Prison Suicides: What can the Courts do?

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Summary

Self-inflicted deaths in prisons are at record levels. The figures make stark reading. According to the recent National Audit Office (NAO) report on mental health in prisons, there were 120 self-inflicted deaths in prison in 2016, which is higher than any previous year on record and more than twice the number in 2012.

This is in the context of the prison system being under considerable pressure. The NAO report highlights that staff numbers in public prisons have reduced by 30% since 2009/10, making the task of managing prisoners' mental well-being harder than ever.

The spotlight has recently fallen on one particular prison - HMP Woodhill - where the rate of self-inflicted prisoner deaths has been especially high, with 18 self-inflicted deaths since 2013, including 7 in 2016 alone.

In an attempt to involve the Courts in imposing change, the families of two men who took their lives at HMP Woodhill recently took their case to the High Court. In *R (Scarfe and others) v Governor HMP Woodhill & Secretary of State for Justice*, the families argued that the Court should exercise its public law powers to order the prison to comply with national prison policy on suicide prevention.

In this briefing, we look at the High Court's decision and its impact, including its relevance to other settings such as mental health hospitals.

What was the case about?

At the time this case was heard, 11 of the 18 deaths at HMP Woodhill since 2013 had been the subject of a jury inquest (with more inquests into deaths at the prison having taken place since). The Coroner had issued a 'Prevention of Future Deaths'/Regulation 28 report in a number of those cases. In addition, the PPO (Prisons and Probation Ombudsman) had produced a report into each of the deaths. HMP Woodhill had accepted all the recommendations made by the Coroner and the PPO about the need to comply with national suicide prevention policy and procedures (known as Prison Service Instructions).

However, the families of two prisoners who had hanged themselves in their cells at HMP Woodhill felt that more needed to be done.

They therefore brought a High Court judicial review challenge against the prison governor (and the Secretary of State for Justice), asking the Court to make a declaration that failure to comply with national prison suicide prevention policy amounted to a breach of their public law duty and a breach of their obligation under Article 2 of the European Convention on Human Rights to put in place appropriate systems to protect life, having assumed state responsibility for these individuals by taking them into custody/imprisoning them. The families also asked the Court to make a mandatory order requiring the prison to comply with the national prison suicide prevention policies/procedures in question.

In order for the High Court to be able to make the type of public law declarations/mandatory orders the families were seeking, however, this had to be about the prison not having proper systems in place (i.e. systemic failures) as opposed to individuals not complying with a system which was in itself adequate.

Everything therefore boiled down to whether the failings identified by the Coroner and the PPO were failings in the prison system itself (which would enable the Court to make the declarations/orders the families were seeking against the prison) or operational failings by staff to follow the system in place (which would not entitle the family to public law remedies, but may still entitle them to damages via the usual civil claim/compensation route if staff had been negligent).

What did the Court decide?

In order to decide whether the failures that had occurred at HMP Woodhill were systemic failures or individual errors, the Court looked carefully at the exact nature of the issues identified from the inquests/investigations into all these deaths.

These included, for example, failures to properly assess the suicide/self-harm risk of newly arrived prisoners (including various failures to follow the required national ACCT - *Assessment, Care in Custody and Teamwork* - assessment/review process), observation checks not being carried out appropriately (e.g. not at unpredictable times as they were required to

be) and failures to comply with provisions about emergency response (e.g. failure to bring the right equipment to an emergency).

The families argued that, because similar failings had been repeated in successive cases, there must have been systemic failure by the prison to put in place measures to ensure that its staff understood and complied with the suicide prevention requirements.

However, in the Court's view, the fact that there had been numerous errors by staff did not necessarily mean the problem lay with the system itself, although the Court did say that if identical (or very similar) errors were being made time and time again, this could indicate a systemic fault.

The Court found on the evidence that there had been a series of different failures/errors by individual staff in complying with prison policy at HMP Woodhill, which could not be fairly characterised as a failure in the system itself. In fact, the prison had in place *'sensible and satisfactory policies'*, but the system is *'prone to operational error'*, which the Court found *'unsurprising'* given that the system involves the inter-relationship between prison officers and prisoners in situations of *'some stress and complexity'*. Accordingly, the Court decided this was not a matter in which it could make the declaration/order sought by the families, even if it had wanted to.

Interestingly though, the Judges said that - even if they had decided there were systemic failures here - they may well have chosen not to exercise their discretion to make a mandatory order against the prison because it is difficult to see what this would achieve given that suicides in prison happen for multiple, complex reasons which the Courts themselves are unfortunately not in a position to resolve.

Impact

This case highlights that organisations responsible for people who are in state detention - whether in prison or in hospital as a patient detained under the Mental Health Act - could in principle find themselves on the wrong side of a High Court declaration that they have breached their legal obligations to have in place adequate systems to protect prisoners/detained patients, plus a mandatory order requiring them to take steps to rectify the situation.

However, this will depend on whether the problems are down to the organisation's systems (e.g. suicide prevention policies and procedures around risk assessments, observations, communication, leave, release/discharge), as opposed to staff compliance with those.

If the same mistake is happening time and time again, this will increase the risk of a finding that the system itself is at fault.

The bottom line, however, is that keeping vulnerable prisoners and patients safe from self-harm depends on a multitude of complex factors - including having the right level of resource in place - and, as acknowledged by the Judges in this case, issuing court declarations/orders is in reality unlikely to fix the problem.

How we can help

Our large national team of healthcare regulatory lawyers have a wealth of experience in supporting providers and individuals across the health and social care sector through the inquest process - from relatively straightforward hospital deaths to very complex Article 2/jury inquest cases involving multiple parties and deaths in state detention, including prison deaths.

The support we can provide includes:

- Initial scoping to explore likely outcomes, level of support needed and next steps;
- Advice on Duty of Candour thresholds and approach;
- Assisting with witness preparation, both at operational level and at strategic level to address Regulation 28 (Prevention of Future Deaths Report) risks;
- Attendance at pre-inquest review hearings, which may cover matters such as inquest scope, juries and expert evidence;
- Representation at final inquest hearings, including witness support throughout.

We can also provide bespoke training on all aspects of inquests, including updates on the latest legal developments and guidance for clinicians/SI investigators on report-writing and giving evidence.

If you need advice on any matter relating to a prison death or inquests generally, please contact Peter Merchant on: +44(0)113 2514806 or pmerchant@dacbeachcroft.com.

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