



Prisons and Probation Ombudsman's learning lessons seminars

Self-inflicted deaths
22 October 2014



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Prisons and Probation Ombudsman

Agenda

- 11.00 Introduction
- 11.10 What PPO investigations involve
- 11.30 Learning Lessons
- 11.50 Recent case studies
- 12.10 Response from Michael Spurr
- 12:30 Q&A
- 12.45 Lunch
- 13.30 Table discussions & feedback to panel
- 14:45 Panel discussion (Rosemary Hanna & Ian Bickers)
- 15:25 Next steps and close

Introduction

- PPO was created in 1994 to independently investigate prisoner complaints. We took on investigation of deaths in custody in 2004
- Our vision is to be a leading investigatory body, a model to others, that makes a *significant contribution to safer, fairer custody and offender supervision*
- New anniversary series of seminars aims to use PPO learning from investigations to support prison staff to improve safety and fairness
- I'm delighted to welcome delegates from prisons, senior NOMS staff and, of course, my own staff

Introduction

- PPO fatal incident investigations have 4 aims:
 - Establish circumstances of death including good and bad practice
 - Provide explanation to the bereaved family
 - Assist the coroner
 - Identify learning for improvement
- Learning comes from individual investigations but increasingly from thematic learning looking across investigations
- We will look at both these sources of learning and then discuss and debate

Introduction

- Never been a more important time to learn lessons about preventing suicide and self-harm
- Horrendous and largely unexplained 64% increase 2013-14
- Yet PPO reports often have to repeat the same recommendations, particularly the need for better risk assessment and better ACCT support
- Today is about learning lessons or at least understanding the obstacles to improvement so that we can reverse the *rising toll of despair* in custody

What PPO investigations involve

Sarah Stolworthy - *Senior Investigator*

Lisa Lambert - *Senior investigator*

Laura Spargo - *Family Liaison Officer*

What PPO investigations involve

Types of investigation:

- Natural Causes – 60%
- Self-inflicted – 32%
- Other: including homicide, drug overdose – 8%

Where?

- Prisons
- YOIs
- Immigration Removal Centres
- Approved Premises
- Secure Training Centres
- Courts and Escort Vehicles

What PPO investigations involve

Advance Preparation in the office

- Notification and Allocation
- Notices sent
- Check previous deaths
- Contact establishment
- Request records be made available
- Contact police and coroner
- Check HMIP and IMB reports
- Media interest
- Allocation of clinical reviewer

What PPO investigations involve

Opening Visit

- Meet with Governor/Equivalent/Representative
- Meet POA and IMB where relevant
- Other members of staff
- Prison tour and cell visit
- Collection documents
- Some investigators draw keys
- Interview prisoners
- Obtain NOK details for FLO and funeral date
- Consider case suspension (during police investigations)

What PPO investigations involve

Gathering evidence and identifying potential issues

- Examine documentation
- Speak to police
- Construct timeline of events
- Identify potential issues
- FLO contacts family
- Family visit?
- Collaboration with clinical reviewer
- Case review with manager

What PPO investigations involve

Interviewing and providing feedback

- Interview staff and prisoners
- Involve clinical reviewer
- Provide verbal feedback to Governor/Representative/Equivalent
- Written feedback

What PPO investigations involve

Completion of report

- Obtain clinical review
- Case review with manager
- Aim to write in parallel with investigation
- Validation process: FLO, Assistant Ombudsman, Deputy Ombudsman, Ombudsman
- Make recommendations
- Annexes

What PPO investigations involve

Issuing the report

- Consider whether advanced disclosure if an individual or organisation has been criticised
- Support team issue draft report to prison, NHS, coroner
- FLO contacts family and issues report to them
- Receive feedback and action plans (family and prison)
- Case review with manager
- Issue Final report (including FLO input)
- Inquest
- Publish anonymised report on website

Learning Lessons

Helen Stacey - *Research Officer*

Sarah Colover - *Research Officer*

PPO thematic report: Risk factors

Looking at self-inflicted deaths:

- History of mental health issues (76%)
- Remand/un-sentenced prisoners (46%)
- Self-harm or past suicide attempts (38%)
- Offence against family (26%)
- Substance misuse/withdrawal (19%)
- Lifers and indeterminate sentences (18%)
- Early days of custody (<3 days, 10%)

Lesson 1: Identifying risk

- **Actively identify risk factors** using records available: PER, NOMIS, Systm1.
- **Act promptly on concerns** raised by police, courts, and family members.
- **Risk is not fixed.** Information about distressing events should be shared urgently. Anyone can open an ACCT.

Lesson 2: Assessing risk

- **Evidence of risk factors** must be balanced against how the prisoner ‘presents’.
- Staff to **record what was considered**, and the reasons for their decision.
- Healthcare and officers access different information. **Risk assessment on reception must be collaborative & holistic.**

Learning from PPO Investigations

Risk factors in self-inflicted deaths in prisons

April 2014

- PPO Thematic report
- April 2014

[http://www.ppo.gov.uk
/document/learning-
lessons-reports/](http://www.ppo.gov.uk/document/learning-lessons-reports/)

PPO thematic report: ACCT

- Report on the death of 60 prisoners who died while on ACCT procedures
- ACCT plan was not properly implemented or monitored in half of the deaths

Lesson 1: ACCT plan

- Should be treated as holistic approach to managing an individual
- All staff who come into contact with prisoner should be responsible for updating the plan
- Training for all staff and refresher training should be provided

Lesson 2: Triggers

- Must be completed, even to say no known triggers
- Should be reviewed and updated
- Immediate case review should be conducted if a trigger behaviour seen

Lesson 3: CAREMAP

- Goals should be:
 - realistic, achievable, and relevant
- A named member of staff should be specified next to each goal
- A target date set for completing the goal

Lesson 4: Reviews

- Must be timely and multi-disciplinary
- Consistent staff attendance and case managers whenever possible
- Invite staff from across the prison to attend and offer input into the individual's care
- Invite agencies working within the prison



Learning from PPO Investigations

Self-Inflicted deaths of prisoners on ACCT

April 2014

- PPO Thematic report
- April 2014

[http://www.ppo.gov.uk
/document/learning-
lessons-reports/](http://www.ppo.gov.uk/document/learning-lessons-reports/)



Case studies

Michael Loughlin - *Deputy Ombudsman*

Kate Eves - *Assistant Ombudsman*

John Cullinane - *Assistant Ombudsman*

Case study 1: Background

- Large local male establishment
- Mr X had a long history of short sentences
- Previous self-harm history
- Methadone detox

Case study 1: Segregation

- Debt issues
- Distressed when caught throwing a line
- Apparent over-reaction to being segregated
- Self harm within an hour of being segregated
- ACCT opened by nurse but assessed as fit for seg

Case study 1: Special accommodation

- Mr X threatens to smash cell
- Furniture removed and alternative clothing given
- Duty Governor gave no reason for decision over special accommodation

Case study 1: ACCT failures

- No immediate action plan completed
- No enhanced case review
- Checked twice per hour
- Obscured panel
- Missed check

Case study 1: Other issues

- Anti-tear blanket was possibly damaged (already torn)
- Emergency response
- Events after the death
- Mr X's family

Case study 2: Before court

- 10 October - Took overdose and was hospitalised
- 12 October - returned to hospital with signs of internal bleeding
- 14 October – arrested
- 15 October – pleads guilty to harassing his estranged wife, including sending images suggesting he would kill himself. Sentenced to 19 weeks.

Case study 2: At court

- Assessed by mental health nurse at court as had cuts to arms and was volatile and uncommunicative.
- Suicide and self-harm warning form opened – noted history of depression and current low mood.
- PER noted that he was forcibly removed from dock, had marks to arms and neck.
- Nurse notified prison by phone and fax to warn of his arrival – included details of overdose and other threats of suicide.

Case study 2: Reception at prison

- Reception SO noted SASH warning form/first time in prison/history of depression/history of self-harm. Told investigator he would usually defer to mental health nurse about opening ACCT
- Man told healthcare assistant about recent overdose, self-harm and had not recently taken his anti-depressants.
- HCA asked mental health nurse to see him. No record made of this assessment. Nurse could not recall what paperwork she read or if she knew about referral from court mental health nurse.

Case study 2: Further assessments

- 18 October, saw a doctor (not ACCT trained) – said he was suicidal after his overdose.
- 19 October, saw a different doctor (not ACCT trained), said would “do something” if he did not have contact with family.
- 21 October, told doctor he would starve himself to death and would not take medication
- 30 October – told housing officer he would kill himself and leave prison in a body bag.
- 4 November – referred to mental health team because of concerns about behaviour.
- 5 November – security listen to phone call and ask officer to speak to man because of low mood

Case study 2: Findings

- Reception staff did not properly consider man's risk factors and warnings from others. They gave greater weight to his presentation and what he said.

Risk factors:

- First time in custody
- Relationship issues
- Offence was against his wife
- Relatively young man
- Very recent suicide attempt
- Diagnosed with depression

Case study 2: Findings (2)

- Unclear reception processes – not sure whether any member of staff had all the information they should have had
- Lack of personal responsibility for opening ACCT
- Not all members of staff ACCT trained
- Nursing assessments and care plans not completed properly
- Referral process to mental health teams not clear.

Case study 2: Family response

“we aren’t laying any blame for [the man’s] method of suicide. We do believe that the level of care he received from arriving at the prison to the time of his suicide was inadequate and would appreciate seeing some changes in people’s attitudes professionally and to certain procedures and actions, particularly regarding ACCT processes. If in the future it means that just one person can be affected for the better as a result of more consistent and adequate care, that’s all that matters.

“Could his mind-set have been changed if he felt he was getting listened to a bit more or he was on an ACCT? We will never know but it is abundantly clear that more could have, and should have been done to eliminate as much risk as possible.”

Response from NOMS

Michael Spurr
Chief Executive Officer
NOMS

Discussion

- What are the barriers to implementing PPO recommendations and how do you overcome them?
- Why do the same problems keep occurring?
- What changes would make ACCT more effective?
- What good practice is there and how can it be shared?

Next steps

- PPO will:
 - Share slides, contact lists and publications discussed on the day
 - Collate the discussion findings, perhaps particularly listing areas for potential revision/refresh of ACCT and sharing with ERDG
 - Look into producing a training package
 - Continue to investigate independently and robustly to identify learning in both individual cases and thematically
- What will you do?

Contact details

If you have any questions following the seminar please contact

Learning.lessons@ppo.gsi.gov.uk

Have you checked out our new website? Our learning lessons publications and anonymised fatal incident reports are now easily accessible at www.ppo.gov.uk