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REVIEW

FATAL INCIDENTS REPORTS:
FROM SEPTEMBER 2008 TO AUGUST 2009

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March 2010

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Foreword

By their very nature, the fatal incident investigations conducted by the Ombudsman's office focus on the circumstances surrounding the end of one person's life. Since being entrusted with this responsibility in 2004, we have opened over 1,000 investigations into the deaths of prisoners, immigration detainees, and the residents of National Offender Management Service (NOMS) probation approved premises. This is the first paper published by my office to begin to draw collective lessons based on a number of cases. It will be followed by others, likewise identifying collective learning.

This particular paper reviews the fatal incident reports on the deaths of 160 prisoners that I finalised during the 12 months to 31st August 2009. It illustrates the cases we investigate, the issues we encounter and the recommendations we make. The paper also draws attention to some very good things the Prison Service is now doing, particularly in the area of family liaison.

In the coming months, my research team will concentrate on the mental and physical health concerns that have arisen from our investigations. I envisage that their research findings will become more and more central to the Ombudsman's annual reports in the years to come.

I would like to thank my colleagues David Ryan-Mills and Sue Gauge for preparing this report. David's position as research officer is funded by the Department of Health, whose support I should also like publicly to acknowledge.

Stephen Shaw CBE
Prisons and Probation Ombudsman

Fatal incident investigations

The Prisons and Probation Ombudsman's fatal incidents team investigate deaths of prisoners, the deaths of residents of probation approved premises, and the deaths of those held in immigration removal centres or subject to managed escort. At the Ombudsman's discretion, we also investigate the deaths of those who have been released from custody or detention, whether temporarily or permanently, where the case raises issues about the care provided. We have also investigated deaths in the Channel Islands at the request of the authorities there.

Figure 1 provides a summary of all deaths investigated since the fatal incidents team's inception in 2004.

Over 90 per cent of our investigations have been into prisoner deaths, with 968 investigations opened.

Our investigation reports are issued to the bereaved families, to HM Coroners, to the services in remit, and to the relevant Primary Care Trust and more recently the National Patient Safety Agency. The reports are anonymised and published on the PPO website after the inquest. This paper provides a review of the 160 reports on deaths of prisoners that were published in the 12 months to 31st August 2009.

Figure 1
All PPO Investigations since 2004

	Prisons	Approved premises	Discretionary	Immigration removal centres	Secure training centres	Total
Natural Causes	510	34	3	2	0	**549**
Self-Inflicted	407	19	4	6	1	**437**
Illicit Drug Overdose	22	23	2	0	0	**47**
Unclassified	15	1	3	0	0	**19**
Homicide or Attack	11	1	0	0	0	**12**
Accidental	3	1	0	0	0	**4**
Total	**968**	**79**	**12**	**8**	**1**	**1,068**[1]

[1] At 29.09.09

As investigations necessarily take different times to be completed, the final reports covered in this paper do not include all deaths over a given period. The natural causes cases covered in this paper took an average of 10 months between notification of death and report publication, and the self-inflicted and other cases took an average of 17 months. Figure 2 summarises the period in which the deaths occurred.

Figure 2:
Summary of cases - year of death

Year of Death	Natural Causes	Self-Inflicted and Other
2005	-	1
2006	-	4
2007	17	39
2008	66	23
2009	9	1
Total	**92**	**68**

This paper therefore does not provide a review of all prisoner deaths in the 12 months to 31st August 2009, but of **all 160 PPO final reports published in this period**. The reports include:

- **92** investigations into deaths from natural causes
- **65** investigations into apparently self-inflicted deaths
- **2** investigations where the cause of death has yet to be classified
- **1** investigation into an illicit drug overdose.

Self-inflicted deaths in prison

We reported on 65 prison deaths that were apparently self-inflicted. They included:

- **60** men and **5** women
- **26** first-time prisoners (40 per cent)
- **13** Black or Minority Ethnic prisoners (20 per cent)
- **16** Foreign National prisoners (25 per cent)
- **21** prisoners with dependent children (32 per cent)
- **15** who had held Rule 45 (vulnerable prisoner) status (23 per cent)
- **7** prisoners with a recorded family history of suicide (11 per cent)
- An average age of **35** years, ranging from **15** years to **63** years.

Although a direct comparison of the demographic profile of the deaths with that of the wider prison population would be premature given the size of the data set, in the period in question some groups were over-represented. In particular, foreign nationals and prisoners who had held Rule 45 status for their own protection (whose offences can often be indicative of a risk of self-harm or suicide) accounted for significant proportions of our caseload.

It should be noted that there was a spike in the number of foreign national prisoners who took their lives in 2007 (23, as opposed to six in 2006) which has contributed to the high proportion of foreign national deaths included in this analysis.

Location

Forty five of the 65 self-inflicted deaths were in local prisons, **seven** in category B or C training prisons, **five** in female prisons, **four** in the high security estate and **four** in young offender institutions. All deaths (or incidents leading to death) bar one occurred in a cell as opposed to a communal area, although the location of the cell did vary:

- **43** prisoners were on normal location
- **11** were in vulnerable prisoner wings or house blocks
- **4** were in segregation units
- **3** were in in-patient healthcare units

- **2** were in first-night centres and **1** was in a therapeutic community.

We are pleased to record that no self-inflicted deaths occurred in 'safer cells' (cells from which potential ligature points have, as far as possible, been removed).

Method

All but four of the 65 self-inflicted deaths were by hanging, with bed sheets the most common ligature and windows / window bars the most common ligature points. We reported on:

- **61** deaths from hanging (94 per cent), **2** from smoke inhalation / arson, **1** from electrocution and **1** from cutting

- **50** with bed sheets as a ligature (82 per cent), and **4** with shoelaces. Other ligatures used included towels, postage sacks and clothing

- **30** used windows / window bars as ligature points (49 per cent), and **11** used beds / other furniture. Other ligature points included sinks, doors, and light fittings.

Latency

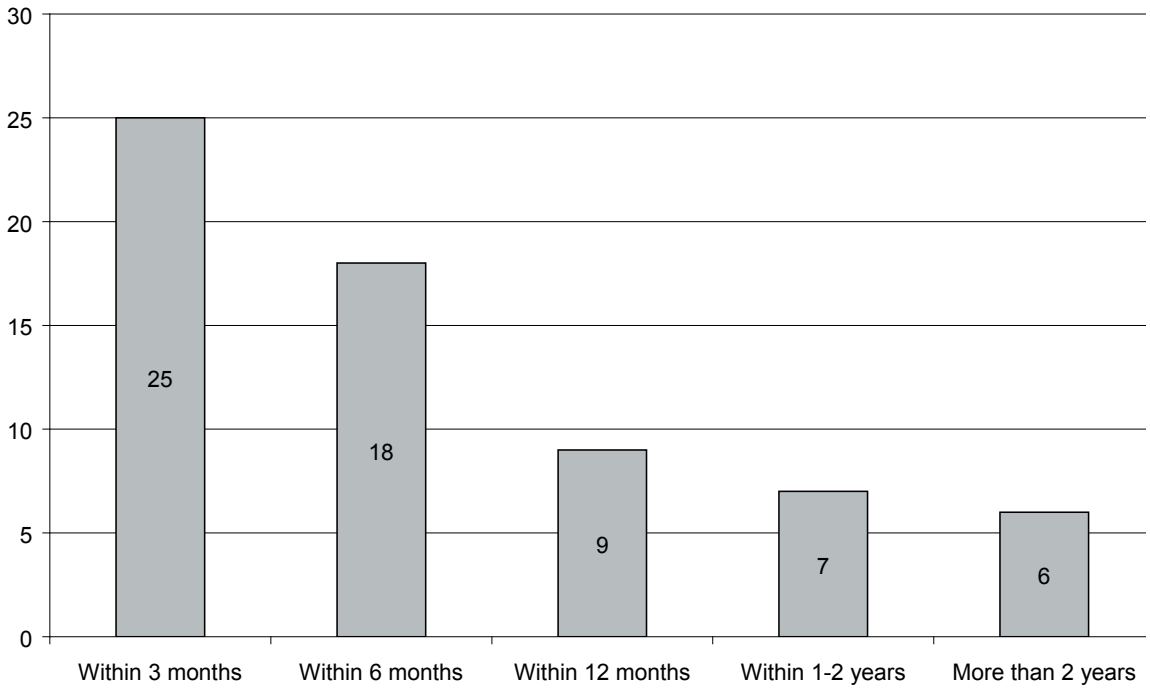
NOMS guidance acknowledges that the risk of suicide in prisoners is greatest in the first few weeks of custody:

PSO 2700 (Para 4.1.1)
"Remand and the early period of custody is a time of high risk of suicide and self-harm for the majority of prisoners. It is important to have reception, first night, clinical substance misuse management and induction procedures that provide opportunities to identify and care for those at heightened risk."

The Ombudsman has commented on the success of more appropriate detoxification processes and better first night and induction procedures in recent years. Nevertheless, **11 of the 65** self inflicted deaths reported on were of prisoners who took their lives within ten days of arrival from court.

Figure 3 plots the time spent in prison in one continuous period of custody amongst the 65 self-inflicted deaths reported upon.

Figure 3:
Months in custody before self-inflicted death



Whilst deaths were most common in the first three months of custody, **25** (38 per cent), significant proportions occurred at a later period of sentence or remand: between three and six months there were **18** (28 per cent), six and 12 months **nine** (14 per cent), and **13** prisoners (20 per cent) took their lives having spent more than a year in custody, one in five of the deaths reported on in this period. Whilst risk is concentrated amongst newly arrived prisoners, it should be remembered that no group of prisoners is entirely free from risk.

Status

The **65** self-inflicted deaths included:

- **32** remand prisoners (49 per cent) including **5** prisoners convicted and awaiting sentence
- **7** serving indeterminate sentences for public protection (IPP)
- **6** serving life sentences
- **15** (23 per cent) serving a determinate sentence of less than two years, and **5** a determinate sentence of more than two years
- **12** prisoners (18 per cent) who were due for release in six months or less.

The figures reinforce the point that, whilst being held on remand or having received a lengthy and/or indeterminate sentence can both indicate risk, no group of prisoners can be considered entirely 'safe'.

A significant number of prisoners whose deaths we investigated had received shorter, determinate sentences (**15** cases), or had relatively little time left to serve (**12** cases).

More than ten years on, this is a reminder of the continued relevance of the thematic study by the former Chief Inspector of Prisons, Sir David Ramsbotham: *"Suicide is Everyone's Concern"* published - 1999.

Offence

The self-inflicted deaths reported on occurred amongst prisoners convicted or charged with a range of offences, the majority being either violent or sexual. We reported on the self-inflicted deaths of:

- **13** prisoners convicted or charged with offences against the person (20 per cent)
- **13** prisoners convicted or charged with homicide (20 per cent)
- **11** prisoners convicted or charged with sexual offences (17 per cent)
- **7** prisoners convicted or charged with theft and handling (11 per cent)
- **5** prisoners convicted or charged with criminal damage (8 per cent).

NOMS guidance acknowledges that those charged with homicide are a particularly high risk group, and that those charged with homicide against a family member are at an exceptionally high risk of suicide (PSO 2700, Para. 4.10.1). This increased risk of suicide amongst those charged with or convicted of domestic homicide or abuse is evidenced to some extent in the reports studied: **seven** prisoners had been convicted or charged with domestic homicide and **seven** with domestic violence and/or domestic sexual abuse.

Self-harm and attempted suicide history

We have seen how demographic factors, time spent in prison, sentencing and offence type can help identify risk of suicide. There are health issues to be considered too, with concerns about the mental health of the prisoners noted by prison staff in over three-quarters of the cases.

However, the most common indicators of risk that need to be noted by those managing an

"In over half of all reports, the deceased had a history of self-harm at some time, whether in prison custody or in the community"

individual in prison are previous episodes of deliberate self-harm or attempted suicide:

- **38 of the 65** had reported a history of deliberate self-harm at reception into their final establishment (58 per cent)

- **27** of these reported having deliberately self-harmed in the previous twelve months: **17** whilst in custody and **10** whilst in the community

- **14 of the 65** had a documented history of self-harm whilst in their final establishment.

In over half of all reports, the deceased had a history of self-harm at some time, whether in prison custody or in the community, with the majority of these having self-harmed in the previous 12 months. Individual instances of self-harm whilst in custody are difficult to document accurately and often depend on severity. Fewer than half of those who had self-harmed prior to reception went on to self-harm in their final establishment.

The same applies when the prisoners' history of attempted suicide is considered:

- **24 of the 65** had a history reported of attempted suicide prior to reception into their final establishment (37 per cent)

- **17** of these reported having attempted suicide in the previous twelve months: **10** whilst in custody and **7** whilst in the community

- **8 of the 65** had a documented history of attempted suicide in their final establishment.

Assessment, care in custody and teamwork (ACCT)

The introduction of the Assessment, Care in Custody and Teamwork (ACCT) process, a multi-disciplinary approach to reduce self-harm and suicide in prisons, has helped care for the most vulnerable of prisoners. In his 2008-2009 annual report, the Ombudsman observed that, when done well, ACCT is a 'world-class' system. The process involves identifying those at risk of self-harm or suicide, and case managers working with them using a range of available resources (e.g. Samaritan trained 'Listeners', healthcare staff and the chaplaincy) to help resolve or manage periods of crisis. Prisoners are initially assessed and are then subject to more frequent observation. ACCTs are reviewed by panels consisting of representatives from the agencies involved as well as the prisoners themselves.

29 of the 65 prisoners reported on were not on an ACCT at any time. Investigation suggested that this was wholly appropriate in the majority of cases: if a prisoner gives no outward indication to staff that they should be subject to such monitoring and support then opening an ACCT document is not justified.

Over half (36) of the 65 were on an ACCT document at some time whilst in their final establishment. Of these:

- **3** transferred into their final establishment on an open ACCT, **10** had an ACCT opened at reception and **23** at a later time

- **23** had an ACCT opened once (35 per cent), **9** between two and five times, **2** between six and ten times, and **2** on more than ten occasions.

In other words, over half of the self-inflicted deaths investigated were of those who had been identified at some time as 'at risk' by prison staff.

Deaths whilst on an open ACCT

One quarter (16) of the 65 self-inflicted deaths reported on were of prisoners on an open ACCT at the time of death. These deaths were often of those who were the most difficult to manage, and in **six** of these cases we found no notable weaknesses with the ACCT process.

In the **ten** cases where concerns were expressed, two shortcomings were the frequency or predictability of observation (in **four** cases) and the absence of healthcare or mental health staff at some case reviews (also in **four** cases). Where the latter concern was raised, recommendations to the effect of the following were made:

PPO Recommendation
The Governor should remind staff that it is good practice for ACCT case reviews to be multidisciplinary and include key people who know the person at risk or are involved in his care.

Post-closure reviews

NOMS guidance notes the importance of scheduling and holding case reviews following the closure of an ACCT document:

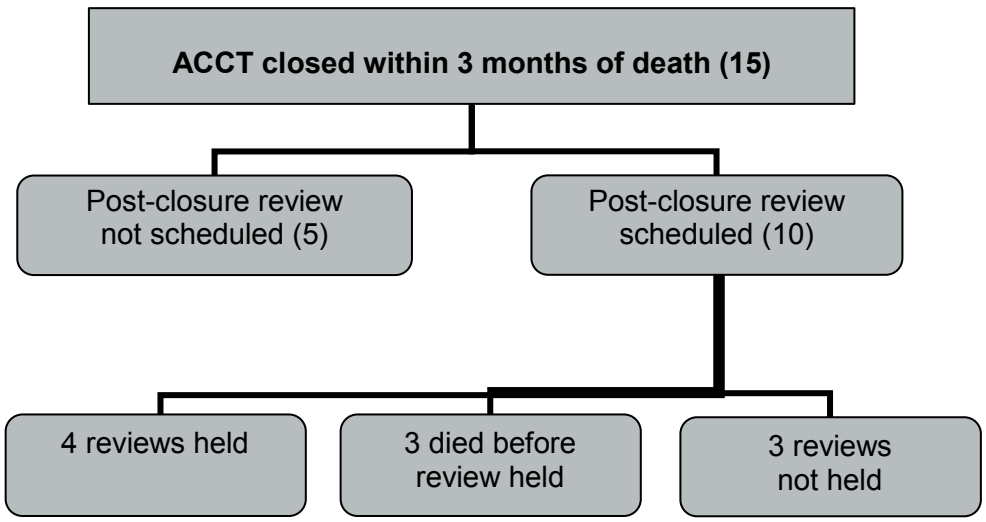
PSO 2700 (Para. 1.10.3)
"Unit Managers must adhere to the local system of post-closure monitoring, and review each closed case at least once after closure of the ACCT Plan (or as stipulated in the record of the closing case review)"

However, of the **15** prisoners who had ACCT documents closed within three months of death, only **ten** had ACCT post closure reviews scheduled. Of the **ten** reviews scheduled, only **four** were held as scheduled, **three** were not held, and **three** prisoners took their lives in the intervening period between ACCT closure and post-closure review. Figure 4 provides a summary.

We have made **seven** recommendations to different establishments reminding Governors and staff of their responsibility to schedule, hold and document ACCT post-closure reviews.

PPO Recommendation
The Governor should ensure that all prisoners on ACCT plans have at least one post-closure interview as required by PSO 2700.

Figure 4
ACCT post-closure reviews



Deaths from natural causes in prison

The majority of investigation reports published in this 12 month period covered deaths resulting from natural causes **(92 of all 160 reports)**. Individual reports can focus on themes ranging from equity of care and symptom management (using the clinical review as evidence), to communication between prison staff and outside hospitals, issues of compassion and dignity, and emergency response and family liaison.

The **92** deaths in prison from natural causes included:

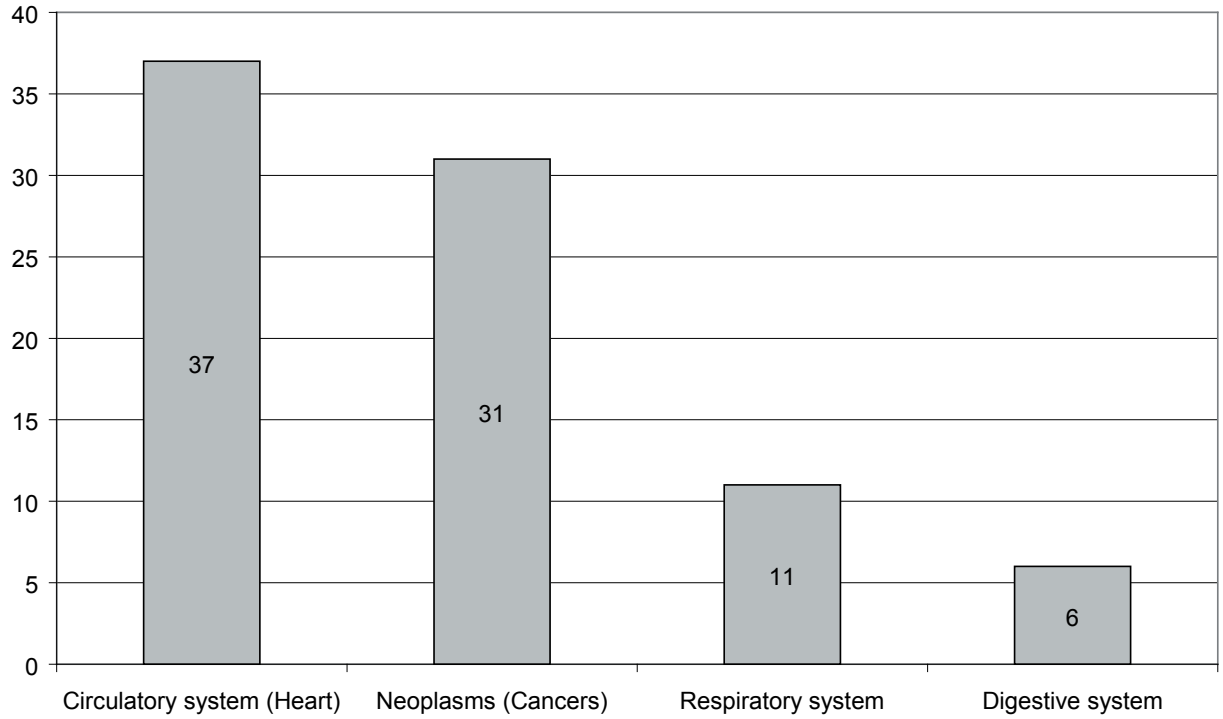
- **90** men and **2** women
- **23** deaths in normal accommodation (25 per cent) and **2** deaths in communal areas
- **52** deaths in outside hospitals (57 per cent), **9** deaths in prison healthcare (10 per cent) and **5** deaths in outside hospices / nursing homes (5 per cent)
- **40** deaths of those charged or convicted with sexual offences (43 per cent), **19** with homicide (21 per cent) and **14** with serious drugs offences (15 per cent)
- **24** deaths of those sentenced to life or to an indeterminate sentence for public protection (IPP) (26 per cent), **18** prisoners serving a determinate sentence of 4-10 years (20 per cent), and **15** serving determinate sentences in excess of 10 years (16 per cent).
- **7** foreign national prisoners (8 per cent)
- An average age of **55 years**, ranging from **24** to **81 years**.

The average age at death from natural causes (on the basis of 12 months reports) is significantly lower than that in the community. However, this should be understood in the context of the proportion of the prison population aged over 65 years being very low, at less than two per cent. There has, nevertheless, been a slight rise in the number of elderly prisoners in recent years, as a result of conviction and sentencing patterns. Should this continue, it is reasonable to assume that the average age of prisoners whose deaths we investigate will follow in a similar direction in the years to come.

Cause of death

We have reported on deaths from a range of causes, including heart attacks, asthma, liver failure, meningitis and many forms of cancer; these have been categorised by primary cause of death using the International Classification of Disease (ICD10).

Figure 5
Natural cause death investigations – most common causes of death



The most common causes of death were diseases of the circulatory system from which **40 per cent** had died, followed by neoplasms (cancers, **34 per cent**) and respiratory diseases (**12 per cent**).

The average age at death from circulatory (heart) diseases was **53 years**, with the youngest aged **24 years** (biventricular failure) and the oldest aged **81 years** (cardio-respiratory failure and ischaemic heart disease). Some **11** deaths from circulatory diseases were of prisoners under the age of **45 years**, over half of all natural cause deaths in that age group. Whilst only **two** of the **37** deaths from heart disease were described by investigators as reasonably foreseeable, known risk factors such as obesity, lack of exercise and smoking were often involved. It should be noted that smoking cessation clinics are now embedded in many prisons, although when offered they can be met by refusal. Individual establishments may also run healthy living courses, although exercise and diet regimes may warrant further exploration with the prevalence of premature deaths from circulatory diseases in mind.

Deaths from certain types of cancer were more likely to be reasonably foreseeable, with palliative care plans in place for **24** of the **31**. The average age of this group was nearer to **59 years**.

Dignity and restraint

A recurring theme in the reports studied was the use and level of restraint upon terminally ill and dying prisoners in outside hospitals. In the cases studied, restraints were used during final inpatient stays on **29 out of 52** occasions. The Ombudsman judged that the levels of restraint were both appropriate and proportionate to risk in the majority of these, although concerns were expressed in one in five cases.

Restraints were removed more than 24 hours before death in **19** cases but there were five cases where the restraints were removed less than five hours before death. The Ombudsman understands why decision-making has become risk-averse, but considers that there are many

occasions when earlier decisions to remove restraints would be more consistent with the Prison Service's own 'decency' agenda.

Release on temporary licence and compassionate release

Should a prisoner be taken ill, release on temporary licence can be sought on medical grounds for in-patient stays in outside hospices and hospitals. The decision whether to release on medical grounds is a local one made by Governors. We reported on **seven** cases where prisoners died free from supervision in outside hospices and hospitals on temporary licence.

As an alternative to release on temporary licence, a terminally ill prisoner can be considered for compassionate release. Prison Service Order (PSO) 6000 suggests that a life expectancy of three months or less would be sufficient for compassionate release to be considered, providing other criteria (e.g. reduced risk of re-offending, a suitable release address) can be met. Applications are referred to the Secretary of State. Should compassionate release be granted, the Ombudsman can (at his discretion) investigate the care provided whilst the deceased was in custody.

We published **two** discretionary investigations into deaths following compassionate release, although we reported on a further **nine** cases where applications were considered. All but one of these applicants were prisoners suffering from an aggressive and debilitating cancer. PPO investigators reported that an application should have been made in **one** further case, and **one** investigation found that the application was handled inappropriately by the prison. Whilst **five** of these applications were refused, **four** were still being considered at the time of death.

It is wholly accepted that compassionate release is not appropriate in every case (indeed not every prisoner wishes to be released), and that the Secretary of State will exercise the power with great care. However, the condition of terminally ill prisoners can deteriorate rapidly, and the process needs to be started in a timely manner. We made recommendations to this effect on **four** occasions.

PPO Recommendation
The Governor should ensure that, when prisoners have indicated they wish to apply for early release on compassionate grounds, the process is started as soon as it is known that a prisoner is terminally ill so that arrangements are in place for a speedy release.

Furthermore, terminally ill prisoners should always be given the opportunity to apply for release.

Family liaison

The Ombudsman's reports have acknowledged the strides the Prison Service has taken to improve communication with the families of the deceased. This includes the notification of death through to providing financial assistance for funerals. The Ombudsman recommended formal commendations for **eight** family liaison officers who demonstrated special professionalism, perseverance and commitment in their actions:

I congratulate the Governor's secretary, who acted as Family Liaison Officer, for tracing and breaking the news of X's death within three and a half hours of death being pronounced despite the immense difficulties she encountered.

Similarly, local practices and policies in the area of family liaison were also identified by the Ombudsman as good practice, both formally and informally:

I commend the use of the family liaison booklet as good practice as it gives the family a great deal of helpful information in a very accessible way. The prison were clear from the beginning with X's family about the amount they would contribute to funeral expenses. This saved the family financial worry at a sensitive time. I wish other prisons were so open and highlight this as good practice that could be used to encourage learning elsewhere.

It is noted that funeral expenses were properly offered in all but **two** of 160 instances (with both prisons concerned attributing this to administrative error).

Recording and maintaining up-to-date next of kin records

Nevertheless, the quality of family liaison is often let down by a commonly criticised area of prison work: that of simple record keeping.

In the **160** reports published in the 12 months to 1st September 2009, we reported on **20** incidences where correct and up-to-date next of kin records were not held by the prison at the time of death.

Whilst there can be difficulties in obtaining correct next of kin details from prisoners (indeed, **five** prisoners offered false or unsuitable next of kin at reception), this is still disappointing, and often leads to unnecessary delays in notification. Given that over half of the self-inflicted deaths covered here occurred within three months of reception into their final

establishment, and a significant proportion of natural cause deaths were reasonably foreseeable, it could be argued that in many cases there was little excuse for not holding up-to-date records. We made **five** recommendations to the effect that next of kin records should be recorded accurately at reception and throughout a prisoner's sentence.

PPO Recommendation
I recommend that the Governor ensures the accuracy of every prisoner's next of kin details and puts in place an annual check of these details.

Informing the family of the death

Supplementary guidance to chapter 4 of PSO 2710 (follow up to deaths in custody) provides useful information as to the actions to take and risks to consider when undertaking the difficult task of informing family of a death in prison. Whilst investigation reports have acknowledged the good practice of many prisons in this area, there have been occasions where guidance has not been followed as effectively. We expressed concern with the way in which bad news was broken in **15** (9 per cent) of the 160 cases.

This is not to suggest that news was delivered inappropriately or with a lack of compassion. Rather, there have been concerns over when, by whom, and by what method the news was delivered. Whilst it is standard practice to inform the next of kin of serious in-patient admissions by telephone, breaking the news of a death should only be done in this way as a last resort. Concerns were raised over the use of the telephone in **four** cases where investigation suggested all other methods had not been exhausted.

We also reported on **16** cases where the news of death was delivered by a police officer (one in every ten cases), when ideally it should be a member of the Prison Service. We have also noted inadequate contingency plans in prisons to cover situations when (due to the family's distance from the deceased) next of kin cannot be informed by prison staff, and delays are caused by the involvement of other prisons and local police. Formal recommendations were issued to this effect in **eight** of these cases.

PPO Recommendation
The Governor should ensure that, where possible, the news of a death in custody is broken to the next of kin by a member of prison staff face to face and at the earliest opportunity in accordance with national instructions.

Contact us

For further information on this paper and future PPO fatal incident research please contact:

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