead in his cell two days after being sentenced to five years. By virtue of the sentencing alone this person should have been considered as a risk of self-harm and or suicide. To compound this the man had a well-documented history of self-harm and had expressed intentions of suicide if he received a sentence. He previously disclosed this to prison staff, a barrister, a probation officer, family members, and a prison officer. However, on his return from court, he was not placed on any self-harm monitoring procedures because he presented as calm and did not express self-harm or suicidal tendencies, which may suggest the young man had made his mind up and was now willing to say what was necessary to achieve his goal of suicide.

On reading the reports, it was also apparent that the focus of the investigation by the Ombudsman was usually on the risk assessment and monitoring of people with mental health challenges. There was little reference in the PPO reports to any plans for support or details of interventions to assist people with their mental health. Details of any support and interventions would have been useful in these reports as they could offer practice insights into what has worked, and what failed.

Sentencing, transitions and moves before death.

In the circumstances leading up to the deaths of the 20 people in the reports, there were recurring examples of young people having experienced some form of significant transition. This was often a new sentence, a move of cells, wings, or prison. This has been previously documented as a risk factor for the wider prison population of young adults who completed suicide. A Prison Ombudsman's report found '*A fifth of the young adults (20 per cent) had moved cells in their last 72 hours. Sometimes moves between cells or wings in the same prison occurred very shortly before the prisoner took their life… these were often very vulnerable young men, frequently with a history of recent self-harm*'[16]. Across the 20 reports we analysed this was also a common theme in the lead up to the suicides. For example, in relation to the death of a boy aged 15 at HMYOI Lancaster Farms he was involved in multiple transitions including children's home and YOI's. During his time at Lancaster Farms, he moved to multiple different units. Another man who died at aged 26 at HMP Highpoint took his life just two days after arrival at the institution and the sentencing at court.

These vulnerabilities around transitions are potentially more acutely felt for people with a care experience as they have often experienced multiple transitions in childhood, which result in disruption to their attachments, relationships, and social networks[17].

16. Prisons and Probation Ombudsman, 2014. *Learning Lessons Bulletin: Fatal Incident Investigation Issue 6*
17. Rogers, J., 2017. 'Different' and 'Devalued': managing the stigma of foster-care with the benefit of peer support. *British Journal of Social Work*, 47(4), pp.1078-1093.

These disruptions happen at the point of entry to care, when they are removed from their families and they are often compounded whilst in care because on average they can experience four placement moves[18].

Social networks, relationship challenges with family, friends, and peers.

Secure settings can be difficult environments where people experience bullying and exploitation. It is important to acknowledge that care experienced people are often without the external support of family and friends and at higher risk of exploitation within prison culture. Across the reports we analysed, there were examples of people having to risk borrowing from fellow inmates, creating debt and vulnerability. For example, the 28-year-old man at HMP Ranby told an officer he was being pursued for a large debt. Another example is the 18-year-old man in HMP Highdown who told an Officer he had been punched on both sides of his head and that the attack was related to a tobacco debt.

There is also evidence of care experienced people having increased risks of getting involved in illegal activity, for example, to fund their canteen. In 2015, the man who died in HMP Ranby aged 28 was charged with disciplinary offences and in the lead up to his suicide in 2015 he was charged for fermenting alcohol in his cell.

There were also examples of bullying, taunting through the windows at night by other prisoners, incidences of physical violence and general intimidation. Some young men had to be transferred to a different prison to be kept safe. Often after being moved on several wings to keep them safe. As we highlighted in the previous theme each transition would likely have added to their pre-existing anxieties.

Previous reports have documented that people in custody have strong attachments to their families and partners, they can be a risk factor when relations are fraught[19]. Again, for young people and those with a care experience this can be a more complex situation with often disrupted relationships to family and carers. For example, in the case of the 18-year-old who died in Reading in 2007, during the lead up to his suicide he had disagreements with his girlfriend. On the day of his death the man had 7 phone calls within 1 hour, to his mother, and girlfriend. He then expressed lots of anger, remorse, and blame. The man wrote three suicide letters that afternoon and was found dead in his cell the following morning.

Learning lessons and looking at this issue from a strengths-based perspective it also highlights the need for practitioners to support people in custody with their family relationships as when they are positive, they can serve as a protective factor, supporting their wellbeing and reducing the risk of mental health, self-harm, and suicide.

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Social work involvement, visits and support.

Across these PPO reports, there was little to no mention of the person engaging with their social workers or leaving care advisors. For example, in the report of the 18-year-old man who died in HMP Reading prison there was reference to a care experience and eligibility for care leaving services. However, there was no mention of a pathway plan, visits while in custody or planned support for release. We acknowledge this lack of detail in the reports about social work support may have been due to it being outside of the Ombudsman's terms of reference for their investigation. However, this may be further evidence of the HM Chief Inspector of Prisons[20] finding in their review that half of looked-after children in prison received no visits from their social worker. We know from our practice experiences that sometimes social workers and their managers feel that when a person is sentenced to custody, they are comparatively safe and perceived as being looked after. However, these 20 deaths suggest otherwise, they are at their most vulnerable and need urgent support.

Care experienced people involved in the criminal justice system are sometimes for social workers the hardest to engage with. Custody provides an opportunity for practitioners to build relationships,

18. Morgan, R. (2011) Children's care monitor 2011, Available at: https://www.education.gov.uk/publications/eOrderingDownload/Children%27s%20care%20monitor%202011.pdf [Accessed 27 June 2021].
19. Prisons and Probation Ombudsman, 2014. *Learning Lessons Bulletin: Fatal Incident Investigation Issue 6*
20. Her Majesty's Prison and Probation Service, 2019. *Care leavers in prison and probation*. Available at: https://www.gov.uk/guidance/care-leavers-in-prison-and-probation [Accessed: 26 June 2021]

whilst they are secured, with acts of kindness and practical support. Further research would be useful to explore how social workers are engaging with young people in custody. Social workers are uniquely placed to bridge the world of custody and community. They can play a role in facilitating relationships with people outside of prison. This is particularly important when you consider the examples in the report where arguments with family and partners, and the longing for missed relatives, were triggering events in the lead up to the suicides. For example, one young person, the 15-year-old boy in Cookham Wood, was desperate to get in contact with his grandmother. This boy experienced inconsistent support from children's services, his case was managed by a duty social worker, and he was only allocated his own social worker shortly before he died, whom he never met.

Consistency of reports and the Ombudsman's investigation.

The Ombudsman reports provide valuable insights into the lead up to these untimely events and they highlight the failings of the system and the lessons that need to be learned. However, reports were often inconsistent in their format and included differing levels of information. For example, some lacked even the most basic information like the person's age. The reference to a person having a care experience is often difficult to identify in the reports. This would have allowed data in reports to be aggregated more easily and better provide the ability to learn lessons for this marginalised group. As we have previously highlighted, this reporting omission of care status seems particularly relevant for care experienced people in custody in the older age ranges.

Conclusion

To conclude, the paper highlights recommendations for policy and practice and then reaffirms the previous calls of academics and advocates for a government inquiry into the deaths of care experienced people in custody.

Recommendations for policy and practice

- It would be beneficial for practitioners, managers, and policy actors to build on the recent work of Barnados[21] to further develop toolkits and practice guidance to better support care experienced people in custody. This would be best with organisations that advocate and work closely with or are led by care leavers. For example, Rees Foundation; Become; Care Leavers Association.
- The development of a clear system for identifying and supporting care leavers and care experienced people in prison during times of transition. Including, sentencing; arrival at the institution; moving cells; moving wings; moving institutions. A review of processes for transfer of key documents during these moves, for example medical records and ACCT assessments would be advisable.
- A review of mental health support of care experienced people in custody is needed. The reports suggest there is a focus on managing the risk of self-harm and suicide, which is important. However, support and interventions are vital to help people cope with their mental health and often their experiences of childhood trauma.
- There is a need to assess and support the social relationships of care experienced people in custodial settings. When relationships are good and well supported, they present as a protective factor. Disrupted and fraught relationships presented across these reports as a trigger in the leadup to the suicides.
- It is vital for social workers to not only maintain but to build their support when people enter custody. The reports suggest opportunities were missed to show kindness, connect, and build relationships, this could provide the basis of professional and supportive relationships, which could support meaningful social work interventions.
- The Ombudsman reports often followed a variety of formats and some lacked basic information like the person's age. The reference

A review of mental health support of care experienced people in custody is needed. The reports suggest there is a focus on managing the risk of self-harm and suicide, which is important.

21. Barnados, 2019. Toolkit for supporting Care Leavers in Custody. London: Barnados

to a person having a care experience is often difficult to identify in the reports. A systematic and uniform approach would allow data in reports to be aggregated more easily and provide the ability to learn lessons to better support care experienced prisoners, particularly in the older age ranges.

The fatal incident reports of the people analysed in this paper refer to the former children of the state. In the past 16 years, there have been at least 20 lives cut short; this scale of loss is unacceptable. In policy documents of both local and central government they often refer to themselves as the corporate parent to children in care [22]. The suicides of these twenty people are a stark reminder that the corporate parent needs to do better. More needs to be done to strengthen and support families, so that children are kept out of care wherever possible, and for those that need the protection of the care system, they need quality services and support, that provide love and kindness to overcome trauma.

Although these PPO fatal incident reports provide lessons for policy and practice, as Goldson and Coles[23] highlight, what is needed is a government inquiry into child deaths in custody. They stated that 'Investigations and inquests following child deaths in penal custody simply do not allow for a thorough, full and fearless inquiry, for discussion of the wider policy issues, or for accountability of those responsible at an individual or institutional level.' Through our engagement with these twenty reports, sixteen years after Goldson and Coles recommendation, we reaffirm their conclusion and the need for an inquiry. Given the scale and indeed the tragedy of the problem, we argue that this specific issue of the suicide of care experienced people, both children and adults, in custody warrants a government inquiry so that lessons are learned, and lives of care experienced people are saved.

22. Gov.UK, 2018. Applying corporate parenting principles to looked-after children and care leavers, London: Department for EducationHer Majesty's Chief Inspector of Prisons and United Kingdom, 2011. Care of Looked After Children in Custody: A Short Thematic Review. Available at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/08/Looked-after-children-print.pdf [Accessed: 26 June 2021]
23. Goldson, B. and Coles, D. 2005. In the Care of the State? Child deaths in penal custody in England and Wales, London: INQUEST.