

Non-custodial deaths: Missing, ignored or unimportant?

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Non-custodial deaths: Missing, ignored or unimportant?

Abstract

This article presents the findings from two separate pieces of research that were conducted by the authors on deaths that occur within the criminal justice system, but outside custodial settings. The article begins with a review of the literature on deaths both within and outside custody before going through the research findings which inform the paper. The overarching argument is that deaths outside custodial settings are less understood, and receive much less scrutiny and public attention than equivalent deaths that occur in custody. We explore the reasons for this neglect, drawing attention to policy, methodological, and sociological factors. We conclude by reflecting on possible ways of overcoming this neglect by drawing on a body of work which argues in favour of an ethic of care.

Keywords: non-natural deaths, probation, police, prison, ethic of care.

Introduction

In this article we reflect on the findings of two pieces of research which we have conducted, both of which examined the deaths of offenders that occurred in the criminal justice system, but outside of custodial settings. The article explores what we know about the extent of the problem (i.e. how many criminal justice deaths occur outside secure settings), as well as some reasons why such deaths are neglected, both in research and in policy. We also consider what more might be done to prevent these deaths. The article begins with an overview of the literature on deaths that occur within criminal justice settings, as well as a discussion of the relevant legal and policy frameworks. Deaths in custody, be they in prisons or police stations, receive much greater attention from policymakers, researchers and the media than do deaths outside these settings. Whilst this may not be surprising, the neglect of non-natural deaths that occur outside of these settings is concerning and worthy of significantly greater levels of attention.

The first piece of research that we examine here concerned deaths of people under probation supervision and was conducted on behalf of the Howard League for Penal Reform in 2010, published in 2012 (Gelsthorpe, Padfield and Phillips 2012). The second focused on deaths that occurred within 48 hours of people leaving police custody or 28 days of them leaving prison, and was commissioned by the Equality and Human Rights Commission (EHRC) in

2015, and published in 2016 (Phillips et al. 2016). We describe the datasets that were generated for both pieces of research, focusing on the difficulties in obtaining them. None of the datasets were of sufficient quality to determine the precise extent of the numbers of people who die whilst in contact with the criminal justice system. That said, we outline the main findings of both pieces of research.

We then turn to the crux of the problem – that such deaths are largely neglected and, drawing upon our experiences, we reflect on why this might be. We argue that this neglect stems from a range of policy, methodological and societal/sociological issues. Finally, the article explores what an ethic of care might look like and how it might help to bring issues to light, as well as helping to prevent similar deaths in the future.

What can we learn from previous research?

A criminal justice related death might be the death of someone who has been released from a police station with or without charge, or of someone released from prison on licence. A death might occur at any point along the criminal justice ‘process’, and this contact with ‘criminal justice’ might be relevant to the death. However, to date, the focus of research on deaths in the criminal justice system has been on those deaths which occur in the prison estate, or in police stations (or at the hands of the police in the course of their duties). These deaths also get the most media and policy attention. In the next section of the article we explore existing research on five categories of deaths of people who were engaged, to varying degrees, with the criminal justice system:

(i) *Deaths in prison*

Deaths in prison have been scrutinised by governments, charities and academic researchers for many years. The psychological pains of imprisonment have long been considered in prison research (Sykes, 1958) and, since the 1980s, there have been several important studies into deaths in prison, with a particular focus on suicide (e.g. Liebling 1995; Biles, 1991; Dooley, 1990; Crighton and Towl, 1997). Moreover, they have also been the subject of several official reviews and inquiries such as the EHRC’s (2015) inquiry into preventing the deaths of people with mental health illness and the Harris Review (Harris, 2016). For the purposes of this article, it is necessary simply to highlight the evidence that deaths in prison have, rightly, received lots of attention; so too research which suggests that suicide in prison

is the product of prisons exposing already vulnerable people to a stressful environment which exacerbates any risk of suicide that they might already face (Liebling and Ludlow, 2016).¹ We note particular concerns about the record number of women who died by suicide in prison in 2016 (11 women, out of a total of 92 women since 2000). Indeed, the total number of deaths classed as ‘self-inflicted’ increased by 28 per cent compared with the previous year, and more than doubled for women (Ministry of Justice, 2016).

(ii) *Deaths after prison*

Non-natural deaths that occur *after* a period of prison custody have been subject to considerably less research than similar deaths in custody. In 2015-16, 296 people died whilst on post-release supervision (Ministry of Justice, 2016a, page 6). In Australia, Graham (2003) found that the death rate amongst recently released prisoners was ten times the rate of the general population and Rosen et al’s (2008) study in North Carolina, US, found that the mortality rate amongst white and black ex-prisoners was higher than the general population (2.08 times higher for white ex-prisoners, and 1.03 times higher for black ex-prisoners). A review of the literature suggests that the two most common causes of non-natural death amongst people who have been released from prison are drug-related deaths, and self-inflicted. In their research on suicide in recently released prisoners in England and Wales, Pratt et al. (2006) found that 382 suicides occurred amongst 244,988 individuals within one year of release from prison, which equated to 156 suicides per 100,000 person-years. In all age categories, the suicide rate of newly released prisoners was higher than for the general population. In a systematic review of suicide amongst recently released prisoners in England and Wales, Jones and Maynard (2013) found that the risk of suicide in released prisoners was 6.76 times that of the general population.

In the USA, Zlodre and Fazel (2012: e73) found that ‘released prisoners are at substantially increased risk of death from all causes, and from drugs, suicide, and homicide in particular’. In Sweden, Hakansson and Berglund (2013: 502) found that the ‘single substance associated with death was heroin’. Such drug-related deaths after custody stem from ex-prisoners having lower tolerance levels, as well as from a possible tendency for celebration post-release. They may not know the purity of the drug they are using, the risk of which may be exacerbated by the fact that they have spent time away from drugs in the community. It is difficult to discern,

¹ For a detailed discussion of the causes of suicide in prison Liebling and Ludlow (2016).

based on the various meta-analyses and other research, whether drug-related deaths are purposeful (suicide) or accidental overdoses.

Regardless of the cause of death, research suggests that the risk of dying from a non-natural cause is elevated in the first few weeks after release. In Pratt et al.'s (2006) study, 79 (21%) of the suicides occurred within the first month following release whilst Merrall et al.'s multi-national (but solely Anglophone) study (2010) found that the relative risk of dying from a drug-related death post-custody in the UK was up to eight times higher in the first two weeks after release when compared to non-drug-using ex-prisoners.

(iii) *Deaths in police custody*

According to INQUEST, 1043 people have died whilst in police custody since 1990 (Inquest, 2017). Academic interest in deaths in police detention started at a similar time to when academics began to look at deaths in prison. There is continuing debate over what classifies as a 'death in police custody': the Independent Police Complaints Commission (IPCC, 2016) defines such deaths as those 'of persons who have been arrested or otherwise detained by the police. It includes deaths which occur while a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle'. This definition means that some deaths outside custody may be counted as a death in custody, although Heide and Chan, comparing different countries, note that it 'does not capture all deaths that might arise in conjunction with events associated with police custody. Cases that are problematic include those in which there was a relevant incident that took place during police custody followed by death after some time delay' Notwithstanding these definitional uncertainties, much of the existing research points to the relevance of drug and alcohol use, the possibility of people dying from excited delirium and death occurring because of the use of restraint (Heide and Chan, 2016).

(iv) *Deaths after police custody*

There has been little research on deaths that occur *following* police custody. Baker's (2016) research into deaths after police contact found that investigations tend to treat cases as individual instances of something going wrong rather than the effect of more systemic failings. The IPCC publishes an annual report on *Deaths During or Following Police Contact* (IPCC, 2016b). From these data, we can see that there were 60 apparent suicides within two

days of police custody in 2015-16; of these, 56 were men and four were women. The average age of those who died was 43 years (with the most common age group being 41-50). The youngest person was 16 years old. Most of those who died as the result of apparent suicide were White (58) and two were Asian. The number of apparent suicides in 2015-16 is slightly lower than in the previous year (2014-15) when the number was 70; however, the IPCC stress that 'Reporting of these deaths relies on police forces making the link between an apparent suicide and a recent period of custody. The overall increase in these deaths may therefore be influenced by improved identification and referral of such cases.' (IPCC, 2016: 15). Moreover, the figure of 60 is the fourth highest recorded over the 12 year period since 2004-05.

Similarly, drawing on the same data source, of the 60 apparent suicides in 2015-16, 18 apparent suicides occurred on the day of release from police custody, 24 occurred one day after release and 16 occurred two days after release. (There were also two cases where the apparent suicide took place longer than two days after release from custody: one was 5 days and the other 27 days after release). More than half (33) of the people who died by suicide following police detention had known mental health concerns. One had been detained under section 136 of the Mental Health Act 1983. Other mental health concerns included depression, schizophrenia, post-traumatic stress disorder, or previous thoughts or incidents of suicide attempts or self-harm. There was an indication that 28 people may have been intoxicated with drugs and/or alcohol at the time of the arrest, or it featured in their lifestyle (21 – alcohol and 14 – drugs). Interestingly, most people had been arrested for sexual offences (22) and of these, 17 were in connection with sexual offences or indecent images of children. In addition to these 60 apparent suicides, four people died from a variety of causes which may or may not have been related to their time in police detention.

(v) *Deaths under probation supervision*

Our final category of death concerns those which occur amongst people under probation supervision. Supervision, of course, can include both community sentences and supervision following custody and so may include those deaths that occur in the immediate aftermath of a prison sentence. However, the research discussed below is more focused on probation supervision than specific post-release deaths as discussed above under (ii). An early study by Pritchard et al. in England and Wales (1997), which examined suicide and violent death in a six-year cohort of male probationers compared with the general population (1990-95), found

that males (aged 17-54) had twice the death rate and nine times the suicide rate of the general population. Sattar (2001) noted that deaths among people under supervision tended to occur soon after they were released from prison. Within her sample of 1,267 deaths in the community (drawn from data collected in England and Wales in 1996-97), a quarter of all deaths noted occurred within four weeks of release from prison, over half occurred within 12 weeks of release, and within 24 weeks of release just under three-quarters of all deaths had occurred. Whilst accidents (as they were classified in the analysis) accounted for the largest proportion of deaths of supervisees in the community, the number of deaths in the community was five times the rate of the 236 deaths of prisoners; the mortality rate for the supervisees was four times higher than that for the male general population rate. Sattar (2001) noted that drugs and alcohol played a larger part in the deaths of those under community supervision than for those in prison. A further analysis of deaths under supervision by Mills (2004) highlighted the fact that many people who have offended, drug-misusers in particular, lead lives which place them at high risk of harm. Continuing the same theme of a vulnerable population of offenders under supervision, Solomon and Silvestri (2008) found that the rate of suicide of those under probation supervision was nine times higher than in the general population and higher than in prison. Indeed, Singleton et al. (2003), Canton (2008), and Brooker et al. (2009) have all noted that those under probation supervision (including those on supervision following prison custody) have poor physical and mental health and have chaotic lifestyles. These observations have been confirmed more recently by Brooker and Sirdifield (2013) and by Denney, Brooker and Dirfield (2014) in a pilot study and review examining the prevalence of mental illness amongst those under supervision. Collectively, these two publications consider the manner in which offenders with mental health conditions serving community sentences are identified and treated by probation staff in the community.

King et al. (2015) found that 13 per cent of suicides in the general population in England and Wales were, or had recently been, under supervision by the criminal justice system. They report a 'significantly elevated suicide risk among individuals who had: received a police caution, recently been released from prison, recently completed a supervised community sentence, served other community disposals, been remanded as a suspect on police bail and dealt with no further action' (King et al., 2015: 175). Interestingly, they found that 'individuals serving a community sentence under the supervision of the Probation Service had a relatively low risk' of suicide. Thus, it might be suggested that the new supervisory requirements introduced by the Offender Rehabilitation Act 2014 may reduce the risk of

suicide amongst those recently released from prison because they will now receive probation supervision. Much will depend on the frequency and quality of contact.² King et al.'s findings were not statistically significant but they point to the potential for probation supervision to serve as a protective factor and 'as a crucial source of support for vulnerable offenders' (2015: 176). Again, writing about the situation in England and Wales, Cook and Borrill (2015) found that the key indicators for an offender to be considered at risk of suicide were previous incidents of self-harm or attempted suicide and, to a lesser extent, 'coping skills, psychiatric treatment/medication, attitude to self, childhood abuse, current psychological problems/depression, and history of close relationship problems'. Borrill et al. (2016: 12) analysed the case records of 28 people who died by suicide whilst under probation supervision in England and highlight 'the complex association of events and experiences that may contribute towards pathways to suicide among probation service users under supervision'.

In 2016 the Ministry of Justice (2016a) published, for the first time, data on deaths of offenders in the community. In 2015/16, there were 725 deaths of offenders in the community, a 30 per cent increase from 557 deaths in the previous year. Of the 725 deaths, 264 were self-inflicted and show an increase of 40 per cent from 2014/15. A further 68 were accidental and there were 22 apparent homicides. The remaining 371 were from natural causes or unknown (Ministry of Justice, 2016a).

Policy and Legal context

The European Court of Human Rights has taken the view that the state has a duty to protect life and to investigate deaths in state custody effectively (Hannan et al., 2010). Thus, when someone dies in a police station the police have a duty, under the Police Reform Act 2002 to inform the IPCC. When a death occurs in prison, the prison must inform the PPO (MoJ 2010 PSI 58/2010). In both cases, an independent investigation then takes place. The aim of the investigation is to understand what, if anything, went wrong and identify what could be done better in the future. The PPO and IPCC regularly publish 'learning the lessons' reports based on their investigations. Examples of these include a thematic report on older prisoners, self-inflicted deaths amongst female prisons or a focus on the use prisoner escort forms or the role

² Although thus far, Her Majesty's Inspectorate of Probation has indicated that there are real concerns about both things in provisions for supervision in some areas.

of appropriate adults whilst in police custody.³ In addition to these independent investigations, the senior coroner has a legal duty under the Coroners and Justice Act 2009 to investigate a death in custody. When someone dies within 48 hours of leaving police detention the local police force should, but does not have to, refer the death to the IPCC who can then, based on the information provided, conduct an independent investigation or ask the local police force to conduct its own investigation locally. The rules around what should happen when someone dies whilst under probation supervision are detailed in Probation Instruction 01/2014 (Ministry of Justice 2014). The PI stipulates that when someone dies whilst under probation supervision or on post-release supervision, the death is reported by the probation provider to the National Offender Management Service which, at the end of the year, publishes and collates the statistics accordingly (Ministry of Justice 2014).

It is important to note that deaths which occur outside secure settings are investigated on a discretionary basis. Whilst it is naïve to expect that all deaths in the community could, or even should, be investigated by independent bodies (due to resource constraints or in cases where there is no obvious culpability on the part of the relevant agency or institution), it is worth noting that the PPO has the discretion to investigate the deaths of recently released prisoners, but that none were investigated during the period 2010-2015, with the exception of those that occurred in Approved Premises. We do not know why this is but would suggest it is down to resource constraints. The PPO does not investigate deaths that occur whilst under probation supervision. IPCC data suggest that 400 suspected suicides after police detention have occurred over the last 6 years, but only two investigations have been published to date and two are ready to be published. There may be more investigations underway, but the small numbers are notable. Coroners may investigate the cause of someone's death, but it is only deaths in custody where the coroner is required to hold an inquest in public with a jury.⁴ Again, it is the deaths in custody which attract attention.

Our Research

³ For a full list of PPO Learning the Lessons reports, see: <http://www.ppo.gov.uk/document/learning-lessons-reports/> and for the IPCC's equivalent see: <https://www.ipcc.gov.uk/reports/learning-the-lessons/learning-lessons>.

⁴ Section 7 of the Coroners and Justice Act 2009 requires a jury where the deceased died 'while in custody or otherwise in state detention, and that either the death was a violent or unnatural one, or the cause of death is unknown'. An inquest into a death may be held with a jury if the coroner thinks that there are sufficient reasons for doing so.

The main argument here is that deaths which occur *in* the criminal justice system, but outside secure settings, receive considerably less attention than their equivalents in custody. In order to come to such a conclusion, and to explore why this is the case, we draw on two pieces of research that we conducted between 2010 and 2016. In order to provide some context, and to substantiate our argument, we outline the aims of those pieces of research, the methods utilised, and our experiences of doing the research which have helped us to form our argument.

The first study was commissioned by the *Howard League for Penal Reform* in 2010. During that year, they had obtained information regarding the number of adults who had died under probation supervision by writing to all Probation Trusts (as they then were) in England and Wales. Subsequent requests to the Probation Trusts and to the Ministry of Justice produced some supplementary material in the form of information relating to recording procedures. These data were analysed alongside other management information. The resulting report looked at a four-year period, 2006-07, 2007-08, 2008-09, and 2009-10, highlighting that there was a death rate of 5.1 per 1,000 people under supervision in 2009-10, for instance, twice as high as the rate of deaths in custody. In this same period of analysis, 151 people under post-release supervision died (a rate of 0.43 per cent) compared with 0.33 per cent of the total number of people under community supervision.⁵

There were considerable uncertainties regarding the quality of the data provided. This meant that we could not test for statistical significance and the figures were indicative only. Nevertheless, we identified some interesting proportions when looking at those who had died under community supervision (including post-custody supervision):

- Natural causes: men are equally as likely to die as women
- Suicide: men are more likely than women to complete suicide
- Drug use Disorder: men are more likely than women to die from a drug overdose
- Alcohol use Disorder: women are more likely than men to die from alcohol misuse
- Unlawful killing: men are more likely than women to be unlawfully killed
- Misadventure/accident: men are more likely than women to die from an accident

⁵ This includes those under supervision whilst on a Community Order, Suspended Sentence Order or on licence.

- People aged 25 to 49 were over-represented; they accounted for 59 per cent of those under supervision, but 64 per cent of all deaths over the four periods under examination.
- People aged 50 and above were also over-represented, accounting for 5 per cent of people under supervision (4 per cent male, 1 per cent female), but 21 per cent of deaths (16 per cent male, 5 per cent female) over the four periods under examination.
- Women aged 36-49 accounted for 45 per cent of all deaths of women during the four periods under examination.

Our conclusion included recommendations for policy and practice:

- Clearer procedures to collect data (we highlighted the fact that the data sets were too limited to identify commonalities or differences with regards age, gender, or ethnicity).;
- Clearer distinctions between those on supervision under licence (post-release supervision) and those on community orders;
- Clearer distinctions between those on supervision under licence who are still in the community and those who had been recalled to prison or arrested for allegations of further offending; and
- Clearer explanations about the length of time that people were on supervision, and the quality/depth of that supervision.

We urged a need for further attention to deaths of those under supervision in the community (including those released from prison custody and under licence), and the need for staff training in relation to the need to create an ethics of care in regard to this vulnerable group of people. Whilst there has been gathering momentum in relation to concerns about deaths in police custody and prison custody, relatively little attention has been paid to those under supervision or leaving custody (Gelsthorpe, Padfield and Phillips 2012).

The second study was commissioned by the *Equality and Human Rights Commission* (EHRC) in 2015. The aims were to uncover the extent of deaths that occurred after prison or police custody as a follow up to the EHRC's *Inquiry on Preventing the Deaths of Adults with Mental Health Illnesses whilst in Detention* (EHRC, 2015). The remit of the research was deaths that occurred within 48 hours of leaving police detention or 28 days of leaving prison.

The EHRC requested data from the IPCC and NOMS on our behalf. From the IPCC, we received a sample of referrals and investigations which had been conducted following a suspected suicide following police detention. From NOMS, we received a dataset which detailed every death that occurred amongst people under probation supervision since 2010. This included people who had been released from prison but not those who, prior to the implementation of Offender Rehabilitation Act 2014, had served a prison sentence of 12 months or less, because they would not have been released on licence. In addition, we obtained access to a small sample of police custody officers via contacts in the Police Federation and conducted two focus groups and an interview with them. We also obtained NOMS approval to conduct interviews with relevant staff in prisons and probation. We were able to interview four people who worked in prisons, but no one in probation volunteered to take part. In addition, we interviewed a coroner and psychiatrist who had been heavily involved in research with people released from prison (Phillips et al. 2016).

The IPCC data showed that 400 people had died of a suspected suicide within 48 hours of leaving police detention. However, it is difficult to assess the reliability of this figure. Firstly, the IPCC only collect data on suspected suicide. Secondly, there is considerable discretion in recording practice and, as the IPCC admits, responses to political pressures and changes to recording practices may result in fluctuations as much as changes in the actual number of relevant deaths. Nevertheless, it is worth noting various features: people who had been arrested for sex offences featured most commonly amongst those figures; mental health featured highly; there was also indication of poor record keeping; and problems in regard to both pre-release risk assessments and referrals to other agencies post-release.

The NOMS data showed us that 66 people died within 28 days of leaving prison. By far the most common cause of death amongst this cohort was a self-inflicted overdose (n=44) and the most common offences were acquisitive (n=35), an offence type which is commonly associated with problematic drug use. The majority (n=37) of those 66 deaths occurred in the first two weeks after release. The interviews shed light on the difficulties in terms of onward referrals upon release, pre-release risk assessments and around communication, especially in communicating information in ACCT assessments to probation providers.

Whilst the first study relied on Freedom of Information (FOI) requests, the involvement of the EHRC in the second meant that we had, in theory, ready access to the data. As a statutory

non-departmental public body, the Commission has access to sources of data as part of its ‘business as usual’ relationship with the Government. Thus, in theory, the Commission was able to request data on our behalf without recourse to FOI requests or NOMS research approval (but ethical approval was received from one of the author’s Faculty Ethics Review Committee). However, the EHRC did have to resort to an FOI request in order to access NOMS’ analysis of deaths under supervision. Interestingly, both modes of access resulted in limited access to data, and to data that were unreliable. Thus the two pieces of research, conducted five years apart and with different methods, aims and access to data, bore many similarities. Indeed, the most consistent finding across both pieces of research was that this is an under-researched topic and that relevant good quality data is difficult to come by.

As discussed in an earlier section of the article, data suggest that the mortality rate amongst people who are in contact with the criminal justice system is higher than the general population. However, the fact that deaths in the community receive much less attention than deaths that occur in secure settings is problematic because it may be that the mortality rate amongst people in the community is higher than those in custody, but we do not know this. The true figure may be significantly higher. We know that the number of deaths in prison is increasing and that this is explained by factors such as reduced numbers of staff, and increasing levels of drug use, especially new psychoactive substances. There have been recent massive changes in the field of probation, and since issues around drug use are the same across the prison population and probation caseloads, we might surmise that changes in probation are having a similar effect in terms of mortality rate. Of course we do not know this, but it is reasonable to speculate that chaotic arrangements for the supervision of offenders in the community, as highlighted in several HMIP reports (HMIP, 2016; 2017) will have a deleterious impact on offenders’ wellbeing. That said, those offenders who are released into Approved Premises remain under the supervision of the National Probation Service (NPS) which has been performing considerably better than Community Rehabilitation Companies (CRCs) and so we do not wish to be too pessimistic here.

Why the neglect?

These non-custodial deaths are neglected, and not as well understood as deaths within secure settings. This may be because secure settings have a more obvious duty of care to look after people and so any death represents, in the words of Theresa May MP, when she was Home Secretary, a ‘failure’ (May, 2015). It may also be because deaths in prisons and police

stations have a much more direct impact on the people surrounding the person who dies, both staff and fellow prisoners/detainees. But these reasons in themselves do not justify the relative neglect. In order to understand more fully why such deaths are neglected, we suggest in next section of the article that it is down to a combination of methodological, policy and sociological factors.

(i) Methodological factors

As will be clear, it is difficult to know whether a period of detention, incarceration or supervision in the community is a factor in the cause of death, and so care must be taken before attributing blame or culpability. Standardised mortality rates are difficult to calculate and comparisons are difficult to make between institutions and between deaths in the criminal justice system and allied agencies. This is partly because prison populations and offender caseloads are dynamic, which means that mortality rates are calculated on a per 100,000 person-years basis rather than the mortality rate amongst the general population which is calculated per 100,000 people.

When it comes to suspected suicides, intentionality is difficult to discern and there is a level of discretion involved in the recording of such data. For example, a probation practitioner may complete relevant paperwork prior to an inquest and then not update NOMS should an inquest result in a different cause of death to the one first supposed. A similar issue arises with drug-related deaths and it is likely that some drug-related deaths are counted as an apparent suicide and vice versa. Changes to the structure of Probation makes comparison across time difficult. Our time frame includes the change from local Probation Areas to Trusts (in 2007) to the implementation of the Transforming Rehabilitation reforms in 2014,⁶ as well as the introduction of mandatory post-release supervision under ORA 2014. Trends will not be meaningful for another five years or so. Finally, much of the existing research is epidemiological in nature, and quantitative in approach. Such an approach neglects the nuanced and lived experience of people who experience criminal justice at first hand, which

⁶ *Transforming Rehabilitation* was a reform agenda instigated by the previous Coalition Government in which Probation Trusts were abolished in 2014 and replaced by a newly formed National Probation Service and 21 Community Rehabilitation Companies (CRCs). The NPS is primarily responsible for supervising high risk offenders, risk assessment and preparing court reports. The CRCs, which are run by a combination of private and charitable organisations, supervise low and medium risk offenders. For more on this – see the CLINKS guide to TR: <http://www.clinks.org/criminal-justice/guide-criminal-justice-system>

may well shed light on why people engaged in the criminal justice system die at a higher rate than others. However, the people at risk, or their families, can be very difficult to identify, making primary research with the people who are most directly affected challenging.

(ii) Policy and Practice Factors

Not only is it hard to collect accurate data, but it is hard to identify what exactly ‘responsibility’ means once someone has been released from police detention or prison custody, even if on licence or under community-based supervision. It is also difficult to identify who, or what agency or institution has ‘responsibility’ for the person in the community. The duty to collect data might fall within the remit of a prison, one or more ‘probation providers’, or several bodies in the ‘supply chain’ of probation services.⁷ There are a number of other factors which make this subject particularly difficult:

- the absence of a legal duty on any organisation to investigate such deaths makes it difficult to identify common themes or learning points. Even those common themes which do emerge from deaths which occur in Approved Premises⁸ are rarely included in the PPO’s annual report.
- these deaths do not attract high levels of external scrutiny by NGOs and other influential organisations such as INQUEST.
- Coroners’ inquests are unlikely to uncover more information in relation to community deaths, especially, perhaps, because they are unlikely to involve a jury.
- probation and supervision in the community has undergone such enormous structural change in the last few years, that it may well be that collecting and recording data relating to deaths under supervision has not been high on the list of providers’ priorities (see Padfield, 2016).
- since the implementation of the Offender Rehabilitation Act 2014, 12 months post-custody supervision is required for even those who serve the shortest sentences (over one day). There are now 50,000 more people a year being supervised post-custody who previously would not have received any supervision post-release. It is worth noting that the implementation of ORA 2014 could result in better recording of the

⁷ The lack of clarity around where responsibility lies introduces the risk of over- as well as under-reporting.

⁸ Approved Premises are often referred to as bail hostels but are, according to the Ministry of Justice, ‘primarily a public protection measure for offenders released from prison on licence’ (PI 32/2014).

deaths of anyone who dies whilst under the supervision of a probation provider although this is very much contingent on CRCs and the NPS identifying, recording and collecting data properly.

(iii) Sociological

It has long been considered that probation and community related work is marginalised – and indeed, has been described by numerous researchers (e.g. Gelsthorpe and Morgan, 2007, but most recently by Robinson, 2016a) as the ‘Cinderella’ of the criminal justice system. Probation is both less visible and less well-funded than other areas of criminal justice, and arguably, less well understood by the public and politicians. It may be that practitioners and policymakers have been unwilling to recognise the potentially malign effect of probation – despite this being a theme in research ever since Cohen’s (1985) *Visions of Social Control* which envisaged tight monitoring and supervision in the community through both welfare and criminal justice agencies. Moreover, the increased control involved in ‘mass supervision’ has been noted by a network of 60 researchers examining the justice systems of 23 European countries and regions (Robinson and McNeill, 2015).

The issues raised above relate both to communication within institutions and to communication between institutions. The ‘silo mentality’ between prisons and probation have long been identified as a problem (Carter, 2004). Recently, Moore and Hamilton (2016) identified characteristics of a ‘silo mentality’ on the part of a resettlement team in a male open prison which ‘detracted from providing a sufficiently focused level of service according to the multi-faceted requirements of the seamless sentence and the “through the gate” ethos’. They explore the implications of this ‘myopic exclusivity’ and ‘organisational dysfunction’ for resettlement policy. We would suggest that this ‘silo mentality’ may have a significant impact on the future well-being of released prisoners.

An Ethic of Care

In our first study (Gelsthorpe, Padfield and Phillips 2012), we made the case for an ‘ethic of care’. This is much needed and serves to highlight the issues raised in this article. Whilst criminal justice agencies have a *duty of care* to the people they supervise, an ethic of care goes further than this. A duty of care, of course, relates to the legal obligation to provide

reasonable care while performing any acts which could foreseeably harm others. It is the first element that must be established to proceed with an action in negligence. Breaching a duty may subject an individual to liability if a claimant can show a duty of care imposed by law which the defendant has breached. The duty of care may be imposed by operation of law between individuals with no current direct relationship (familial or contractual or otherwise), but eventually become related in some manner, as defined by common law (meaning case law). Another way of putting this is to suggest that a 'duty of care' may be considered a formalisation of the social contract, the implicit responsibilities held by individuals towards others within society. This has not been tested in law, in a post-release or probation supervision context, but is clearly relevant here.

But more relevant is the need for an '*ethic of care*' which can be interpreted as a normative ethical theory which holds care or benevolence as central to moral action. Andrew Rutherford's discussion of working credos in the criminal justice system has resonance here. Having described two operational philosophies (credos) as revolving around 'dislike and moral condemnation of offenders' and 'giving expression to the hatred of offenders' (1993:11) and 'smooth management' rather than 'moral mission' respectively (1993:13), a third credo relates to 'empathy with suspects, offenders, and the victims of crime, optimism that constructive work can be done with offenders, adherence to the rule of law so as to restrict state powers, and an insistence on open and accountable procedures' (1993: 18). This credo suggests 'care' as well as control of offenders. As Canton (2011) reminds us, for many years, a vexed question was whether probation's purpose was to 'care' or 'control'. Needless to say, this was debated at the level of aims and aspirations rather than 'lived experience' of care or control, but what is relevant here is the question of values. Our quest for a stronger ethic of care relates to the affirmation of values which reflect 'care' for detainees and offenders. As Clark has put it: 'values...should always be understood as the ongoing accomplishments of skilled and knowledgeable persons imbued with a moral sense' (2000:31). So an 'ethic of care' in this sense means something which goes well beyond a business plan, operational manual, managerial memo or mission statement; rather, it is something which can be inferred from the daily practices of organisations. This is more challenging than it once was due to the shift away from the credo of probation officers being to 'advise, assist and befriend' offenders towards 'risk assessment and control', 'offender management' and 'punishment in the community' (Nellis, 2007) and the search for a clear set of values has continued (Gelsthorpe and Abbas, 2017). It might be argued that the values that

the Probation Service espoused in its early development and operation were social work values. General changes in penal practices, values and sensibilities, including changes to probation officer training, now denuded of 'social work' content, mean perhaps that an 'ethic of care' is in the background rather than foreground of criminal justice work, but given that such values continue to be expressed in everyday practice there is scope for them to be made more explicit. Worrall and Mawby's (2011) study of the occupational cultures of probation, for instance, suggests continued commitment to be 'responsibly creative' in work with offenders and a 'persistence of care' (see also Robinson et al., 2014) Moreover, Annison et al's (2008) study into trainee probation officers demonstrated that people chose to enter the profession because of a desire to help rather than punish and Deering (2010) did not identify a new breed of managerial probation officers in his research on trainees.

Similar tensions arise in other relevant criminal justice agencies which have an effect on people after release. In police custody there is a tension between what Skinns (2011) terms crime control values and due process values which puts pressure on custody officers to ensure that detainees are looked after properly whilst also facilitating high conviction rates. Such a tension means that custody officers potentially prioritise a conviction over and above the welfare of a detainee. In the context of the prison, cuts to the numbers of officers have put pressure on staff, and increased the tension between having to maintain high levels of security and what Liebling (2004) might term 'moral performance'. The tension here means that prison staff are more focused on identifying drug use, for example, rather than working with prisoners to reduce their own use of drugs. The effect of this is that the care which is needed to do thorough, personalised pre-release risk assessments cannot materialise. We would argue that all criminal justice agencies have the capacity to care but more work is needed to bring that care to the fore.

Thus, much greater care in the community is needed for vulnerable people leaving prison on licence, or police detention, or under probation supervision. Prevention of the deaths of people under supervision in the community should be as much of a priority as it is in prison. An 'ethic of care' revolves around the moral salience of attending to and meeting the needs of others for whom we take responsibility (as individuals and as a state).

If such an ethic could be implemented it could work to prevent future criminal justice related deaths because the 'problem' - in this case, offending and engagement in criminal justice- is

seen to have arisen ‘from conflicting responsibilities rather than from competing rights and requires for its resolution a mode of thinking that is contextual and narrative rather than formal and abstract’ (Gilligan, 1982: 19). By contrast, Gilligan (1982: 19) identifies an ethic of justice which ‘ties moral development to the understanding of rights and rules’. Thus, there is a seeming tension between justice and care. Much of our criminal justice system attempts to treat people equally, albeit with varying degrees of success by being predicated on an ethic of justice. This means that people in conflict with the law either get treated simply as a member of an aggregate group of people who pose risk, or are categorised for the sake of administrative convenience and management. It is presupposed by the idea that such treatment can coerce people into conforming with the law. Whilst this might be justifiable in terms of equality, it creates problems of equity because it does little to overcome the structural inequalities that different people in society face and which contribute, to varying degrees, to their involvement and continued engagement with the criminal justice system. An *ethic of care* aims to meet the needs of all – a holistic approach - whilst an *ethic of justice* protects equality and freedom, focusing on the minimisation of any conflict between two parties. Indeed, we would argue that there can be no justice without care. This means that people who are in contact with the criminal justice system should be ‘cared for’ as much as they are managed, treated or supervised.

We might go beyond this to suggest that human rights theory should be embedded within practice and the professional decision-making process (Gelsthorpe and Abbas, 2017). Offenders are often dismissed as ‘aliens’ or as ‘moral strangers’ (one might describe this as ‘othering’) and therefore their interests are peripheral. At the same time, we might argue that offenders should not forfeit their basic dignity as persons. Fears about being seen to be ‘soft’ on crime has arguably resulted in a neglect of offenders’ moral and human rights, but such rights perhaps signal ‘care’. It could never be argued that ‘human rights’ as conceived as a ‘dry enumeration of entitlements in constitutional codes’ (Ignatieff, 2000:125) alone will provide ethical salvation for the agencies and institutions, but a ‘human rights culture’ might serve as a resource for sustaining ethical ideals and moral sensibilities in regard to offenders. Put simply, offenders are ‘people’ first and foremost. What is needed is ‘ethical imagination’ to think through the consequences of being detained in police custody for questioning or charge, for being released from prison custody with little practical help to face ‘life in the community’, or being supervised ‘in the community’, and the establishment of a culture of care. In practice, this might mean assuming responsibility until another agency or

organisation has assumed responsibility post-release from prison custody; checking that those released from police detention know about the Samaritans and other similar support organisations. We would advocate for a system which works to reduce risk rather than simply displaces risk which appears to occur when a risk assessment takes place during detention, or when a referral is deemed sufficient in mitigating a person's suicide risk.⁹

Arguably, what is really required is a return to first principles in probation: advising, assisting and befriending people who offend, as well as putting increased effort into reducing crime via more effective programmes in the community. Only then we will begin to understand the true extent and cases of non-custodial deaths more fully as well implement policies which might serve to prevent such deaths in the future. Moreover, a fuller understanding of the deaths which occur amongst those under probation supervision would allow for a more critical look at the effects of mass supervision on those being supervised as well as society more broadly.

Conclusion

We have shown what we perceive to be a distinct lack of responsibility to investigate criminal justice-related deaths in the community, especially in comparison to deaths in police and prison detention. As a result of this, there is a lack of understanding of the extent of any such problem (although previous research does show that the mortality rate amongst these groups are higher than the general population). This neglect can be put down to the practical issues highlighted in this article but we would suggest that responsibility and lines of accountability should be strengthened through an ethic of care as discussed above. Our analysis of PPO reports, IPCC referrals and interviews with prison staff do not suggest that it is widespread incompetence which causes these deaths. What our data does point to are problems in terms of a lack of resources, training and communication. Our data, and line of argument, highlight the general neglect of offenders who are supervised in the community within both policy and criminology. We know that the mortality rate amongst this group is higher than the general population and so responding to these concerns is imperative. It becomes more important when we consider the rate at which probation caseloads are increasing (HM Inspectorate of Probation, 2016). The deaths of those who have been in contact with criminal justice agencies should not be ignored. Nor are they unimportant. Much

⁹ For more on the policy implications of the findings, please see Equality and Human Rights Commission (2017).

work remains to be done to improve our data, but also to improve the support for police, prison, probation and other staff by the development of an ethic of care.

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