BBC NEWS

Deaths on probation

Adam Petto/Getty

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THE DRUM ONLINE MEDIA AWARDS FINALIST 2018

Contents:

What's the story?

The number of people dying under probation supervision has risen by almost a third in three years, analysis of official figures show.

Campaigners have told the BBC there had been "institutional indifference" towards offenders following their release from custody.

A social worker told us her job had become "a treadmill of bureaucracy".

But the Ministry of Justice told us a "great deal of caution was needed when trying to draw conclusions" from the data.

Background:

The arrangements for managing offenders were overhauled in 2014, with the probation service split in two.

A new state body, the National Probation Service (NPS), which has eight divisions, was set up to supervise high-risk offenders, with 21 privately run Community Rehabilitation Companies (CRCs) supervising low and medium-risk offenders.

But the partial privatisation of of probation has been beset with criticism in recent months. In March, the National Audit Office said the number of people returning to prison for breaching their licence conditions had "skyrocketed".

And the chief inspector of probation, Dame Glenys Stacey, said later in the same month the system was "irredeemably flawed".

We've analysed the most recent figures for complete financial years:

- Last year, 966 deaths of offenders in the community were recorded, compared to 752 in 2015-16, the first year when the government's restructure of the Probation

Service took effect. At this point, an additional 40,000 people came under supervision.

- For 18 out of 28 National Probation Service (NPS) divisions and Community Rehabilitation Companies (CRC) in England and Wales, the number of deaths has increased

Probation Service	2015/16	2016/17	2017/18	% increase
Approved premises	13	13	11	-15%
Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire CRC	12	27	42	250%
Bristol, Gloucestershire, Somerset and Wiltshire CRC	34	16	15	-56%
Cheshire and Greater Manchester CRC	27	42	71	163%
Cumbria and Lancashire CRC	18	36	31	72%
Derbyshire, Leicestershire, Nottinghamshire and Rutland CRC	25	25	40	60%
Dorset, Devon and Cornwall CRC	12	20	19	58%
Durham Tees Valley CRC	21	25	34	62%
Essex CRC	12	23	23	92%
Hampshire and Isle of Wight CRC	17	9	22	29%
Humberside, Lincolnshire and North Yorkshire CRC	29	39	26	-10%
Kent, Surrey and Sussex CRC	54	48	54	0%
London CRC	47	32	28	-40%
Merseyside CRC	15	21	36	140%
Norfolk and Suffolk CRC	9	19	12	33%
Northumbria CRC	21	16	20	-5%
NPS London	13	22	22	69%
NPS Midlands	25	25	39	56%

NPS North East	64	78	95	48%
NPS North West	36	72	59	64%
NPS South East and Eastern	55	47	30	-45%
NPS South West and South Central	25	26	33	32%
NPS Wales	23	16	18	-22%
South Yorkshire CRC	13	18	34	162%
Staffordshire and West Midlands CRC	28	19	25	-11%
Thames Valley CRC	16	23	20	25%
Wales CRC	56	41	54	-4%
Warwickshire and West Mercia CRC	16	7	15	-6%
West Yorkshire CRC	16	27	38	138%

Caseload over time:

Provider	Year	Total supervision (excluding pre-release)
NPS North East	2015/16	8698
NPS North East	2016/17	9732
NPS North East	2017/18	9919
Durham Tees Valley CRC	2015/16	3421
Durham Tees Valley CRC	2016/17	3525
Durham Tees Valley CRC	2017/18	3365
Northumbria CRC	2015/16	6086
Northumbria CRC	2016/17	3986
Northumbria CRC	2017/18	3335
Humberside, Lincolnshire and North Yorkshire CRC	2015/16	4798

Humberside, Lincolnshire and North Yorkshire CRC	2016/17	5330
Humberside, Lincolnshire and North Yorkshire CRC	2017/18	4800
South Yorkshire CRC	2015/16	5772
South Yorkshire CRC	2016/17	3709
South Yorkshire CRC	2017/18	3396
West Yorkshire CRC	2015/16	6793
West Yorkshire CRC	2016/17	7389
West Yorkshire CRC	2017/18	6918
NPS North West	2015/16	8749
NPS North West	2016/17	8560
NPS North West	2017/18	9030
Cheshire and Greater Manchester CRC	2015/16	10618
Cheshire and Greater Manchester CRC	2016/17	10987
Cheshire and Greater Manchester CRC	2017/18	10385
Cumbria and Lancashire CRC	2015/16	5402
Cumbria and Lancashire CRC	2016/17	5224
Cumbria and Lancashire CRC	2017/18	4782
Merseyside CRC	2015/16	5437
Merseyside CRC	2016/17	5563
Merseyside CRC	2017/18	5176
NPS Midlands	2015/16	8130
NPS Midlands	2016/17	8660
NPS Midlands	2017/18	9130
Derbyshire, Leicestershire, Nottinghamshire and Rutland CRC	2015/16	7679
Derbyshire, Leicestershire, Nottinghamshire and Rutland CRC	2016/17	7746
Derbyshire, Leicestershire, Nottinghamshire and Rutland CRC	2017/18	7647

Staffordshire and West Midlands CRC	2015/16	11971
Staffordshire and West Midlands CRC	2016/17	12239
Staffordshire and West Midlands CRC	2017/18	10832
Warwickshire and West Mercia CRC	2015/16	3034
Warwickshire and West Mercia CRC	2016/17	3166
Warwickshire and West Mercia CRC	2017/18	2794
NPS London	2015/16	6418
NPS London	2016/17	6913
NPS London	2017/18	7983
London CRC	2015/16	24104
London CRC	2016/17	25402
London CRC	2017/18	25729
NPS South East and Eastern	2015/16	6881
NPS South East and Eastern	2016/17	7279
NPS South East and Eastern	2017/18	8274
Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire CRC	2015/16	6875
Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire CRC	2016/17	7072
Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire CRC	2017/18	6476
Essex CRC	2015/16	3874
Essex CRC	2016/17	3811
Essex CRC	2017/18	3348
Norfolk and Suffolk CRC	2015/16	2567
Norfolk and Suffolk CRC	2016/17	2698
Norfolk and Suffolk CRC	2017/18	2553
Kent, Surrey and Sussex CRC	2015/16	7630
Kent, Surrey and Sussex CRC	2016/17	8121

Kent, Surrey and Sussex CRC	2017/18	7811
NPS South West and South Central	2015/16	5940
NPS South West and South Central	2016/17	6308
NPS South West and South Central	2017/18	7063
Hampshire and Isle of Wight CRC	2015/16	3519
Hampshire and Isle of Wight CRC	2016/17	3472
Hampshire and Isle of Wight CRC	2017/18	3544
Thames Valley CRC	2015/16	4510
Thames Valley CRC	2016/17	4537
Thames Valley CRC	2017/18	3881
Bristol, Gloucestershire, Somerset and Wiltshire CRC	2015/16	6053
Bristol, Gloucestershire, Somerset and Wiltshire CRC	2016/17	6011
Bristol, Gloucestershire, Somerset and Wiltshire CRC	2017/18	6672
Dorset, Devon and Cornwall CRC	2015/16	3831
Dorset, Devon and Cornwall CRC	2016/17	3853
Dorset, Devon and Cornwall CRC	2017/18	3742
NPS Wales	2015/16	3416
NPS Wales	2016/17	3859
NPS Wales	2017/18	3924
Wales CRC	2015/16	9405
Wales CRC	2016/17	8398
Wales CRC	2017/18	7992
Approved premises	2015/16	NA
Approved premises	2016/17	NA
Approved premises	2017/18	NA

How to use the data pack

This data pack and accompanying spreadsheet show:

- Total deaths on probation by cause
- Total deaths by region
- Expert analysis
- Case studies including an ex-offender who took his own life while on probation

The material can all be used to compile your story alongside copyright approved images from the experts/ case studies.

Stock images are **not included** for use and are subject to copyright.

Regional findings:

England and Wales

Region	2015/16	2016/17	2017/18	% increase
London	60	54	50	-17%
Midlands	94	76	119	27%
North East	164	203	247	51%
North West	96	171	197	105%
South East and Eastern	142	164	161	13%
South West	104	94	109	5%
Unknown	13	13	11	-15%
Wales	79	57	72	-9%

Scotland:

Local authorities' data

- There were a total of 565 recorded deaths of offenders under probation supervision across Scottish councils areas in the four years up to 2017-18, excluding four authorities which did not provide data.

Local Authority	Total deaths	% of total deaths
Glasgow City Council	113	20%
Fife Council	48	8%
Aberdeen City Council	47	8%
North Ayrshire Council	31	5%
Falkirk Council	27	5%
Dundee City Council	23	4%
South Ayrshire Council	22	4%
East Ayrshire Council	21	4%
The Highland Council	21	4%
Dumfries and Galloway Council	19	3%
Renfrewshire Council	19	3%

Northern Ireland

- Seven more offenders died under supervision in 2017-18 than the year before, increasing from 14 to 21.

Experts' quotes:

England

A spokesman for the Ministry of Justice:

The MoJ has said it is important to note the difficulties in obtaining conclusive information about an offender's cause of death. Whilst the primary role of probation is to protect the public and prevent reoffending, it does not have sole responsibility for caring for offenders.

"Our probation reforms were a positive change for public safety, extending supervision and support to approximately 40,000 extra offenders each year – nearly 20% more than in 2014," a spokesman said.

"This significant increase in volume, along with the rising age of offenders and improved recording practices, means a great deal of caution is needed when trying to draw conclusions from this data.

"We are investing an extra £22m in 'through-the-gate' assistance for offenders, to help them

find the support they need on issues such as housing, healthcare and employment, and they have the same access to these services as any other person in the community."

Editor's notes from the MoJ:

On the deaths of those under probation:

- We work closely with other agencies to support offenders in the community. When an offender being supervised by probation dies, staff must examine the circumstances of the death to identify whether improvements could be made.
- The National Probation Service is working on a national Suicide Prevention strategy, which is linked to our ongoing work to improve safety in prisons. This will give staff new training, guidance and support in helping to identify and support vulnerable offenders, to ensure they are receiving the appropriate standard of care.

On Government reforms:

- Our reforms [Transforming Rehabilitation] were challenging and ambitious and were a positive change for public safety, but we have also seen challenges and there's been a shift in the type of offenders coming to the courts.
- An increase in violent and sexual offences has had a knock-on effect on probation services, with more cases going to the NPS and fewer to CRCs than expected. That is

why we are taking decisive action to improve CRCs by ending current contracts early, investing £22 million in Through the Gate services, and have consulted on how best to deliver probation services in the future.

On community treatment requirements:

- We recently announced a programme to improve access to health services for vulnerable offenders with mental health, alcohol and substance abuse issues. As part of this, we are working with the Department of Health and Social Care, NHS England and Public Health England to develop a protocol to support greater use of community sentences with treatment requirements (CSTRs) in courts, including drug rehabilitation requirements.
- The CSTR protocol focuses on reducing reoffending by addressing the health needs of offenders that may be contributing to their offending behaviour.
- It is operating across five courts within England – Milton Keynes, Northampton, Birmingham, Sefton and Plymouth – and has increased confidence among sentencers, resulting in more community sentences with treatment requirements being issued.

Frances Cook, chief executive of the Howard League for Penal Reform

“It is extremely concerning to see such a sudden rise in the number of people who have died while being supervised in the community.

“Further investigation is required, but it raises fears that the cycle of homelessness, cuts to local government and voluntary sector provision, and the spread of drugs, such as Spice, are having a devastating impact.

“Most significantly, it highlights the continued failure of private probation companies to keep people safe. Whereas before we had a successful publicly-run probation service with qualified

and trained staff who saw their mission as befriending and turning lives around, we now have a fragmented service with a tick-box culture where some people have not even met face-to-face."

Rebecca Roberts, head of policy at the charity Inquest

"In our work around deaths in custody we see families struggling to get answers about how their loved one died. Independent investigations and inquests can help to identify any failings, hold agencies to account and prevent further deaths.

"The lack of formal investigation of deaths post-custody means the facts surrounding a death are unlikely to come to light. This also means coroners will not have sufficient information to fully scrutinise these deaths."

"The problem is post-death investigations, even in the prison system, aren't perfect, but at least there's an investigation with the Prisons and Probation Ombudsman and efforts are made to learn from that death.

"The Independent Office for Police Conduct investigates deaths after police custody. The same levels of scrutiny should apply to deaths of people after they leave prison.

"There's been complete institutional indifference towards the lives and deaths of people following release from custody and a total lack of visibility and investigation.

"Transforming Rehabilitation reforms to probation services have been a disaster and many people are just abandoned after release.

"Deaths have been rising year after year, and we need more scrutiny on why this is and what can be done to prevent these deaths in future."

Dr Jake Phillips, senior lecturer in criminology at Sheffield Hallam University

Compared to when Dr Phillips first began researching the subject of deaths under supervision nearly a decade ago, he feels there have been significant improvements in the way deaths are recorded.

The returns from Probation Trusts back then were “shockingly bad – with lots of gaps in the data”, but the crucial step now is for the authorities to recognise the need for more post-death investigations.

“There’s no scope for looking across all of the deaths which occur in one area, for example, and learning from those, never mind across the whole country.”

On probation reforms: “The Government was incredibly short-sighted, especially to introduce the post-release supervision. Adding 40,000 people onto the caseload with no immediate plan for more staff was highly irresponsible.

“There’s quite a lot of evidence now from inspection reports and academic research that Through the Gate and post-release supervision for short sentences is inadequate.

“People leaving short-term prison sentences do need support - before they were just left to look after themselves when they were released so the principle of giving them access to support was good, but making it mandatory was problematic because it extends people’s sentences disproportionately and not putting the resources in was irresponsible.”

On who has a legal duty of care for offenders in the community: “It’s complex, but I don’t think we should shy away from it. They are in the community, the probation service do not and cannot have total duty of care over a service user because they’re not with them all the time, but I think it could be much clearer about where that responsibility does sit.

“At the moment we don’t know if there are key ways to reduce these deaths because there isn’t any systematic learning taking place.

“There’s a fairly strong argument for saying that we know a lot about why people kill themselves in prison, for example, because there’s been learning taking place for the last 20 years or so, from a range of angles. Under probation supervision, we just don’t know that.

“I think there’s a really unhealthy attitude to people who have broken the law in this country.

“People who are on probation are of a much higher risk of dying, but the immediate response is, ‘Well, they shouldn’t be on probation in the first place’ and that’s not helpful. That’s not seeing those individuals as people in their own right - it’s very much ostracising and stigmatising.

“The other problem, particularly with people on probation is – where does that responsibility lie? You get push back from society saying, ‘I don’t care about offenders’, you get push back from probation providers saying: ‘Well, what are we supposed to do about it? We can’t be with them 24/7’, whereas at least the Prison Service has fully accepted it’s responsible to reduce the number of deaths which occur among the population, but probation hasn’t.”

Tania Bassett, press officer at Napo trade union for probation staff and probation officers (Photo credit: Napo)

“The biggest flaw in the probation model is the fact it is split.

“CRCs have needed to focus on profit and have made huge job cuts – we estimate 2,000 staff in the past four years.

“They have massive caseloads and do less one-to-one contact than usual. Some companies still do telephone monitoring but if that person is an ex-drug user, you wouldn’t pick up on subtle changes in their behaviour which would indicate a return to drugs, over the phone.

“CRCs are routinely slammed by inspection reports. Safeguarding is one of the big issues and we’re also seeing a 28 per cent increase in recalls to prison since 2014, including those serving short-term sentences, which indicates something is not working as it should do.

“The Probation Service is also significantly short-staffed and being part of the Civil Service means it’s paralysed with bureaucracy and there’s a lack of flexibility in service delivery to meet local needs.

“Put all of that together and I’m not overly surprised we’re seeing an increase in the deaths of people on probation.”

“An NPS trainee is starting with a caseload of high-risk offenders without the build-up you’d expect. We’ve informed the MoJ newly-qualified probation officers don’t feel confident and it has yet to arrive at a solution. Professional development isn’t as much of a priority due to time constraints.”

Scotland

A Scottish Government spokesman

“The death of any individual, no matter what the circumstances, while on release under supervision or licence, is regrettable, and our sympathies go to their family and friends.

“The annual criminal justice statistics record the number of deaths relating to individuals on a Community Payback Order or Drug Treatment and Testing Order. The Care Inspectorate is notified of cases, in line with guidance on serious incident reviews, as well as any circumstances where an individual dies while residing in an offender accommodation service.

“The recent Criminal Justice Social Work Serious Incident Reviews report found that between February 2015 and December 2017, the Care Inspectorate received 43 notifications on this basis.”

Editor's notes:

Serious Incident Review guidance from the Care Inspectorate states a review should always be carried out when:

- An individual on statutory supervision or licence is charged with, or recalled to custody on suspicion of, an offence that has resulted in the death of, or serious harm to, another person.
- The incident, or accumulation of incidents, gives rise to significant concerns about professional or service involvement, or a lack of involvement.
- An individual on supervision has died or been seriously injured in circumstances likely to generate significant public concern.

The Care Inspectorate's regulation of care services includes offender accommodation, of which there are five registered services in Scotland. These services are inspected a minimum of every 12 months.

If an individual residing within the service died, in any circumstances the care service is required to submit a notification to the Care Inspectorate. This would then be considered by the inspector and further information sought as required.

Case studies:

Caspar Capel (Photo credits: The Capel family)

At the age of 43, Caspar Capel took his own life in 2015 while a resident of Bowling Green Approved Premises, Carlisle.

Three weeks after Mr Capel went missing, he was found dead about 21 miles away in Beacon Edge Woods – a place he would visit as a young adult with his father, Dick.

His body was found on February 7.

A Prisons and Probation Ombudsman (PPO) report concluded there was nothing staff could have done to prevent his death but acknowledged his long history of mental health and alcohol misuse problems.

Mr Capel, who had borderline personality disorder, had been troubled with anxiety and depression, which worsened in the ten years prior to his death.

In a report to the coroner following Mr Capel's death, his family detailed many occasions when their son threatened, or expressed an intention, to end his life over the years.

They explained their son found it difficult to engage with the support offered to him. Forming friendships and maintaining relationships was difficult so therefore, he became increasingly isolated.

Contact with the law

Mr Capel first came into contact with probation in August 2013 when he was subject to a community order with three years supervision for possession of a bladed article, affray, and a public order offence, whilst under the influence of alcohol.

In June 2014 he was remanded to HMP Preston and charged with burglary, when a pub landlord found him inside after closing. He was released on tag in late July for six weeks.

But after exposing himself to a male train conductor, whilst drunk at Penrith Rail Station, he was arrested that September and remanded to HMP Durham for sentencing.

In the days leading to the incident, Mr Capel was hospitalised when his parents found an empty alcohol bottle and half pouch of pills under his bed. He stayed overnight at Carlisle Hospital but discharged himself after being transferred to a general ward.

The next day police found him walking barefoot down the A6 and he was taken to the Carleton Clinic in Carlisle. However, he walked out before anyone could see him. That same day he was arrested for exposing himself.

During those months on remand, Mr Capel further contemplated suicide.

An entry in his journal read: “What I really want is a nice way to cease living…I am desperate to alleviate this anxiety hell.”

Three months later in December 2014, he received a two-year community order and took his life the following year.

Q&A with mother-of-two Mrs Sue Capel, of Kirkby Stephen, Cumbria.

What would you like to tell people about your son Caspar?

“Caspar was a sweet but shy and anxious child, and made very few friends.

Later he discovered a love of outdoor activities. These activities helped alleviate his depression to a certain

extent but he was always dissatisfied with his performance, and became disenchanted if he didn't always do so well.

He had ambitions that were impossible for him to achieve and was very unrealistic about life. In his early thirties, he decided to try for academic achievement and gained the entrance qualifications to study for a BA in Philosophy [at the University of Central Lancashire].

We were so pleased with his achievement, but he was very disappointed when this didn't lead to instant employment. This only added to his depression and feelings of isolation.

"When in a positive frame of mind, he had a lovely sense of humour but at other times was thrown into the depths of depression, frustration and anger about life."

How did Caspar become introduced to drugs and alcohol, and how did this connect to his criminality?

"Caspar soon discovered he needed alcohol to cope in social situations and was encouraged by a friend who saw him as a heavy drinking companion. The criminality was a natural extension of his loss of inhibition in public and a growing anger about seeing people in happy social situations when he was always alone. He would always end up in a pub where he would sometimes initially try to engage people in an inappropriate way and then get angry when they didn't respond."

You'd mentioned various authorities almost gave up on him?

"Certainly psychiatric services gave up on him quite quickly after he opted out of some of the options they offered and failed to attend appointments. One of the big problems was they all saw his drinking as separate to his mental health problems. Caspar was constantly told he couldn't get help until he stopped drinking but he was drinking because he couldn't cope.

“The only time he stopped drinking completely was for a short while on tag and staying with us, but he couldn’t sustain it. By the time he was really hooked on alcohol, he was also giving up on life and couldn’t see the point of making the effort. Earlier on he would have periods when he was focused on achieving something and would be more stable, but he was never satisfied with himself in the end.”

One of the ways you feel the justice system failed Caspar is by putting someone so vulnerable in prison - what were your concerns?

“By that time it was a bit late for a meaningful psychiatric intervention and there was certainly not going to be one on offer. He was frightened of the prospect of being sent to prison and both times the judge was against it, but couldn’t find another alternative. In the case of his second prison detention on remand, there was a ridiculous delay whilst they waited for a useless psychiatric report, which was just a rehash of an old one. Meanwhile, because he was on remand, he had no opportunities to take advantage of rehabilitation, was anxiously avoiding all the bullies, and was writing about everything in detail, including working out his final suicide plan.”

When he was released from prison, did you feel there was enough support for him?

“We didn’t think it was appropriate for responsibility to be passed over to Carlisle probation officers who he’d never met and for him not to have had any visits in prison from his Kendal probation officers, or not to have been met from court by one of them when released. If we’d not been there to help him sort out his prescription with the GP and fill out forms, he’d have been in a worse anxious state than he already was, which was pretty severe.”

How did you both feel reading the PPO report which said, 'There was little staff could have done to prevent or predict Caspar's death'?

"Communication between the police and probation services needs to improve when a person vulnerable to suicide is involved. Initially we allowed ourselves to believe he might have absconded and both the police and probation service seemed keen on that possibility so time was wasted in looking much farther afield."

As a family, what support were you offered by the probation provider or other agencies after Caspar's death?

"We've never been offered any support by any of the official agencies since he died…As a family we supported each other."

What changes do you want to see made for offenders under probation supervision?

Photo captions:

Page [x] - Caspar Capel before he went missing

Page [x] - Caspar Capel in his twenties

Page [x] - Caspar Capel racing outdoors

Page [x] - Caspar Capel as a young boy

Page [x] - Caspar Capel with mother Sue at the Angel of the North in 2009

A probation worker with nearly 20 years' experience

From a caseload of about 30 people when she began as a probation officer, she now manages more than double that amount. At its highest, in the year post-Transforming Rehabilitation, caseload per person peaked at 100.

Speaking on condition of anonymity, she said: "

"You're prioritising the work with the people you need to and those who are perhaps more stable, don't get the interventions and support they need. It's constant firefighting.

"In the early days within probation it was a trust-based model so there was a lot of local partnerships, you knew all the services in your area, and it was victim-led public protection work.

"What we have now is very much a bureaucratic system where it's about performance, money, and within CRCs there's very little partner working. It's very much about commissioning and new work coming in without managing the work you've already got.

"It's just become a whole different job and it hasn't got the service user and public protection at the heart of it. It's become a treadmill of bureaucracy, recording, performance, and none of it is about making positive changes."

SolStock/Getty

In one week the division she works for had several service users die. In some of the cases, new psychoactive substances were involved.

But the courts having less confidence in drug treatment services and less time to review them mean fewer drug rehabilitation requirements are added to community sentences, she explained. As a result less money is invested to commission these services.

“When you lose a service user it has a massive emotional impact on you.

“Officers, when they know someone is quite vulnerable, will go above and beyond to try and mitigate some of that risk, but then there’s frustration felt when services are in a similar boat to us and can’t commit the time some of these service users need.

“In terms of improving practice and how we can minimise the potential of service users dying, it’s really hard at the moment because there’s no money anywhere. We’re very much relying on charities to underpin some of our work, whose staff will not only offer practical help but have a cup of tea with service users.”

Katarzyna Bialasiewiczck/Getty

As CRCs endeavour to bring more money in by being commissioned for extra services, staff workload is increasing by default.

Any one-to-one work with service users is “more reactive than proactive,” she said, and there are “holes” in the services they are delivering.

“There now isn’t a relationship with service users, although this has often been the biggest factor in provoking change.

“There needs to be more about the service user-probation officer relationship. That has got to be fundamental to anything going forward in terms of this new Government consultation and CRC contracts.

“But there also has to be a complete rethink as to how the private sector views these contracts - they don’t see it as dealing with people with difficult histories.

“A lot of them have been victims of abuse, have had traumatic childhoods or experiences, but are seen as people who should fit into nice neat boxes, and if they don’t, probation officers should find a different way of working with them.

“That’s a difficult message for us to take because that’s not how it should be.

“For every person we’re not doing a good job with, there’s a victim at the other side of it.

“As much as probation isn’t attractive because the public doesn’t want to think about an offender being a person, especially if they’ve been a victim of crime, the people we’re working with have been in similar situations.

“If we don’t deal with the service user and the issues they bring to the table then potentially they’ll keep doing what they’re doing, which creates more victims.”

Notes on data

What is a death in the community?

The Ministry of Justice describes this as a death which happens while an offender is under probation supervision, either serving court order sentences in the community, (including community orders and suspended sentences) or on supervision after leaving prison.

For Scotland, deaths are recorded for people who are serving a community payback order (CPO) or drug treatment and testing order (DTTO) – both may or may not include a community requirement such as unpaid work or supervision.

The MoJ states that the role of an offender manager in the community is to assess, supervise and rehabilitate offenders, but their ability to manage their health and wellbeing is limited. Therefore, the level of accountability for deaths which occur during probation supervision is substantially different from deaths in custody.

Only deaths which occur while an offender is staying in Approved Premises (previously called ‘Approved Probation and Bail Hostels’) are independently investigated by the Prisons and Probation Ombudsman (PPO), of which there has been 46 deaths since 2014-15.

However, not all of these deaths will have happened on the premises.

Prevention of Future Deaths reports are also produced when a coroner feels further action should be taken after an inquest.

Internally, NPS divisions and CRCs record details of a death which then informs annual reports published by the MoJ.

Definitions for causes of death

- Self-inflicted - a person who has taken his or her own life irrespective of intent.
- Accident - a death arising from external causes, accidental overdose/poisoning and in cases where taking a drug (not in fatal amounts) contributed.
- Homicide - when a person dies at the hands of another (includes murder and manslaughter).
- Natural causes - death due to naturally occurring diseases.
- Other - where a death cannot easily be classified under other causes and it may not be possible to determine the cause.
- Unclassified - when there is insufficient information to make a judgement about the cause of death at the time of reporting.
- Other (medical) - death due to a pre-existing medical condition or a sudden medical-related death such as a heart attack. (Angus Council, Scotland, only).
- Suspected drug overdose/ substance misuse - a category used by the Probation Board for Northern Ireland, which records another three causes of death: suspected suicide, natural causes and unknown.

ONS suicide figures reflect deaths which occurred each calendar year, rather than registered deaths. Therefore, incomplete figures for 2017 had not been included and 2016 data will be a slight underestimate of the number of suicides occurring that year.

The MoJ's figures are for financial years.

Methodology

England and Wales

- The BBC Shared Data Unit has analysed data from 2015-16 to 2017-18 from the Ministry of Justice's Deaths of Offenders in the Community statistics and Offender Management statistics.

Scotland and Northern Ireland

In Scotland, there is no Probation Service, so equivalent roles are carried out by local authority criminal justice social workers.

Where an offender is subject to license conditions and is being supervised, their death will be reported to the local authority through the supervising officer.

We sent an FOI and the response from each local authority, including the Scottish Government, revealed several variations among councils, such as:

- A cause of death not being recorded as councils are not given the information, or legally obliged to know it for their records.
- There being no central register to store information.
- Data being unreliable within the given timescales because a person's death can be recorded a significant time post-mortem.

We were unable to obtain data from Orkney Islands Council, South Lanarkshire Council, City of Edinburgh Council and Clackmannanshire Council.

Only ten out of 27 councils were able to provide a cause of death, and the Scottish Government also does not record this information so it has not been included.

The same FOI was sent to the Probation Board for Northern Ireland which only began collating information on deaths under supervision in November 2016. But those records do not cover deaths post-release from prison.

Background: Reform of the Probation Service

- In 2014-15 the Government introduced reforms to the National Probation Service in a bid to reduce reoffending, dubbed Transforming Rehabilitation (TR).
- These changes, which included the Offender Rehabilitation Act (ORA) 2014, meant approximately 40,000 prisoners serving sentences of less than 12 months should receive a year's mandatory community supervision after leaving prison.
- Meanwhile, 35 probation trusts across England and Wales were reduced to seven National Probation Service (NPS) divisions and 21 privately-run Community Rehabilitation Company (CRC) areas, both responsible for preparing prisoners for release and resettling.
- Despite ORA introducing a new drug appointment requirement for offenders being supervised in the community – we can reveal drug and alcohol treatment and mental health support have been some of the worst hit.