PRISONS AND PROBATION OMBUDSMAN
for England and Wales

January 2015

Independent Investigations

Learning lessons bulletin

Fatal incident investigations issue 7

Deaths of Travellers in prison

This learning lessons bulletin is one of a number that my office is producing on minority groups in prison. It looks at issues identified in my fatal incident investigations into both self-inflicted and natural cause deaths and highlights learning points for prisons.

Gypsies and Irish Travellers[1] are among the most marginalised groups in society and there is research evidence that both physical ill health and suicide are more prevalent among this group than in the wider community[2]. Research also suggests that Travellers may receive poor treatment in the criminal justice system and in prison[3].

Only a relatively small number of my office's fatal incident investigations identify the prisoner who died as a Traveller. However, it is evident that poor recording of ethnicity in prisons makes it difficult to know how accurate this is and how widespread the problems identified are. Not all the issues identified are unique to Travellers. Nonetheless, a number of learning points emerge for the Prison Service which I hope can contribute to keeping members of these groups safe in prison.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Background

Romany Gypsies, Irish Travellers and other travelling communities who share some historical and cultural traditions[4], are recognised and protected as an ethnic group under the Equality Act 2010. We refer to these different groups as 'Travellers' for ease of reference in this report.

'Gypsy or Irish Traveller' was first included as an ethnic group in the Census in 2011, and 58,000 people selected this option. This made it the smallest ethnic group in 2011, accounting for 0.1% of the population of England and Wales. This is likely to be a substantial undercount, as non-official figures put the number of Travellers in the UK between 122,000[5] and 300,000[6] (accounting for 0.2% to 0.5% of the UK population).

Levels of self-reporting are low and, in prisons, it has only been possible to record ethnicity as "Gypsy or Irish Traveller" since the introduction of the P-NOMIS prison record system (which included this as an ethnicity for the first time). Those prisoners who were already in prison before the new system was introduced are probably not recorded as Travellers. It is therefore difficult to know the actual size of the Traveller population in prison.

A survey by HM Inspectorate of Prisons[7] found that 5% of prisoners identified themselves as a Gypsy, Romany or Traveller, suggesting that this group is considerably over-represented in prison. Travellers are not evenly spread throughout the prison system, so in some establishments the proportion is much higher. There was one adult prison where the proportion was as high as 12% and a Secure Training Centre (which holds children) where it was 22%.

This bulletin is based on investigations of prisoners who were identified as Travellers, but it is likely that we have investigated deaths of others who were not identified as Travellers. If prisons do not collect data on the ethnic make-up of the population, it is easier to overlook the needs of minority groups[8].

There is evidence to suggest that Travellers in the community have more health issues and are at increased risk of suicide than other ethnic groups[9]. Travellers have lower life expectancy than the general population and conditions such as bronchitis, asthma and angina are much more prevalent. There are no official statistics to show the suicide rate for Travellers in the community in the UK, but there are many studies which show the rate to be higher than the general population.

Family contact

All prisoners are affected by the separation from their family. However, for Travellers, this separation is often a particularly difficult aspect of imprisonment. Travellers are highly family orientated, often marrying young and having large families. Although not all have nomadic lifestyles, Traveller families often do not have landline telephones, resulting in extra cost to call a mobile. Irish Travellers, in particular, are more likely to have family in the Republic of Ireland[10]. This combination of factors can lead to expensive calls to mobiles charged at an international call rate.

The effect separation can have, and the distress it can cause, is illustrated by the case of Mr A.

Case study A

Mr A had a history of self-harm. He had taken an overdose of medication once and tried to kill himself four other times by tying ligatures. When he transferred to another prison, no information was provided about these suicide attempts.

When Mr A arrived at the new prison, he applied to move to another prison closer to his father, who was ill and unable to visit him. The prison refused his request and said he had not been at the prison long enough. Mr A then requested a move on compassionate grounds and repeatedly asked staff about it. He never received a response to this request and there is no evidence it was ever considered.

Mr A was often found using illegal mobile phones in the prison. One of his cellmates said that he used them to call his family every evening to talk to his children and say goodnight. When Mr A was found with mobiles he was dealt with through the prison disciplinary system, as expected.

Another prisoner said that Mr A was often upset and stressed because the Head of Security was pressing him to give information about where he got the mobile phones from. The prisoner said Mr A had been tearful when talking about it. Mr A claimed that the Head of Security had threatened him, and said that he would not be able to see his family if he did not give him information.

The day before Mr A died, he was charged with assaulting an officer during a search to find his mobile phone. He spent the night in the segregation unit and the disciplinary hearing was held the next day. The hearing was adjourned and afterwards, Mr A told another prisoner that he was very upset and finding it hard to cope. Shortly afterwards, Mr A hanged himself in his cell.

In the months before his death, Mr A had faced a number of problems. For three months, Mr A could only have closed visits and had not been allowed to see or speak to his children. (Our investigation found this was a disproportionate response to a minor incident.) He had a number of disciplinary hearings, for possessing mobile phones and assaulting an officer. Mr A's application for a compassionate transfer to a prison closer to his family was not properly considered.

A recent learning lessons bulletin[11] from this office highlighted the key role family contact plays in the rehabilitation of many prisoners. For Mr A, his lack of contact was especially stressful because, as with many Travellers, he placed such importance on these relationships.

Mental ill health

There are high levels of mental illness in the Traveller population[12]. Travellers have been found to be nearly three times more likely to suffer from anxiety and over twice as likely to be depressed compared to the rest of the population[13]. HM Inspectorate of Prisons found higher levels of mental health problems among Travellers compared to other prisoners (27% compared with 13%)[14].

Of the Travellers whose deaths we investigated, over half had at least one mental health problem. Depression and schizophrenia were common. Unfortunately, our investigations found that the mental health support Travellers received in prison was variable.

Travellers whose death was self-inflicted had either attempted suicide before, or had self-harmed. When suicide and self-harm procedures (ACCT[15]) were in place, they were not always implemented fully. The appropriate assessments were not always consistent or adequate and there was a lack of mental health input at some reviews. This reflects what we found more widely in our recent thematic report on the ACCT process[16].

Mr B's case illustrates some of these issues. Mr B had mental health problems and the care that he received was deficient in a number of ways.

Case study B

Mr B was diagnosed with schizophrenia and had a history of substance misuse. When he arrived in prison, ACCT procedures were started as he had recently harmed himself in the community. During the next four months, he attempted suicide four times.

Mr B told healthcare staff that he had used illegal drugs over a long period and he started a detoxification programme. Mr B was under the care of the mental health in-reach team as he had episodes of psychosis where he heard voices and told staff the voices were telling him to kill his cellmate.

Mr B took an overdose of drugs and was sent to hospital. An ACCT was opened when he returned to the prison. Mr B asked to transfer to a prison closer to his family so it would be easier for them to visit. Mr B was worried about transferring and the possibility that he might be moved further away from his family.

Mr B started a behavioural therapy course and continued to see a psychiatrist who regularly reviewed his medication. Mr B self-harmed and made a ligature from bedding, so another ACCT was opened. During the ACCT assessment, Mr B said that he was feeling depressed and upset because he could not see his family as often as he would like, because of the distance from the prison.

Mr B was told he would be transferred closer to his family and was happy about this move. However, when Mr B was moved, he was taken to a different prison, further away from his family, and without any explanation. A member of the mental health team did not assess Mr B when he arrived at the new prison. Mr B told staff that he was feeling anxious because his family were so far away and could not visit him. He continued to self-harm and was kept on an ACCT. Mr B's risk was assessed as low on his ACCT, even though he had harmed himself the night before. Mr B hanged himself that afternoon.

The support and treatment that Mr B received for his mental health problems was variable. Suicide and self-harm monitoring processes did not always involve a member of the mental health team, despite his mental health problems. His risk, even after he had self-harmed shortly before, was not appropriately assessed.

The behavioural therapy that Mr B was receiving is a recognised treatment for suicidal patients. Mr B was finding it helpful, yet the prison he transferred to did not provide this therapy. The possibility of postponing his transfer until he had completed the therapy should have been considered and discussed with Mr B. Yet Mr B received a double blow: he moved further away from his family and was unable to continue his therapy for his mental health problems.

Literacy

Not being able to read or write is a huge barrier to accessing information and taking part in prison life. Written applications form the basis for nearly all requests in prison, from visiting orders to asking for appointments to see a doctor. Literacy among prisoners is generally low and is even lower for Travellers. Research has identified that over half the population of Travellers in prison have serious problems with literacy[17]. The marginalised status of Travellers within broader society can also limit their capacity and willingness to request help when they need it in prison. As a result, there is a particular need to provide Travellers with alternative sources of information and support so that they can take part in prison life.

The case of Mr C shows how illiteracy can affect the well-being of a Traveller. In this case, the healthcare staff overlooked this Traveller's needs, with fatal consequences.

Case study C

Mr C received a sentence of eight years and transferred to another prison. Mr C could not read or write, but other prisoners helped him out.

Mr C had previously had triple heart by-pass surgery and was a diabetic. He took medications for numerous health conditions including angina, high cholesterol, diabetes and hypertension.

A nurse saw Mr C when he arrived at the prison and recorded his health conditions in his medical record. The nurse and Mr C signed a form called the 'Offender Medication Policy'. The form lists a prisoner's responsibilities when they are allowed to have their own medication to self-administer. The form also asks the prisoner to give details of their next of kin or other person they want the prison to contact in the event of a medical emergency. This part of the form was not completed.

Mr C was given a week's supply of his medication to keep in his cell. He kept his tablets in a special box with the days of the week on them (known as a dosset box) to help him remember to take them correctly. One of his friends on the wing said he reminded Mr C if he had forgotten to take his tablets. Healthcare staff did not make routine checks to ensure Mr C was taking his medication appropriately.

The morning that Mr C died, the officer who did the early morning roll check and the officer who later unlocked the cells, did not wake prisoners up or seek a response from them. Mr C's friend went to see him just after unlock and called his friend's name, but got no response. He sensed that Mr C might have died, and alerted an officer. Nurses attended and started CPR but did not manage to revive Mr C.

The investigation found the decision to allow Mr C to keep his medication in his cell was reasonable and he appeared to have been given appropriate support to help ensure he took it. However, the initial decision was based on an inaccurate assessment. Mr C could not read and therefore was unlikely to have been able to understand the medication leaflets supplied with his medication, unless they were read to him. There was no indication that this was done. This could have been a major oversight if Mr C had lacked the confidence to ask for help and if he had been unsure about taking his medication.

Prisons need to communicate procedures appropriately to prisoners who have low literacy levels. For reasons of safety, this is especially the case for healthcare procedures. As medical information can be complicated, prisons should consider alternative, accessible ways of providing medical instructions and other important information. This could include picture cards, where instead of written instructions, a set of pictures provide the explanation. Buddy schemes, such as Toe by Toe, where literate prisoners are paired to support prisoners who need help with reading or writing, are also useful.

Bullying

Bullying is an issue that came up in a number of our investigations into self-inflicted deaths of Travellers. Bullying in prison has been identified as increasing the risk of suicide and self-harm in a number of previous PPO publications[18]. Discrimination towards Travellers is still commonly experienced in the community and this can manifest itself in prison as threatening behaviour, intimidation or bullying[19].

While there is no direct evidence that bullying was linked to his ethnicity, Mr D's case starkly illustrates the potential impact of bullying.

Case study D

Mr D had been recalled to a local prison. Shortly afterwards he was transferred to another prison. When he was leaving the prison, officers found drugs on him. Mr D said he had been given the drugs to pass to a prisoner at the prison he was moving to. Mr D was charged with a disciplinary offence for possession of the drugs.

When Mr D arrived at the new prison, he said that prisoners had threatened him and demanded £500 in payment for the drugs which he had not been able to deliver as they had been confiscated. A few days after moving prison, Mr D was found hanging in his cell. Fortunately, officers were able to save him in time. He said that other prisoners were still demanding payment for the missing drugs and were threatening violence. The staff opened an ACCT but only for a week.

Mr D was involved in a number of disciplinary hearings for various incidents of poor behaviour. These included barricading himself in his cell, and having a broken table leg under his bed. Mr D was moved to the segregation unit before the hearing for having a broken table leg under his bed. After the hearing, he refused to leave the segregation unit because of threats from other prisoners. An officer submitted a report to the violence reduction team about this.

Mr D moved back to his wing, but refused to go to work because he said he was being bullied. Mr D said he feared for his life and would not come out of his cell. Another officer from the violence reduction team spoke to him, but made no further incident report.

Mr D phoned his father and told him that he was frightened because of the threats he had received. The prison's security department heard Mr D's call to his father (as part of the random screening of phone calls) and passed the information on to the safer custody department. There is no evidence that safer custody staff took any action.

The day after Mr D phoned his father, he stayed on the wing because of the threats against him. He broke his cell window, then asked an officer if someone from the violence reduction team was coming to see him about the bullying. The officer said that he did not know, but if paperwork had been submitted, they would come at some point. Mr D was found hanging in his cell later that afternoon.

Mr D did not feel safe in the prison and the prison did not make sufficient attempts to resolve his concerns. Mr D's disruptive behaviour seemed to be a deliberate attempt to engineer a move to the segregation unit, or another wing. No one appeared to question his motivation or investigate whether this was a result of threats or intimidation from other prisoners. It appeared his behaviour was seen as disruptive, rather than a cry for help.

No one spoke to the prisoners that Mr D alleged were threatening him or managed them under violence reduction procedures. The prison failed to look at all the incident reports together and did not identify or consider the links between his self-harm and bullying.

Footnotes

[1] We refer to the various different groups as 'Travellers' for ease of reference in this report.

[2] Cemlyn, S. et al (2009) I*nequalities experienced by Gypsy and Traveller communities: A review. Research Report 12*. Manchester: Equality and Human Rights Commission.

[3] Mason, P., Hughes, N., Hek, R., Spalek, B. and Ward, N. (2009), *Access to justice: a review of existing evidence of the experiences of minority groups based on ethnicity, identity and sexuality* (Series 7/09). London: MoJ

[4] Scottish Gypsies and Travellers, Welsh Gypsies and Traveller, New Travellers or New Age Travellers, bargees and other people living in boats, fairground and circus families, known as travelling showmen.

[5] Irish Traveller Movement in Britain (2013) *Gypsy and Traveller Population in England and the 2011 Census*.

[6] Council of Europe (2012) *Roma and Travellers*. http://www.coe.int/t/dg3/romatravellers/archive/documentation/strategies/statistiques_en.asp

[7] Her Majesty's Inspectorate of Prisons (2014) *People in prison: Gypsies, Romany and Travellers. A findings paper by HM Inspectorate of Prisons*. London: HMIP.

[8] Irish Penal Reform Trust (2014) *Travellers in the Irish Prison System, a qualitative study*. Dublin: Irish Penal Reform Trust.

[9] Op. cit. (2)

[10] Mac Gabhann, C. (2011) *Voices Unheard: A study of Irish Travellers in prison*. London: Irish Chaplaincy in Britain.

[11] PPO (2014) *Learning Lessons Bulletin: Complaints investigations issue 5, Maintaining family ties*. London: PPO http://www.ppo.gov.uk/document/learning-lessons-reports/

[12] Op. cit. (2)

[13] Parry, G. et al (2004) *The Health Status of Gypsies & Travellers in England*. Report of Department of Health inequalities in Health Research Initiatives Project: 121/7500. Sheffield: The University of Sheffield.

[14] Op. cit. (2)

[15] The Prison Service suicide and self-harm prevention procedures, standing for Assessment, Care in Custody and Teamwork monitoring system.

[16] PPO (2014) *Learning from PPO investigations: Self-inflicted deaths of prisoners on ACCT*. London: PPO. http://www.ppo.gov.uk/document/learning-lessons-reports/

[17] Op. cit. (10)

[18] PPO (2011) *Learning from PPO investigations: Violence reduction, bullying and safety*. London: PPO. http://www.ppo.gov.uk/document/learning-lessons-reports/
PPO (2014) *Learning lessons bulletin: Fatal incident investigations issue 6, Young adult prisoners*. London: PPO. http://www.ppo.gov.uk/document/learning-lessons-reports/

[19] Op. cit. (10)

Lessons to be learned

A number of interlinked issues are visible in most of our investigations of Traveller deaths in prison. Not all these issues are unique to Travellers, but their marginalised status and the prevalence of discrimination against them in prison (and in the community), as well as their lifestyle, can heighten vulnerability. Learning the following lessons would help address this:

Lesson 1 – Prisons should ensure that they identify and record Travellers at reception and update their records for those who were in prison before P-NOMIS was introduced. Prisons should update their records if they find out later that a prisoner belongs to this group.

Lesson 2 – Prisons should be aware that Travellers are at an increased risk of suicide in the community. When assessing level of risk, this should be taken into account, along with other factors.

Lesson 3 – Prison equality groups (or equivalent) should have both a prisoner and staff member representing the needs of Travellers. This role should include meeting and inducting Travellers and providing them with help and support in prison. This could include distributing the 'Travellers in Prison News' publication from the Irish Chaplaincy and signposting education and family support.

Lesson 4 – Prisons should ensure that information and support to maintain family ties is given to prisoners and families. This should include arrangements for visits, telephone calls and assistance for prisoners to write letters. As well as processing applications for transfer requests and compassionate release in a timely and prompt manner.

Lesson 5 – Prisons should consider the risk of suicide and self-harm for apparent victims of bullying and intimidation. This should also be reflected in the anti-bullying strategy so that it is in line with current practice and policy and reflects the links between bullying, self-harm and suicide.

Lesson 6 – Prisons should provide healthcare compacts and agreements in forms other than written for illiterate prisoners. This could include picture explanations.

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.

The Prisons and Probation Ombudsman's vision is:

To be a leading, independent, investigatory body, a model to others, that makes a significant contribution to safer, fairer custody and offender management.

Contact us

Bulletins available online at www.ppo.gov.uk

Please e-mail PPOComms@ppo.gsi.gov.uk to join our mailing list.