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Independent Investigations

Learning from investigations into self-inflicted deaths in custody in England and Wales

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Prisons and Probation Ombudsman

16 November 2016

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Agenda

- About the PPO
  - Background
  - Methods
  - Outcomes
- Too many self-inflicted deaths
- Learning how to tackle the increase
- Conclusion

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About the PPO

- Created 1994 following prison riots and Woolf report
- Investigations of fatal incidents added 2004
- Purpose
  - Ensure compliance with article 2 ECHR
  - Establish facts and good\bad practice
  - Give answers to bereaved families
  - Assist the Coroner's inquest
  - Identify learning for the organisations investigated

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Methods

- I independently investigate ***all*** deaths in prison and immigration custody or in probation approved premises from any cause (natural causes, homicide and self inflicted)
- Published terms of reference
- Accredited investigators from multi-disciplinary backgrounds, accompanied by a clinical (medical) reviewer from the NHS
- Bereaved families central to investigation
  - consulted and involved
  - supported by Family Liaison Officers
- Strict timetable 20-24 weeks – 100% of investigations on time 2015-16 despite huge growth in demand (only 14% on time 2011)

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Outcomes

- Investigation can make local and national recommendations
- Recommendations SMART and outcome focused
- In 2015-16, all recommendations accepted
- We require an action plan to demonstrate how improvement will be achieved and when
- Independent assurance of progress (or not) by HM Inspectorate of Prisons

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But too many deaths

- We started investigations into 304 deaths in 2015-16
- Of these, 103 (35%) were self inflicted
- Highest number in a single year, since PPO took on investigations
- And a shocking 34% increase from 2014-15
  - 85 male prisoners
  - 9 female prisoners
  - 5 young offenders (under 21)
  - 3 approved premises residents
  - 1 immigration detainee

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Tackling the increase

- Never been a more important time to learn lessons about preventing self-inflicted deaths
- Yet hard to be definitive about cause of such a shocking increase:
  - **Staffing** cuts, crowding and regime restrictions must all play a part in reducing protective factors against self-inflicted deaths
  - So must troubling levels of **mental ill health**
  - And an epidemic of **new psychoactive substances**
  - But each case is an individual crisis, an individual story and no simple, single explanation suffices

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Tackling the increase

- In a complex context, effective efforts by staff using evidence based procedures are key to preventing self-inflicted deaths.
- My investigations show much commendable work by staff but, in a strained prison system, suicide and self-harm procedures not being consistently applied.
- As a result, investigations often repeat the same lessons.
- This is not good enough and I frequently have to call on prison staff to redouble their efforts.

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Also thematic learning

- New emphasis on thematic analysis across investigations to encourage services to learn lessons and avoid preventable deaths
- Thematic studies 2015-16:
  - Homicides
  - Suicides in segregation
  - Dementia
  - ***Prisoner mental health***
  - ***New psychoactive substances***
  - ***Early days and weeks in custody***

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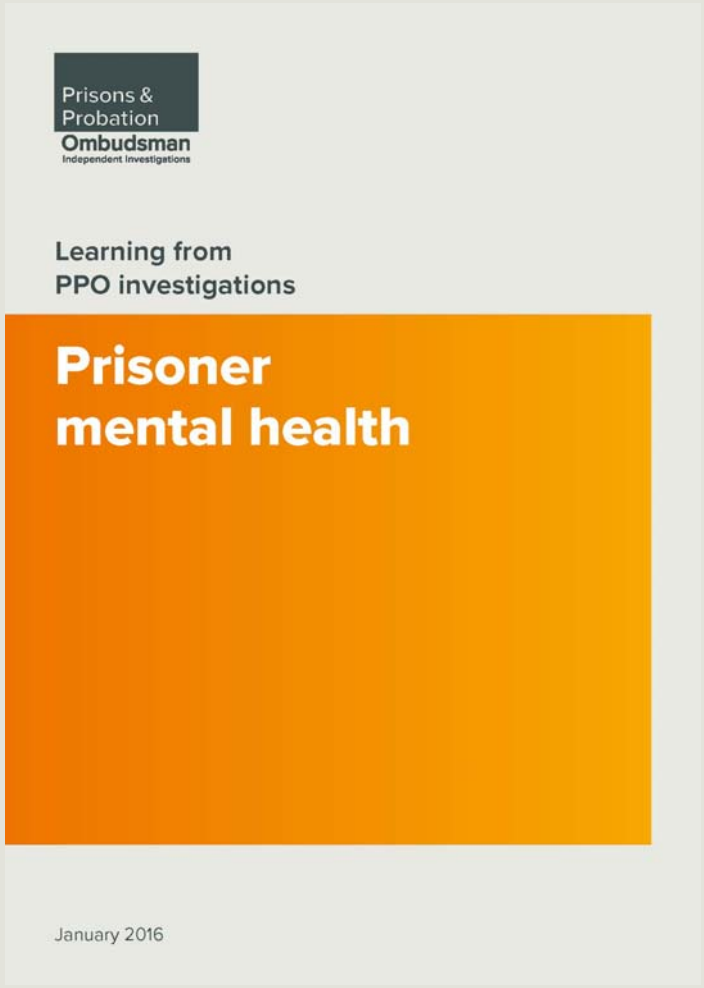

"Learning from PPO investigations: prisoner mental health"

Published January 2016

A thematic review of the identification of mental health needs and the provision of mental health care for prisoners, based on the learning from our fatal incident investigations.

Available online:
http://www.ppo.gov.uk/?p=6737

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Learning: prisoner mental health

- Sample of 199 self-inflicted deaths 2012-14
- High prevalence of mental health issues in prison – 70% of self-inflicted deaths
- Findings:
  - Weaknesses in identifying mental ill-health which limit appropriate care and support
    - Distress too easily interpreted as merely bad behaviour
  - Weaknesses in timely referrals and treatment

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Prisoner mental health (cont.)

- Key lessons:
  - Staff need mental health awareness training
  - Screening must consider documented risk not just presentation
  - Healthcare should be equivalent to the community
  - Compliance with medication should be monitored and encouraged; and
  - Mental health teams should attend or contribute to all suicide prevention reviews

Case Study – Mr A

- Mr A was already prescribed antidepressants before arriving in prison and cut himself frequently
- On arrival, a nurse conducted a reception screening and noted Mr A's apparent mental health issues but did not make a referral for mental health assessment by relevant staff.
- The following day, Mr A said that he felt suicidal and asked to see the mental health team. No referral was made
- At his suicide prevention (ACCT) case review, his case was discussed but again no referral was made
- Mr A was discussed at the next mental health referral meeting but was not booked for an assessment
- Shortly after, Mr A hanged himself in his cell without ever having been assessed.

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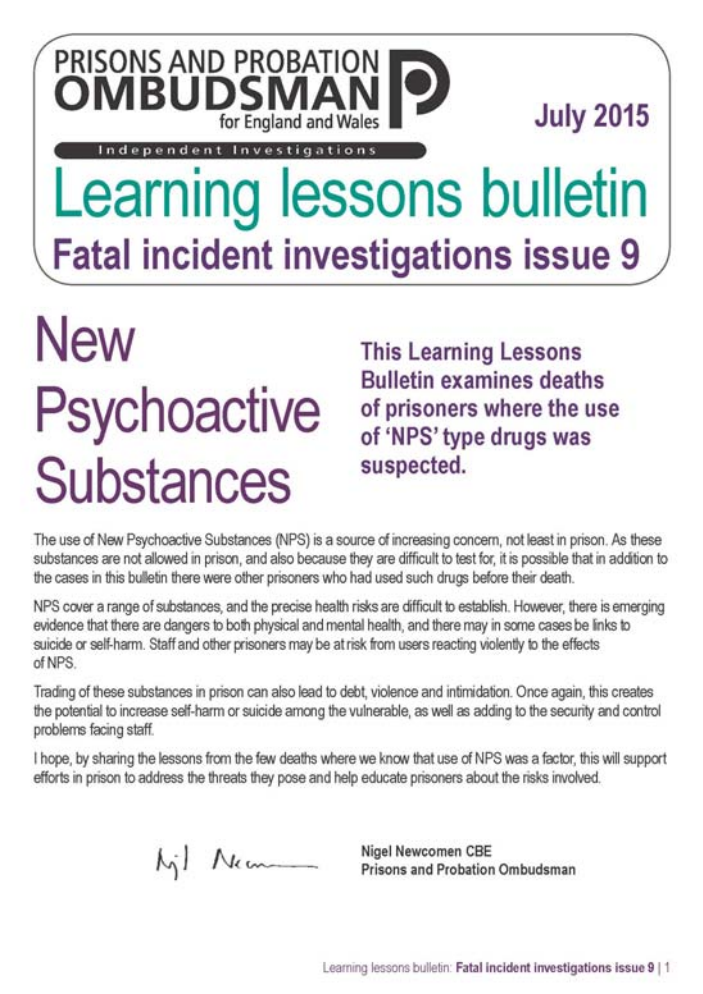

PRISONS AND PROBATION OMBUDSMAN
for England and Wales

July 2015

Independent Investigations

Learning lessons bulletin

Fatal incident investigations issue 9

New Psychoactive Substances

This Learning Lessons Bulletin examines deaths of prisoners where the use of 'NPS' type drugs was suspected.

The use of New Psychoactive Substances (NPS) is a source of increasing concern, not least in prison. As these substances are not allowed in prison, and also because they are difficult to test for, it is possible that in addition to the cases in this bulletin there were other prisoners who had used such drugs before their death.

NPS cover a range of substances, and the precise health risks are difficult to establish. However, there is emerging evidence that there are dangers to both physical and mental health, and there may in some cases be links to suicide or self-harm. Staff and other prisoners may be at risk from users reacting violently to the effects of NPS.

Trading of these substances in prison can also lead to debt, violence and intimidation. Once again, this creates the potential to increase self-harm or suicide among the vulnerable, as well as adding to the security and control problems facing staff.

I hope, by sharing the lessons from the few deaths where we know that use of NPS was a factor, this will support efforts in prison to address the threats they pose and help educate prisoners about the risks involved.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Learning lessons bulletin: **Fatal incident investigations issue 9** | 1

"Learning lessons bulletin: new psychoactive substances"

Published July 2015

Examines the death of prisoners suspected to have been using NPS

Considers risks and behaviour related to NPS use

Available online:
http://www.ppo.gov.uk/?p=6137

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Learning: new psychoactive substances

- We identified 58 deaths in prison between 2013 and 2016, where the prisoner was known or strongly suspected to have been using NPS
- 39 self-inflicted deaths, 2 homicides, 9 natural causes, 5 drug related, 4 not ascertained
- NPS pose risks to:
  - physical health
  - mental health, psychotic episodes linked to self-inflicted death
  - bullying and debt associated with self-inflicted death

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New psychoactive substances (cont.)

- Key lessons:
  - supply needs to be reduced
  - staff awareness needs to increase
  - prisons need to address the bullying and debt associated with NPS
  - drug treatment services need to address NPS
  - demand for NPS among prisoners must be reduced

Case Study – Ms B

- Ms B had several long term medical conditions and had frequent contact with the prison healthcare team.
- She had no history of self harm and had not shown any sign that she might hurt herself.
- Other prisoners said Ms B regularly taking NPS.
- One night, staff heard singing coming from her cell but this changed to a loud and aggressive noise, so officers went to investigate
- The cell was dark and Ms B was in bed. She had made a deep cut in her arm, severed an artery and lost a lot of blood
- She died in hospital later that day
- Our clinical reviewer considered that NPS triggered a rapid onset psychotic episode which led Ms B to self harm

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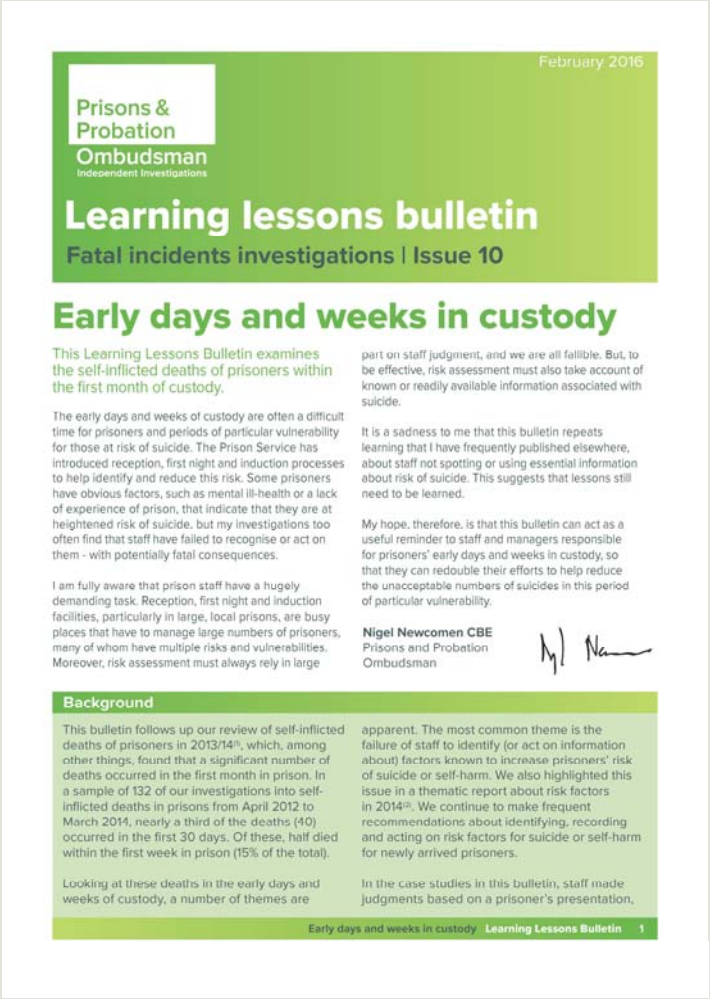

February 2016

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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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Background

This bulletin follows up our review of self-inflicted deaths of prisoners in 2013/14[1], 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[2]. 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,

"Learning lessons bulletin: early days and weeks in custody"

Published February 2016

The bulletin examines the self-inflicted deaths of prisoners within the first month of custody.

Availaible online at:

http://www.ppo.gov.uk/?p=6855

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Learning: early days in custody

- Sample of 132 self-inflicted deaths 2012 to 2014:
  - 1/3 occurred in first 30 days
  - Half of these in the first week
- Key lessons:
  - Need better risk assessment
    - too much weight put on presentation or assurance by prisoner not on known risk factors
  - Inadequate induction makes early days and weeks more stressful
  - Recalled prisoners a particularly high risk (1/5 of cases)
  - Continuity of mental healthcare important, allowing prisoners to continue to receive the same medication they did in the community

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Case Study – Mr C

- Mr C was charged with serious violent offence against his partner
- A recent attempt at suicide was noted at court and in escort warning forms
- Despite this, no ACCT opened on reception
- Did not go to first night centre and had no induction
- That day, his partner and a probation officer both phoned to raise concern about Mr C's risk of suicide with prison
- Staff spoke to Mr C, but accepted his assurance that he was ok and didn't open an ACCT
- Next day, Mr C's lawyer faxed a further expression of concern, but this was not urgently passed on to safer custody staff
- Mr C hanged himself two days after arriving in prison

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Conclusion

- Prisons in England and Wales facing huge challenges, among the most serious is the unacceptable increase in self-inflicted deaths.
- Increase coincides with austerity, high levels of mental ill-health and an epidemic of drugs, such as NPS.
- In this context, need robust suicide and self-harm prevention measures and staff do save many lives
- But investigations identify repeated procedural failures and an urgent need to improve safety.
- Possible light at end of tunnel, as the Government has committed itself to prison reform and providing some new resources.
- But without improved safety, progress will be limited.
- My investigations will continue to support this improvement.