Deaths on probation:

An analysis of data regarding people dying under probation supervision

Summary

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

Key points

- Not enough is known about deaths under probation supervision. 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.
- Notwithstanding difficulties in obtaining accurate data, a total of 2,275 deaths of men and 275 deaths of women under probation supervision were counted between 2005 –10. This represents a rate twice as high as deaths in custody.
- Additional information is needed about deaths under probation supervision in order to highlight prevention as a priority.
- There is a need for an ethics of care. This revolves around the moral salience of meeting the needs of others for whom we take responsibility, as individuals and as a state.
- It is important to reflect on whether things might have been done differently, and if so, how, in order to prevent deaths.
- More support is needed for probation staff. It is currently not clear how far they can go in supporting vulnerable clients within the constraints of their current duties and restricted resources. It is also not clear how far they 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.

Introduction

This summary is based on a report produced by the Howard League for Penal Reform investigating deaths under probation supervision (available at www.howardleague.org/deathsonprobation). The report was prompted by data obtained under Freedom of Information requests from probation trusts. The data relates to the number of adults who have died under probation supervision, including deaths following release from custody.

This summary provides brief background information about people under probation supervision and provides an overview of data available. It concludes with a series of recommendations around improving care for those under probation supervision to try to prevent 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 forms produced following the introduction of new recording procedures for deaths under supervision. Having reviewed this, the researchers approached the Ministry of Justice to see if it had carried out its 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, and this analysis of statistical data was received on 16 September 2010.

The current strategy for monitoring deaths under probation supervision was developed following the publication of a Home Office research study. The procedures were introduced in Probation Circular 60 in 2005 (PC60/2005). These required an Assistant Chief Officer in every Probation Area to be responsible for monitoring deaths under supervision and for making an annual report to the National Probation Service. A template form for this annual report was attached to PC60/2005 (known as Annex A).

Probation Circular 37 (2007) stated, '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'. Annex A was then 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 Areas were also asked to submit further information (Annex B and C forms only for these categories.

Profile of people on probation supervision

Most people in contact with the criminal justice system are male and people under probation supervision are no exception. 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.

Arguably, people under probation 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.

People under supervision are likely to have come from disadvantaged backgrounds, to have witnessed violence in the home as children, to have experienced early contact with the criminal justice system and to have experienced drug addiction problems compared with the general population (Ministry of Justice, 2010b; Centre for Social Justice, 2010). People under supervision are also more likely to have been in care, to have truanted and to have experienced harsh or neglectful parenting (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 often chaotic lifestyles and dependencies, for example) or whether there were any distinctive features relating to their specific needs and experiences.

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

Type of sentence	2006	2007	2008[1]	2009	2010
Men and Women					
Community sentences[2]	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

1. 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.

2. Including deferred sentences and suspended sentence orders.
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).

The Ministry of Justice data suggests 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 five per cent (4% + 1%) of people under supervision but 21 per cent (16% + 5%) of deaths.
- Women aged 36–49 years age accounted for 45 per cent of all deaths of women.

Analysis of data

This summary is an overview of the more complex version available in the full report. As such, it concentrates only on headline figures. However, a few key discrepancies in data must be pointed out.

Probation 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. Further, only 15 Areas submitted Annex A forms for all four of the remaining periods.

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. The researchers 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 – confusion about what might be filed under 'drug overdose'.

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 a fully accurate picture of the statistics, but key conclusions can be drawn from what is available.

Table 2 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 2: Number of people dying under supervision

	2006–7[1]	2007–8	2008–9	2009–10
Persons under supervision (OMCS – calendar years)[2]				
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

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.
Source: Source: Ministry of Justice data, released under FOI.

Table 3: People dying 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 4: 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%

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.
Source: Ministry of Justice FOI request (both tables)

Table 5: 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.

Tables 3 and 4 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 causes 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.

A much smaller number of people are on post-release supervision than are on community orders. Yet analysis of the data revealed that in 2009–10, a total of 446 people on community supervision died. 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 represented 0.35 per cent of that population. 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 that population. A slightly higher proportion of those on post-release supervision died than those serving community orders. The proportions may be higher, of course, if it was known into which category the 'unknowns' fit.

Table 5 summarises deaths by cause and gender across all periods.

Conclusion

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 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 other duties.

The fact that this small study is the first attempt to analyse reports on deaths on probation suggests that this 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.

There can be no justification for considering deaths in custody as more important than those under supervision, especially where deaths may be preventable.

What is very clear is that much greater care in the community is needed for vulnerable people leaving prison. Prevention of the suicide of people under supervision should be as much of a priority as it is in prison. There should be 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). 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.

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.

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 recomendations

- Additional information is needed about deaths under probation supervision in order to highlight prevention as a priority. At present, it is not clear 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 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 forms used to record deaths under probation supervision. 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.

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About the Howard League for Penal Reform

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