Prisons & Probation Ombudsman
Independent Investigations

Update from the PPO

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INQUEST Lawyers, 22 November 2016

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Agenda

- Numbers
- Learning
- Pressures on the PPO
- Inquests
- Future

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Statistics: 2015-16

PPO started investigations into 304 deaths in 2015-16

- +21% increase in investigations compared to 2014-15
- 170 natural cause deaths (+8% from 2014-15)
- 105 self-inflicted deaths (+36% from 2014-15)
  - 56% natural causes
  - 35% self-inflicted
  - 6% other
  - 2% homicide
  - 1% awaiting classification

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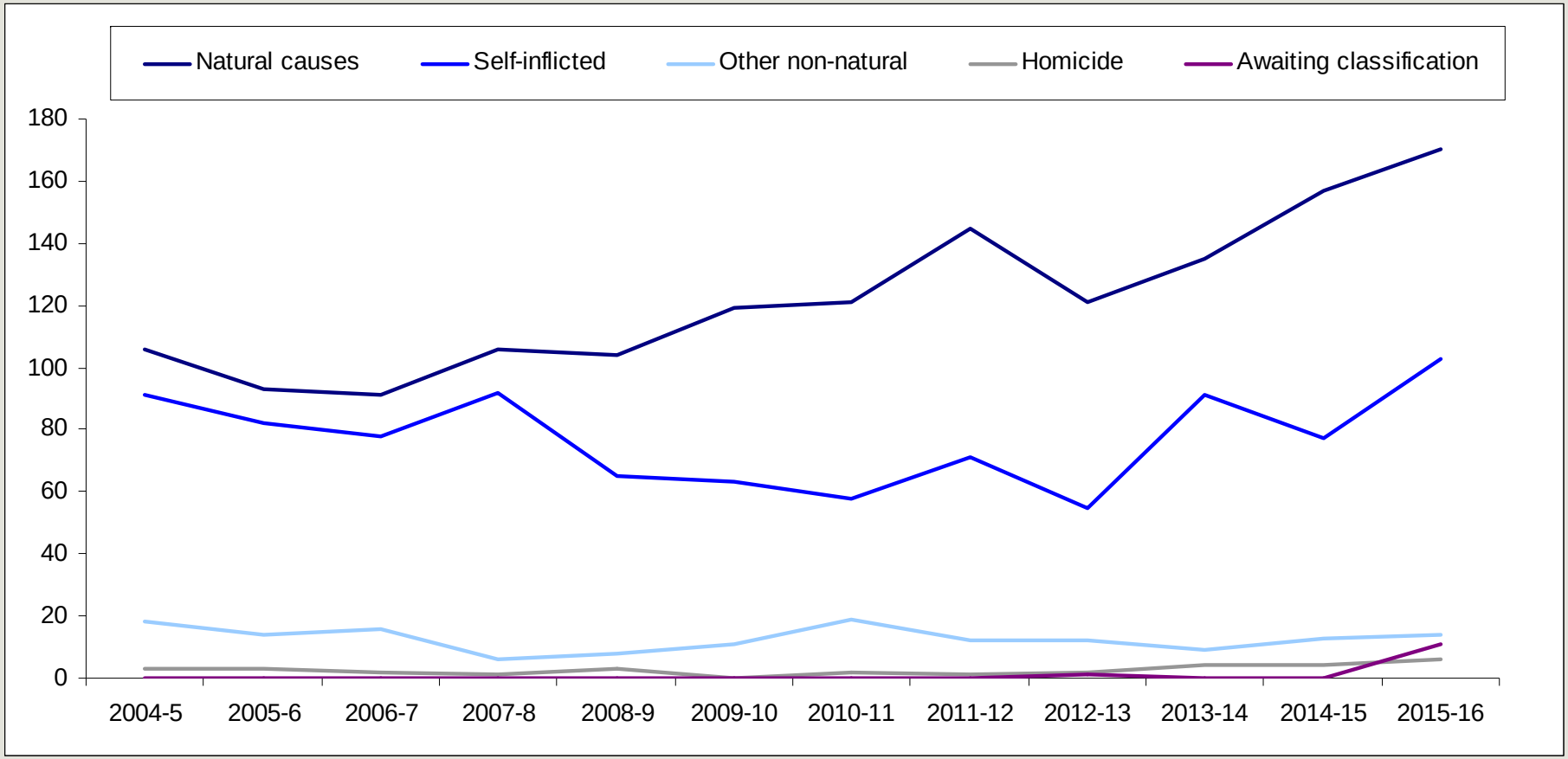
Deaths investigated by type



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Statistics: 2016 half-year figures

Remorseless increases

182 new fatal incident investigations already between April – September 2016

- + 22% on same time period in 2015
- + 18% (natural causes)
- + 12% (self-inflicted)

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Explaining the increases

- Increase in natural cause deaths explicable (if unplanned)
- Hard to be definitive about cause of shocking increase in suicide:
  - **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 picture inconsistent and each tragic case is an individual crisis, an individual story and no simple, single explanation suffices

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Tackling the increase in suicides

- In a complex context, effective efforts by staff using evidence based procedures are key to preventing self-inflicted deaths.
- Our investigations do illustrate some commendable work by staff but, in a strained prison system, too often suicide and self-harm procedures not being consistently applied.
- As a result, investigations often repeat the same lessons.
- This is not good enough and we frequently have to call on prison staff to redouble their efforts.
- Never been a more important time to learn lessons about preventing self-inflicted deaths

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Learning Lessons publications

Recent publications:

- Deaths in segregation
- Dementia
- Homicides
- **Prisoner Mental Health**
- **NPS**
- **Early Days**

Future publications:

- Transgender prisoners
- Young prisoners
- Women prisoners
- Older prisoners

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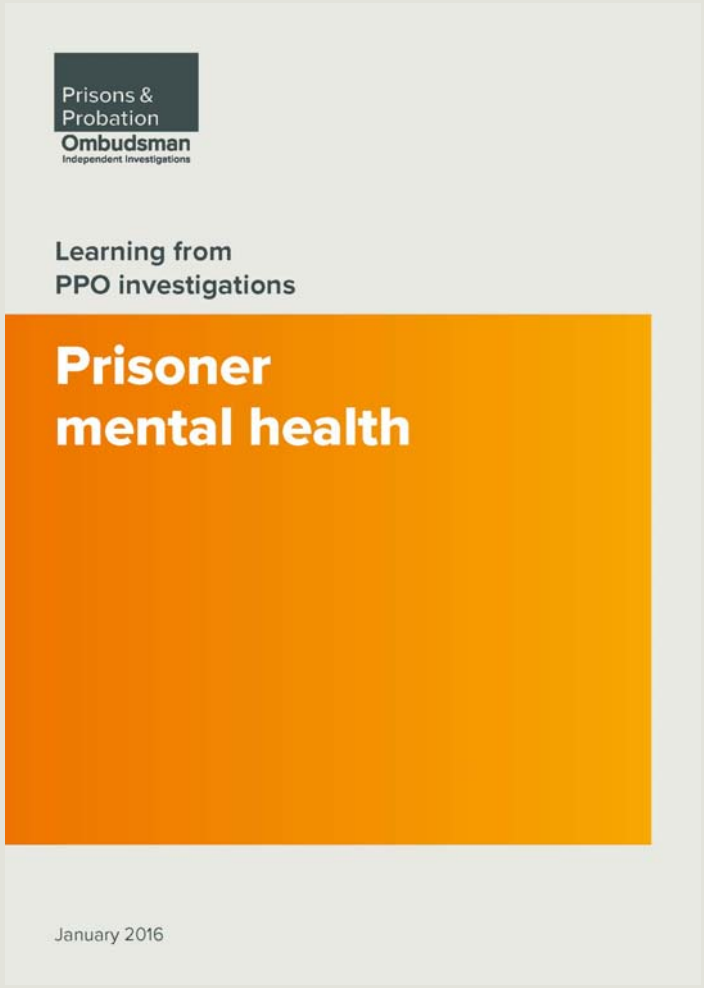

"Learning from PPO investigations: prisoner mental health"

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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Prisoner Mental Health

- Huge prevalence of mental ill health in prison – 70% of self-inflicted deaths
- Weaknesses in identification limits appropriate care and support
- Distress can be easily misinterpreted as bad behaviour
- Weaknesses in timely referrals and treatment
- Key Lessons:
  - mental health awareness training for staff
  - screening should consider documented risk as well as presentation
  - care should be equivalent to the community
  - compliance with medication should be monitored and encouraged
  - mental health teams should attend or contribute to all ACCT reviews

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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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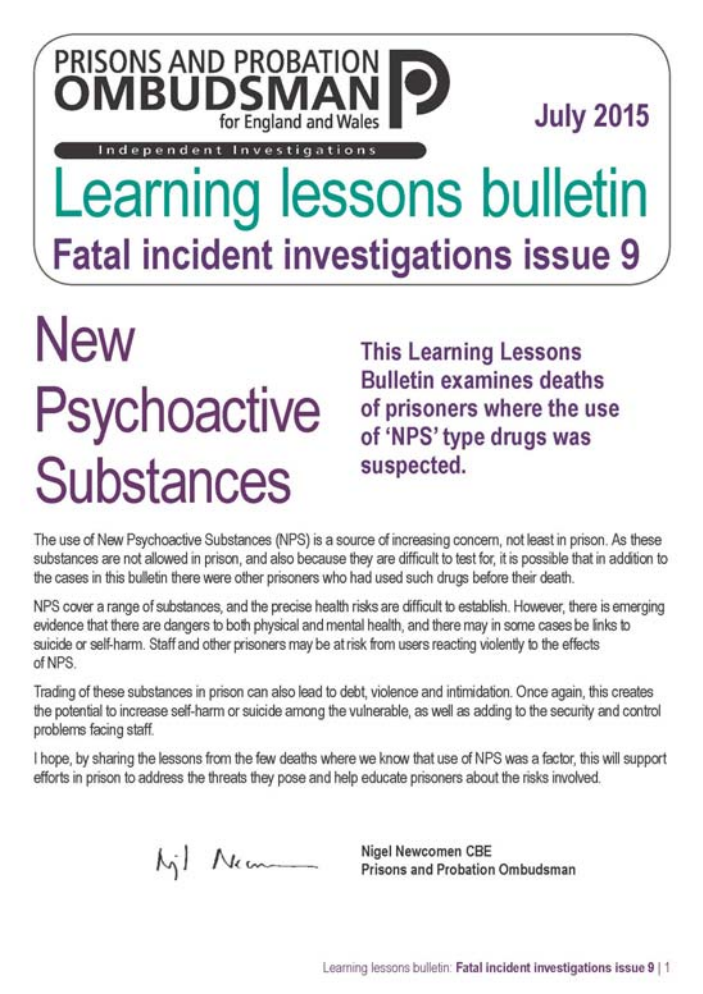

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for England and Wales

July 2015

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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

- Now identified 64 deaths in prison between June 2013 and April 2016, where the prisoner or perpetrator of the death was known or strongly suspected to have used or possessed NPS before their death
- 44 self-inflicted, 9 natural causes, 6 drug-related, 3 not ascertained; 2 homicides
- Risks to physical and mental health, behaviour, bullying and debt.

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New psychoactive substances (cont.)

- Key lessons:
  - supply needs to be reduced
  - staff awareness needs to increase
  - governors 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

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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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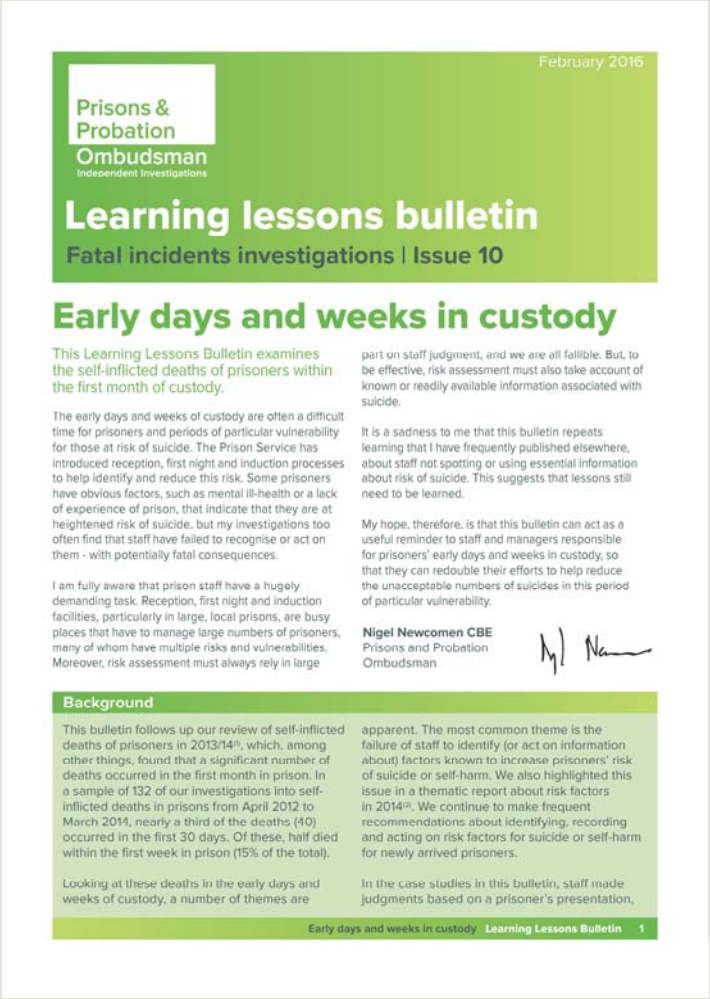

February 2016

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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,

Early days and weeks in custody Learning Lessons Bulletin 1

"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 April 2012 to March 2014:
  - 1/3 occurred in first 30 days
  - Half of those in the first week
- Key lessons:
  - Risks factors: too much weight put on presentation of prisoner or statements made than on known risk factors
  - Induction: inadequate induction makes early days and weeks more stressful
  - Recalled prisoners: a high risk; in 1/5 of cases the prisoner was on recall
  - Mental health: continuity of mental healthcare is important, allowing prisoners to continue to receive the same support 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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Pressures on PPO

- Change at the top (not)
- Coping with demand
- Resources cut by 4.6% in 2016-17
- Performance still excellent
  - Initial reports issued within target:

    2010/11 – 15%

    2015/16 – 100%

    2016/17 - 100% (up to October 2016)

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Stakeholder survey results

- General stakeholder survey
  - Nine out of 10 stakeholders, including all coroners, agreed that the quality of the work and services provided by the PPO was satisfactory or better
- Bereaved families survey
  - Around three-quarters of families who responded said that the PPO's investigation had 'fully' met their expectations in this respect
- Post-investigation survey
  - of all stakeholders, including all coroners, agreed that the fatal incident report met their expectations.

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Efforts to get greater traction

- Focus on outcomes
  - SMART recommendations
  - All accepted
  - Action plans
- More joint working
  - HMIP follow up on all FII investigation recommendations.
  - New protocol with IMBs to undertake similar follow up.
  - Discussions with HMI Probation on similar role in APs
- Innovations
  - Third series PPO learning lessons seminars for custodial managers.
  - Regional NOMS action plans
  - NOMS SIDs project

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Inquests

- Clinical reviews:
  - Coroner concerns about qualifications of clinical reviewers - but they are not expert witnesses.
- PPO investigator attendance at inquests:
  - Coroners still unnecessarily calling PPO investigators to inquest and pre-inquest hearings. Difficult to resource.
- Post-mortem and toxicology reports:
  - Increasing delays – sometimes leading to suspension of investigation.
- Timeliness:
  - PPO has improved, inquests less so.

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Future

- Demand – no sign of reduction, in fact
  - More older prisoners and rising number of natural cause deaths
  - Sharp, unexplained and continuing increase in self inflicted deaths
  - Particularly troubling rise in women killing themselves
- No foreseeable reduction in demand for independent PPO
- No foreseeable increase in resource to match demand
- High risk of impact on PPO performance
- That's the cloth from which we'll be cutting our coat

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Future

- The state of prisons
- Prison and regulatory reform – White Paper
  - No progress without safety
  - Statutory footing?
  - Relationship with other scrutiny bodies
  - Status of PPO and its recommendations
- Legislation?
  - Governor autonomy
  - Future policy framework
  - Equity and consistency

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Areas for discussion?

- Relationship with INQUEST
  - Liaison with Inquest about learning lessons
  - Training for investigators with Inquest lawyers
- Engagement with families
  - Signposting of sources of advice/support
  - Revised family leaflet (references Inquest)