Independent Advisory Panel on Deaths in Custody – response to the HMIP evidence review on neurodiversity in the criminal justice system (January 2021)

1. The Independent Advisory Panel on Deaths in Custody (IAP) welcomes this review of neurodiversity in the criminal justice system and the opportunity to respond to this call for evidence. The role of the IAP is to advise Ministers and officials on how they can meet their human rights obligations, prevent deaths and keep those under the care of the state safe.[1]

2. This brief submission takes as its focus the prevention of deaths in custody. Our consultations with people in custody on how to keep safe, as well as correspondence from prisoners, indicate that people who have suicidal thoughts and feelings often do not have a prison staff member who they can trust and turn to, find the prison system difficult to understand and navigate, and may have experienced threats from, or bullying by, other prisoners.[2] These are all concerns likely to be exacerbated by the presence of a learning disability or neurodiverse condition.

3. There is a lack of data and research linking neurodiverse conditions to deaths and self-harm in custodial settings. This is despite the accepted view that there is a high rate of comorbid mental illness across most neurodevelopmental disorders and prisoners with intellectual disabilities are more likely to harm themselves or become suicidal.[3] The potential risk faced by those with neurodiverse conditions are likely to be compounded by the overall increased risk of suicide which prisoners pose when compared to the general population.[4]

4. As a result, problems with identifying or meeting need may be increasing the risk of further avoidable deaths. The IAP highlights the following five cross-cutting justice and health proposals for consideration to help ensure that needs are identified and met:

    a) An opportunity for validated and standardised **screening** to take place at contact with the criminal justice system, such as at engagement with liaison and diversion services in police stations and courts pre-sentencing or on reception to prison custody. This would help to identify an individual's needs at an early stage and help ensure that they are met and, if possible, diverted from custody into an appropriate community alternative.

    b) Probation Pre-Sentence Report writers should be proactive in seeking out support, while sentencers should be informed of the **importance of local provisions**.

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[1] About the Independent Advisory Panel on Deaths in Custody, https://www.iapondeathsincustody.org/about-us-1.

[2] See, for example, Independent Advisory Panel on Deaths in Custody, Keeping Safe: Preventing Suicide and Self-harm in Custody, December 2017, https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ed5178d95645801a7a5e321/1591023614282/Keeping+Safe+-+FINAL+-+Dec+2017.pdf.

[3] Chaplin, E., McCarthy, J., Underwood, L., Forrester, A., Hayward, H., Sabet, J., Murphy, D. (2017). Characteristics of prisoners with intellectual disabilities. *Journal of Intellectual Disability Research,* 61(12), 1185-1195.

[4] Jack, H. E., Fricchione, G., Chibanda, D., Thomicroft, G., Machando, D., & Kidia, K. (2018). Mental health of incarcerated people: A global call to action. *The Lancet Psychiatry,* 5(5), 391-392.

c) Court staff should be aware of how the Court environment impacts those with neurodiverse conditions and should consider what **reasonable adjustments** could be put in place to support them during proceedings.

d) A **needs lead approach** should be prioritised, especially when someone first arrives in custody. Examples of such improvements could be:
   i. A clear channel for Liaison and Diversion information to be sent to the receiving establishment from Court (for further information contact Kate Davies, NHS England).
   ii. Reinforce the importance for completion of the prisoner escort record during transfer (for further information contact Wisa Garmroudi, NHSE).
   iii. Appropriate first night care for those identified as needing support (for further information contact Alan Scott, Executive Director, HMPPS North).
   iv. Automatic referrals to mental health in-reach team should needs be identified (an example can be found at HMP Bristol).
   v. Specific keyworker sessions with a member of staff trained in neurodiversity (for further information contact Lyn Saunders, HMP Whatton).
   vi. The production of communicative literature which is easy to understand and relatable for prisoners (see Keyring and adapted CirclesUK materials).
   vii. Greater staff training to improve awareness of neurodiverse conditions and the behaviours people might exhibit.

e) It is important to address the **lack of data** relating to the prevalence of neurodiverse conditions in prisons and how such characteristics may relate to deaths. Such a dataset must then form the grounding for **subsequent research**.

Implications for deaths in custody

5. Data is not currently collected in individual establishments or centrally across prisons in England or Wales on the prevalence of neurodiverse conditions[5] and as a result little is known about whether autism, a brain injury or learning disability, for example, may have been a characteristic associated with a death in custody.

6. **The collation of improved data on the neurodiversity of people in prison, and specifically on those individuals who have taken their own lives, would allow for greater understanding of trends, contribute to the learning that can be derived from reports by the Prisons and Probation Ombudsman and Prevention of Future Death reports issued by coroners, and permit further focused research and improvements in policy and practice.**

7. *The IAP would also like to highlight the separate full response provided by panel member Jenny Talbot on behalf of the Prison Reform Trust. The IAP also notes that the RCGP Secure Environments Group chaired by Dr Jake Hard is a source of good information on prison (individual establishment and area) responses to neurodiversity.*

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[5] Loucks, N. (2006) *No One Knows: Offenders with Learning Difficulties and Learning Disabilities. Review of prevalence and associated needs*. London: Prison Reform Trust.

About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel (IAP)
- Practitioner and Stakeholder Group

The remit of the IAP (and overall of the Council) covers deaths, both natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAP, a non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAP's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE chairs the IAP.

Members of the IAP appointed in July 2018 are:

- Deborah Coles, Director, INQUEST
- Professor Seena Fazel, professor of Forensic Psychiatry, University of Oxford
- Professor Jenny Shaw, professor of Forensic Psychiatry, University of Manchester
- Jenny Talbot OBE, Prison Reform Trust
- John Wadham, Chair, National Preventative Mechanism

Further information on the IAP can be found on its website: www.iapondeathsincustody.org

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