the **Howard League** for **Penal Reform**

Deaths on probation

An analysis of data regarding people dying under probation supervision

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A report for the Howard League for Penal Reform by

Loraine Gelsthorpe, Nicola Padfield and Jake Phillips
Institute of Criminology, Faculty of Law
University of Cambridge

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Foreword

The Howard League for Penal Reform is publishing this report written by eminent academics because it deepens our collective knowledge about deaths on community supervision. The charity has led the way in campaigning for vulnerable people involved in the criminal justice system to be protected; leading the national campaign to prevent deaths in custody and commissioning the first independent review of deaths in prison following the suicides of five teenage boys in Leeds prison in 1988–89, which led to the review by HM Chief Inspector of Prisons. Over 25 years the Howard League has conducted research into self-injury in prison, suicides in prisons and following release, all the time trying to develop our understanding of the causes of such distress and how policy and practice can be improved to save lives. The charity works closely with ministers and the prison and probation services, provides advice to Parliamentary committees and seeks to educate the public about deaths in custody and on release. The Howard League has worked with, and supported, many families of people who have died in prison.

In 2002 the Howard League published a report, as part of a series of research papers on deaths, suicide and self-harm prevention following release from prison. We subsequently raised the issue with the Ministerial Council on Deaths in Custody, the body that includes all the heads of correctional services, so that this is now a key part of its policy consideration.

There have been significant changes to the way that people in acute suicidal distress are treated inside prisons. The Samaritans trains Listeners to support people, there are confidential phone lines directly to the Samaritans, and, following a Howard League campaign, people are no longer put into strip cells as a suicide prevention measure. The new monitoring system for prisoners who are identified as potentially suicidal is based on support rather than surveillance. There is no doubt that these measures have saved lives. Nevertheless, the death rate inside prisons remains scandalously high, too many wasted lives, too many bereaved families, too many distraught staff.

The charity's concern is also to impress upon all state agencies that they have a responsibility to preserve and enhance life. When the court curtails freedom it hands over to the organs of the state some responsibility for safeguarding an individual. Probation and community sentences are increasingly intrusive and controlling and this must bring with it increased duty of care. As Loraine Gelsthorpe, Nicola Padfield and Jake Phillips recommend, 'there is a need for an ethic of care'.

This critical review of data relating to deaths under probation supervision should generate increased concern about policy and practice regarding the most vulnerable people in this country. We need to prevent deaths as 'the moral salience of attending to and meeting the needs of others for whom we take responsibility (as individuals and as a state) …' should underwrite all our actions.

At a time when government is looking to outsource to private companies the supervision of people sentenced by the courts, there are lessons in this report that must be learned by everyone concerned.

Frances Crook
Chief Executive of the Howard League for Penal Reform

Executive Summary

Background

This report was prompted by data obtained by the Howard League for Penal Reform under Freedom of Information (FOI) requests from probation trusts. The data related to the number of adults who have died under probation supervision, including deaths following release from custody.

The request arose from increasing awareness on the part of the Howard League that not enough is known about these deaths. While deaths in custody and in Approved Premises are investigated by the Prisons and Probation Ombudsman[1] and statistics are published by the National Offender Management Service (NOMS); reports on deaths under supervision have not been put into the public domain.

This report presents data available, points out some of the discrepancies between the different sources, and identifies a number of issues and concerns about the ways in which the Probation Service[2] deals with adult deaths under probation supervision. The report concludes by raising questions about who should take responsibility for trying to prevent these deaths.

Methodology

Data on deaths under probation supervision has been collected since 2005 and was obtained under a FOI request by the Howard League. Additional data from NOMS was gathered using a further FOI request. The NOMS management information is presented largely as received and is then contrasted with the material obtained by the Howard League.

The analysis of data is also located within other published data: mortality rates in the population as a whole and in prisons (where data has been collected for many years) and investigations carried out by the Prison and Probation Ombudsman into deaths in custody and deaths in Approved Premises. Probation statistics are also discussed, as well as key articles from academic literature.

Key findings

- Notwithstanding difficulties in obtaining accurate data, a total of 2,275 deaths of men and 275 deaths of women under probation supervision were counted across each of the financial years for which data was requested.
- The data show that whilst a high proportion of the deaths related to natural causes (over 25 per cent in each year); suicide (not less than 13 per cent in each year), alcohol issues (8 per cent in each year for which there are figures), unlawful killing (5 per cent in each year), and misadventure/accident (not less than 8 per cent) also feature in significant proportion. Also, a large number of deaths were classified as 'unknown' cause (not less than 15 per cent).
- The data show that men and women under probation supervision are equally likely to die from natural causes. Men are more likely to commit suicide, die from a drug overdose, be unlawfully killed or to die from an accident. Women are more likely to die from alcohol-related issues.

1 See www.ppo.gov.uk/probation-investigations.html

2 The National Probation Service for England and Wales is a statutory criminal justice service within the Ministry of Justice, and comprises 42 geographical Probation Areas which are coterminous with police force area boundaries, served by 35 Probation Trusts. Local probation services were previously operated under the auspices of Probation Boards (and are responsible for policies and performance of Probation Areas, as well as the selection of staff). They became Probation Trusts in the Offender Management Act 2007 – responsible for commissioning interventions and other services and for scrutinising probation service provision.

- Younger people (those aged 18–24) on probation supervision are under-represented in the deaths (accounting for 35 per cent of those under supervision but 14 per cent of the deaths); yet people aged 25–49 are over-represented (accounting for 59 per cent of those under supervision but 64 per cent of all deaths); people aged 50 and above are also over-represented (accounting for 5 per cent of those under supervision but 21 per cent of deaths). Women aged 36–49 years accounted for 45 per cent of all deaths of women under supervision.
- It is not clear how far probation staff are equipped to support the families of those who die under probation supervision nor how far they are prepared to do this within the context of other duties and constraints.
- This report identifies what is and what is not recorded by probation staff. There is some suggestion that the forms used to record deaths under probation supervision (see Appendices 2, 3, 4 and 5) are seen as a tool primarily for self-protection, rather than contributing to an understanding of deaths under supervision and improving related practice. This highlights the need for more support for staff.

Key recommendations

- There is a need for an ethics of care. This 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) and the conception of persons as relational rather than a collection of independent individuals.
- It is important to reflect on whether things might have been done differently, and if so, how, in order to prevent deaths under probation supervision. There needs to be investigation of suicide cases in particular, to reflect the fact that there is 'care' for this group of people.
- More support is needed for probation staff in order to prevent deaths. It is currently not clear how far probation staff can go in supporting vulnerable clients within the constraints of their current duties and restricted resources.

Further recommendations

- Additional information is needed about deaths under probation supervision in order to highlight prevention as a priority. At present, it is not clear who cares or whose responsibility it is to care. Are the deaths under supervision related to length of prison sentence or licence conditions for example? Which other agencies beyond the Probation Service were involved at the time of death? Were different agencies aware of the vulnerabilities of this group of people? Did the prison authorities inform the local Probation Service where people were perceived to be particularly vulnerable upon release? What information, if any, was received from prisons to inform probation practice for those on licence?
- NOMS may wish to reconsider the wording of the Annex B and C forms used to record deaths under probation supervision in order to improve recording and aid qualitative analysis. Is it still considered appropriate to focus only on suicide, drug overdose, unlawful killings and alcohol-related deaths? At the same time, there is also opportunity to clarify the purpose of collecting the data: is it for prevention or analysis or both?

- Notwithstanding deficiencies within data, there is a need to review the analyses and to consider which deaths might be preventable. Further research which takes into account probation perspectives is recommended. A study which incorporates empirical research through interviews or questionnaires would add depth and breadth to this small study and help understanding as to what can be done to help prevent deaths under probation supervision.

Introduction

During 2010 the Howard League for Penal Reform obtained information regarding the number of adults dying under probation supervision. The information request arose from increasing awareness on the part of the Howard League that not enough is known about these deaths. While deaths in custody and in Approved Premises are investigated by the Prisons and Probation Ombudsman and statistics are published by the National Offender Management Service (NOMS), reports on deaths under supervision are not put into the public domain.

This report provides background information on probation supervision; presents the data available and contexualises it against data for the general population; points out some of the discrepancies between the different sources of information on the deaths of those under probation supervision; identifies a number of issues and concerns about the ways in which the Probation Service deals with adult deaths under supervision and raises questions about who should take responsibility for trying to prevent these deaths.

Research methodology

The Howard League wrote to all probation trusts in February 2010. This was followed by another letter in May 2010, with Freedom of Information requests seeking all Annex A, B and C forms produced following the introduction of new recording procedures for deaths under supervision. The material obtained by the Howard League was all in 'hard-copy' paper form, and was gathered into ten lever arch files.

Having reviewed this, the authors approached the Ministry of Justice to see if they had carried out their own analysis of the data. After a meeting with a member of the Performance, Information and Analysis Group of NOMS, a Freedom of Information application to receive this analysis was submitted. The analysis of Annex A statistical data was received on 16 September 2010.

1 Background

Definition of supervision

In this report, 'supervision' includes two main categories of people who have offended. Those who are serving a community order, a suspended sentence order or a deferred sentence (people who have committed offences which are not so serious as to require an immediate custodial sentence) and people on post-prison release supervision (people who have been released from prison, usually at the halfway point in their sentence or earlier, and are being electronically monitored on Home Detention Curfew. Most of these people will be supervised until the end of their sentence). The study also includes life sentence prisoners, who may remain under supervision for the whole of their lives.

Number of people under probation or post-prison release supervision

Table 1 shows the number of people who were under probation or post-prison release supervision from 2006–10.

Table 1: Total number of people under supervision 2006–10

Type of sentence	2006	2007	2008[3]	2009	2010
Men and Women					
Community sentences[4]	155,614	162,648	164,873	166,837	161,687
Pre and post release supervision	43,160	43,638	47,482	45,970	46,204
Men					
Community sentences	132,363	138,260	139,540	140,794	136,582
Pre and post release supervision	40,062	40,573	44,059	42,795	43,124
Women					
Community sentences	23,251	24,388	25,333	26,043	25,125
Pre and post release supervision	3,098	3,065	3,423	3,175	3,080

Source: Table 4.1 of the OMCS Annual Tables 2010 (available at: www.justice.gov.uk/publications/statistics-and-data/prisons-and-probation/oms-quarterly-editions.htm).

A much smaller number of people are on post-prison release supervision than are on community orders in any one year. The number of people under community order supervision in any one year has declined over time, but there has been a continued growth in the number of people serving custodial sentences of twelve months or more (up 38 per cent between 1999 and 2009)(Ministry of Justice,2010a). People serving these types of sentences require supervision on release from custody. New arrangements brought in by the Criminal Justice Act 2003 mean that people are now spending longer periods on licence and under supervision after release from custody.

Profile of people on probation supervision

Most people in contact with the criminal justice system are male and people under supervision are no exception here. However the evidence of disproportionality in terms of black and ethnic minority group representation prominent in the prison population is not mirrored in the profile of people under supervision in the community.

3 The post release figures for 2008 are slightly understated, due to an under-recording of the caseload data submitted by the West Midlands Probation Area for the fourth quarter 2008.

4 Including deferred sentences and suspended sentence orders.

Table 2: Ethnic profile of people under probation supervision

Asian	4.8%
Black	6.5%
Chinese or 'other'	1.3%
Mixed race	2.9%
White	82%
Unknown	2.5%

Source: Ministry of Justice (2010b) Green Paper Evidence Report *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders.* London: Ministry of Justice.

At a general level, people under supervision are likely to have come from disadvantaged backgrounds – for example, they are likely to have witnessed violence in the home as children, to have experienced early contact with the criminal justice system, and are more likely to experience drug addiction problems compared with the general population (Ministry of Justice, 2010b; Centre for Social Justice, 2010). In a compendium of research and analysis based on OASys[5] data, Debiden (2009) highlights that drug misuse is a strong predictor of recidivism (especially in relation to acquisitive crime). People under supervision are also more likely to have been in care, to have truanted from school and to have experienced harsh or neglectful parenting (Ministry of Justice, 2010b).

Arguably, people under supervision are disadvantaged on almost every index of need (Mair and May, 1997; Social Exclusion Unit, 2002; Solomon and Silvestri, 2008). Of those under supervision, approximately 14 per cent are considered to be homeless or in temporary accommodation. More than half (approximately 55 per cent) of people on community orders are unemployed at the start of their sentences and/or have difficulties with regard to education, training and employability. OASys data indicates that 37 per cent of people under probation supervision have drug misuse needs and that 32 per cent have alcohol problems (Ministry of Justice, 2010b).

By many criteria, the physical health of those under probation supervision is thought to be worse than the average population (Brooker et al., 2009). Canton (2008) suggests that at least 40 per cent of those under supervision have mental health problems. Rates of suicide among people under probation supervision in the community have been found to be nine times higher than in the general population and higher than in prison (Solomon and Silvestri, 2008).

There is a need to consider whether those who have died under probation supervision reflect the general profile of people under supervision and their needs (their chaotic lifestyles and dependencies for example) or whether there were any distinctive features relating to their specific needs and experiences. Discussion in section 5 suggests we do not currently have sufficient information to answer these questions.

Procedure for monitoring deaths under probation supervision

The current strategy for monitoring deaths under probation supervision was developed following the publication of a Home Office research study (Sattar, 2001). The new procedures were introduced in a Probation Circular ('PC') in 2005, known as PC60/2005.

These required an Assistant Chief Officer (ACO) in every Probation Area[6] to be responsible for monitoring deaths under supervision and for making an annual report to the National Probation Service.[7] A template for this annual report was attached to PC60/2005. This form is known as Annex A (see Appendix 2 for an example). Although the forms were subsequently changed in 2007 (see Appendix 3 for the revised version) the reporting procedure has remained the same as that introduced in 2005.

5 OASys – the Offender Assessment System is an instrument used in probation practice to measure criminogenic (i.e. crime-related) needs and risk of reconviction as well as risk of serious harm to others and to self. Importantly, the instrument is used to identify risks and needs, showing the priorities for the court sentence and risk management plans.

6 These Areas now make up 35 Probation Trusts: see also footnote 2.

7 The National Probation service was undergoing significant changes at this time due to the introduction of the National Offender Management Service.

When a staff member supervising an individual becomes aware of their death, he or she should immediately report the death to the Senior Probation Officer (SPO) responsible for that case. Within 24 hours of the office being informed of the death, the SPO should complete a report informing the Assistant Chief Officer (ACO) of that death (this report is known as Annex B, see Appendix 4 for an example). The ACO should review the circumstances of the person's death and discuss them with the SPO and other relevant staff. A clear and detailed factual record should be kept. When the investigation is complete, the SPO should arrange an interview with the supervising officer so that the SPO can prepare a further brief report (known as Annex C, see Appendix 5 for an example) for the ACO.

Revisions to procedure for monitoring deaths under probation supervision

As a result of a report on the implementation of PC 60/2005, monitoring procedures were revised. For the year 1 April 2006–31 March 2007, 39 of the 42 Probation Areas had returned figures, covering 679 reported deaths. However, 'it had become apparent that the information provided on the national return alone (Annex A of PC 60/2005) [was] insufficient to be of real benefit in highlighting potential areas for policy and practice improvement' (Probation Circular 37, 2007).

Annex A was modified in order to focus analysis on four causes of death: i) suicide, ii) drug overdose, iii) unlawful killing and iv) alcohol-related deaths (a new category). Probation Circular 37 (PC37/2007) asked Areas to submit Annex B and C forms only for these four key categories.

Annex A acts as the annual report to NOMS on deaths, on which national statistical data has been based. Annex A ends with two questions i) 'Have you made any changes to policy/procedures as a result of a death or deaths of offenders under supervision (training/development/staff care)?' and ii) 'Can you highlight any good practice undertaken that has arisen out of this monitoring?' Much more information is provided in the other two annexes: Annex B, the initial report to the ACO, asks for details of the deceased (name, gender, ethnicity, age, offence, type of supervision, whether Approved Premises resident) and also a brief description of reporting level, programme requirements, compliance etc.; whether there is likely to be media interest; and for the name of the victim liaison officer. Annex C is designed to record the official cause and circumstances of death in more detail. As well as the person's details (name, gender, ethnicity, age, date of death and official cause of death or coroner's verdict), it asks the SPO to describe briefly whether the cause of death was linked to any identified criminogenic need in OASys – risk of harm levels (age, locality, presenting behaviour, whether support measures were in place); whether they have made any changes to policy/procedure as a result of the death; and whether any further action needs to be taken in regard to the person's death.

2 Context: A review of data and relevant research

General mortality rates

The Office for National Statistics (ONS) publishes annual mortality statistics for the general population at large. In 2010, the average life expectancy at birth in England and Wales was 78.6 years for men and 82.5 years for women (Office for National Statistics, 2011a). Data on deaths for 2010 reveal that since 2000 age-standardised mortality rates have decreased by 24 per cent for males and 19 per cent for females. The 2010 age-standardised mortality rates for both males and females are the lowest ever recorded in England and Wales. Reasons for the fall in mortality rates include medical advances in the treatment of many illnesses and diseases. Generally, circulatory diseases, such as heart disease and strokes, remained the most common cause of death, contributing to almost one third (32 per cent) of all deaths registered in 2010. However, there is an overall downward trend in circulatory disease death rates. Cancer accounted for just over a quarter (29 per cent) of all deaths registered in 2010 (Office for National Statistics, 2011a).

Observations regarding mortality rates

There are obvious differences in mortality rates across geographical areas. For example, from analysis of mortality rates carried out by the Poverty Site[8] (2011), using the UK data archive, it seems that Scotland has by far the highest proprotion of premature deaths[9] for both men and women. The north west of England has the second highest rate of premature deaths (258 and 158 respectively). In the east of England – the area with the lowest rates – the rates were 185 and 119 respectively. What is more relevant are the notable differences on grounds of 'wealth' and 'poverty' (as shorthand for differences in lifestyle and human and social capital in regard to self-preservation). The rate of premature death has fallen steadily over the last decade for both men and women. In 2009 this rate was 223 per 100,000 males and 138 per 100,000 females, compared to 271 and 166 respectively in 1999.[10] This is a fall of around a fifth for both men and women (Office for National Statistics, 2011b).

Over the period 2001–3 (the most recent period for which there is data) men aged 25 to 64 from routine or manual backgrounds were twice as likely to die as those from managerial or professional backgrounds (The Poverty Site, 2011). Such social class differences appear to exist for all the major causes of death, including cancers and circulatory diseases (including heart disease). Over the same period, women aged 25 to 59 from routine or manual backgrounds were also much more likely to die than those from managerial or professional backgrounds (see Table 3).

8 The Poverty Site (created in 2002) draws on roughly one hundred statistical indicators from income and work to health and education to monitor poverty and social exclusion in the UK. See www.poverty.org.uk for more information.

9 A premature death is one which occurs before the average age of death in any one set of national or regional data.

10 The most recent year for which data are available.

Table 3: Death rates according to gender and background amongst the general population

Social class	Death rates per 100,000	
	Men aged 25 to 64	Women aged 25 to 59
Routine or manual backgrounds	454	194
Intermediate backgrounds	301	145
Managerial or professional backgrounds	231	137

Source: The Poverty Site, 2011.

Considering what is known about the backgrounds of people on supervision (Mair and May, 1997; Ministry of Justice, 2010b), one might expect the mortality rate amongst them to be higher than the average across the UK.

Data on suicide rates

Suicide rates in the community at large (as measured by the World Health Organisation[11]) reveal that 10.9 per 100,000 men and 3.0 per 100,000 women committed suicide in 2009. This represents 6.9 per 100,000 of the total population. The suicide rate is highest for men in the 35–44 age group (18.6 per 100,000 of the population), followed by the 45–54 and 25–34 age groups (17.3 and 13.9 per 100,000 of the population respectively). The suicide rate for women is different insofar as the highest rate is within the 45–54 age group (4.5 per 100,000 of the population), followed by 4.3 in the 35–44 age group and 3.4 in the 25–34 age group (per hundred thousand of the population). In terms of actual numbers, 563 males aged 25–34, 830 males aged 35–44 and 712 45–54 year old males committed suicide in the UK in 2009. For females, the figures were: 133 (25–34), 195 (35–44), and 191 (aged 45–54).

Data on deaths in custody

Data on deaths in custody has been available for many years. Indeed, one of the curious aspects of the task of looking at the deaths of people on supervision has been the contrast between the priority given to reducing deaths in custody, with the apparent lack of priority given to understanding deaths under supervision in the community. In 2009 the government established an Independent Advisory Panel (IAP) on deaths in custody.[12] Until 2010, deaths in custody appeared as Table 9.12 in the annual NOMS caseload statistics. Now they are published separately as a Ministry of Justice statistics bulletin.

The *Safety in Custody 2010* statistics were published on 28 July 2011.[13] In 2010, there were 196 deaths in custody – an increase from 169 in 2009 (due to an increase in deaths from natural causes). There were 58 deaths classified as self-inflicted.[14] The death rate for 2010 was 2.31 deaths per 1,000 prisoners. This rate was higher than the 2009 figure (2.02 per 1,000) but lower than the peak in 2004 (2.79 per 1,000). In 2009, there were 168 deaths in custody of which 60 were self-inflicted. The equivalent figures for 2008 were 165 deaths of which 60 were self-inflicted. The suicide rate for men in prison is five times greater than that for men in the community. Boys aged 15–17 are 18 times more likely to take their own lives in prison than in the community (Fazel et al., 1985).

Data available from Prison and Probation Ombudsman investigations

Some data is also available from the investigations carried out by the Prison and Probation Ombudsman (PPO), who became responsible for investigations into deaths in custody (including deaths in Approved Premises)[15] in 2004. The Ombudsman also has discretion to investigate other deaths, for example the deaths of those recently released from custody, but rarely does so. Individual reports are posted on the PPO

11 http://www.who.int/mental_health/media/unitkingd.pd

12 Their work is well advertised on their website (http://iapdeathsincustody.independent.gov.uk). They published a statistical analysis of all recorded deaths in custody 2000–2011 in October 2011.

13 www.justice.gov.uk/downloads/publications/statistics-and-data/mojstats/safety-custody-2010.pdf

14 It should be noted that there were eight deaths in 2010 which had not been classified at the time of writing.

website. In 2011 the PPO published a brief overview of prison deaths in Learning from PPO investigations: Self-inflicted deaths in prison custody 2007–2009 (PPO, 2011) but this did not include deaths which occurred in the community, perhaps because these made up only a small percentage of their fatal incident investigations.

In 2010–11, the PPO opened investigations into 200 new deaths, compared to 193 in 2009–10, eleven of which were deaths of residents of Approved Premises (similar to the number in the last two reporting years, eleven in 2009–10 and ten in 2008–9). Of these, four deaths were due to natural causes, three were self-inflicted and two were the result of drug overdoses. One death remains unclassified although it appears to be drug-related, and a further death occurred in a road traffic incident. While the number of deaths in Approved Premises remains relatively low, the incidence of probable drug overdoses is proportionally much higher than in the rest of the office's caseload, reflecting wider access to sources of supplies (PPO Annual Report, 2010–11: 46).

On the PPO website, there are a total of 71 PPO reports investigating deaths in Approved Premises, dating from 2004 onwards. This is fewer than the total number of deaths investigated, because reports are not published until the inquest is concluded, causing significant delay. The vast majority of these investigations concerned people who were on supervision under licence, though some were living in the premises as a condition of bail or as a requirement of a community order. As the PPO often points out, Approved Premises have a specific function, to protect the public through the monitoring of residents' behaviour. Thus they are often more controlling than prison, with more tightly enforced and restrictive rules. The PPO reports suggest some recurring themes, which are summarised below.

- The difficulties of life on release, particularly after a long period inside. The PPO points out that getting out of prison can prove 'too much' and lead to suicide (see for example a report which comments that, since prison was a controlled and structured environment, 'a phased release period could have benefited him' (PPO, 123.08).[16]
- The need for good medical and first aid practices. This includes the provision of safe ligature knives and defibrillators (as in prisons) and better training in resuscitation techniques.
- The limited ability of Approved Premises to care for elderly and frail hostel residents or those people struggling with chronic ill health. The PPO points out that if the current trend for longer prison sentences continues, there will be more older former prisoners. The implications of this are far-reaching, and extend far beyond those hostels making up the Approved Premises estate (PPO, 110.06). Reports also raise questions about the care of those with mental health issues (e.g. PPO, 126.05).
- The need to educate residents about the dangers of intravenous drug use. This is especially important after enforced abstinence in prison and is an important responsibility of hostel staff (PPO, 138.05).
- The difficulty of managing the recall process. For example, the risk that if the probation staff tell a person that they are to be recalled, he may disappear: in the case PPO 071.06, the man involved then died of a drugs overdose.

Relevant research literature

An early study by Pritchard, Cox and Dawson (1997) examined suicide and violent death in a six year cohort of male probationers compared with the general population (1990–95). The main conclusion was that males (17–54) had twice the death rate and nine times the suicide rate of the general population, which highlighted the need for more attention to be given to psychosocial difficulties and the need for better psychiatric-criminal justice system efforts in supporting people under probation supervision.

15 Approved Premises were formerly known as Probation and Bail Hostels and are approved by the Secretary of State under Section 9 of the Criminal Justice and Court Services Act 2000.

16 These reference numbers are those used by the PPO on their website. See www.ppo.gov.uk/probation-investigations.html.

Sattar (2001) clearly attempted to highlight the problem in a survey which involved analysis of data collected on those who died while under community supervision or in prison in England and Wales from 1996 to 1997. She noted that there were 1,267 deaths in the community (1,140 men and 127 women) and 236 deaths of prisoners (228 men and 8 women). The largest categories were suicide/self-inflicted death (accounting for almost half of prisoner deaths), and accidents (accounting for one third) of community deaths. All deaths involving drugs and/or alcohol (as a main or contributing factor) were combined (suicide and accidental, homicide and other violence, and other drug/alcohol). These deaths were found to account for a far greater proportion of deaths among those in the community (46 per cent) than prisoners (3 per cent). This is perhaps not surprising as drugs and alcohol are more readily accessible in the community than in prison. Almost two thirds of all accidental deaths and around one third of all suicide/self-inflicted deaths among those in the community could be traced to drugs/alcohol.

Sattar also noted that deaths among people under supervision tended to occur soon after being released from prison. Within four weeks of release over one quarter of all deaths had occurred; within 12 weeks of release over half of all deaths had occurred; and within 24 weeks of release just under three quarters of all deaths had occurred. Accidents accounted for the largest proportion of deaths. Those under community supervision had an overall mortality rate that was about double the prisoners' rate and four times the male general population rate. Those in the community and prisoners were relatively similar in terms of the death rates for natural causes and suicide/self-inflicted death. The accidental death rate for those in the community was more than five times the rate of those in custody and the homicide rate was also higher than the custody rate (five times in 1996 and nine times in 1997).

Sattar also observed that violent death (suicide, accidental death, homicide and other violent death) was an even greater problem among people under probation supervision than those in custody. Both groups were similarly vulnerable to suicide/self-inflicted death; however the risks of accidental death and homicide were greater for those under community supervision. Drugs and alcohol played a bigger part in the deaths of those under community supervision.

A key conclusion of Sattar's analysis was that the Probation Service and relevant external agencies needed to consider developing a strategy to reduce violent death among those under probation supervision, a theme which she continued in subsequent research and publications (Sattar, 2003; Sattar and Killias, 2005). Her work may well have prompted the introduction of the new recording mechanism included in PC 60/2005, notwithstanding the seeming absence of major policy and practice changes in regard to prevention.

A further analysis of deaths under supervision was carried out by Karen Mills, who highlighted the fact that many people who have offended, drug-misusers in particular, lead lives which place them at high risk of harm (Mills, 2004). Another study worth mentioning is one by Marie Segrave and Bree Carlton (2011) which focuses on women's mortality rates following release from prison in Victoria, Australia. The study highlights the high risk and rates of death soon after release from prison, and the need to address the institutional silence surrounding them.

3 Analysis of data

It should be made clear that the data obtained is management information data and, due to the potential application of different validation rules, may not tally with official statistics (i.e. the statistical data collected from the Annex A forms submitted by individual probation trusts).

Table 4 shows the number of deaths under probation supervision by financial year. From this data it is possible to calculate that there was a death rate of 5.1 per 1000 people in supervision in 2009–10 for instance, twice as high as the rate of deaths in custody.

Table 4: Number of deaths under supervision

	2006–7[1]	2007–8	2008–9	2009–10
Persons under supervision (OMCS – calendar years)				
Men and Women	**146,532**	**150,179**	**146,725**	**140,951**
Men	125,504	128,561	125,229	119,884
Women	21,028	21,618	21,496	21,067
Deaths under supervision (financial years)				
Men and Women	**679**	**659**	**736**	**722**
Men	569	578	666	631
Women	110	81	70	91
Deaths under supervision per 1,000 persons under supervision[2]				
Men and Women	-	4.4	5.0	5.1
Men	-	4.5	5.3	5.3
Women	-	3.8	3.3	4.3

Source: Ministry of Justice data, released under FOI.

Notes:

1. In the first year of reporting, three probation trusts did not submit returns. As a result, 2006–7 is under-reported compared with subsequent years and the rate has been omitted.
2. The numerator used in this rate relates to financial years. The denominator uses calendar years as financial year figures were not available at the time of writing.

N.B Figures are different to table 1 as they are from different Ministry of Justice sources.

Tables 5 and 6 show the number of deaths by cause of death according to data received from the Ministry of Justice. It is difficult to discern any distinct pattern here apart from the fact that natural and unknown are the most common causes of deaths under supervision. It is interesting to note that with the exception of suicide and unknown, each cause of death peaks in 2008–9.

Table 5: Number of Deaths under supervision by cause of death and gender

	2007–8		2008–9		2009–10		3 year average	
	M	W	M	W	M	W	M	W
PERSONS UNDER SUPERVISION								
Persons supervised (calendar years)	128,561	21,618	125,229	21,496	119,884	21,067	**124,558**	**21,394**
Percentage of population	85.6%	14.4%	85.3%	14.7%	85.1%	14.9%	**85.3%**	**14.7%**
CAUSE OF DEATH	**578**	**81**	**666**	**70**	**631**	**91**	**625**	**81**
Natural causes	150	19	179	30	160	33	**163**	**27**
Suicide	82	9	90	7	101	3	**91**	**6**
Drug overdose	91	12	100	7	87	8	**93**	**9**
Alcohol issues	39	14	48	9	43	16	**43**	**13**
Unlawful killing	28	3	37	2	33	3	**33**	**3**
Misadventure/ accident	60	6	83	3	71	6	**71**	**5**
Other (inc. narrative verdict)	7	2	14	0	13	1	**11**	**1**
Open	12	0	17	0	7	0	**12**	**0**
Unknown	109	16	98	12	116	21	**108**	**16**
ESTIMATED DEATHS PER 1,000 OFFENDERS BY CAUSE								
(Allows for unknowns and assumes distribution of causes in this category is the same as where cause is known)								
Natural causes	1.2	0.9	1.4	1.4	1.3	1.6	**1.3**	**1.3**
Suicide	0.6	0.4	0.7	0.3	0.8	0.1	**0.7**	**0.3**
Drug overdose	0.7	0.6	0.8	0.3	0.7	0.4	**0.7**	**0.4**
Alcohol issues	0.3	0.6	0.4	0.4	0.4	0.8	**0.3**	**0.6**
Unlawful killing	0.2	0.1	0.3	0.1	0.3	0.1	**0.3**	**0.1**
Misadventure/ accident	0.5	0.3	0.7	0.1	0.6	0.3	**0.6**	**0.2**

Table 6: Proportion of deaths by cause/verdict

	2006–7[1]	2007–8	2008–9	2009–10
Natural causes	34%	26%	28%	27%
Suicide	14%	14%	13%	14%
Drug overdose	17%	16%	15%	13%
Alcohol issues[2]	n/a	8%	8%	8%
Unlawful killing	5%	5%	5%	5%
Misadventure/accident	8%	10%	12%	11%
Other (Inc. narrative verdict)	1%	1%	2%	2%
Open	1%	2%	2%	1%
Unknown	20%	19%	15%	19%

Sources: Data from both tables from Ministry of Justice FOI request.

1. Although 2006–7 figures are somewhat under-reported, the distribution by cause appears fairly consistent with subsequent years and has therefore been included in the table.
2. Deaths arising from alcohol issues was a new category. In 2006–7 deaths arising from alcohol issues would mostly have been included in the natural causes category.

A much smaller number of people are on post-release supervision than are on community orders. Yet analysis of the data reveals that in 2009–10, a total of 446 people on community supervision died. As a proportion, of the total number of people under supervision on community orders in December 2009, 0.33 per cent died; while 151 people on post-prison release supervision died (or 0.43 per cent).

65 women died on community sentence. That is 0.3 per cent of the 21,067 on community orders. The eight women who died on post-prison release supervision were 0.35 per cent of the population of women on post-release supervision. For men, the 381 who died on community order formed 0.32 per cent of the population on community order. The 143 who died on post-prison release supervision were 0.43 per cent of the population on post-release supervision on December 2009. A slightly higher proportion of those on post-release supervision die than those serving community orders. The proportions may be higher, of course, if it was known into which category the 'unknowns' fit.

Table 7 shows deaths by sentence type. The majority of deaths were amongst those on a community order. However, the deaths per 1,000 were higher for those on licence than those on a court order (3.5 and 2.85 respectively for 2010).

Table 7: Deaths under supervision by sentence type

SENTENCE TYPE	2006–7			2007–8			2008–9			2009–10		
	M	W	Total	M	W	Total	M	W	Total	M	W	Total
Community Orders	n/a	n/a	0	432	76	508	427	56	483	381	65	446
Licence	n/a	n/a	0	146	5	151	128	3	131	143	8	151
Other	n/a	n/a	0			0	44	4	48	43	5	48
Unknown	569	110	679			0	67	7	74	64	13	77

Source: Data from Ministry of Justice FOI request.

It is suspected that this data (as the Ministry of Justice readily accepts) may not be totally reliable. The fact that the data is presented as percentages rather than numbers (or as well as numbers) makes interpretation rather difficult. There are a high number of unknown cases. This could be because the outcome of inquests was still not known at the time the annual report was submitted (data having been collected before outcome of any inquest).

The Ministry of Justice suggests that even allowing for these uncertainties, we may conclude that:

- Natural causes: Men and women are equally as likely to die.
- Suicide: Men are more likely to commit suicide.
- Drug overdose: Men are more likely to die from a drug overdose.
- Alcohol issues: Women are more likely to die from alcohol issues.
- Unlawful killing: Men are more likely to be unlawfully killed.
- Misadventure/accident: Men are more likely to die from an accident.

From the age data released, we can conclude that:

- Younger people aged 18–24 are under-represented. They account for 35 per cent (16% + 19%) of those under supervision but only 14 per cent deaths.
- People aged 25 to 49 are over-represented. They account for 59 per cent of those under supervision but 64 per cent of all deaths.

- People aged 50 and above were over-represented. They account for 5 per cent (4% + 1%) of people under supervision but 21 per cent (16% + 5%) of deaths.
- Women aged 36–49 accounted for 45 per cent of all deaths of women.

See Appendix 1 for a detailed breakdown of deaths by age.

Probation Area data obtained following the Howard League's FOI initial request under the Freedom of Information application was followed up by a second FOI request from the researchers in September 2011 for national data which had been compiled centrally but which in part reflected the information that the Howard League had sought to obtain by applying individually to each Probation Area. The initial FOI data consisted of hard copies of the Annex A, B and C. We took receipt of 505 Annex B forms and 337 Annex C forms following the Howard League's FOI request.

It was very difficult to cross-check these forms: often the names had been removed (though this was not universal practice) and dates were rarely given. But there were a sufficient number to undertake qualitative analysis of the design, content and style of these forms and the concluding section of the report identifies themes that arose out of this analysis alongside more general observations on the data analysis and the policy and practice implications which emerge.

In order to assess the usefulness of the data in terms of quantitative analysis, each Area was trawled to count up the number of deaths across the five periods. Where an Annex A was present this was taken as being the most definitive count of the number of deaths. Where no Annex A was present the information in Annex B and Annex C was used to come to an estimated figure. In some cases there was no official cause of death listed and the cause was entered as 'unknown'. Therefore the data probably overrepresents the number of unknowns. Similarly, it is not known whether notice of all the deaths for those Areas which did not submit Annex As have been received. Confidence in having an accurate tally can only be achieved where an Annex A was submitted. Only twelve Areas submitted Annex As for all five periods. An extra ten have submitted Annex As for four periods (but not necessarily the same periods).

A total of 2,275 deaths of men and 275 deaths of women were counted across each of the five financial years for which data was requested. Table 8 gives a breakdown of the cause of death by gender. Despite counting a total of 2,575 deaths, just 505 Annex B and 337 Annex C forms were provided. Considering each death is supposed to result in both an Annex B and C being completed, this makes statistical analysis yet more difficult.

Moreover, Areas varied considerably in terms of what they provided: some provided only Annex A forms, some provided only Annex B and C (but not necessarily the same number of each). No Area provided the Howard League with the complete data: i.e. Annex As for each period and a corresponding number of Annex B and C forms. Whilst it might be expected that Annex C could be lacking – due to the time it takes for the Coroner to make a decision in certain cases – one would expect an Annex B to exist for each death represented in the Annex As.

Table 8: Breakdown of deaths by cause and gender across all periods

Cause of Death	Men	Women
Misadventure/accident	231	20
Drugs/alcohol-related	437	66
Natural causes	560	97
Unlawful killing	105	9
Open	31	1
Other (inc. narrative verdict)	42	3
Suicide	333	25
Awaiting/unknown	536	54
Total	**2275**	**275**

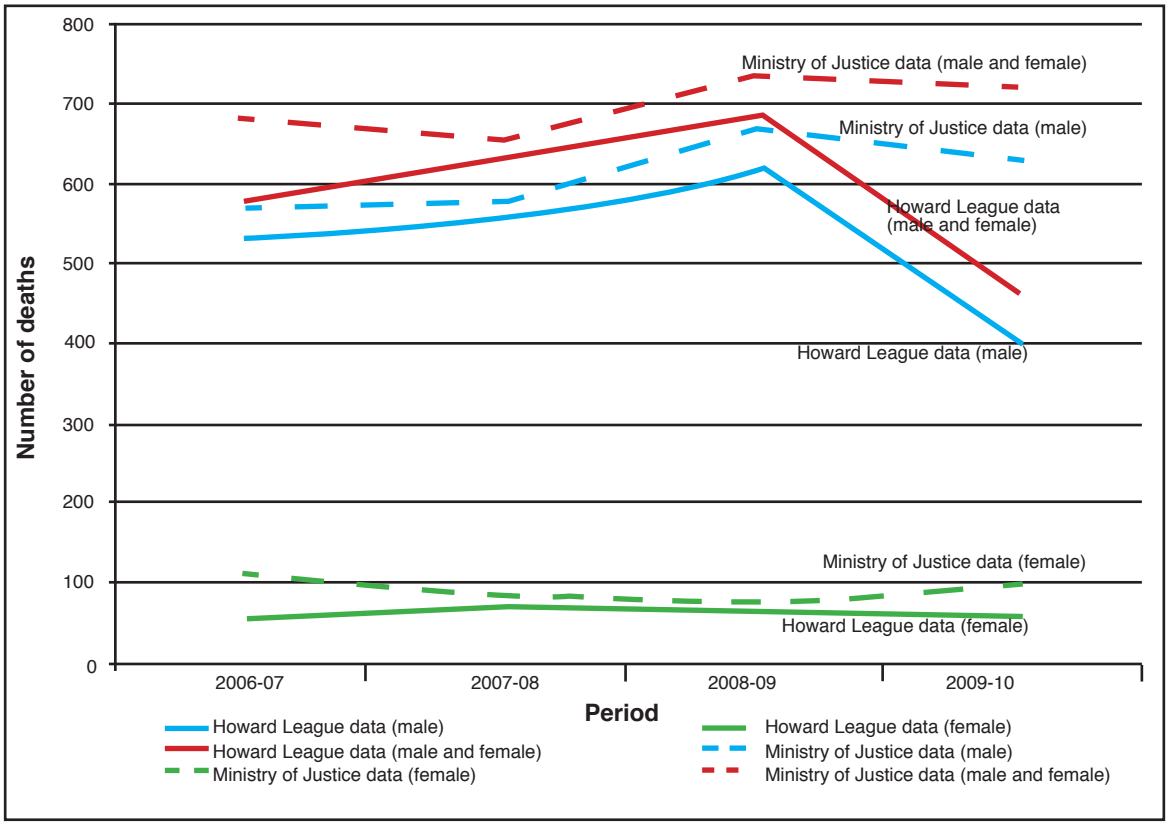
Source: Ministry of Justice data, released under FOI.

There are several issues with the data. Areas were only required to start recording deaths under supervision from 1 October 2005. Therefore, the period 2005–6 does not represent the full financial year. Thus, this period could reasonably be omitted when conducting quantitative analysis. However, only 15 Areas submitted Annex As for all four of the remaining periods. A nationwide comparison of deaths under supervision is not feasible. Opting to use only these 15 Areas to identify trends would, essentially, result in data that is unreliable and non-representative, to the extent that no conclusions could be drawn.

Reporting requirements changed during 2007 so that Areas had to start recording alcohol-related deaths separately. This makes comparison between the periods before and after this date difficult, as it must be assumed that alcohol-related deaths were included under other causes. We identified several instances in which alcohol-related deaths were inputted under drug overdose. This indicates a third issue with the data, specifically related to drugs and alcohol. It was clear that there was some confusion about what might be filed under 'drug overdose'. In some instances, drug issues were submitted as a drug overdose when the facts of the case (as discerned in the corresponding Annex B or C) suggested overdose was not the cause of death.

Comparing the Howard League data with that provided by the Ministry of Justice illustrates the inadequacy of the data. The data received through the researchers' separate Freedom of Information request to the Ministry of Justice cannot be considered an accurate picture of the statistics. However, the data generated through the Howard League's FOI requests are even poorer in terms of quality and accuracy. Figure 1 shows the number of deaths by gender according to analysis of the data collected by the Howard League compared with numbers provided by the Ministry of Justice.

Figure 1: Comparison of number of deaths by gender and data source

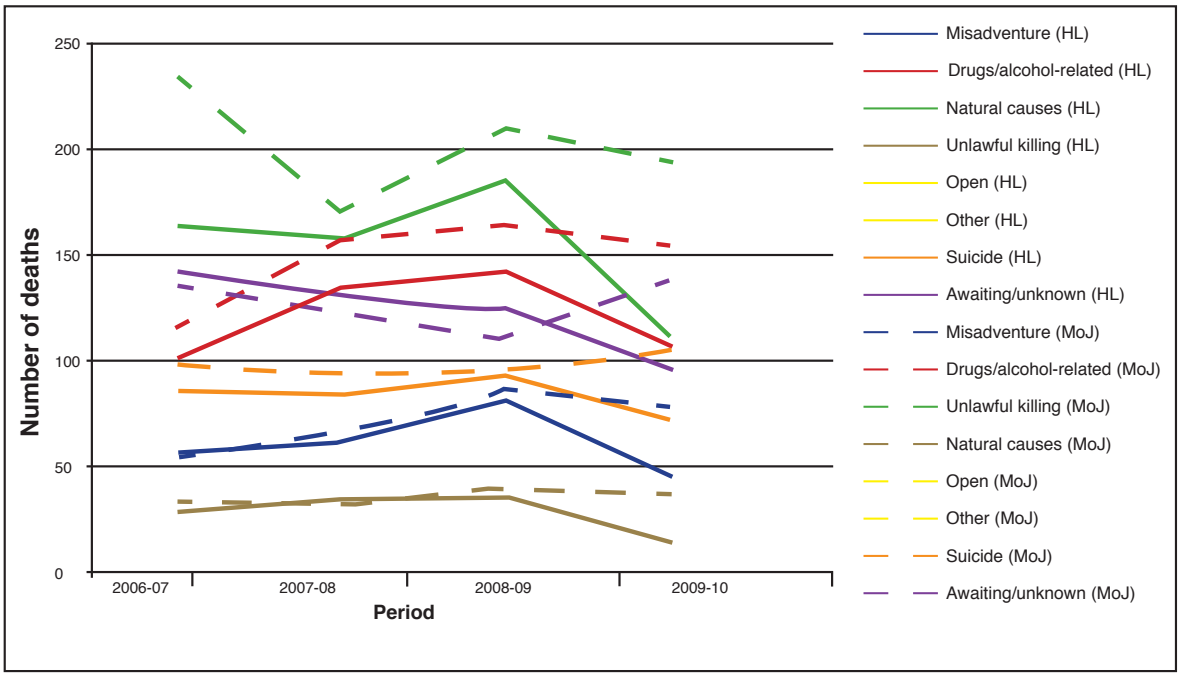


The Howard League tally is notably lower than that presented in the Ministry of Justice data. The drop in the numbers into the year 2009–10 is due to the fact that less information for this period was received. It may also be partially accounted for by highlighting the fact that London submitted data for all periods except 2009–10. As London has (unsurprisingly) the greatest number of deaths in previous periods, this may explain this particular inadequacy.

It has been previously noted that the tally of awaiting/unknowns may be overstated due to the lack of Annex As. Consideration was given to removing this cause from the data to see if analysis would bear greater resemblance to the data provided by the Ministry of Justice.

Figure 2 below shows that, barring 2009–10 which is underrepresented in the Howard League data, there is a similarity in the trends for each cause of death with the exception of awaiting/unknown. For example, both sets of data show that drug and alcohol-related deaths rose slightly until 2008–9 and then dropped; natural causes rose and then dropped according to both datasets. However, as the Ministry of Justice report (Ministry of Justice, 2011:2) also highlights, to draw conclusions on trends and patterns over such a short timescale would not be rigorous.

Figure 2: Comparison of number of deaths by cause of death and data source (males and females combined)



The implications from this brief discussion of the problems with the data are clear: there is more reliable data available on the number of deaths under supervision from the Ministry of Justice. Any attempts to identify trends and patterns across the country should utilise the Ministry of Justice data.

However, analysis also highlights problems with the recording of data by Areas and this is something that the Ministry of Justice itself needs to address. If, as might be inferred by the requirement to collect such data, the Ministry is keen to find out more about the issue of deaths under supervision, the generation of reliable data is key to this endeavour. That said, data has only been collected for four and a half years thus limiting the possibility of identifying meaningful trends. There is clearly a need to improve data collection and to wait for the collection of data over a longer timeframe before a full and comprehensive quantitative analysis of deaths under supervision can be undertaken.

4 Discussion: How can things be improved?

A number of important themes have emerged from this research, and these are discussed below. The risk of death is higher for people under probation supervision than those in custody as people under supervision experience a very different and often chaotic lifestyle. However, there is evidence of an even greater risk for those on licence than under supervision, suggesting that the transition from custody to the community entails its own risks.

Problematic information gathering

It is very difficult to draw any clear conclusions from the data studied on the profile of those who have died on probation supervision. The data sets are too limited to identify commonalities or differences in the age, gender, geographical area, ethnicity, mental health situation, housing, use of drugs, and use of alcohol for example. In relation to deaths in custody, NOMS collects many more details (age, time in custody and gender) which help explain much of the variation between risk groups. For example, most suicides occur in the early stages of prison custody with a peak age-specific rate among those in their 30s. With deaths under probation supervision, the information is collected in a way which precludes such analysis.

It is suggested that the data should be collected in ways which allow for much clearer analysis. There should be:

- 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
- clearer explanations about the length of time that people were on supervision, and the quality/depth of that supervision.

NOMS may wish to re-consider the wording of Annex B and C forms. These were designed to help shape changes to policy and practice and yet, as far as can be discovered, have not been analysed to date, let alone used to improve policy and practice. The forms raise two important questions:

- Is it still considered appropriate to focus only on suicide, drug overdose, unlawful killings and alcohol-related deaths?
- Does NOMS plan its own qualitative analysis of these forms?

Defensiveness on the part of probation staff?

One of the most interesting things to emerge from the analysis was what might be seen as a somewhat defensive tone within comments recorded on Annex B and C forms. The focus on media interest is also striking. Media attention is rarely paid to the death of a person under supervision in the community. Thus the media are unlikely to offer effective scrutiny in this area. That this should be a relief to probation managers is problematic. Clearly those cases in the public eye should not necessarily earn more attention from probation staff simply because of that media attention. However, the defensive tone identified within the Annex B and C forms may also be reflective of general attitudes within the Probation Service itself. (There is anecdotal evidence to suggest that probation workers may see risk

assessment tools as protective devices for themselves rather than as a tool to measure need and risk). It could be the case that the introduction of these forms provided probation officers with another tool primarily used for self-protection, rather than contributing to an understanding of deaths under supervision and improving related practice. If the intention is to learn more about why people die under supervision then there may be more productive ways of collecting the data.

This points to an ambiguity in the use of the forms: are they intended to strengthen accountability, or is the intention to improve practice and policy? This issue reaffirms the suggestion above that a redesign of the forms themselves may be helpful.

Staff management and support

Narrative comments on Annex B and C forms frequently focused on staff support. Whilst this is vitally important, it is not clear how far the support was also extended to the families of people under supervision who had died.

Many reports mentioned health and safety issues. This echoes the concerns in PPO investigations (see section 3). Effective medical and first aid practices need constant vigilance, yet the comments on Annex B and C forms were sometimes 'bland'. One reported that the recent attendance by a senior manager at a suicide prevention strategy launch party 'will further embed good practice in the coming year.' It would be interesting to see how this was followed up.

Ambivalence and ambiguity

Annex B asks officers to comment on the 'reporting level, programmes, requirements, compliance etc.' of people who had died under supervision. However, the utility of this information is unclear and resulted in statements such as:

> *Attending once a week for a minimum of 6 hours to complete his unpaid work. Acceptable absence and 1 unacceptable absence. Completed 15.5 hours of a 100 hours order, had 84.5 left to do.*

This does little to inform about what was done and certainly does not highlight what might have been done better. That the corresponding Appendix C indicates that no change to policy or procedure was required as a result of the death is perhaps not surprising given the paucity of information on the actual work done with the person.

Other Annex B and C forms suggest greater need for monitoring and surveillance (for example, mandatory room checks to reduce the risk of people in Approved Places bringing in substances/materials that would place people at risk of harm). Few Annex B or C forms expressed concern about the level of support offered, though one Annex B form included a chain of emails between the police, the prison and the Probation Service about the lack of support given to a suicidal homeless man who had died some three weeks after his release from prison in a public park. The case was not really one to be included here (because the person in question was not actually under supervision), but clearly the relevant agencies were all shocked and concerned that this person had fallen through all support networks.

There are several examples where the brief reports contained within the Annex A and B forms hint at the failures of the criminal justice system to adequately manage the transfer from custody to supervision. For example, one case of death by murder appears to suggest that the person under supervision had decided to leave the Probation Area because he feared for his life. In the related Annex B form, the probation officer highlighted the fact that the person was unable to leave immediately because there had been no one in the office authorised to sign a travel warrant. The person was murdered the following day, before he had managed to leave. That the officer chose to highlight the lack of authorised persons perhaps reflects the defensiveness noted elsewhere as well as pointing to resource limitations.

To the researchers, as outsiders, analysis of the Annex B and C forms has given some insight into managerial concerns, but of course these observations must be seen in the light of a certain ambiguity about the nature and purpose of the forms.

One further observation is that relatively few of the records mention ongoing work with people who have offended. In this sense, what is not included in the Annex B and C forms is as interesting as what is there. It is clear that where there are more detailed descriptions of the support given, it is considerably easier to discern what (if anything) might have gone awry.

5 Conclusion and recommendations: Where next?

Policy and practice implications
A number of important policy and practice implications can be identified. So much more is known about deaths of people in custody than the deaths of those under supervision and this indicates proper concern (even if some questions remain unanswered).[17]

The fact that this small study is the first attempt to analyse these reports suggests that the subject of deaths under probation supervision remains a low priority for those who manage and lead probation services. The fact that data is patchy and unreliable underscores this point. Much more effort should be expended on collating and exploring the nature of deaths under supervision. This might be done in a variety of ways. Clearly, statistical analysis of deaths under supervision would be beneficial in terms of highlighting where and when people are most vulnerable. It would also put deaths in the community on a par (in terms of attention, and thus perceived importance) with deaths in custody. There can be no justification for considering deaths in custody as more important than those under supervision, especially where deaths may be preventable.

Prevention as a priority: Who cares and whose responsibility is it to care?
Deaths under supervision might also be analysed thematically (as we have done, albeit in brief fashion). A study which incorporates empirical research through interviews or questionnaires would add depth and breadth to this small study. It is clear from the forms we received that this information represents only part of what occurs prior to and following a death under supervision. Talking to officers, managers and policy makers could reveal relevant information about deaths under probation supervision and how the number of deaths might be reduced. This would also help us understand matters from a probation perspective. The bare data does not indicate what attempts had been made to work with people in challenging circumstances, and under what constraints.

As part of this, it would be possible to focus on particular causes of death which might be seen as more preventable. For example, suicide in prison has received considerable attention and has resulted, indirectly perhaps, in a greater appreciation of morality and dignity within prison work. A study of suicide on probation could have a similar impact in terms of a reconsideration of probation values. Even if it did not have such wide ramifications, any kind of analysis which explicitly compares what happens immediately before and after deaths of differing kinds would be beneficial to understanding and prevention.

The task before us is a challenging one. Deaths in custody have a huge impact on the prison, on the prisoner's family, on other prisoners, on wing and governing staff. Despite a 'managerial' ethos and a concomitant 'tick box' approach to achieving targets, the death of someone in custody is still recognised as a human tragedy. In contrast, deaths in the community – under supervision or licence – have been neglected. The issues are also more complex and the impact more diffuse. The death of someone may not be noticed until they fail to appear for an appointment. It is not clear who has immediate responsibility for supporting the family and friends of the person who has died. It is also not clear how far probation staff can go in supporting vulnerable clients within the constraints of their duties to manage people and ensure their compliance to court orders. The managerial ethos here appears to emphasise data collection, yet it is not clear to what purpose.

17 See Inquest: http://www.inquest.org.uk

What is very clear is that much greater care in the community is needed for vulnerable people leaving prison on licence or under probation supervision. Prevention of the suicide of people under supervision in the community should be as much of a priority as it is in prison. There should be an 'ethics of care'.[18] This 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). But 'care' on its own can be distorted into controlling domination or wrongful self-denial in the interests of expressing benevolent concern.[19] For these reasons, it is argued that care and caring relations need to be subjected to moral scrutiny and evaluated, not just described (Held, 2005).

The Coalition government's 'big society' initiative has been interpreted and promoted as an opportunity to give local people and communities more power and signals a system shift. Could there not be a further shift in the direction of an 'ethics of care' to facilitate the development of caring relations? Of course, there are complexities here, not least concerning the relationship between 'care' and 'justice', but in civil society without which the liberal institutions of justice cannot function, we should presume a background of some degree of caring relations rather than of merely competing individuals (Held, 2005). There can be no justice without care. Thus 'care' for people under supervision should have higher status in the priorities of probation trusts. 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.

Both *Cutting Crime, the case for justice reinvestment* (Justice Committee, 2009) and the Green Paper *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders* (Ministry of Justice, 2010c) emphasise the need to make community penalties more effective. From the Justice Committee we learn:

> *There should be significant strengthening of community rehabilitative provision to enable probation to focus on the management of high risk offenders. The underlying needs of many persistent offenders who cause the most problems to local communities could be managed more coherently in the community. Prison resources could then be focused on higher risk offenders and, when they left custody, there would be better community provision for resettlement. All of which would improve effectiveness in reducing re-offending, improve public safety and reduce the prison population* (Justice Committee, 2009: paragraph 52).

The Green Paper suggests that there will be efforts to 'divert more of the less serious offenders with mental illness and drug dependency into treatment rather than prison' (Ministry of Justice, 2010c) and there is broad recognition that a significant proportion of crime is committed by those who have multiple problems (Ministry of Justice, 2010a).

If the aim is to increase the legitimacy of community penalties, then this is likely to come through proven effectiveness rather than political posturing around 'offender management.' The aim should be to reinvigorate a frontline professional and skilled service equipped to engage with people who offend and address the complex problems and chaotic lifestyles which they experience. An ethics of care in this context is both value and practice.

18 The 'ethics of care' is one of a cluster of normative ethical theories developed in the second part of the twentieth century (Held, 2005). As Diemut Bubeck puts it: '…the ethics of care [is] a system of concepts, values and ideas, arising from the practice of care as an organic part of this practice and responding to its material requirements, notably the meeting of needs' (Bubeck,1995:206).

19 The 'ethics of care' depends on a conception of persons as relational rather than a collection of independent individuals.

Key recommendations

- There is a need for an ethics of care. This 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) and the conception of persons as relational rather than a collection of independent individuals.
- It is important to reflect on whether things might have been done differently, and if so, how, in order to prevent deaths under probation supervision. There needs to be investigation of suicide cases in particular, to reflect the fact that there is 'care' for this group of people.
- More support is needed for probation staff in order to prevent deaths. It is currently not clear how far probation staff can go in supporting vulnerable clients within the constraints of their current duties and restricted resources.

Further recommendations

- Additional information is needed about deaths under probation supervision in order to highlight prevention as a priority. At present, it is not clear who cares or whose responsibility it is to care. Are the deaths under supervision related to length of prison sentence or licence conditions for example? Which other agencies beyond the Probation Service were involved at the time of death? Were different agencies aware of the vulnerabilities of this group of people? Did the prison authorities inform the local Probation Service where people were perceived to be particularly vulnerable upon release? What information, if any, was received from prisons to inform probation practice for those on licence?
- NOMS may wish to reconsider the wording of the Annex B and C forms used to record deaths under probation supervision in order to improve recording and aid qualitative analysis. Is it still considered appropriate to focus only on suicide, drug overdose, unlawful killings and alcohol-related deaths? At the same time, there is also opportunity to clarify the purpose of collecting the data: is it for prevention or analysis or both?
- Notwithstanding deficiencies within data, there is a need to review the analyses and to consider which deaths might be preventable. Further research which takes into account probation perspectives is recommended. A study which incorporates empirical research through interviews or questionnaires would add depth and breadth to this small study and help our understanding as to what can be done to help prevent deaths under probation supervision.

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Appendix 1: Proportions of deaths by age band (Ministry of Justice, 2011)

Age band	2006–07	2007–08	2008–09	2009–10
Male and Female				
18-24	14%	15%	15%	14%
25-35	32%	31%	27%	27%
36-49	33%	33%	37%	35%
50-65	17%	17%	15%	17%
65+	4%	5%	5%	5%
Unknown	0%	0%	1%	2%
Male				
18-24	n/a	16%	15%	14%
25-35	n/a	32%	27%	28%
36-49	n/a	31%	36%	33%
50-65	n/a	16%	15%	18%
65+	n/a	6%	5%	5%
Unknown	n/a	0%	1%	1%
Female				
18-24	n/a	7%	11%	8%
25-35	n/a	28%	21%	24%
36-49	n/a	43%	46%	46%
50-65	n/a	21%	13%	13%
65+	n/a	0%	0%	1%
Unknown	n/a	0%	9%	8%

Appendix 2: Annex A form

ANNEX A–ANNUAL REPORT TO NPD ON DEATHS OF OFFENDERS UNDER NPS SUPERVISION

NATIONAL PROBATION SERVICE

Probation Area: **Originating Officer:**

Contact details:

Total Number of Deaths During the Year to 31 March:

Total Number of Deaths Investigated:

Total Male Deaths				
CAUSE OF DEATH OR CORONERS VERDICTS:	**Misadventure or Accident:**	**Suicide:**	**Unlawful killing:**	**Open**
	Other including Narrative Vertict:	**Industrial Diseases:**	**Natural Causes:**	**Drug Overdose:**
	Awaiting:			
TYPE OF SENTENCE/ SUPERVISION:				
OLD SENTENCES:	**Community Order:**	**Suspended Sentence Order :**	**Automatic Conditional Release (ACR):**	**Discretionary Conditional Release (DCR):**
	Lifer:	**Non-Parole Release (NPD):**	**Young Offender:**	
NEW	**Imprisonment**	**Extened**	**Standard**	**Intermittent**

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SENTENCES:	**for Public protection (IPP):**	**SENTENCES:**	**Determinate Sentence (SDS):**	**Custody:**
	New Community Order:	**Suspended Sentence Order (Custody Minus):**	**Custody Plus:**	**Deferment of sentence:**
NUMBER RESIDENT IN APPROVED PREMISES (Bailles Included):				
ETHNICTY				
TOTAL WHITE:	**TOTAL MIXED:**	**TOTAL ASIAN:**	**TOTAL BLACK:**	**TOTAL CHINESE:**
British:	**W&B Caribbean:**	**Indian:**	**Caribbean:**	**Chinese:**
Irish:	**W&B African:**	**Pakistani:**	**African:**	**Other:**
Other:	**W&B Asian:**	**Bangladeshi:**	**Other:**	
		Other:		
ETHNICTY NOT AVAILABLE:				
AGE RANGE				
18-24:	**25-35:**	**36-49:**	**50-65:**	**65+**

TOTAL FEMALE DEATHS:				
CAUSE OF DEATHS OR CORONERS VERDICTS:	**Misadventure or Accident:**	**Suicide:**	**Unlawful killing:**	**Open**
	Other including Narrative Vertict:	**Industrial Diseases:**	**Natural Causes:**	**Drug Overdose:**
	Awaiting:			

TYPE OF SENTENCE/ SUPERVISION:				
OLD SENTENCES:	**Community Order:**	**Suspended Sentence Order:**	**Automatic Conditional Release (ACR):**	**Discretionary Conditional Release (DCR):**
	Lifer:	**Non-parole Release (NPD)**	**Young Offender:**	
NEW SENTENCES:	**Imprisonment for Public Protection: (IPP):**	**Extended Setence:**	**Standard Determinate Sentence (SDS):**	**Intermittent Custody:**
	New Community Order:	**Suspended Sentence Order (Custody Minus):**	**Custody Plus:**	**Deferment of sentence:**
NUMBER RESIDENT IN APPROVED PREMISES (Bailles Included):				
ETHNICTY				
TOTAL WHITE:	**TOTAL MIXED:**	**TOTAL ASIAN:**	**TOTAL BLACK:**	**TOTAL CHINESE:**
British:	**W&B Caribbean:**	**Indian:**	**Caribbean:**	**Chinese:**
Irish:	**W&B African:**	**Pakistani:**	**African:**	**Other:**
Other:	**W&B Asian:**	**Bangladeshi:**	**Other:**	
		Other:		
ETHNICTY NOT AVAILABLE:				
AGE RANGE				
18-24:	**25-35:**	**36-49:**	**50-65:**	**65+**

Have you made any changes to policy/procedures as a result of a death or deaths of offenders under supervision (training / development / staff care)? YES / NO

If yes, please describe:

Can you highlight any good practice untaken that has arisen out this monitoring?

Appendix 3: Annex A revised

Appendix: revised return for deaths under supervision

(PC60/2005 Annex A (revised)

Category		Male	Female
Cause of Death	Natural causes		
	Suicide		
	Drug Overdose		
	Alcohol issues		
	Unlawful killing		
	Misadventure/accident		
	Other Inc narrative verdict		
	Open		
	Industrial Diseases		
	Awaiting verdict		
Sentence	Community order		
	Licence		
Age	18-24		
	25-35		
	36-49		
	50-65		
	65+		
Ethnicity	Total white		
	British		
	Irish		
	Other		
	Total mixed		
	W&B Caribbean		
	W&B African		
	W&B Asian		
	Total Asian		
	Indian		
	Pakistani		
	Bangladeshi		
	Other		
	Total black		
	Caribbean		
	African		
	Other		
	Total Chinese		
	Chinese		
	Other		
Number in Approved Premises			

Have you made any changes to policy/procedures as a result of a death or deaths of offenders under supervision (training / development / staff care)?

Can you highlight any good pratice that has arisen from monitoring?

For any deaths in the catergories of suicide, drug overdoose, unlawful killing or alcohol related, please send Annexes B and C of PC 60/2005 with this return.

Appendix 4: Annex B

ANNEX B–REPORT TO ACO ON THE DEATHS OF OFFENDERS UNDER NPS SUPERVISION

Office:

Originating Senior Probation Officer:

Contact details:

Offender Details

Offender's Name:
Gender:
Ethnicity:
Age:
Offence(s):
Type of supervision:
Approved Premises resident:

Brief description of reporting level, programmes,requirements, compliance etc:
Likely to be Media Interest:
Victim Liaison Officer:

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Appendix 5: Annex C

ANNEX C–OFFICIAL CAUSE AND CIRCUMSTANCES OF DEATH

NATIONAL PROBATION SERVICE

Office:

Originating Senior Probation Officer:

Contact details:

Offender's Name:
Gender:
Ethnicity:
Age:
Date of Death
Official Cause of Death or Coroner's Verdict

Describe briefly:

- **Was the cause of death linnked to any identified criminogenic need in OASys - Risk of Harm levels (age; locality; presenting behaviour; were support measures in place)? YES / NO**

  If yes, please describe:

- **Have you made any changes to the policy/procedure as a result of the death (welfare; training / development)? YES / NO**

  If yes, please describe:

- **Does any further action need to be taken in regard to the death of this offender YES / NO**

  If yes, please describe:

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About the authors

Loraine Gelsthorpe is Professor in Criminology and Criminal Justice, Director of the MPhil Programmes in Criminology and Criminological Research at the University of Cambridge and Fellow of Pembroke College. She is Editor (with Rod Morgan) of the Handbook of Probation (Willan Publishing) and has extensive publications relating to criminology and criminal justice, especially in relation to women. Loraine is current President of the British Society of Criminology.

Nicola Padfield is a Senior Lecturer at the Law Faculty, University of Cambridge. A barrister by training, she has published widely on criminal law, sentencing and criminal justice. She has edited other collections of essays, and is editor of Archbold Review. She sits as a Recorder (part-time judge) in the Crown Court and is a Bencher of the Middle Temple.

Jake Phillips is completing his Ph.D. under the supervision of Loraine Gelsthorpe at the University of Cambridge. His work looks at the Probation Service in the context of recent policy changes, focusing on practitioner's use of, or opinions towards, rehabilitation, discretion, compliance, managerialism and risk management. From September 2012 Jake will take up a Lectureship in Criminology at Sheffield Hallam University.

About the Howard League for Penal Reform

The Howard League for Penal Reform is a national charity working for less crime, safer communities and fewer people in prison. It is the oldest penal reform charity in the UK. It was established in 1866 and is named after John Howard, one of the first prison reformers.

We work with parliament and the media, with criminal justice professionals, students and members of the public, influencing debate and forcing through meaningful change to create safer communities.

We campaign on a wide range of issues including short term prison sentences, real work in prison, community sentences and youth justice.

Our legal team provides free, independent and confidential advice, assistance and representation on a wide range of issues to young people under 21 who are in prisons or secure children's homes and centres.

By becoming a member you will give us a bigger voice and give vital financial support to our work. We cannot achieve real and lasting change without your help.

Please visit www.howardleague.org and join today.

Howard League pubilcations that may be of interest

Grindrod, H., and Black, G. (1989) *Suicides at Leeds prison. An enquiry into deaths of five teenagers in custody furing 1988/89.* London: Howard League for Penal Reform.

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These are available to download from:
http://www.howardleague.org/pubsindex/

the **Howard League** for **Penal Reform**

1 Ardleigh Road
London
N1 4HS

t 020 7249 7373
e info@howardleague.org
w www.howardleague.org

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