Prisons & Probation Ombudsman
Independent Investigations

March 2026

Learning lessons bulletin

Fatal incident investigations | Issue 22

Self-inflicted deaths in reception prisons

Foreword

This learning lessons bulletin summarises research from Prisons and Probation Ombudsman (PPO) investigations into the self-inflicted deaths of prisoners in reception prisons over the past five years. Our research highlights the importance of early days in reception prisons and of staff identifying and managing prisoner's risk during this time. The role of staff in reception is crucial and it is important that they receive appropriate and accredited training.

Our data shows that reception prisons (whose purpose is primarily to take people from court either on remand or awaiting sentence) have one of the highest rates of self-inflicted deaths of all prison functions. As such, we were keen to analyse these deaths further. The PPO's researchers analysed 170 self-inflicted deaths from December 2020 to November 2025. This bulletin highlights the repeat issues found within the investigations we looked at.

Our analysis shows that reception prisons present a high-risk environment for self-inflicted deaths. This is likely due to the high levels of churn (the number of prisoners arriving and leaving in a given timeframe) and the vulnerability of prisoners who are entering custody. Most prisoners entering these establishments are on remand or unsentenced, facing uncertainty about their future, and for some it is their first experience of prison.

In 11% of cases, self-inflicted deaths occurred within the first 48 hours of entering the reception prison and 30% in the next three weeks, highlighting the vulnerability of prisoners in the early days. This means that individuals arriving at the prison require particularly careful assessment and appropriate support to manage risk. Too often, our research found that this was not the case.

This bulletin highlights two areas: the importance of early days in reception prisons and challenges beyond early days. Despite the vulnerability of the population, 66% of the sample were not on an Assessment, Care in Custody and Teamwork (ACCT) at the time of death. Our analysis highlights the importance of assessing a prisoner's risk properly when

entering a reception prison and effective training for staff to identify and support those who are high-risk.

We believe that training for reception staff should be accredited and repeated regularly to ensure that staff working in reception have been trained properly on managing risk. This is especially important in reception prisons.

This report was prepared by the PPO's research and policy teams (Scarlet Page, Owen Gregory, Jasmine Mann, Elizabeth Smith, Rebecca Kennedy, Ioana Diac and Juliana Andrianou). I would like to thank all those who helped and participated in any way in the completion of this piece. Without their help and co-operation, this would not have been possible.

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Self-inflicted deaths in prisons

Over the five years from 2020 to 2025, self-inflicted deaths (SIDs) among prisoners in England and Wales have stayed consistently high. The World Health Organisation identifies people in prison as an 'at risk population' for suicide.[1] A person's risk can come from a variety of factors, including an individual's background and history, the regime and general environment of prisons. To better understand this, the PPO published a learning lessons bulletin in 2014, reviewing self-inflicted deaths and the individual risk factors of prisoners.[2] The bulletin explored a range of risk factors, identifying the key risks as a history of self-harm and mental health issues, committing certain offences, first time in prison, being on remand, receiving upsetting news and substance use.

Different prison functions hold different populations; the regimes and day-to-day life look completely different and, as such, the risks within all of them will be unique to that environment. For example, those in Long-Term High Security Estate prisons are more likely to have received a life sentence and those in reception prisons are more likely to be on remand. Both are risk factors for self-inflicted deaths but need to be managed differently. There is a difference in the rate of SIDs across prison functions and it is important for HMPPS to understand the difference and to manage risk as effectively as possible.

Reception prisons

Reception prisons (sometimes known as 'local' prisons) have a high self-inflicted death rate in comparison to the other prison functions (see Table 1). They present an especially challenging environment for staff and prisoners as they experience high levels of churn in which staff have very limited time to build rapport or conduct in-depth assessments which are vital in the early days.

A high number of prisoners will be on remand and awaiting sentencing while it may also be their first time in prison; two risk factors for suicide and self-harm identified in the PPO 2014 bulletin. It is important to understand the elevated risk this population has and the ways in which the prison service could improve its practices to lower the risk of SIDs.

1 **World Health Organization** (2000). Preventing suicide in jails and prisons. Available at: www.who.int/publications/i/item/9789241595506

2 **Prisons and Probation Ombudsman** (2014). Learning Lessons Bulletin: Risk Factors in Self-Inflicted Deaths in Prison. Available at: https://ppo.gov.uk/learning_research/learning-lessons-bulletin-risk-factors-in-self-inflicted-deaths-in-prison/

Table 1. Self-inflicted death rate by prison function – 1 December 2020 to 30 November 2025[3]

Prison function	SIDs per 1,000 prisoners
High security	7.13
Category B	8.14
Category C	2.50
Female	5.03
Open	1.32
Reception	**8.08**
Youth Custody Service Young Offenders Institution	0.00

Context and data

To understand learning from self-inflicted deaths in reception prisons, we sampled 170 PPO fatal incident investigation reports from 1 December 2020 to 30 November 2025. Our researchers thematically analysed these reports and created a questionnaire to quantify various issues identified from the thematic analysis. Of the cases, 169 prisoners were male and 1 was female. 7% of prisoners were Asian or Asian British, 5% were black or black British, 0.6% were people with a mixed ethnic background and 84% were white or white British. This is largely proportionate to the general prison population.[4]

3 Category B and high security prisons also have a high number of SIDs per 1,000 prisoners. The PPO will undertake further work to understand this risk better.

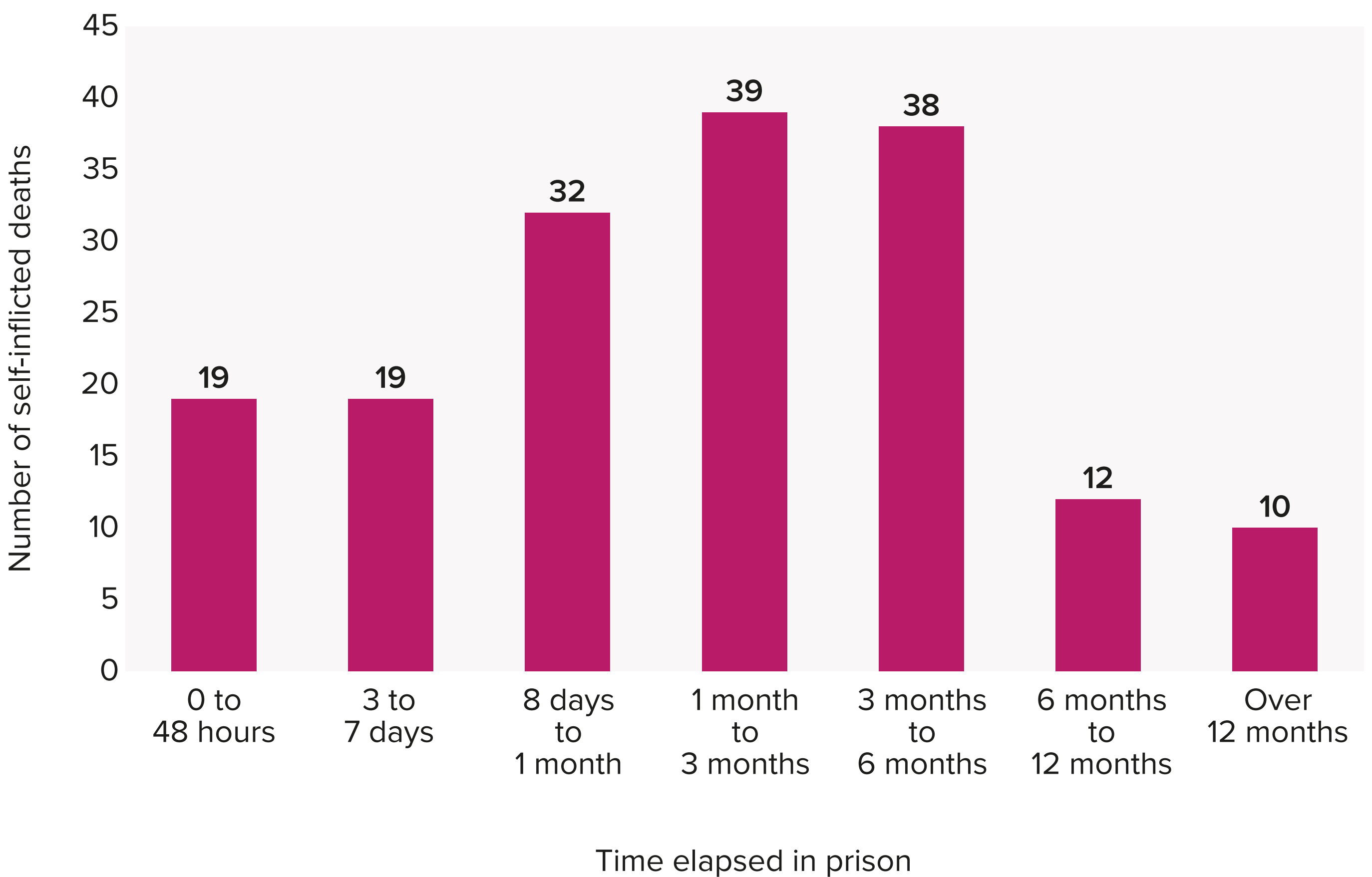
4 Ministry of Justice (2024). Ethnicity and the Criminal Justice System 2024. Available at: www.gov.uk/government/statistics/ethnicity-and-the-criminal-justice-system-2024

The importance of early days in reception prisons

The Prison Safety Policy Framework recognises that early days in custody are a known period of increased risk of suicide and self-harm. This vulnerability is especially pronounced in reception prisons, which act as the entry point into custody and hold a population predominantly made up of remanded or unsentenced prisoners. Staff have very limited time to make meaningful contact with prisoners due to high levels of churn. Therefore, meaningfully assessing each person when they enter a reception prison is crucial in identifying and supporting those posing a high risk of suicide and self-harm.

Within the sample, 11% of SIDs were found to have occurred within the first 48 hours of entering the reception prison and 30% in the next following three weeks. Therefore, 41% of all SIDs in reception prisons within our sample occurred within the first month (see Figure 1). This highlights the extreme vulnerability of prisoners in those early days in reception prisons and the importance of robust early days processes.

Figure 1. Length of time elapsed in the incident establishment before death



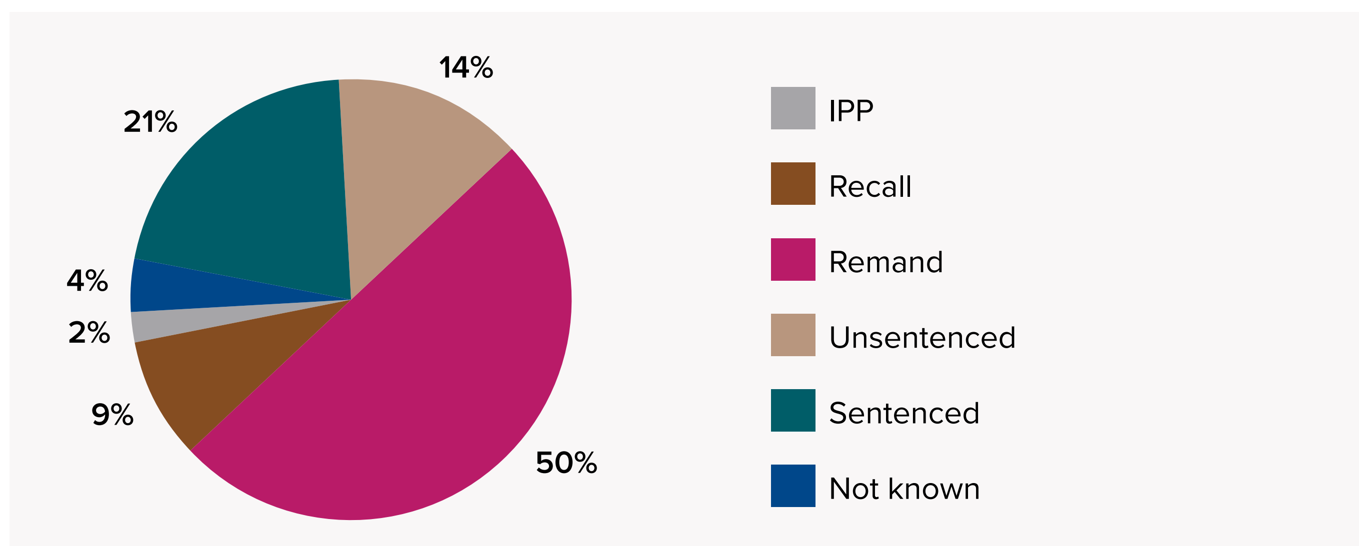
Vulnerabilities of prisoners entering custody

Prisoners arriving at reception prisons often present with a combination of vulnerabilities that heighten their risk during the early days of custody. Our bulletin in 2014 highlighted that sentence type, mental health issues and being in prison for the first time were all key risk factors for suicide and self-harm, which remains the same 12 years later.

Sentence and offence type

Our sample revealed that 64% of the population in reception prisons were individuals on remand or unsentenced (see Figure 2). Remanded and unsentenced prisoners often experience uncertainty about their future and may be anxious about upcoming hearings and court appearances. The anxiety about their future is compounded by having to adjust to an unfamiliar and challenging environment at the same time as navigating their legal situation. This is especially true for prisoners where it is their first time in prison (28% of the sample). As a result, remanded and unsentenced prisoners in reception prisons require particular attention, as the lack of sentence clarity and early-stage vulnerability place them at an increased risk of deteriorating wellbeing, suicide and self-harm.

Figure 2. Sentence type at time of death[5]



The type of criminal offence the prisoner has committed can also be a risk factor. The PPO bulletin in 2014 highlighted that committing violent offences – such as murder or violent acts against family members – was often associated with an increased risk of suicide and self-harm. Within the sample analysed for this bulletin, researchers found that in the majority of cases reviewed, the prisoner had committed a violent offence. Prisoners in reception prisons may be coming to terms with the offence they have committed as well as managing any impact this has had on their personal relationships, further increasing their vulnerability.

Mental health issues and neurodivergence

As seen across the whole prison population, our sample had high levels of mental health needs and neurodivergence, with 21% of prisoners having a known form of neurodivergence or learning difficulties. In 77% of the cases analysed, the prisoner had a prior mental health condition, 69% had a history of

5 There is some overlap in these groups as some individuals will have more than one of these sentence types.

self-harm and/or attempted suicide, and in 58% of cases, the prisoner had both a prior mental health condition and a history of self-harm and/or attempted suicide, highlighting the acute vulnerability of many prisoners entering reception prisons.

Failures in early days assessments

Given the heightened vulnerability of prisoners entering reception prisons and the increased risk within the first month, the early days process plays a critical role in identifying those at risk of suicide and self-harm and providing them with the necessary support. Reception staff are required to assess risk quickly, and they often have no prior relationship with the prisoner. This makes the role of working at reception in a reception prison particularly important because these staff members are playing a crucial role in potentially reducing the number of self-inflicted deaths.

The Prison Safety Policy Framework, which governs ACCT procedures, requires all staff to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. We found that 66% of prisoners in the cases we reviewed were not supported by an ACCT at the time of death and in 21% of cases, an ACCT was not started when the prisoner first entered the reception prison when it should have been. Key reasons for this included failures to review risk information, a lack of multidisciplinary working and an overreliance on a prisoner's presentation – all of which were most likely caused by a lack of adequate staff training.

Failures to review risk information and multidisciplinary working

Within many of the cases analysed, there was evidence that relevant risk information for individuals entering the reception prisons was not reviewed, often resulting in a missed opportunity to start an ACCT. The cases analysed provided multiple examples of where prisoners had a documented history of suicide attempts and/or self-harm, prior and ongoing mental health issues and substance use history, but information had not been reviewed by staff. There was also evidence of a lack of collaboration between prison and healthcare staff to identify and manage risk in early days assessment. This may be due to staff requiring access to multiple data sources and not having the training or IT available to do this easily.

Case study 1

Mr A was sentenced to four years and 14 days imprisonment for the acquisition, use and possession of criminal property. He had long-term physical health conditions, a history of alcohol use, and depression, for which he was prescribed medication.

Mr A arrived at the reception prison with a suicide and self-harm (SASH) warning form on his digital and paper person escort record (PER).

The nurse who completed Mr A's reception healthcare screening did not see Mr A's PER or SASH warning form because she did not have access to them. However, the officer who conducted Mr A's first night reception interview did have access but did not pass this information on to the nurse, as was policy at the time. For reasons unknown, the prison officer conducting Mr A's first night reception interview did not consult the details on his PER and SASH warning form and decided not to open an ACCT, despite Mr A's significant risk factors. Consequently, an opportunity to put in place early support for Mr A's mental health was missed. Mr A took his life 11 days later.

This case shows how important it is that healthcare and prison staff work collaboratively in reception to review all sources of risk information properly and share their concerns with each other.

Overreliance on a prisoner's presentation

When assessing a prisoner's risk of suicide and self-harm on arrival to a reception prison, we found several examples of staff basing their decisions primarily on how a prisoner was presenting rather than on an objective assessment of their known risk factors using documentation such as medical records, the PER, or SASH warning forms. This is an issue that the PPO recurringly finds within its investigations.

In some cases, prisoners who denied any current thoughts of suicide or self-harm were assessed as low risk, despite clear evidence in the accompanying documents indicating otherwise. This meant that individuals who should have been placed on an ACCT were not, leaving them without the monitoring and support that may have reduced their vulnerability during this critical period.

Case study 2

Mr B was remanded into custody charged with robbery. He had a history of suicidal behaviour and had been supported through ACCT during a previous sentence at the same prison.

Before his arrival, Mr B's probation officer emailed the prison asking for an ACCT to be opened and that Mr B be monitored closely due to his mental health and risk of self-harm. A court Liaison and Diversion nurse rang the prison's reception department expressing similar concerns. His PER contained a warning that he had taken an overdose a month before entering custody.

Despite these known risk factors, the nurse conducting Mr B's initial health assessment decided not to start ACCT monitoring because of his presentation. She said that Mr B denied any current thoughts of suicide or self-harm, appeared to be in a good mood and was dancing in the reception area. Two days later, staff started ACCT procedures after Mr B was found with a ligature around his neck. He died less than a month later.

A prisoner's presentation, particularly in the early days in a reception prison, is not a reliable indicator of underlying risk. Information from external agencies and documented records is essential to forming a fuller understanding of a prisoner's vulnerability. Where all available information is considered at the point of arrival, it increases the opportunity for early support and safeguards to be put in place, even when a prisoner outwardly appears stable.

The inherent nature of reception prisons means that the initial reception process is vital; staff carry a significant weight of responsibility in identifying and managing risk in the early days. It is important that staff are offered the right support and training to be able to identify these risks and start ACCT processes where appropriate.

Communication and engagement in early days

For individuals experiencing prison for the first time that are on remand, unsentenced or are already coping with complex mental health needs, effective communication and engagement in the early days is critical. When prisoners are unable to communicate their needs due to language difficulties, or when they cannot contact family to seek emotional support, their feelings of anxiety can intensify. These early days are when protective factors, such as relationships with family and friends, are most needed and when their absence is most keenly felt.

Interpretation services

The Prison Safety Policy Framework states that staff must use interpretation services when interacting with prisoners whose first language is not English. In the context of engagement and contact, interpreters are fundamental to enabling communication; these services allow prisoners with limited English skills to communicate their feelings, vulnerabilities and urgent needs within the early days. When considering suicide and self-harm prevention, interpreters are a vital safeguard that can help to ensure timely intervention for those at risk.

In 8% of cases reviewed, we found issues with the use of interpretation services. In several cases, staff used other prisoners to interpret, something the Prison Safety Policy Framework explicitly states should not happen, as it breaks confidentiality and potentially increases the risk of bullying or coercion.

Family contact and access to phones

Contact with family and friends is one of the most important protective factors during the early days of custody. For many people entering a reception prison, this is a moment of fear, uncertainty and emotional shock. In the early days in a reception prison, where staff have very limited time to build rapport or understand a prisoner's emotional state, access to family contact becomes even more critical as an additional source of support and stability. Some prisoners faced administrative issues that prevented them from being able to contact their friends or family, and in our view, these situations could have been avoided.

In 7% of the cases analysed, there were issues with the prisoner's prison phone account, preventing the prisoner from having contact with their support network leading up to their death. Some prisoners were unable to contact family who lived abroad due to problems getting approval for foreign numbers. In other cases, phone numbers were entered incorrectly in the system and, despite prisoners complaining about this, staff took no action to investigate and rectify the mistake. There were also examples where the prisoner had run out of phone credit and in times of distress, could not access family support when needed.

Case study 3

Mr C was charged with murder and remanded in custody. He was supported under ACCT from the day he arrived at the prison until a month before his death.

Mr C was unable to make any telephone calls for nearly two weeks after he arrived due to a delay in approving his contact numbers because of staffing pressures. Mr C also struggled to access an in-cell telephone during his time at the prison. The first cell he was placed in did not have a telephone handset and he was later moved to a cell with a broken telephone socket. Mr C reported the broken telephone socket several times to both prison and healthcare staff, but it was not fixed before he died.

In Mr C's report, we said that authorising telephone numbers for someone on ACCT should not have taken so long. In response to our investigation, the prison introduced a new process to ensure that all staff within the unit know who is subject to ACCT and these prisoners are prioritised. Any issues with access to in-cell telephones should be recorded and fixed promptly to enable prisoners to have contact with their support network as and when they need it. We recognise as good practice the occasions where officers have provided prisoners without phone credit additional calls to their family when they are in moments of distress.

Challenges beyond early days

While the early days at a reception prison represent the highest period of risk, a proportion of prisoners remain in reception prisons for several months or even years. The cases in this review show that vulnerability does not end after the first few weeks, with 36% of individuals taking their life beyond spending three months at the prison.

Reception prisons are not designed to hold people for extended periods of time; their primary function is to process new arrivals and facilitate movement to longer-stay establishments. When prisoners remain in these environments for months, they continue to experience the instability, high churn and limited regime that characterises reception prisons. As a result, longer stays in reception prisons can lead to poorer outcomes, with fewer opportunities for consistent engagement, access to purposeful activity or meaningful support.

The following sections outline the key issues identified for those who remained in reception prisons beyond the initial assessment period and highlight where improvements are needed to ensure their ongoing safety.

Court dates and video links

Key dates can also be a trigger for suicide and self-harm, and it is recognised that the time around court and family court appearances is particularly difficult and may make prisoners anxious as they await information about their sentence. The reception prison population is more likely to be attending court hearings and therefore potentially be at an increased risk.

Within the cases analysed, 41% of the deaths occurred near a court hearing, highlighting the risk that this time poses. Given this heightened risk, staff should review risk following court appearances. Prison Service Order (PSO) 3050 'Ensuring continuity of healthcare for prisoners' says that events such as attending court or sentencing at court are factors that might have a significant impact on the health of a prisoner.

When prisoners pass through reception on their return, prisons are required to have protocols in place to assess risk. The Prison Safety Policy Framework says that the prisoner must be spoken to regardless of whether the court appearance was in person or by video link.

However, within our sample, in cases where a court hearing was near the time of death, 32% did not have an adequate risk assessment after the hearing. It is vital that risk is reassessed after prisoners attend hearings as they may have received news and outcomes that were difficult to handle.

Case study 4

Mr D was remanded in prison charged with burglary. It was not his first time in prison, and he had been supported by ACCT multiple times during previous sentences.

On the day he was due to be sentenced, Mr D self-harmed and refused to attend his video link court hearing. Staff started ACCT procedures. Mr D then received a call requesting he attend his court hearing. He was taken to the official visits area to attend the hearing virtually. Staff failed to take Mr D's ACCT document with him to the visits area, and they did not reassess Mr D's risk after he attended the court hearing. He received a longer than expected prison sentence and took his life later that day. As no one had checked in with Mr D following his hearing, opportunities to put in place additional support for him were missed. This is especially concerning given that Mr D was being monitored for suicide and self-harm under ACCT. Regardless of this, the prison should have followed the standard procedure to assess a prisoner whose risk may have changed after a court appearance.

As prisoners appearing by video link do not leave the prison, they are not always subject to the standard screening procedures they would receive if they had attended court in person and passed through reception when returning to the prison. The PPO has commented on this previously. It is vital that prisons ensure their staff follow the correct procedures to risk assess prisoners attending court by video link so that opportunities to put in place support for this group are not missed. This will support prisoners who are struggling with their mental health and thoughts of suicide and self-harm following court hearings (including family court) where they might have received difficult news.

Key worker schemes

Key worker schemes are an important part of HMPPS' response to self-inflicted deaths, self-harm, and violence in prisons. Key work is intended to improve safety by engaging prisoners, building better relationships between staff and prisoners, and helping prisoners settle into life in prison. Male prisoners in the closed estate should be allocated a key worker who spends an average of 45 minutes per week with the prisoner. We would expect an introduction to key work within the induction and formal sessions to begin within the first month.

Within our sample, it was apparent that many prisoners had very few or no key work sessions during their time in custody because of staff shortages or because they were not deemed to be sufficiently vulnerable to be prioritised for key work. As reception prisons are designed for accommodating prisoners before they are sentenced, many prisoners transfer quickly and some of those who died did so before a key worker could be allocated. However, for individuals who remain in a reception prison for longer periods, consistent key work becomes far more important.

For 27% of cases within the sample, researchers found there were issues with key work during prisoner's time in the reception prisons. Even where prisoners had a key worker, they often did not see the same member of staff due to staff shortages. As prisoners on remand or awaiting sentence are not expected to work or attend education, many spend a significant amount of time in their cell. For many of the prisoners, key work sessions are important opportunities to help identify changes in risk and to help support their mental health.

Poor ACCT management

For prisoners who were supported by an ACCT, the effectiveness of the process relied heavily on how well it was managed on a day-to-day basis. There were some examples of good ACCT management. However, across several of the cases reviewed, there were weaknesses in how ACCTs were managed, which meant that the level of support and oversight provided did not always meet the required standards. The issues fell broadly into two areas: checks not being carried out as frequently as required and the falsification of records, and failures in governance. These shortcomings undermined the safeguarding purpose of ACCT and contributed to missed opportunities to intervene during periods of heightened vulnerability.

Inadequate record keeping, insufficient checks and falsification of records

In the cases analysed, there was evidence that risk information was not always passed on to relevant staff which led to circumstances where prisoners were not given the support they needed.

Poor record keeping was a primary reason for this. In 50% of cases where the individual had been on ACCT during their time in prison, we found evidence of poor record keeping in ACCT documents.

A key part of ACCT is staff undertaking visual checks of the prisoner in line with the frequency set at case reviews. As the frequency is set according to the perceived risk of suicide and self-harm, it is important that staff conduct the checks as required. Keeping to these checks is an important part of the care of a prisoner on ACCT (and failure to keep to these checks may lead to a range of

consequences, including delays in identifying a prisoner has self-harmed or attempted suicide and delays in requesting emergency response). Within the analysed cases of prisoners who had been on ACCT during their most recent time in prison, 40% were found to not have had the number of checks they should have had while on ACCT for various reasons. These checks should have been prioritised.

In several cases, the number of ACCT checks documented in prison records did not correspond with the checks corroborated in CCTV footage, showing that staff had falsified records of their checks. Too often, PPO investigations find evidence of falsified ACCT checks. Following our national recommendation in 2025, the Director General of HMPPS directed Governors to introduce robust quality assurance processes to check the accuracy of recorded ACCT checks, including against available CCTV footage, so that there is not a systemic issue with false entries in their prison.

Insufficient governance

In conducting this research, we also found issues around the governance of ACCT. In several cases, there was evidence of healthcare staff not being involved in ACCT reviews. Additionally, we saw in some cases prisoners did not have a consistent case coordinator overseeing their ACCT, with responsibility instead being passed to multiple staff members. The lack of continuity made it difficult for establishments to maintain a clear understanding of a prisoner's risk which is particularly important in reception prisons where prisoners are at increased risk. In many cases we also found that staff were not sufficiently trained on ACCT. Cumulatively, these issues meant that often, even where a prisoner was on ACCT, their risk was not managed properly.

Lessons to be learned

Governors and Heads of Healthcare should ensure staff working in reception understand the increased risk of prisoners in early days in reception prisons, receive appropriate accredited training to manage this risk, and are organisationally valued.

Governors and Heads of Healthcare should ensure that:

- staff in reception work collaboratively and are supported in this by appropriate technology
- all information is reviewed, and assessment of risk is based on a holistic review of all available evidence
- access to external sources of support is prioritised by the effective management of prisoner phone accounts

About the data

Thematic analysis

The research team reviewed the case group collectively, dividing the total cases between each other equally. Each researcher reviewed different cases and highlighted key parts of the report. They then applied three-level coding to identify key themes. A meeting was held with all researchers for each group to compare these and ensure validity. The most prevalent and key themes were chosen and then organised into the structure of the final write up.

Quantitative analysis

A working group designed a questionnaire to review the cases. The group involved the research team and fatal incident investigators from the PPO. We discussed the questions and any key themes that would be quantifiable.

Cases from the groups were allocated and the questionnaire form was completed. The clinical review and PPO reports were reviewed to complete the form.

The data was collated and the results for each question were analysed. On occasion, the responses to more than one question were analysed together (for example, of the prisoners who had a mental health condition, how many were not taking their medication). Some totals may not add up to 100% due to rounding.

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