

# Learning lessons bulletin

## Fatal incidents investigations | Issue 10

## Early days and weeks in custody

This Learning Lessons Bulletin examines the self-inflicted deaths of prisoners within the first month of custody.

The early days and weeks of custody are often a difficult time for prisoners and periods of particular vulnerability for those at risk of suicide. The Prison Service has introduced reception, first night and induction processes to help identify and reduce this risk. Some prisoners have obvious factors, such as mental ill-health or a lack of experience of prison, that indicate that they are at heightened risk of suicide, but my investigations too often find that staff have failed to recognise or act on them - with potentially fatal consequences.

I am fully aware that prison staff have a hugely demanding task. Reception, first night and induction facilities, particularly in large, local prisons, are busy places that have to manage large numbers of prisoners, many of whom have multiple risks and vulnerabilities. Moreover, risk assessment must always rely in large

part on staff judgment, and we are all fallible. But, to be effective, risk assessment must also take account of known or readily available information associated with suicide.

It is a sadness to me that this bulletin repeats learning that I have frequently published elsewhere, about staff not spotting or using essential information about risk of suicide. This suggests that lessons still need to be learned.

My hope, therefore, is that this bulletin can act as a useful reminder to staff and managers responsible for prisoners' early days and weeks in custody, so that they can redouble their efforts to help reduce the unacceptable numbers of suicides in this period of particular vulnerability.

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### Background

This bulletin follows up our review of self-inflicted deaths of prisoners in 2013/14<sup>(1)</sup>, which, among other things, found that a significant number of deaths occurred in the first month in prison. In a sample of 132 of our investigations into self-inflicted deaths in prisons from April 2012 to March 2014, nearly a third of the deaths (40) occurred in the first 30 days. Of these, half died within the first week in prison (15% of the total).

Looking at these deaths in the early days and weeks of custody, a number of themes are

apparent. The most common theme is the failure of staff to identify (or act on information about) factors known to increase prisoners' risk of suicide or self-harm. We also highlighted this issue in a thematic report about risk factors in 2014<sup>(2)</sup>. We continue to make frequent recommendations about identifying, recording and acting on risk factors for suicide or self-harm for newly arrived prisoners.

In the case studies in this bulletin, staff made judgments based on a prisoner's presentation,

or took their word for it that they had no intention of committing suicide, rather than considering identifiable risk factors. While staff judgment is an essential part of any risk assessment, so is taking account of known or readily available information about risk associated with suicide. However, deaths in the early days in prison are

not only typified by a failure to identify risks when prisoners first arrive in reception or induction. Three cases illustrate that a prisoner's particular vulnerability to suicide and self-harm on arrival in custody also extends into early weeks in prison, hence the title of this bulletin.

## Risk factors

As we have noted many times in individual investigation reports, thematic reports and annual reports, too often staff in prison receptions make decisions based on their perceptions of a prisoner's presentation and statements from the prisoner that they do not have any thoughts or intention of suicide or self-harm. Known risk factors which might increase the prisoner's risk, such as a history of suicidal behaviour, or the circumstances of their offence, can often be overlooked.

Our investigations into deaths in the early weeks of custody frequently uncover failures to identify risk factors, and therefore to begin Prison Service suicide and self-harm prevention procedures (known as ACCT<sup>(3)</sup>). This emphasises the importance of getting this right early on – or there may not be another chance to make another formal assessment of risk.

Failings in reception processes have recently been identified in a report by Her Majesty's Inspectorate of Prisons<sup>(4)</sup>, which concluded that "local prisons need to do more to ensure that reception and induction processes aim to support these 'at risk' individuals more effectively."

While assessment of risk of suicide and self-harm needs to happen before, during and after someone arrives in prison, the assessment process that should take place in reception when a prisoner first arrives is the best time for risks to be identified and recorded. Too often, staff in prison receptions miss obvious signs of risk.

In the case of MR A, we were critical were critical that no one in the prison took any action to begin ACCT procedures, even though Mr A had a number of evident risk factors for suicide when he arrived. He was charged with a violent offence against his partner, there was clear information that he had recently made a serious suicide attempt and he was a young man with relationship difficulties. He had arrived with a warning about his

risk and his family, probation officer and solicitor subsequently contacted the prison to alert staff about his risk of suicide.

We were concerned that there were no clear reception procedures to ensure that staff working in reception understood their responsibilities. Not all the staff in reception saw all the information they needed to assess his risk, information was not shared and no one recorded his risk factors or the reasons they had decided not to begin ACCT procedures.

## Lessons to be learned

### Lesson 1

Staff need to identify, record and act on all known risk factors during reception and first night.

## Case study A

Mr A was charged with a serious violent offence against his partner and was remanded to prison. He had been released from the same prison six months earlier. In the interim, he had attempted suicide and had previously taken an overdose. At court, it was recorded that Mr A was at risk of suicide and he arrived with a suicide and self-harm warning form completed by the escort contractor. Despite his history, the warning form and his risks, reception staff did not begin ACCT procedures to support him in line with Prison Service Instruction (PSI) 64/2011<sup>(5)</sup>.

Mr A did not stay in the prison's first night and induction centre but went to another wing where he had been previously. There was no record of any induction or secondary general health screen, which should have happened, so further opportunities to assess his risk were missed. Mr A's sister and his probation officer both

contacted the prison to alert them to his risk of suicide. A wing manager spoke to him but accepted Mr A's assurance that he did not have any thoughts of suicide or self-harm.

The next day, Mr A's solicitor faxed a letter to the prison, noting that he had made several attempts to commit suicide, suffered from hypoxic brain damage and should be monitored. No one acted on the information or passed the fax urgently to the safer custody team. Two days later, a prisoner found Mr A had hanged himself in his cell.

## Induction

Prison Service Instructions<sup>(6)</sup> set out mandatory requirements for what happens when prisoners first arrive in custody. Prisoners should be interviewed on their first night, and assessed to identify any risk they might pose to themselves or others. They should also receive information about prison life and be allowed to make a telephone call.

Our investigations into self-inflicted deaths in custody often find that there are ineffective induction procedures in place. This means that newly arrived prisoners, particularly those who have never been in prison before, and are likely to find the first days at the prison particularly daunting, do not have all the information they need about the basics of prison life.

Effective induction involves a lot more than simple provision of information. Regular contact with staff is important. Staff need to talk to the prisoner and check that they are coming to terms with their situation. Sadly, this does not seem to have happened for Mr B.

Although Mr B did not show signs of being at risk of suicide or self-harm, we considered that the lack of contact with staff and the lack of effective induction procedures isolated him.

This did not help him to settle in a new, stressful and intimidating environment or allow staff the opportunity to identify any signs of distress.

## Lessons to be learned

### Lesson 2

All prisoners should receive an induction, regardless of location.

## Case study B

Mr B was convicted of sexual offences and sentenced to five years imprisonment. He was 60 years old and this was his first time in prison. When he arrived at a large local prison, Mr B was taken to a cell in the prison's induction unit, but there is no record that Mr B had any further contact with staff that evening, or that staff offered him a first night telephone call as is required. The nature of Mr B's offence meant that he would usually have been regarded as vulnerable to attack by other prisoners and kept separate from the general population, but this did not happen until the next day, when he was moved to the prison's vulnerable prisoners unit.

The next day, although an officer recorded that Mr B had received a basic induction to the prison, there was no documentary evidence to support this, such as signed compacts, which we would usually expect to see. Other records, such as his cell sharing risk assessment, were clearly inadequate.

Mr B remained at the local prison for a week. There were no meaningful entries in his prison record while he was there and he had no contact with healthcare staff. After a week, Mr B was transferred to a resettlement prison where he was allocated a single cell in the vulnerable prisoners unit. He received a first night pack, including tobacco, but he was not offered a telephone call when he arrived.

When Mr B arrived at his second prison, he still did not have a full understanding of prison processes, such as how to use the prison telephone system. Eleven days after arriving in prison, Mr B did not know how to make telephone calls and had not been able to speak to his family since he had been sentenced. He was booked to attend a two-day induction at his new prison, the following week.

Over the next few days, Mr B had little direct contact with prison staff, but those who saw him had no concerns about him and did not consider he appeared at risk of suicide or self-harm. Two weeks after Mr B first arrived in prison, an officer found him hanged in his cell.

## Recall

Recall to prison after a breach of licence was a noticeable characteristic of several of the deaths within the first few weeks in prison. Recall is an inevitably distressing experience and is a known risk factor for suicide and self-harm. However, we found cases where little information about their recall was provided to recalled prisoners, increasing their distress even further. The case of Mr C shows the potential consequences.

### Lessons to be learned

#### Lesson 3

Recently recalled prisoners can be especially vulnerable.

did not note this relationship breakdown in Mr C's records, did not alert prison staff, and did not consider beginning ACCT procedures.

That same day, Mr C's formal recall papers setting out the reasons for his recall arrived in the prison, with a covering letter drawing attention to his risk of suicide and self-harm. No one took any action as a result of the warning and no one passed the papers to Mr C.

The next day, a prisoner found Mr C hanging in his cell, twelve days after he had been recalled. Although he should have had his recall papers within ten days of his recall, he had still not received them when he died.

### Case study C

Mr C was recalled to prison shortly after he had been released on licence from a 13 year prison sentence. Mr C believed he had been recalled for a fixed period of 28 days, but he did not accept the reasons for his recall.

The reception nurse noted that Mr C had a history of anxiety and depression. She referred him to the mental health team, but she did not begin ACCT procedures in line with PSI 64/2011 as he told her that he had no thoughts of suicide or self-harm.

Four days after Mr C's recall, the prison's probation officer told him why he had been recalled. Mr C said that he could not cope with being in prison and became tearful and agitated. Like the reception nurse, this officer did not begin ACCT procedures, because Mr C said that he had no thoughts of harming himself. Mr C said that he wanted to see a mental health nurse so the probation officer referred him to the mental health team. The mental health team did not take any action, as they thought it was a duplicate referral (in addition to the one from the reception nurse) and not because of new concerns.

Ten days after his recall to prison, a senior probation officer told Mr C that he faced the prospect of serving a number of additional years in prison, potentially until his sentence expired in 2022. Mr C told the senior probation officer that his partner, who he spoke to most days, had ended their relationship. The probation officer

### Mental health referrals

We recently published a thematic report covering many aspects of mental ill-health in prisons and its links to death in custody<sup>(7)</sup>. Inadequate consideration of mental health concerns was a common failing among the sample of deaths in the early weeks reviewed for this bulletin. This included failure to recognise symptoms of mental illness, failure to review or continue medication prescribed in the community and failure to make mental health assessment referrals.

Some mental health problems can lead to difficult and challenging behaviour. This is often dealt with only under disciplinary procedures, rather than being considered as a trigger for a mental health assessment. When a prisoner has not been in a prison for very long, it can be more difficult to judge what lies behind strange behaviour. It is essential, therefore, that a full picture is established, through professional mental health assessment, in order to keep the prisoner, and potentially others, safe.

### Lessons to be learned

#### Lesson 4

Continuity of mental healthcare and responsiveness to a prisoner's mental health needs are essential.

## Case study D

Mr D had been recalled for breaching his licence conditions after a previous prison sentence and was facing further charges. He had a history of severe mental health problems, for which he was on medication, and he was managed under the care programme approach, for patients with complex mental health problems.

Mr D had been in prison before and had attempted suicide several times in the past. These risks were noted on his escort record and were seen by reception staff. Mr D said he had no thoughts of suicide or self-harm and no one opened an ACCT

A prison doctor prescribed a much lower dosage of medication than indicated in Mr D's community GP records, until the consultant psychiatrist, who had also been responsible for his care in the community, could see him. No one subsequently reviewed or adjusted his medication, despite his protestations that he was not on the right dose. The psychiatrist never reviewed him. Just over a week after his arrival, there was an abortive attempt to transfer him to another prison, which was unable to deal with his mental health conditions. Mr D protested against the transfer and was held overnight in the segregation unit at the new prison. He was taken back to the original prison the next day and taken directly to the segregation unit.

The next morning, Mr D told staff in the segregation unit that his poor behaviour was because he was not on the right medication. That evening, he self-harmed by cutting his arm. Staff began to monitor him as at risk of suicide and self-harm. He was observed hourly, rather than five times an hour as required by the prison's local policy for those at risk of suicide and self-harm in the segregation unit.

In the morning, Mr D was angry and aggressive. He continually shouted at staff and refused to engage in conversation. He refused to take his medication, which had still not been reviewed and he had still not seen the psychiatrist. An hour later, an officer went to check Mr D and found him hanged in his cell. He was taken to hospital but never recovered and died three days later.

## Endnotes

- <sup>1</sup> Prisons and Probation Ombudsman (2015) Learning from PPO Investigations: Self-inflicted deaths of prisoners – 2013/14. Available online: <http://www.ppo.gov.uk/?p=5434>
- <sup>2</sup> Prisons and Probation Ombudsman (2014) Learning from PPO Investigations: Risk Factors in self-inflicted deaths in prison. Available online: <http://www.ppo.gov.uk/?p=3728>
- <sup>3</sup> Assessment Care in Custody and Teamwork process.
- <sup>4</sup> HM Inspectorate of Prisons (2015) Life in prison: The first 24 hours in prison. <http://www.justiceinspectorates.gov.uk/>
- <sup>5</sup> Prison Service Instruction (PSI) 64/2011: Management of prisoners at risk of harm to self, to others and from others.
- <sup>6</sup> Set out in Prison Service Instruction (PSI) 07/2015: Early days in custody – reception in, first night in custody and induction to custody.
- <sup>7</sup> Prisons and Probation Ombudsman (2016) Learning from PPO investigations: Prisoner mental health. Available online: <http://www.ppo.gov.uk/?p=6737>

## Lessons to be learned

The lessons from this bulletin have appeared in previous publications but they are repeated as the need for prison staff to learn them clearly remains.

### Lesson 1

Staff need to identify, record and act on all known risk factors during reception and first night. Staff working in prison reception and first night areas need to be aware of the known risk factors for suicide and self-harm. They must actively identify relevant risk factors from the information and documents available to them.

Evidence of risk should be fully considered and balanced against the prisoner's demeanour. Reception staff should record what factors they have considered and the reasons for decisions.

### Lesson 2

All prisoners should receive an induction, regardless of location. Prisons must ensure that new arrivals promptly receive an induction to equip them with information about how to meet their basic needs in prison. This is especially important for prisoners who are unable – for whatever reason – to attend standard induction sessions.

### Lesson 3

Recently recalled prisoners can be especially vulnerable. Prisons must ensure that prisoners receive prompt and accurate information about the reasons for their recall and that the risk of suicide for recalled prisoners is kept under review.

### Lesson 4

Continuity of care and responsiveness in mental healthcare is essential. Mental health referrals need to be made and acted on promptly. Care should be taken to ensure continuity of care from the community. Attention must be paid to the potential for increased risk when medication is changed, ended or otherwise disrupted.

The Prisons and Probation Ombudsman investigates complaints from prisoners, young people in secure training centres, those on probation and those held in immigration removal centres. The Ombudsman also investigates deaths that occur in prison, secure training centres, immigration detention or among the residents of probation approved premises. These bulletins aim to encourage a greater focus on learning lessons from collective analysis of our investigations, in order to contribute to improvements in the services we investigate, potentially helping to prevent avoidable deaths and encouraging the resolution of issues that might otherwise lead to future complaints.

### PPO's vision:

To carry out independent investigations to make custody and community supervision safer and fairer.

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