9 March 2015

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OMBUDSMAN SETS OUT LESSONS TO HALT RISE IN PRISON SUICIDES

There is no simple answer to why the number of prisoners committing suicide rose so sharply last year, but the rise was unacceptable, said Nigel Newcomen, the Prisons and Probation Ombudsman (PPO). Today he published a thematic report on lessons to be learned from investigations into self-inflicted deaths of prisoners in 2013/14.

In his most recent Annual Report, the Ombudsman reported a 64% increase in self-inflicted deaths in custody investigated by his office. This latest report, *Learning from PPO Investigations: self-inflicted deaths of prisoners – 2013/14* looked at 84 of 89 self-inflicted deaths in prison between April 2013 and March 2014 and compared the issues that arose to the year before.

PPO investigations into those deaths found that:

- there were self-inflicted deaths at 53 different prisons, 56% more than the previous year, including prisons where there had not been self-inflicted deaths for many years, sometimes ever;
- prisoners were more likely to have been in their first month of custody;
- more prisoners had spent less than two hours out of their cell in the days before their deaths, although nearly twice as many had spent over 5 hours out of cell;
- fewer prisoners who died in 2013/14 had been convicted or charged with violent and sexual offences;

- the investigations identified a number of concerns about early days in prison, including poor risk assessment on reception and weaknesses in first night support, induction and access to mental health services;
- weaknesses in the implementation of prison self-harm and suicide procedures (ACCT) continued to be a serious problem;
- some cases reflected the cumulative impact of disciplinary punishments, reduced privilege levels and segregation;
- a number of investigations found evidence of bullying relating to substance misuse, including several cases where prisoners had been taking new psychoactive substances, such as spice and mamba.

The lessons that need to be learned are:

- staff working in prison receptions should actively identify known risk factors for suicide and self-harm and not simply act on a prisoner's presentation;
- relationship breakdown and violent offences against family members are known risk factors for suicide and being subject to a restraining order can be a sign of increased vulnerability;
- all new arrivals should promptly receive an induction to provide information to help them meet their basic needs in prison;
- mental health referrals need to be made and acted on promptly and there should be continuity of care from the community;
- prisoners are most at risk in the first month of custody;
- the cumulative impact on potential suicide of restrictions, punishments, IEP levels and access to work need to be considered;
- prisoners on open ACCT documents should only be segregated in exceptional circumstances;
- suicide prevention procedures should focus on the prisoner as an individual and the processes must be correctly implemented;
- increased risk of suicide and self-harm should be considered when a prisoner is a suspected victim of bullying; and
- effective and confident emergency response saves lives.

Nigel Newcomen said:

> "This review reinforces the tentative view, set out in my annual report, that there is no simple well-evidenced answer to why self-inflicted deaths increased so sharply, so quickly. Some commentators have argued, perfectly reasonably, that staff reductions and other strains in the prison system may have reduced protective factors against suicide. This report does suggest some association between suicides and increased prison crowding, and between suicides and less time out of cell, but the picture is less than clear. For example, deaths occurred in a much wider range of prisons than the year before, including private prisons and high security prisons, both of which were largely immune from the cutbacks and pressures elsewhere in the estate.
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> "It is also troubling that many investigations simply repeated criticisms that we have made before. In particular, too many cases illustrated the inadequacy of reception and first night risk assessment. Even when risk of suicide or self-harm was identified, too often the support and monitoring put in place was poor. This repeated failure is why I have called for – and continue to call for – a review of Prison Service suicide and self-harm procedures and their implementation. There needs to be assurance that these procedures, now a decade old, remain fit for purpose and that staff are able to implement them as intended."
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> "There remains an urgent need to improve safety in custody and reduce the unacceptable rate of suicides in prison. I hope the lessons from this report offer a guide for action and better support for prisoners in crisis."

- ENDS –

NOTES TO EDITORS

1. A copy of the report can be found on the PPO website. Visit www.ppo.gov.uk.
2. The PPO's Annual Report 2013/14 can be found here.
3. The PPO investigates deaths that occur in prison, secure training centres, immigration detention or among the residents of probation approved premises. The

PPO also investigates complaints from prisoners, young people in secure training centres, those on probation and those held in immigration removal centres.

4. **Contact us**: Please contact Jane Parsons, PPO Press Office, on 020 3681 2775 or 07880 787452 if you would like more information, or email mail@ppo.gsi.gov.uk.