

07 February 2025

Reference: FOI 601 Freedom of Information request

Thank you for your email, which we received on 3 January 2025. Your request has been handled under the Freedom of Information Act 2000.

You asked us:

To provide the number of self-inflicted deaths recorded in prisons (broken down by prison) for each of the past six years from 2019 to 2024.

Our response:

In accordance with section 17 of the Freedom of Information Act, this letter acts as a refusal notice. The absolute exemption is described below. In applying this exemption, we do not have to apply a public interest test to the disclosure of this information.

The exemption applied (under the Freedom of Information Act) is:

- Section 21 (1) 'Information accessible by other means'

This exemption applies because the PPO's annual report data tables will provide this information. These are available on the PPO website and can be found using the links below:

https://ppo.gov.uk/corporate_document/annual-report-2019-20/

https://ppo.gov.uk/corporate_document/annual-report-2020-21/

https://ppo.gov.uk/corporate_document/annual-report-2021-22/

https://ppo.gov.uk/corporate_document/annual-report-2022-23/

https://ppo.gov.uk/corporate_document/annual-report-2023-24/

However, these annual reports tables do not include the full calendar years for 2019 and 2024, as they focus on financial years rather than calendar years. For data beyond these periods, please refer to the tables below, which show the number of self-inflicted deaths from 1 January to 31 March 2019 and from 1 April to 31 December 2024, categorised by prison establishment.

Number of Self-Inflicted Deaths from 1 January to 31 March 2019

Establishment	Number of SIDs
Aylesbury	1
Bullingdon	1
Doncaster	1
Durham	3
Garth	1
Leicester	1
Lewes	1
Lindholme	1
Long Lartin	1
Manchester	1
Stocken	1
Styal	1
Winchester	1
Woodhill	1
Wormwood Scrubs	1
Total	17

Number of Self-Inflicted Deaths (SIDs) from 1 April to 31 December 2024

Establishment	Number of SIDs
Altcourse	3
Belmarsh	2
Birmingham	2
Brixton	1
Bullingdon	1
Cardiff	1
Chelmsford	1
Doncaster	1
Dovegate	1
Drake Hall	1
Durham	2
Elmley	1
Erlestoke	1
Exeter	3
Forest Bank	2
Fosse Way	1
Frankland	1
Garth	3
Guys Marsh	1

Establishment	Number of SIDs
Hewell	1
Holme House	1
Hull	1
Humber	1
Isle of Wight	1
Leeds	5
Lincoln	1
Liverpool	1
Long Lartin	2
Manchester	2
Moorland Closed	1
Northumberland	1
Norwich	1
Parc	2
Pentonville	1
Preston	1
Ranby	1
Standford Hill	1
Styal	2
Swaleside	2
The Mount	1
The Verne	1
Wakefield	1
Wandsworth	1
Warren Hill	1
Wayland	1
Wealstun	1
Wymott	2
Total	67

You asked us:

Between 2019 and 2024, how many self-inflicted deaths were found by the clinical reviewer not to have received a standard of healthcare or mental healthcare equivalent to that which they would receive in the community.

After being informed that your request for information would not be processed, as it the costs of locating and retrieving the information exceeds the 'appropriate limit' as stated in the Freedom of Information (Fees and Appropriate Limit) Regulations 2004, you refined your request to the between 2020 to 2023.

Our response:

We have searched our records and we hold the requested information on the above question.

A copy of the information that you requested is shown below. The information below includes cases that we were notified of between 1 January 2020 and 31 December 2023 that also have an initial report or clinical review, as this is where the information is held.

Therefore, any cases that did not have an initial report or clinical review will not be included.

The number of cases we had been notified of that had an initial report or clinical review were 234, but one case was discarded as it was determined that the death did not occur within a prison setting and so no evaluations of equivalency could be made. Therefore, we have provided the clinical review conclusions for 233 cases.

The first table presents the overall standard of care, considering mental health, physical health, and general clinical care. A 'yes' indicates that the reviewer found both mental and physical healthcare to be equivalent to community standards or specified only one form of care and deemed it equivalent. A 'no' means that neither form of care met the threshold of equivalency, or if only one type was evaluated by the reviewer, it was found to be insufficient.

The overall standard of care was equivalent to that which would have been received in the community	Total
Yes	131
No	35
Partially	66
Unable to make a meaningful comparison	1
Total	233

The 66 cases deemed partially equivalent had varying reasons for this conclusion. Please refer to the second table below for more detailed information regarding what areas of care were found to be insufficient. 'Overall Clinical Care' here refers to cases where the clinical care was partially equivalent, but no specific area was given.

Type of care where issues were identified in partially equivalent cases	Total
Overall Clinical Care	15
Mental Health	45
Physical Health	4
Mental Health and Physical Health	2
Total	66

I hope that this is helpful.

You have the right to appeal against our response if you think it is incorrect. Details can be found in the 'How to Appeal' section attached at the end of this letter.

[REDACTED]

The Prisons and Probation Ombudsman (PPO) carries out **independent investigations** into complaints and deaths in custody. The detailed role and responsibilities of the PPO are set out in our office's Terms of Reference. The PPO has three main duties:

- to **investigate complaints** made by prisoners, young people in detention (prisons and secure training centres), offenders under probation supervision and individuals detained under immigration powers (detained individuals)
- to **investigate deaths** of prisoners, young people in detention, approved premises' residents and detained individuals due to any cause, including any apparent suicides and natural causes
- to **investigate deaths of recently released prisoners** that occur within 14 days of release from prison (except homicide)

The purpose of these investigations is **to understand what happened, to correct injustices** and **to identify learning** for the organisations whose actions we oversee so that the PPO makes a significant contribution to safer, fairer custody and offender supervision.

We may use or share your data only to the necessary extent when conducting our independent investigations in the exercise of our official authority. We will share your data with third parties (e.g. the prison) in order to make sure the information is accurate; to prevent or detect failings; and to identify lessons learnt. We may sometimes need to share your data with third parties if required by law. We only keep your personal data for as long as it is needed, as set out in our data retention policy. If you need any further information about how your data is used, please contact us.

How to Appeal

Internal Review

If you are not satisfied with this response, you have the right to an internal review. The handling of your request will be looked at by someone who was not responsible for the original case, and they will make a decision as to whether we answered your request correctly.

If you would like to request a review, please write or send an email to the Prisons and Probation Ombudsman's office **within two months of the date of this letter**, at the following address:

Prisons and Probation Ombudsman
Third Floor
10 South Colonnade
Canary Wharf
London
E14 4PU
E-mail: Mail@ppo.gov.uk

Information Commissioner's Office (ICO)

If you remain dissatisfied after an internal review decision, you have the right to apply to the Information Commissioner's Office. The Commissioner is an independent regulator who has the power to direct us to respond to your request differently, if he considers that we have handled it incorrectly.

You can contact the ICO at the following address:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Internet address: <https://ico.org.uk/>