Deaths while under probation supervision: what role for human rights legislation?

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Jake Phillips, Loraine Gelsthorpe and Nicola Padfield

Abstract

Article 3 of the Universal Declaration of Human Rights (UDHR) states that 'everyone has the right to life.' This right is contained in all human rights treaties that developed from the UDHR, including the European Convention on Human Rights (ECHR). Yet, as we argue, the UK government is failing to protect this right when it comes to certain groups of people under probation supervision. To date, human rights legislation has failed adequately to protect these vulnerable individuals and to hold the state to account. This article explores the greater potential for using human rights legislation to ensure better accountability in this area.

Keywords:

Probation, penal supervision, Article 2, human rights, accountability.

Introduction

People who die whilst under probation supervision and after leaving prison receive significantly less attention than those whose deaths occur in custodial settings such as police detention and prison. Previous research by ourselves and others[i] has highlighted the high mortality rate amongst this group, especially when it comes to self-inflicted deaths.[ii] We suggest that this high mortality rate should result in a greater level of scrutiny than it currently receives.

In this article, we consider the potential use of human rights legislation to prevent and reduce these deaths. The Universal Declaration on Human Rights (UDHR) and the European Convention on Human Rights (ECHR), both of which guarantee citizens the right to life, have been remarkably ineffective. However, as outlined below, there is much scope for the application of human rights legislation in this area.

Every year the Ministry of Justice[iii] publishes data on the numbers of people who die whilst under the supervision of both the publicly-owned National Probation Service (NPS) and largely private Community Rehabilitation Companies (CRCs). This includes people serving Community Orders, Suspended Sentence Orders and those under supervision following release from a custodial sentence. This article begins by providing an update to our previous analysis of these data to reinforce the point that people under probation supervision are at a higher risk of dying than the general public in the community, focusing on self-inflicted deaths. We then turn to four relevant prevention of future deaths to highlight key concerns and potential relevant risks. Having presented these analyses we consider the role of human rights legislation and outline the difficulties in deploying provision for investigation when it comes to deaths in the community. This primarily comes down to a lack of clarity over who holds responsibility for overseeing such deaths, as raised in a recent Health and Social Care Committee Report.[iv]

This Special Issue 'celebrates the contemporary relevance' of the Universal Declaration of Human Rights (UDHR) within the UK. We would argue that the UDHR has had little if any influence on the subject covered in this article despite its clear relevance. We welcome the political impact that it may have had, but would argue that international human rights

instruments do not appear to be having a significant influence 'on the ground'. Our paper seeks to underline the reality that, whilst rhetoric confirms the importance of fundamental human rights, these 'rights' are easy to overlook in practice. We welcome a greater role for human rights legislation, but without political support (and legal aid) this seems unlikely.

What is the general picture of probation deaths and key trends?

Table 1 shows a breakdown of deaths on the probation caseload by cause and compares this with a breakdown of deaths amongst the general population. The breakdown of deaths which occur among those subject to supervision is very different to that of the general population, with a particular over-representation of self-inflicted deaths. We need to be careful about comparisons between these two groups, because the definition of suicide used by the Office for National Statistics (ONS) is narrower than the definition of a self-inflicted death used by the Ministry of Justice. The definition of suicide used by the ONS is 'Deaths where the underlying cause . . . is intentional self-harm . . . and events of undetermined intent.' The definition used by the Ministry of Justice for a self-inflicted death is: 'Any death of a person who has apparently taken his or her own life irrespective of intent.' The Ministry of Justice definition includes deaths from an unintentional drug overdose, whilst the ONS data does not. Thus the self-inflicted death rate will always be higher than the suicide rate.

Despite this caveat, it would appear that 1 per cent of deaths in the general population are due to suicide, whilst 29.8 per cent of deaths amongst people under probation supervision are self-inflicted.

Table 1 Proportion of deaths by cause

	Deaths by cause on probation caseload (%)	Deaths by cause in general population (%)
Accidental	7.9	3
Homicide	2.8	0.1
Natural causes	31.4	96
Other non-natural (mainly drug/alcohol related)	1.8	N/A
Self-inflicted	29.8	1
Missing	26.3	N/A

Table 2 shows that there is a higher rate of death for people supervised by the (largely privately owned) Community Rehabilitation Companies (CRCs) than the National Probation Service (NPS) which is a statutory criminal justice service in England and Wales. These two 'arms' of probation were created in June 2015 following the implementation of the Offender Rehabilitation Act 2014 (ORA, 2014). CRCs are responsible for supervising 'low' and 'medium risk' offenders, whilst the NPS supervises 'high risk' offenders and has responsibility for preparing court reports and assessing risk.

The ORA 2014 also introduced mandatory supervision for people leaving prison after a determinate prison sentence of between one day and twelve months) and extended the amount of supervision for people serving custodial sentences of less than 2 years so that all

prisoners are supervisied for at least 12 months post-release. Breach of this supervision process can result in sanctions such as recall to prison. This had the effect of increasing the probation caseload by around 40,000 cases by the end of 2016. It is important to note that this new probation structure has received much criticism from a range of sources, including the Justice Select Committee, Her Majesty's Inspectorate of Probation and in March 2019, the National Audit Office. There is a sense of crisis; the new structure means wholly inadequate supervision for many offenders. A consultation on the future of probation closed recently with the responses due for publication soon.[v]

Table 2 Mortality Rates by Cause of Death

	Crude mortality rate (deaths per 100,000)			
	National Probation Service	Community Rehabilitation Companies	All probation providers	General population
All causes	277	423	363	N/A
Self-inflicted	73	133	108	8.9
Natural Causes	93	129	114	N/A
Homicide	6	13	10	1
Accident	14	38	29	1.9
Other	4	8	6	N/A

Evidence that people supervised by CRCs are more likely to die from a self-inflicted death when compared with those supervised by the NPS should be seen in the context of criticisms of a failing system. This said, some of the differences can be explained by age because people on the NPS caseload are generally older than people on the CRC caseload. Unfortunately, the data do not allow us to do any more detailed analysis on this point. Nevertheless, we can see that the suicide rate amongst the general population is 8.9 people per 100,000 people in the population compared with 108 people per 100,000 of the population.

Trends over time suggest there has been a relative increase in the number of deaths under supervision since 2010 and especially since 2015. The Ministry of Justice argues that 'the trend in the deaths of offenders in the community followed a similar pattern to the total caseload of offenders supervised in the community at the end of each financial year'.[vi] However, if we map these changes on to the same chart using percentage changes we get a different picture. Following a sharp rise in 2015, the caseload has subsequently been dropping or levelling out, whilst the number of deaths has been steadily increasing (see Figure 1).

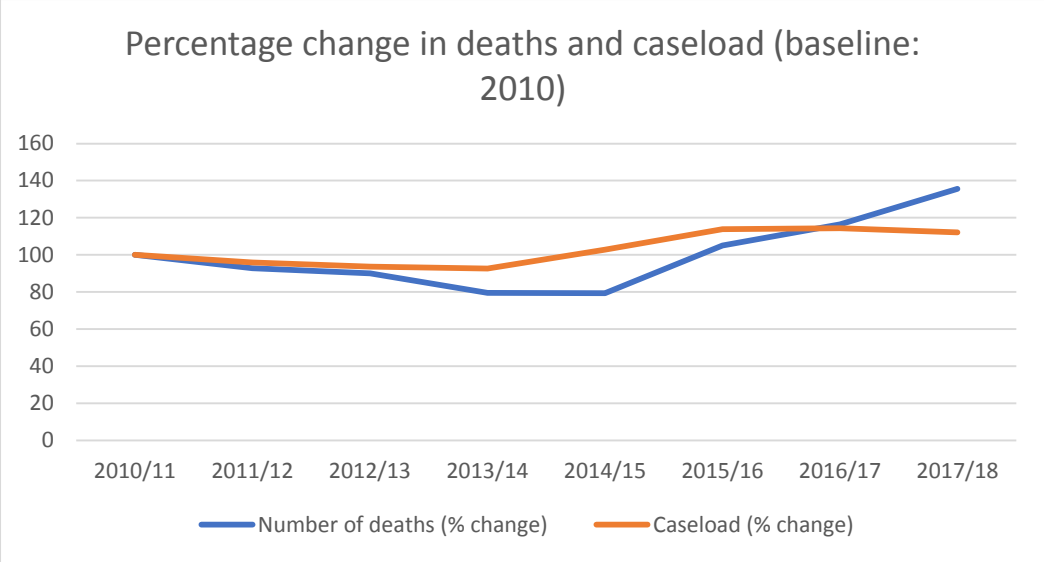

Figure 1: Trends in deaths under supervision

Post-custody deaths

The pains associated with imprisonment are well documented and, quite rightly, there has been much attention from politicians, policymakers and academic researchers to deaths that occur in custodial settings. Relatively little attention has been paid to those deaths which occur after someone has left prison. This is concerning because, as we see below, the self-inflicted death rate for this group, especially women, is particularly high. Moreover, research has demonstrated that imprisonment has adverse effects on people's lives even after they have left custody. As such, there is a strong likelihood that the period of imprisonment, and thus the actions of the state, are relevant to understanding these deaths.

The self-inflicted death rate for men who are supervised by probation following release from prison is 129/100,000 compared to a suicide rate of 24.8/100,000 for the highest risk group of men in the general population. The self-inflicted death rate for women leaving

prison is 251/100,000 compared to a suicide rate of 6.8/100,000 for the group of women with the highest rate of suicide in the general population. It is likely that many factors play into this. For example, the link between poverty and crime, especially for women, means that people who are given a prison sentence are more likely than non-offenders to have experienced inequality in social life which, in turn, is correlated with an elevated risk of suicide.[vii] The role of shame, which is correlated with suicidal ideation, should also be considered. The Integrated Motivational Volitional model of suicide highlights the importance of feelings of entrapment and defeat as key drivers in the emergence of suicidal ideation.[viii] That people on probation experience a combination of these emotions should not be surprising.

We already know that women in prison are amongst the most powerless and disadvantaged people in society and that women are significantly more likely to die when in custody when compared to women in the general population. INQUEST have characterised the deaths of women in prison as 'part of a continuum of violence that usually starts in the community and follows them into, and back out of, prison'.[ix] The deaths that we see amongst women in the community when under probation supervision need to be understood as part of this pattern of systemic violence against women. In the absence of data which shows any analysis by age, which could be useful to further our understanding of what is happening, Table 3 uses 2015/16 data from previous research[x] to show that the risk of dying by suicide for women under all forms of probation supervision is between 50 and 86 times higher than the suicide rate amongst women in the general population.

Table 3 The risk of dying by suicide for women under supervision compared with the suicide rate amongst the general population

Age band	Age specific suicide rate/100000 on caseload	Age specific suicide rate in general population/100,000	Rate ratio
18-29	212.01	4.2	50.48
30-39	414.45	4.8	86.34
40-49	468.82	6.8	68.94

There has been a longstanding debate about how best to deal with women who are convicted of an offence. Research has shown that putting women in prisons that were designed 'by men and for men' does little more than perpetuate women's prior experiences of structural inequality and personal violence. This analysis suggests that the ways in which the criminal justice system attempts to support women outside of custodial settings has little impact on mitigating these experiences. This might be surprising given the establishment of nearly fifty community centres or services in England and Wales for women offenders since 2003 and those at risk of offending because of a range of vulnerabilities. Such services offer holistic 'wrap-around' support ranging from assistance in finding accommodation, job training, personal support and supervision, and counselling for drug and alcohol misuse. At the same time, we know that the creation of centres has been uneven across England and Wales, and a number of centres (primarily functioning within the voluntary sector) have closed. [xi] This is down to a lack of sustained funding from government in the general context of austerity and a result of CRCs choosing to develop their own programmes for women, rather than 'purchasing' provision for women offenders

from existing ‘suppliers’, although some centres were provided with extra money through the female offender strategy in 2018.

The trends for deaths which occur after leaving prison are of particular interest especially because of concerns raised about the quality of ‘through the gate’ support which was intended to improve the level of support provided to people leaving prison. Figure 2 shows that the number of deaths occurring after someone has left prison increased at a much faster rate than the caseload itself. It is notable that the number of deaths started to increase more rapidly immediately after the implementation of the Offender Rehabilitation Act 2014. One must also remember that this is against a backdrop where suicides and overall mortality in the general population have been decreasing in recent years.

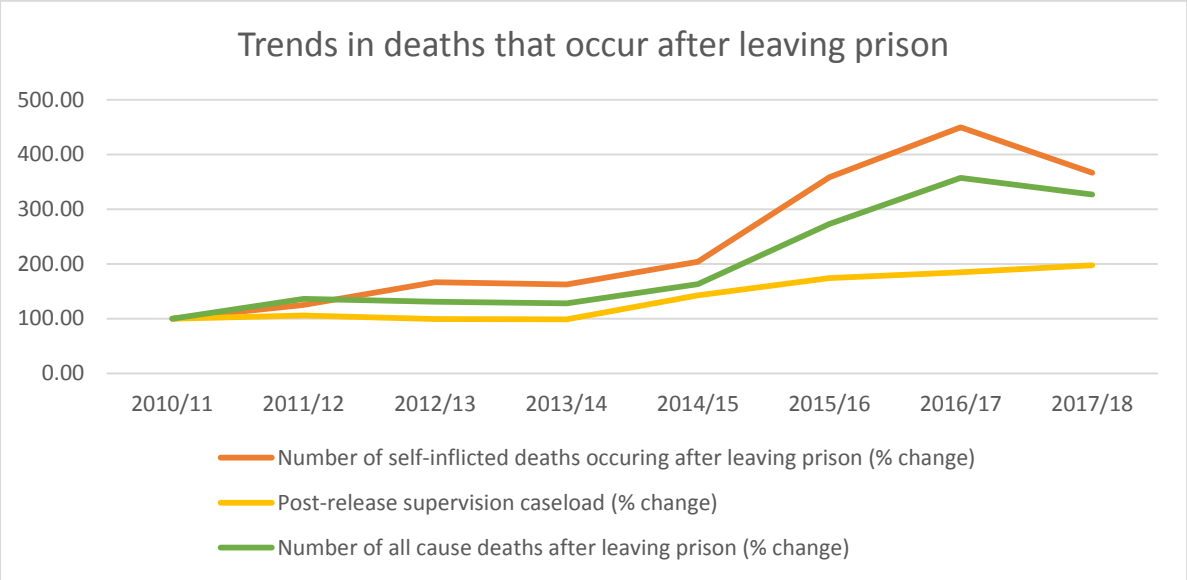

Figure 2: Trends in deaths after leaving and post-release caseload

It is clear then, that all groups under probation supervision face a higher risk of dying by suicide than people in the general population and that such deaths are increasingly

worrying when understood in the context of the probation caseloads. This is especially the case because whilst caseloads have levelled off, staff still hold high caseloads and this affects their ability to properly support and manage offenders.

Learning from inquests and investigations into these deaths

Previous research has highlighted some of the key risk factors for people dying under probation supervision. These include prior bereavement, mental ill-health, a history of suicidal behaviour and drug and alcohol use.[xii] In many respects these mirror risks associated with suicide in the general population. Other research has highlighted specific risks for people on probation which includes changes to the supervision process, the impact of legal proceedings and missed appointments.[xiii] There is also evidence that there are points during a period of supervision which increase the risk of suicide, for example, transition into and out of custody or when staff change. Our own research for the Equality and Human Rights Commission (EHRC)[xiv] highlighted issues relating to poor communication, assessment of suicide risk and inadequate record keeping. We also considered how to work with people deemed to be at risk of suicide when community-based mental health provision has suffered from budget cuts in recent years.

We now turn to an analysis of of Prevention of Future Deaths (PFD) reports that have been written by coroners about people who died whilst under supervision by probation services. According to official guidance, 'The coroner must make a PFD report where the investigation he or she has been conducting reveals something which gives rise to a concern that there is a risk of deaths in the future and that action should be taken to eliminate or reduce that risk'.[xv] PFD reports are thus 'potentially significant agents of harm prevention' although the

resource pressures faced by local coroners limits the potential for any decisive effect.[xvi] Inquests can be used to highlight examples where the state might be implicated in a particular death and so an analysis of them can be instructive in terms of identifying situations in which further investigation may be fruitful in terms of holding the state to account and protecting human rights.

PFD reports are published on the Chief Coroner's website and are categorised by the type of death. There is no specific category for criminal justice related deaths, and so identifying relevant reports is challenging, especially because the reports themselves are not searchable. Nevertheless, we have identified four PFD reports for people who died whilst under probation supervision. That so few were identified is interesting, especially because we know that the self-inflicted death rate is so high. Is the number small because the coroner was not aware that the person was being supervised? Or are probation services doing such a good job that no concerns have been raised? Perhaps more relevant reports exist, but are simply hard to find because of deficiencies in information within the website.

Our four PFD reports:

(i) Christopher Hutton took his own life whilst under post-release probation supervision, having been convicted of sex offences. At the time of his death he had been waiting to undertake an intensive treatment programme related to his offending. The coroner heard that high demand for the relevant programme had led to considerable backlogs. Mr Hutton had said that he would find the programme helpful and the coroner concluded that the National Probation

Service had the power to take action to prevent similar deaths. The response from the NPS was due on 9 March 2018 but has not yet been published.

(ii) Lee Boden also took his own life whilst under probation supervision, this time very soon after release from prison. Shortly before his release, he was informed that he was required to reside in Approved Premises run by the NPS rather than return home. This left him in a particularly vulnerable situation and he died of a drug overdose several hours after arrival at the hostel. As this death occurred in Approved Premises, the Prisons and Probation Ombudsman (PPO) investigated. The PPO did not attribute blame to the AP staff but highlighted that staff should be more aware of the risks for people who use drugs after leaving prison. The coroner was concerned that there were no protocols in place to 'monitor new arrivals who remain vulnerable'. The NPS response to the report is not available on the relevant webpage, despite the report being published in 2015.

(iii) Terence Pimm took his own life whilst under probation supervision. He was also wanted for failing to appear at court. In the weeks prior to his suicide, Mr Pimm had been detained under s136 of the Mental Health Act 1983 and had informed his probation officer that he was planning to take his own life. In her PFD report, the coroner raised concerns about the 'sufficiency of information sharing and coordination between the police, hospital trust and the probation service'. Whilst both the police and hospital trust have responded to the report, the probation provider, Essex Community Rehabilitation Company, has not.

(iv) Unlike the other cases, Anthony Coughtrey died in prison. However, the case remains relevant because Mr Coughtrey had served twenty-three years in prison and, upon release, had struggled to adjust to life in the community. Probation had been unable to help him find accommodation and eventually he was recalled to prison following a further offence. He died by suicide six days after his recall. The inquest found that there had been a failure to manage his licence properly and the coroner was concerned that the Probation Service had not conducted any investigation of its own practices. Again, no response to the PFD report has been made available despite a deadline of March 2018 being imposed on Her Majesty's Inspectorate of Probation.

There are several points to be taken from these cases. Firstly, they highlight the inconsistency in terms of investigation and review. Mr Coughtrey and Mr Boden's deaths received full investigations by the PPO because they were resident in prison/Approved Premises. Yet one of the main reasons that Mr Boden was vulnerable was because of the last-minute changes to his licence conditions, something which is not exclusive to those in Approved Premises. This raises questions about what happens to other people who have last-minute changes to licence conditions imposed upon them. The PPO investigation into Mr Coughtrey's death focused solely on his induction into prison and subsequent treatment rather than the role of probation. In contrast, the coroner raised concerns about the lack of internal review of probation practice in the run up to his death.

Secondly, there are clear issues related to communication. This mirrors our own analysis of PPO investigations for the EHRC into deaths of people who died after leaving prison where

we highlighted the consistent presence of drug and alcohol use, staff shortages and issues around communication. Communication is clearly not only relevant to deaths that occur in APs, with the coroner highlighting similar issues in relation to Mr Boden's death.

Thirdly, these cases serve to underscore the argument that we should not situate our analysis of what is occurring purely in terms of the institution in which the death took place. Rather, each of these deaths need to be understood by thinking about the criminal justice system in its entirety rather than focusing only on what happens in one institution. It is crucial to remember that many people on probation have spent time in prison and move, sometimes frequently, between custodial and community supervision.

What role for 'human rights'?

We can draw three key points out from the previous two sections. Firstly, that people under probation supervision face an elevated risk of suicide when compared to the general population. Secondly, the fact that these people die when under supervision is relevant to understanding their death, even if the institution or staff are not necessarily culpable.

Thirdly, there are considerable inconsistencies around the use of investigations to understand these deaths. When someone dies under supervision and is not resident in an AP, there is no investigation into the circumstance of the death nor of the practice of probation providers. Where a death occurs in custody and the person has recently been under supervision in the community, investigations do not have to take this aspect of the person's criminal justice supervision into account even though it may be relevant to the

death. This neglect is, in part, understandable because there is a clearer duty of care in a custodial setting. This has been recognised by a recent report by the Health and Social Care Committee on Prison Health in which the Committee called on the Government to provide clarity on 'where responsibility for [the] oversight of such deaths should lie and set out a plan to reduce this death rate'.[xvii]

As mentioned above, both the UDHR and the ECHR place a duty on the state to protect citizens' right to life. This is not the place for a detailed critique but we raise some questions. Firstly, it is worth noting that in addition to the UDHR and ECHR the UK has a National Preventive Mechanism (NPM) which was established in March 2009 after the UK ratified the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in December 2003. The NPM's main focus is people in custody but, as we have seen above, deaths that occur outwith custodial settings may be as relevant to the treatment in detention as deaths that occur in custodial settings. Thus, making greater use of the NPM to hold the State to account for such deaths may be of use, and one which the UK government may be willing to consider, especially as it has been a strong proponent a treaty which aims to prevent the ill treatment of people in detention and under the control of the state.

But it is made up of twenty-one different statutory bodies that independently monitor places of detention and is not particularly effective even within the prison context[xviii]. And here we raise our concerns that the existing accountability mechanisms show inadequate interest in deaths outside custody. One problem is the legal structure: too loose to provide adequate duties, guidance or constraints. The privatisation of many criminal justice

institutions makes the problem very much more complex. We would suggest that there is scope for people on probation to benefit from the NPM, especially for cases like Mr Coughtrey, above, whose treatment by the probation service was considered by the coroner to be relevant to his subsequent death in custody. The CPT heavily criticised the state of prisons in the UK following its visit in 2017, drawing particular attention to inadequate safeguards for protecting the mental health of prisoners.[xix] We know that people at risk of dying in the community will have had experience of custody and that custody results in a multitude of adverse psychological effects that persist beyond release. Thus, it would not be unreasonable to suggest that as the NPM seeks to strengthen its membership, that Her Majesty's Inspectorate of Probation becomes a member alongside its prison-focused counterpart which already has membership. Expanding the horizons of the existing accountability mechanisms to look at what happened outside the prison walls would add to our understanding of the effects of prison and the ways in which people in the criminal justice system are treated. This would add impetus to the inclusion of someone's experiences of probation in formal investigations and allow us to understand criminal justice deaths across the criminal justice pathway. The NPM needs to stay focused on ill treatment in detention because this is the mandate from OPCAT, but this should not rule out its relevance to people who die shortly after a period of detention, especially because ill treatment may increase the risk of dying upon release.

The law can help, of course, in other ways. Since the UDHR set out in Article 3 the concept of a "right to life", guaranteed by states, this right has been interpreted by courts to place *positive* duties on the state. Such duties include investigating suspicious deaths and protecting people against the risk of harm from the actions of public authorities. This right

to life was included in Article 2 of the European Convention on Human Rights, incorporated into domestic law by the Human Rights Act 1998. Over the last seventy years, this right to life has been developed in Europe and the UK in a way that has had an important impact on the culture of public decision-making.

One important case in this regard is the European Court of Human Rights' decision in *Salman v Turkey* (2002)[xx]. In this case, the Court held that any death in custody, regardless of whether an agent of the state was involved in the incident, engages Article 2 of the ECHR and so any death that occurs in custody should be investigated by an independent body. One year later, the Court ruled in *Menson and others v UK* (2003) that 'the absence of any direct state responsibility for the death' of an individual who was not in the state's custody or detention did 'not exclude the applicability of article 2'.[xxi]

Case law has therefore widened the applicability of Article 2 of the ECHR significantly over the years, to include failures on the part of the state to prevent killings by third parties, deaths in custody and any suspicious or unexplained deaths even where there is no suggestion of state involvement.[xxii]

Clearly, Article 2 *can be* applied to the deaths of people under probation supervision. In turn, we suggest that such deaths should be subject to an Article 2 compliant investigation. This might be seen to be a big challenge, however, considering 955 people died whilst under probation supervision in 2017 alone. The resource implications for the PPO of having to conduct an additional 955 investigations in a given year would be challenging.

Perhaps there needs to be a means by which to identify a threshold which allows for the identification of deaths which might engage Article 2. Our analysis suggests that this could be deaths which involve someone who has recently left prison or, given their significantly elevated risk of suicide, deaths of women under probation supervision. However, we would argue that further research needs to be done in this area to identify a workable threshold and a satisfactory mechanism. Such research might involve analysis of inquests into the deaths of people under probation supervision as well as empirical research with practitioners, bereaved families and service users.

We would point out that there are myriad practical limitations to holding probation providers and the state to account in this way. Firstly, the way to make progress might be through some form of strategic litigation around a specific case. However, appropriate cases are difficult to identify, partly because there is no contemporaneous reporting system for such deaths. When someone dies under supervision, a form is completed and sent as part of an annual return to Her Majesty's Prison and Probation Service (HMPPS) who collate and publish the data annually. When compared to deaths in custody which are reported swiftly to HMPPS, this makes the identification of relevant cases in a timely manner extremely unlikely.

Secondly, the route to any court is long and, crucially, expensive. There is no legal aid for bereaved families and very few advocacy organisations working in this area who would be willing to take on a case, although INQUEST is increasingly examining the potential for this course of action.

Thirdly, of course, there is a question mark over the role of the European Convention on Human Rights after Brexit as well as the longstanding debate around whether the Human Rights Act 1998 might be repealed in favour of a British Bill of Rights. Although this could limit the effectiveness of Article 2 in domestic law, it seems likely that the judges of the Supreme Court would develop the common law to provide similar 'human rights' protections. For us, the possible repeal of the Human Rights Act 1998 poses a less important challenge than the absence of legal aid. The domestic courts can be convinced that the 'waters of the common law' run deep. We are already seeing many signs, particularly in the Supreme Court, that the courts are grounding fundamental rights in the common law rather than European human rights mechanisms. But this underlines the effectiveness of international human rights norms. And, of course, for a culture of rights to take root in the field of probation, there has to be an awareness of the reality of a problem. So we return to where we started: the law is a blunt instrument, and cannot be expected on its own to reduce the number of self-inflicted deaths of those on supervision in the community. Thus there is a need to focus on what probation is for in a more normative sense in order for a culture of rights to take hold. Rehabilitation is everybody's business and broader than merely reducing reoffending. Once we recognise this, policy reform and developments around holding probation providers to account for outcomes beyond offending are more likely.

Conclusion

We would suggest that the deaths of people under probation supervision in the community are part of a wider area of neglect: we need also to be concerned about those who die in or after detention in police stations and in prisons. But many of those who die under

supervision appear to be particularly marginalised, invisible and ignored. Human rights legislation most certainly can and should have a role, but has been largely ineffective to date. We would argue that the UDHR has enormous contemporary relevance but it, and human rights law more generally, has yet to be effective in this area.

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