

# **Learning from PPO Investigations**

## **Self-inflicted deaths of prisoners – 2013/14**

**March 2015**



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## Foreword



In my annual report for 2013/14, I described the huge increase in suicides in custody during the year as a “rising toll of despair”. Then, as now, I remain shocked by the evident level of despair and the degree of need among the prisoners who took their own lives.

Now that the individual investigations into these deaths have largely been concluded, my researchers have looked thematically across these cases and compared them to the year before to see whether we might understand the increase and – more importantly – contribute learning to help reverse the trend. The need for such learning remains pressing as the number of suicides so far in 2014/15 shows only a modest reduction on the year before.

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 suicide and prisoners spending less time out of cell, but the picture is less than clear. For example, 25% of deaths occurred among prisoners who had over 5 hours a day out of cell, and 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.

Some other notable issues emerge, from which we need to learn. For example, deaths increased significantly in the early days in custody, among those apparently charged with less serious offences and among those on short sentences. There were also a striking number of cases where those who took their own lives were on restraining orders preventing contact with a partner or family member. The use of hard-to-detect “legal” highs also featured in a number of deaths, either because of their pharmacological impact or because of the bullying and indebtedness that attends trafficking in these substances. Worryingly, the quality and timeliness of emergency responses to fatal incidents appeared to deteriorate.

It is also troubling that many investigations 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.

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.

I would like to thank my colleague, Helen Stacey, for preparing this report which is one of a series about learning from my investigations which are intended to contribute to making custody a safer, fairer and more effective place.

A handwritten signature in black ink that reads "Nigel Newcomen". The signature is written in a cursive style with a long horizontal line at the end.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

## Executive summary

In his 2013/14 Annual Report, the Prisons and Probation Ombudsman reported a 64% increase in self-inflicted deaths in custody. The Ombudsman has now completed his investigations into almost all these deaths; 84 of 89 self-inflicted deaths in prison between April 2013 and March 2014 have been included in this research.

This report looks at the Ombudsman's investigations to explore what, if anything, could be identified as having changed between 2012/13 and 2013/14. While no simple well-evidenced answer was found as to why self-inflicted deaths increased so sharply in 2013/14, we aim to draw out learning which could contribute to reversing the trend.

In 2013/14, the prisoners who died were significantly less likely to have been convicted or charged with violent and sexual offences. There was also a significant increase in deaths among those serving short sentences of less than six months.

There were self-inflicted deaths at 53 different prisons, 56% more than the previous year. This included 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. In particular, there was a significant rise in deaths in the first two to four weeks. Prisoners were significantly more likely to have had less than two hours out of their cell in the days before their deaths. This was still the minority of prisoners (14%), and a greater proportion (25%) actually spent more than five hours out of cell.

The investigations identified a number of concerns about the early days in prison: reception suicide risk assessments, first night support, access to prison induction, mental health treatment, and distress at restrictions on family contact.

Some cases reflected the cumulative impact of disciplinary punishments, reduced privilege levels and segregation. These combined to restrict prisoners' access to potential protective factors against suicide and self-harm such as time out of cell, association and a full regime. Decisions in such cases were too often taken in isolation from one another and also in isolation from the ACCT suicide and self-harm procedures intended to support prisoners through crises. In 2013/14, seven prisoners killed themselves while in segregation units.

Weaknesses in the implementation of ACCT continued to be a problem. Too often the individual's triggers were not recorded, there were failures to identify appropriate actions to minimise or resolve the reasons for distress, safety checks were not at the required intervals (or else were too predictable) and too often the case reviews did not include input from a multi-disciplinary team.

There were also a number of prisoners who had very complex issues including mental illness, substance misuse, challenging behaviour and extreme vulnerability. Too little thought appeared to be given to managing such prisoners under the enhanced case review process for ACCT.

Drug use in prison often goes hand in hand with debt, bullying and violence. A number of investigations found evidence of bullying related to substance misuse. This included several cases where prisoners had been taking hard to detect new psychoactive substances, such as spice and mamba. Staff too rarely considered that bullying and drugs made prisoners more vulnerable and can increase the risk of suicide.

Finally, in a number of cases, we expressed serious concerns about the prisons' emergency response. There was a significant rise in cases where there was an unreasonable delay in calling an ambulance.

## Lessons:

- **Seek evidence of risk factors during reception.**

Staff working in prison reception 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.

- **Ensure all prisoners receive an induction, regardless of location.**

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

- **Continuity and responsiveness in mental health care 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 potential increased risk when medication is changed, ended or otherwise disrupted.

- **The first month of custody is especially risky.**

Prisoners are most at risk in the first month of custody. Those whose initial time may be more disrupted – for example due to court appearances – may need additional support.

- **Restrictions on contact with family can be a trigger for self-harm or suicide.**

Relationship breakdown and violent offences against family members are known risk factors for suicide. Being subject to a restraining order can be a sign of increased vulnerability.

- **Increased vulnerability of prisoners with limited access to the main prison regime must be taken into account.**

The cumulative impact of restrictions due to segregation, adjudication punishments, IEP levels and access to work, should be considered for individual prisoners. Lack of activity or lack of income can leave prisoners vulnerable.

- **Prisoners on open ACCT documents must only be segregated in exceptional circumstances.**

Monitor use of segregation for prisoners suffering acute mental illness or at risk of suicide and self-harm. Ensure the reasons are evidenced and that segregation is only used on vulnerable people when there are exceptional circumstances.

Ensure those least able to access regime activities still have opportunities to occupy or distract themselves.

Challenging and anti-social behaviour can be a sign of distress or mental ill-health; it should not be viewed in isolation as a disciplinary issue.

- **Ensure ACCT focuses on the prisoner as an individual, and that the processes are correctly implemented.**

Ensure that prisoners at risk of suicide or self-harm are managed in line with national instructions and guidance.

This includes:

- Ensuring that all staff receive training and are confident in the ACCT procedures;
- Holding multi-disciplinary case reviews involving all relevant people in the decision making;
- Completing ACCT documents fully and accurately, including triggers and realistic, relevant CAREMAP objectives;
- All staff to update the ongoing record. Ensure observations are following the prescribed level at irregular intervals;

- Conducting an ACCT review whenever there is a clear sign, or concerns raised, that risk has changed;
- Using enhanced case reviews for people who present complex issues and behaviours.
- **Increased risk of suicide and self-harm must be considered when a prisoner is a suspected victim of bullying.**

Reports or suspicions that a prisoner is being threatened, bullied, or is vulnerable due to debt need to be recorded, investigated, and robustly responded to.

The potential impact on the victim's risk of suicide and self-harm must always be considered.

- **Effective and confident emergency response saves lives.**

Uniformed and healthcare staff must understand their responsibilities during medical emergencies, including:

- using the correct code to communicate the nature of a medical emergency;
- arriving at the scene with relevant emergency equipment;
- ensuring there are no delays in calling an emergency ambulance.

There should be sufficient staff trained and confident in first aid, including use of defibrillators.



# 1. Introduction

In his 2013/14 Annual Report, the Prisons and Probation Ombudsman (PPO) reported a 64% increase in self-inflicted deaths in custody. Looking just at the prison setting, the number of people who took their own lives increased to 89 from 52 in the previous year<sup>1</sup>.

The Ombudsman has now completed his investigations into almost all these deaths. Anonymous versions of the individual reports are available online<sup>2</sup>, once an inquest has taken place.

This report looks thematically across these cases and offers comparisons to self-inflicted deaths investigated in 2012/13. Our objective was to identify any learning which might contribute to explaining and reversing the troubling upward trend.

The analysis was conducted in November 2014. We were able to include 84 of the 89 deaths in 2013/14 and all 52 deaths from 2012/13.

The first section of the report identifies the characteristics of the prisoners who died. This includes a comparison of demographic and offence-related information between the two years.

Following this, we look at the prisons where there were deaths and those where there were none.

We then explore the circumstances leading to the deaths in more detail, focusing on the prisoners' experiences while in prison. This is done according to three broad themes:

- Early days in prison
- Experiences in prison
- The prison's emergency response.

The final section gives the main lessons.

## 1.1. The Ombudsman's investigations

The Prisons and Probation Ombudsman carries out independent investigations into deaths and complaints in custody. The Ombudsman investigates all deaths, due to any cause, of prisoners, young people in

detention, residents of probation approved premises and immigration detainees.

The purpose of these investigations is to understand what happened, inform bereaved families, identify learning, and assist the Coroner. The PPO aims to make a significant contribution to safer, fairer custody and offender supervision.

PPO investigators have access to the deceased's prison medical record, general prison records (including security information), and can request any other information they need. They interview staff and prisoners if it will aid the investigation.

Almost all the data in this report is drawn from PPO investigation reports and data collection forms about the investigations completed by investigators.

The forms are split into 19 sections and cover most aspects of prison life. They allow some standardisation of the information considered during an investigation which enables comparison. However, not all the information is available or recorded in all cases.

## 1.2. The research

Throughout the report, unless stated, all percentages are out of 84 deaths (2013/14) or 52 deaths (2012/13).

In the report, we highlight where differences were found to be statistically significant<sup>3</sup>. Tests of statistical significance look at how certain we can be about a statistic. They do not tell you about the strength or importance of the difference shown.

We have highlighted where there is statistical significance to 95%. That is, where we can be 95% certain that the difference seen is a true difference between the two years, and not due to chance variation. That is not to say that the other statistics do not show real difference, but just that we can be less certain about it.

## 2. About the deceased

This section looks at the demographic and offence-related information we have about the people who died. For consistency with the rest of this report, we look at 84 deaths in 2013/14, and 52 in 2012/13.

In general, we found that the profile of the prisoners who died was similar between the two years.

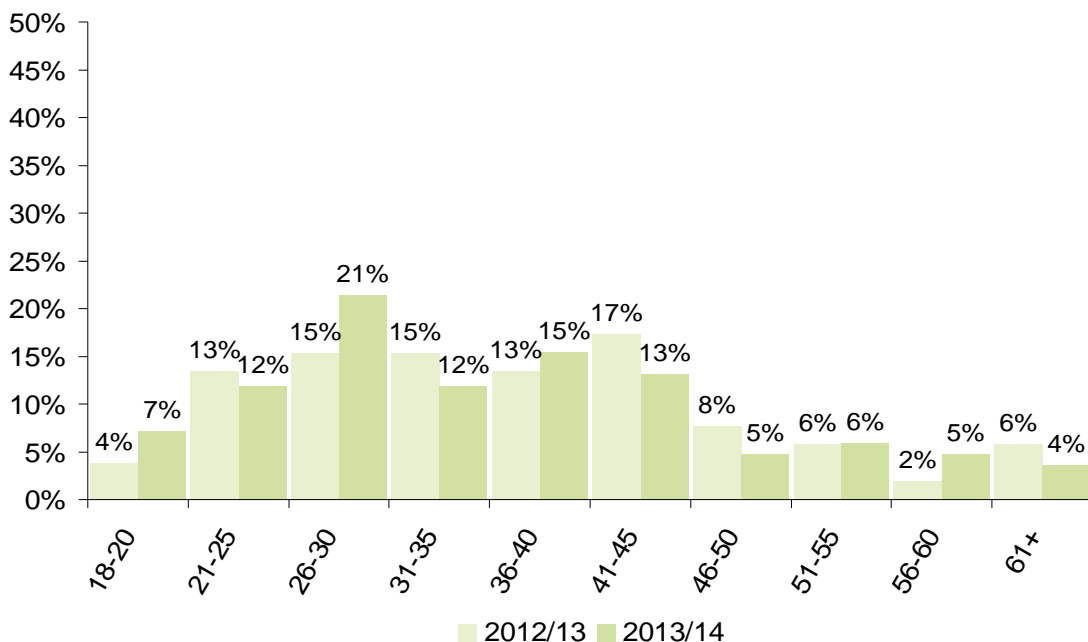
Most were white males. Almost all died after hanging themselves in their cell; typically from window bars or the bed.

Suicide affected all sections of the adult male prison population: different ages, marital statuses, and prisoners with or without children. Few were foreign nationals, although the proportion increased.

Those imprisoned for violent or sexual offences made up over half of deaths in both years. However, this was less pronounced in 2013/14 which saw an increase in deaths among those imprisoned for robbery, criminal damage, and other offences.

Remand and unsentenced prisoners made up a reduced, but still considerable, proportion of deaths in 2013/14. There was a particular increase in deaths of prisoners serving sentences of less than six months.

Figure 1: Percentage of self-inflicted deaths, by age group



### 2.1. Demographic characteristics

In both years, there were just two self-inflicted deaths of women prisoners; 97% of the deceased discussed in this report were men. Men not only make up the vast majority of the prison population, but in the community are at greater risk than women of self-inflicted death.

The average age of those taking their own lives in 2013/14 was 36 years, slightly younger than the previous year (38 years). The main difference seen was in the increased proportion of 26 to 30 year olds (from 15% to 21%) (figure 1).

In 2013/14, 87% of the prisoners were white, compared to 77% the year before.

Table 1: Percentage of self-inflicted deaths, by ethnic group

Ethnicity	2012/13	2013/14
Asian	4%	5%
Black	12%	6%
Mixed	8%	2%
White	77%	87%

The proportion of deaths of foreign national prisoners increased from 4% to 14%. This came very close to our test for statistical significance (it was statistically significant to 92% rather than 95% or above).

Only a small proportion of the prisoners who died had a disability; two per cent in 2012/13 and nine per cent in 2013/14.

The relationship status of prisoners was similar for the two years:

- 42% were single (previously 44%)
- 35% were married or in a long term relationship (the same as in 2012/13)
- in other cases this information was not known, or they were in a relatively new relationship
- 39% had children compared with 42% in 2012/13.

## 2.2. Offence and sentence characteristics

In 2012/13, those convicted or charged with violent and sexual offences made up over three quarters of self-inflicted deaths (figure 2). In 2013/14, the proportion decreased significantly from 77% to 56%. The proportion of prisoners whose offence or charge was robbery, criminal damage, or 'other' increased significantly (13% to 33%).

'Other' includes offences such as harassment, drugs offences, public order offences, and breaches of licence.

In 2013/14, the proportion of deaths where the victim of the offence was a close friend or family member was 30%. In 2012/13, it was 43%. However, there was a large proportion where this information was not known: 20% in 2013/14 and 15% in 2012/13.

A smaller proportion of prisoners were in prison for the first time (27% compared to 35% in 2012/13).

The proportion of deaths of prisoners held on remand, or who were not yet sentenced, fell in 2013/14 (figure 3). At 32%, the proportion was still high compared to the proportion of the prison population who are on remand or unsentenced. This group continues to be at particular risk.

There were also 15% who had been sentenced to less than 6 months in prison. This was a statistically significant increase from the previous year, when there had been none.

Figure 2: Percentage of self-inflicted deaths, by offence type

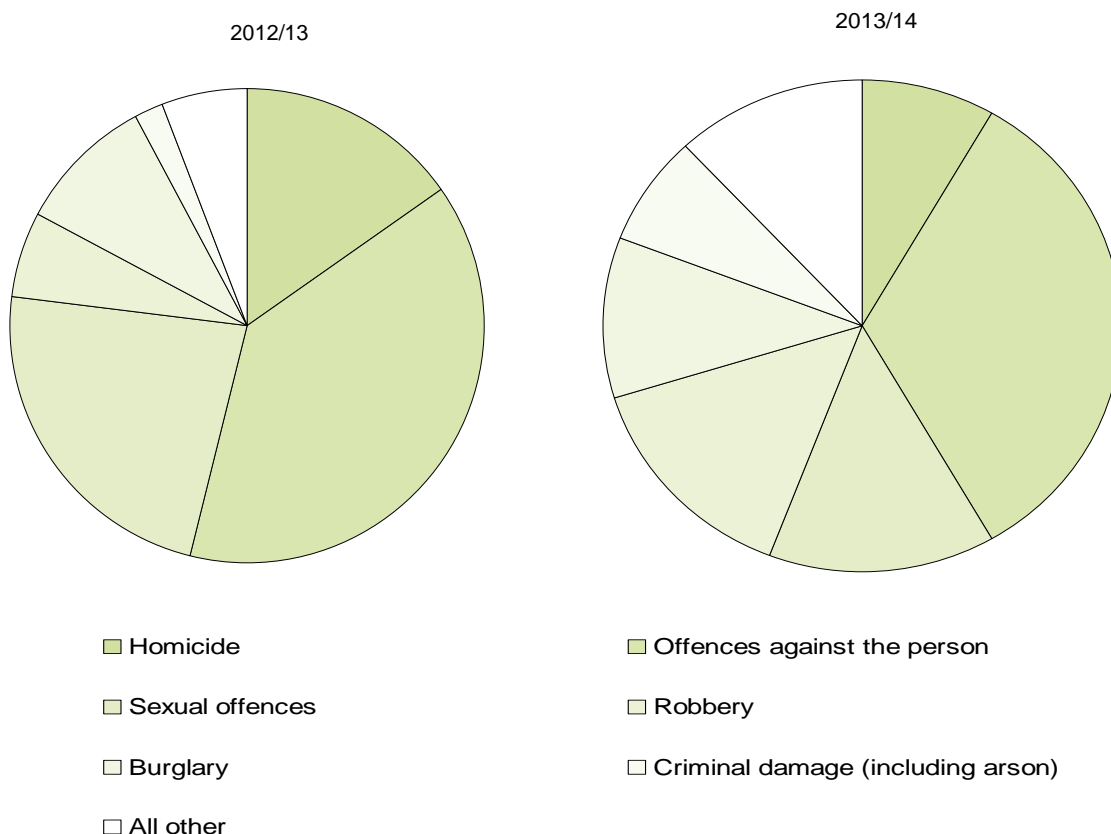
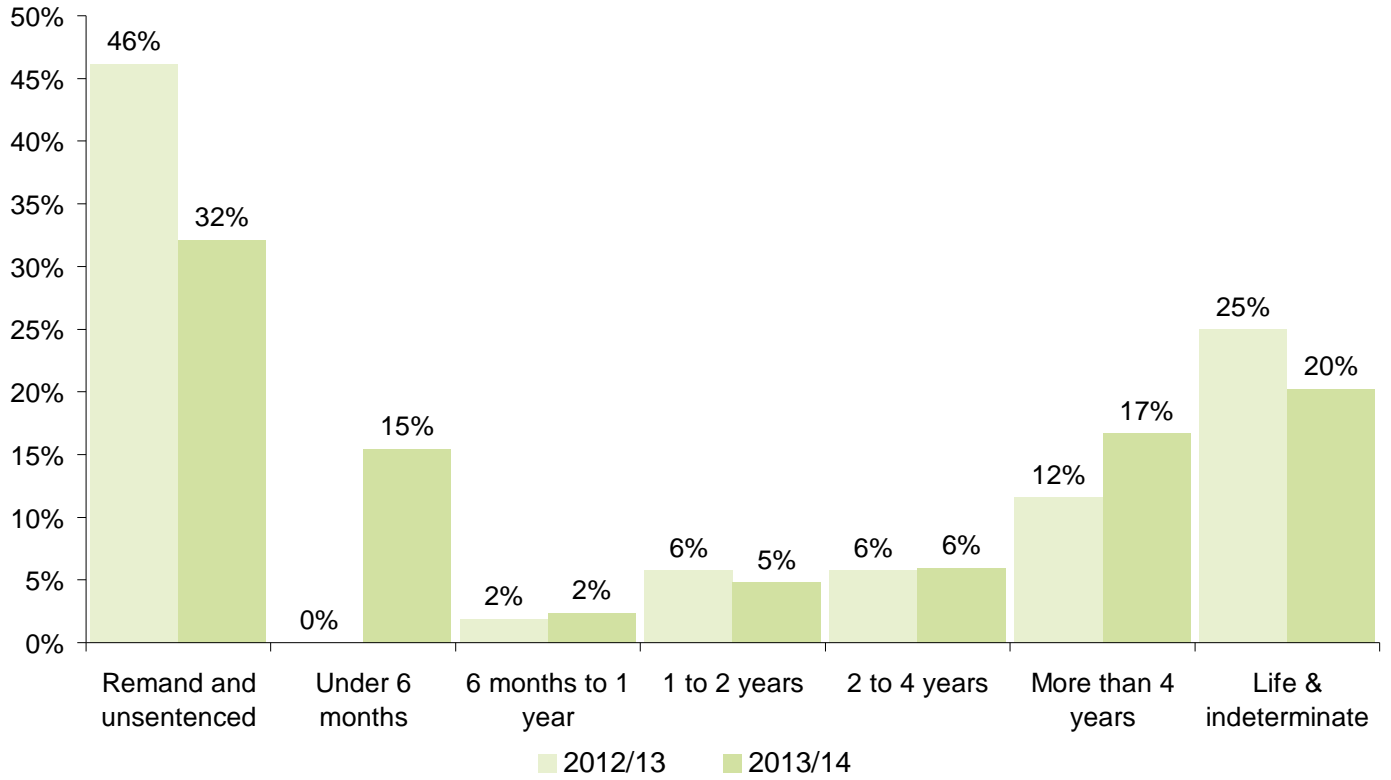


Figure 3: Percentage of self-inflicted deaths, by sentence length



### 3. About the prisons

This section looks at where prisoners died in the two years.

In 2013/14, suicide affected much more of the prison estate than before. In total, there were self-inflicted deaths at 53 prisons; 56% more than the previous year. Nearly half of these prisons (48%) had not had a self-inflicted death in 2012/13 and some had not experienced a self-inflicted death for some years or ever.

There was an apparent increase in self-inflicted deaths in both public and private prisons.

Although there were population pressures across the estate, in 2013/14 the average population for the year was higher at prisons where there were self-inflicted deaths. These prisons were also more likely to have an average population in excess of the prison's 'certified normal accommodation'. This may reflect our previous finding<sup>4</sup> that most suicides occur in local prisons which house some of the most at risk prisoners, for example those on remand and those at the start of sentences. These are also the most crowded and become even more crowded at times of population pressure.

#### 3.1. Type of prison

Self-inflicted deaths increased across the male prison estate. The proportion of deaths in private sector prisons remained stable at one in ten; although this represents an increase in the number of such deaths from five to nine. It is notable that private prisons have contractual protections which make them much less subject to the efficiency and crowding pressures that affected much of the public sector in 2013/14.

One area of change was the high security estate. The proportion of deaths which occurred in these prisons increased. In 2013/14, 13% of the deaths were in the high security estate, compared to just 6% the previous year. Again, it is notable that high security prisons are largely protected against population pressures because of the risks

they must manage and were also not subject to the same efficiency measures in 2013/14 as were applied to the rest of the public sector prison estate.

#### 3.2. Population

Between April 2013 and March 2014, the average prisoner population in prisons where there were self-inflicted deaths was 860. At the other prisons the average was 582.

This is similar to the previous year where the average population in prisons where there were self-inflicted deaths was 884, and 606 elsewhere.

These figures are based on the monthly population statistics published by the Ministry of Justice<sup>5</sup>. They exclude prisons that closed or were emptied of their populations to change their function during the year.

Certified Normal Accommodation (CNA) is the Prison Service's measure of how many prisoners can be held in decent and safe accommodation at the prison. This is sometimes referred to as 'uncrowded capacity'.

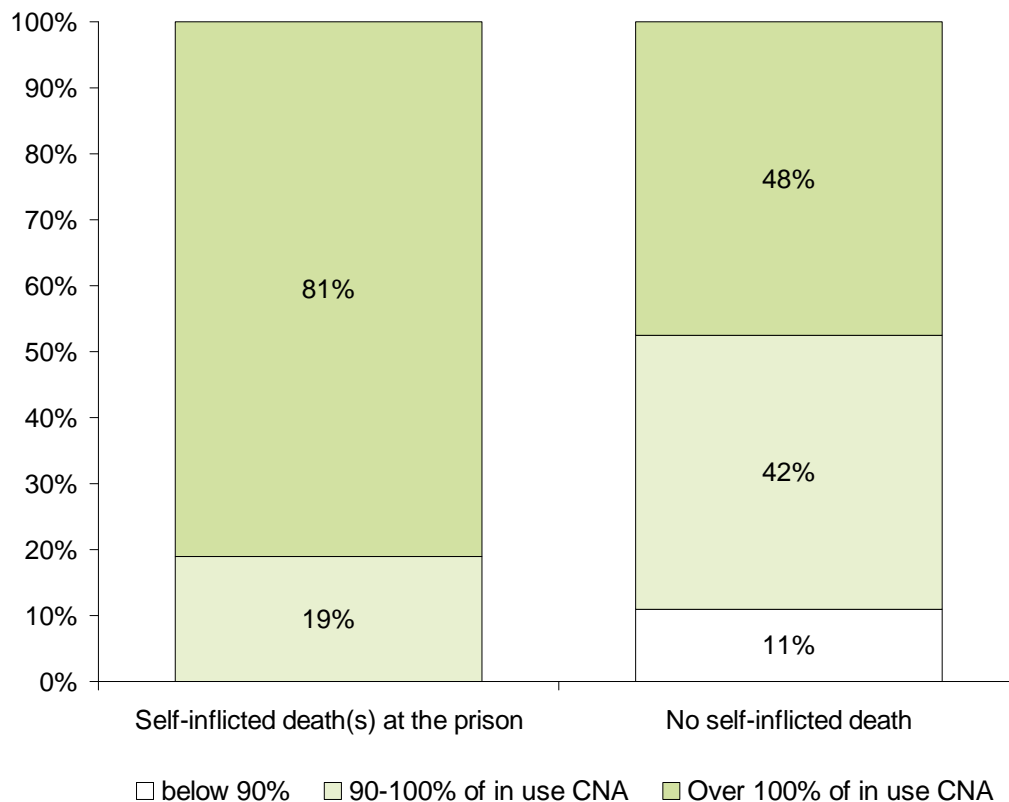
The population statistics give each prison's population as a percentage of 'in use' CNA. In use CNA is CNA excluding any accommodation that is damaged, or otherwise unavailable.

For each prison, we have looked at the mean (average) of this population as a percentage of in use CNA figure between April 2013 and March 2014. There were population pressures on most of the prison estate (except high security prisons) but it appears that pressures were more acute in prisons where there were deaths.

Eighty one per cent of prisons where there were deaths had average populations above 100% of their in use CNA (figure 4). This was true of 48% of the other prisons; however, a further 42% had population levels of between 90 and 100% of their in use CNA.

Compared to the previous year, this is a slight increase. Then 76% of prisons where there were deaths had an average population above 100% of in use CNA.

Figure 4: Percentage of prisons, by average population as a percentage of in use CNA (2013/14)



## 4. What changed in 2013/14?

This section looks more closely at the experiences of custody of the men and women who died.

It looks for differences that might help explain the increased number of self-inflicted deaths in 2013/14, and lessons to help tackle recurring issues.

It is split into three sections:

- Early days in prison
- Experiences in prison
- The prison's emergency response.

### 4.1. Early days in prison

The prisoners who died in 2013/14 were more likely than the previous year to be in the first month of custody (excluding previous sentences). There was a significant rise in deaths during the first two to four weeks in prison.

Investigations of deaths in both years found weaknesses in the reception process. Too often the risk assessments relied heavily on the apparent demeanour of the prisoner, rather than on consideration of documented risk factors. These issues are discussed in greater depth in our recent thematic report about assessing risk of suicide<sup>6</sup>.

In 2013/14, investigators were more likely to note concerns about prison induction. Of particular concern were prisoners who missed receiving induction information – in a number of cases because they were diverted away from the standard process, either because they were not held with mainstream prisoners, or because court appearances and other appointments led to them missing induction sessions.

For the prisoners who died between two weeks and a month into custody, the disruption and worry of continuing court

cases, changes to mental health medication and waiting times for mental health treatment were common concerns identified in the investigations.

A number of short-term prisoners were subject to restraining orders. For these men the breakdown in their relationships and the ban on contact with partners and children seemed a considerable source of their distress.

#### 4.1.1. Time in custody

One of the more striking differences between 2012/13 and 2013/14 was that, on average, the prisoners died earlier into their sentences or remand period. The average (median<sup>7</sup>) number of weeks spent in prison fell from 24 to just 9.

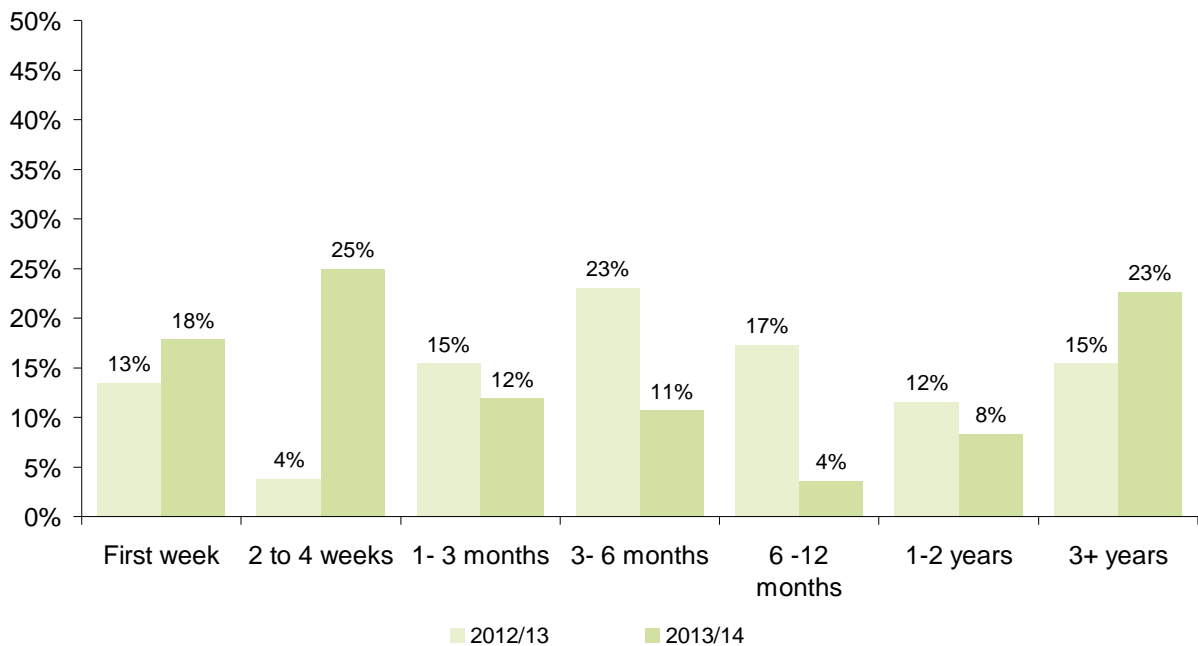
There was a slight increase in the proportion of prisoners dying during their first week in prison. The increase among those in the first two to four weeks was statistically significant (figure 5). In 2013/14, 25% of deaths occurred after the prisoner had spent between two and four weeks in prison, compared to just 4% the previous year.

In both years, the majority of prisoners died during their first few months in prison – the early period in custody is known to be a risky time. After the initial reception and induction period there is often little ongoing support for new arrivals.

During 2013/14, there was also an apparent increase in the proportion of long term prisoners taking their own lives. Twenty-three per cent had been in prison at least three years, most of whom had completed more than five years of their sentence when they died. This compares to 15% in the previous year.



Figure 5: Percentage of self-inflicted deaths, by time in custody



#### 4.1.2. First night and reception

Most of the prisoners who died – including those who had been in prison for some time – had spent less than three months at their final prison.

Fifty-six per cent of the prisoners in 2012/13 and 68% of the prisoners in 2013/14 had recently arrived in prison or had transferred from another prison. We were concerned about the reception process in around 40% of these cases in both years.

The deaths of Mr A and Mr B highlight the importance of effective assessment of suicide and self-harm risk factors on reception. Mr B was facing his first night in prison, whereas Mr A had served a number of years already. Otherwise, the problems presented by the cases are strikingly similar.

In neither case were the men’s clear risk factors for suicide and self-harm identified by reception staff and balanced against their apparent mood in a considered risk assessment. Vulnerable men were left alone and unsupported. In the two cases highlighted (along with others) the men took their lives within hours of passing through reception.

Looking beyond reception risk assessments, both men were located in areas of the prison – the segregation unit and first night centre –

which should have provided additional safeguards but this did not happen.

#### Case Study A

Mr A was an indeterminate sentenced prisoner who had served several years more than his original three year tariff. Mr A was returned to closed conditions from an open prison, after concerns about his risk. On the morning of his transfer he attempted suicide. After being supported under ACCT procedures<sup>8</sup>, including a period of constant supervision, he appeared to settle and staff stopped monitoring him.

A month after returning to a closed prison, he was transferred to a different prison. This took him further from his family. Although risk of self-harm was noted on his Person Escort Record<sup>9</sup> (PER) the sending prison did not send full details about his self-harm and mental health history.

The information was not sent because his last ACCT document had closed 31 days previously. The prison’s discharge checklist asked about ACCT documents in the past 30 days. Reception staff at the new prison did not act on the information in the PER or in his medical record.

In light of his significant and very recent risk factors, we considered that the information should have been included with his core record, or at least flagged as a risk.



Mr A had well documented mental health problems. He had very recently been considered a high risk and been constantly supervised after attempting suicide. A Parole Board review decision had been deferred, and he was being transferred to another closed prison. These were potential triggers for suicide and self-harm because the prisoner perceived them as backward steps affecting the possibility of his release.

Mr A was on the enhanced level of the Incentives and Earned Privileges (IEP)<sup>10</sup> scheme. When he arrived at the new prison staff told him his IEP status had been recorded as standard. He became upset and agitated and refused to participate in the reception process. This meant he did not have an initial health screen.

In protest, Mr A refused to go to the induction unit and was taken to the segregation unit. As an enhanced prisoner he was usually allowed to wear his own clothes and he refused to wear the prison clothes staff gave him. He remained under a blanket in his underwear. The nurse who assessed him as suitable for segregation did not review his medical records.

Hourly checks, intended as a safeguard for those held in segregation, did not take place. Mr A was found hanging in his cell later the same day.

### **Case study B**

Mr B had alcohol problems and was arrested after allegedly assaulting and threatening to kill his mother. In police custody, he had to be taken to hospital, after having a fit caused by withdrawing from alcohol.

He was remanded to prison. The next morning he was found hanged in his cell.

Reception staff at the prison did not properly consider Mr B's risk factors. He had never been to prison before and was withdrawing from alcohol. He had been charged with violent offences against a family member. These are factors known to increase the risk of suicide.

Instead staff relied too much on his personal presentation. They were satisfied with how he appeared and did not begin suicide and self-harm monitoring.

In response to previous deaths, the prison had introduced a new suicide and self-harm screening form, but staff did not complete this properly. A separate assessment used by healthcare staff did not appear adequate to assess risk in the prison context.

Although he was housed in a dedicated first night centre, there were no additional safety checks for new arrivals during the night. This was particularly concerning because of the risk of suicide associated with alcohol (or other drug) withdrawal.

### **Lessons**

*Staff working in prison reception 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.*

### **4.1.3. Induction**

As we have noted, there was a significant increase in deaths in 2013/14 among those who had been in prison between two and four weeks. There was an apparent rise in the proportion of deaths in prison induction units (13% in 2013/14 from 4%). PPO investigations identified concerns about the induction process for recent arrivals.

In some cases the induction, intended to help prisoners understand the rules and how to use the systems in prison, was entirely absent. For Mr C, a first time prisoner convicted of sex offences, this can only have added bewilderment and frustration to the stress of custody. He did not know how to go about even basic tasks such as making a phone call.

It seems induction processes were not robust enough to cover all prisoners. In particular, this affected those unable – for whatever reason – to participate in the standard system.

Mr C was recorded as having an induction session on the one day he was held in a normal location. No sessions were given once he moved to the Vulnerable Prisoner (VP) unit.

Another sex offender who was recalled to prison just before his licence was about to expire, was held in segregation for three days before he died, waiting to transfer to a prison with separate VP accommodation. In the segregation unit, he had no induction, he was not able to use the prisoner telephone system and had a very restricted regime.

The problem was not restricted to vulnerable prisoners. One man was involved in a lengthy court case and so was not at the prison during the day. As a result, he did not receive any induction information, and – despite evident mental and physical health needs – he was not seen by healthcare staff.

#### **Case study C**

Mr C was found hanged in his cell just over two weeks after being sentenced to five years in prison.

Initially, Mr C was incorrectly held on a normal induction wing in a local prison. On his second day, it was identified that he was a sex offender and was moved to the prison's vulnerable prisoner unit.

Within days, he moved to a new prison but he did not receive an adequate induction at either.

When he arrived at the second prison, he clearly still did not understand basic prison processes. He had to ask an officer how to use the phone system. This meant that 11 days into his sentence he still did not know how to contact his family and had been unable to speak to them.

Staff should have offered Mr C the opportunity to call his family when he arrived at both prisons. There is no evidence this happened.

This was particularly concerning as it was Mr C's first time in prison and he was a long way from his family in Ireland.

#### **Lessons**

*Prisons must ensure that new arrivals promptly receive an induction to equip them with information to help them meet their basic needs in prison. This is especially important for prisoners who are unable – for whatever reason – to attend standard induction sessions.*

#### **4.1.4. After 'early days'**

Looking at those who had been in prison between two and four weeks, two clear issues emerge. The initial shock of custody may have begun to pass, but many are faced with continuing disruption, pressure and stress of attending court, weeks or even months, after they first arrive in custody.

Issues about mental health referrals and treatment arose with unacceptable frequency in the investigations into these deaths. Too often, prisoners died before referrals for assessment or treatment were acted upon. This even included prisoners, like Mr D, who were acknowledged to be in crisis and were managed under ACCT procedures.

In other cases, there was little or no continuity with mental health treatment received in the community or in psychiatric hospitals. A frequent consequence was an abrupt change, or end, to previous medication. Mr E had recently been discharged from a secure mental health hospital but didn't receive his antidepressant medication, was not seen by the psychiatrist as he should have been, and had his antipsychotic medication reduced without close monitoring.

Such changes can be extremely dangerous for a group already at particular risk of suicide and self-harm. If changes were necessary, this ought to have been carefully managed and the prisoner closely supported.

### Case study D

When Mr D arrived at prison he told staff he wanted to kill himself. He had a number of other risk factors including a history of self-harm, dependence on alcohol, and he had been sent to prison for a violent offence against his partner.

Staff moved him to a safer cell and began ACCT processes. He was appropriately prescribed anti-depressants.

Mr D appeared to improve over the next two weeks and the ACCT plan was closed. At that time he was still undergoing detoxification and was waiting for the mental health team to assess him.

Mr D's appointment was not given sufficient priority for someone who had a history of depression, had previously taken an overdose, had said he would kill himself, and who was withdrawing from alcohol.

No one from the mental health team attended any of his four ACCT review meetings.

Around a week after the ACCT was closed, Mr D tearfully asked a prison chaplain to help him contact his girlfriend. The chaplain first wanted to check that he was allowed to contact her, so said they would try to arrange a call the next morning. Later that afternoon, Mr D's cellmate found him hanged.

### Case study E

Mr E had a history of mental health problems dating back to when he was a teenager. He was arrested for manslaughter and initially held in prison, but his vulnerability and poor mental health led him to be transferred to a secure mental health hospital.

The treatment he received helped to stabilise him and he was considered well enough to stand trial. Mr E was convicted and received a life sentence. He returned to prison where the Ombudsman's investigation raised concerns about his on-going mental healthcare.

The prescription he was given when discharged from hospital was not verified by the prison on reception and he did not receive an antidepressant and a vitamin supplement. Although the prison later requested details of his treatment and medication, when it was received no one appears to have read it or changed his medication as a result.

Mr E was under the sole care of the prison psychiatrist and should have been reviewed every two months. No other member of the mental health team was given responsibility for his ongoing care. He was not seen at all for nearly nine months, when the psychiatrist re-established contact.

In the weeks before his death, his antipsychotic medication was reduced rapidly at his request, but without any increased monitoring. However, none of the staff or prisoners who came into contact with Mr E noticed any change in his mood or behaviour in the time before his death. Mr E suffocated himself and was found dead by an officer in the morning.

### Lessons

*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 potential increased risk when medication is changed, ended or otherwise disrupted.*

*Prisoners are particularly at risk in the first month of custody. Those whose initial time may be more disrupted – for example due to court appearances – may need additional support.*

#### 4.1.5. Restraining orders

In 2013/14, there were a number of men serving short sentences (less than six months) who took their own lives. In many respects these cases were similar to those where prisoners died only a short way into their sentence. However, one feature in particular stood out: a number of these men were subject to restraining orders preventing contact with their current or former partner (or, less often, other family members).

The restriction on contact – however rightly imposed – was a source of considerable distress. In a few cases, the men indicated lack of contact was a trigger for self-harm.

There were several cases where men had either been sent or recalled to prison for breaching the restraining orders. In other cases, restraining orders had been imposed by the court at the same time that the prisoner was sentenced to prison.

Some prisoners were serving very short sentences. For example, Mr F who was sentenced to 19 weeks in prison. Others included men sentenced to 12 weeks for breaching a restraining order, 8 weeks for harassment, and a 12 week sentence for assault.

### Case study F

Just days before being sent to prison for harassment of his wife, Mr F was hospitalised after taking an overdose. The judge also imposed a restraining order, banning him from contacting his wife or children for two years.

He had a high number of risk factors. It was his first time in prison, he was suffering from depression, he had been convicted of violent offences against a family member, and he had very recently attempted suicide.

Court staff completed a suicide and self-harm warning form. Separately, a mental health worker from court phoned the prison to alert them that he was a risk of suicide.

When he arrived at the prison Mr F was admitted to the healthcare unit as he was still experiencing internal bleeding from the overdose. Mr F told a doctor that, because of the restraining order, he would starve himself to death.

He was seen by two welfare officers to discuss resettlement. One recorded that Mr F continuously spoke of killing himself in prison.

Another officer was sufficiently concerned that she asked the mental health team to assess him. Sadly, the next day, before he could be seen, Mr F hanged himself.

None of the staff who saw him – including officers, nurses and doctors – began ACCT self-harm monitoring.

### Lesson

*Relationship breakdown and violent offences against family members are known risk factors for suicide. Being subject to a restraining order can be a sign of increased vulnerability.*

## 4.2. Experiences in prison

This section looks more closely at the issues in prisoners' daily lives before their deaths. The circumstances leading to a self-inflicted death are particular to the individual but here we seek to draw out common themes and broad changes seen in 2013/14.

In the days before they died, the proportion of prisoners who had less than two hours out of cell increased significantly. Few had effective relationships with personal officers.

Access to distractions such as work and association, or even opportunities to use coping mechanisms like smoking, can be very important. This is particularly true for prisoners held in segregation who do not have access to a normal regime.

The number of deaths in segregation units rose in 2013/14 and included prisoners monitored under ACCT, who should have been segregated only if there were exceptional reasons.

Almost 3 in 10 prisoners were being monitored under ACCT procedures at the time of their death. This is unchanged from the previous year. The investigations found increased deficits in the implementation of the process, and complex cases which could have benefited from the enhanced case review system.

### 4.2.1. Regime

One of the striking differences in 2013/14 was that more prisoners had less than two hours a day out of their cell in the week before they died. In 2013/14 14% had less than two hours out of cell compared to 2% the previous year. The difference was statistically significant.



However, the picture is not entirely clear. In both years, there was a large proportion of deaths – over a third – where this information was not recorded. And in 2013/14, the proportion of the prisoners who had had more than five hours out of cell was relatively stable (25% in 2013/14 and 21% in 2012/13).

In most prisons prisoners are assigned a 'personal officer', usually someone who regularly works on their wing. The officer is intended as the prisoner's main point of contact and is expected to get to know the prisoner, check their welfare regularly and help them with any problems.

In 2013/14, a smaller proportion of prisoners had a named personal officer than the year before (43% compared to 52%). Of those who had one, the proportion of prisoners who were at least 'quite well' known by their personal officer was 23% – exactly the same as in 2012/13.

The picture is mixed when you look at prisoners' ability to stay in touch with friends and family. The proportion receiving monthly (or more frequent) letters fell – from 31% to 21%. But the proportion receiving monthly visits was stable at around 20%. Those who were in monthly telephone contact increased from 52% to 62%.

The death of Mr G highlights how important these issues can be to prisoners. In over five years, Mr G gave little indication that he was at risk of suicide.

A prison disciplinary punishment, in the run up to a parole decision, caused him significant distress while at the same time severely limiting his access to the regime and possible coping mechanisms.

### Case study G

Mr G had been serving an indeterminate prison sentence for over five years when he took his own life.

He had only once previously shown any signs of being at particular risk of suicide when several years into his sentence he told staff he wanted to kill himself. Soon after, he claimed he had only said it to annoy staff and cause them more work.

The year before his death, Mr G was returned to closed conditions from an open prison. The turning point, however, appears to have been slightly later at an adjudication (disciplinary hearing) when he was found guilty of failing to provide a urine sample for drug testing.

The investigation found that the hearing had been fundamentally flawed. In particular, Mr G had not been allowed to question the evidence against him or give any mitigation. Mr G received a relatively severe punishment. He also lost his prison job and his 'enhanced' IEP status. He appears to have been placed on the basic (lowest) regime level.

This had a number of consequences for Mr G. He had a parole hearing scheduled and he was worried the disciplinary finding would harm his chances of release.

He lost his income, and the ability to spend the money he already had. His access to television and use of the gym was stopped. He was angry about the hearing, and felt unfairly labelled as a liar.

Mr G was a smoker. He had tried to give up but found not smoking too stressful. Before he was locked in on the night he died, he asked friends for tobacco.

The investigator did not find evidence that he was in debt to other prisoners. However, with no income and unable to spend any private cash for a prolonged period, he would have been vulnerable to such exploitation. There was no indication that the adjudicator had taken into account the effects on Mr G when deciding on the level of punishment.

One of the main ways a prisoner's access to the regime is regulated is the Incentives and Earned Privileges (IEP) scheme. At higher levels of privilege prisoners can (for example) rent a television, wear their own clothes, have more time out of cell, and spend more of their money. Some jobs in prison are also reserved for those at certain levels of privilege.

In a number of cases we saw prisoners with a history of mental health problems on the lowest level of privilege (known as basic). This reduced their access to possible coping strategies. For some, such as Mr H, some behaviours that led staff to downgrade their privilege seem likely to have been related to their mental health condition.

### **Case study Mr H**

Mr H had a history of self-harm, alcohol and drug misuse, mental health problems and physical complications related to a previous injury. He had been charged and subsequently convicted of a serious violent offence and due to court restrictions was unable to have contact with his family, which distressed him.

Mr H was sometimes abusive towards staff. He was difficult to manage and frequently self-harmed, including one occasion where he took an overdose. He was managed under ACCT for most of the few months he spent in prison. Despite this, his behaviour was often viewed in isolation as a discipline issue. Sanctions to address his difficult behaviour were not coordinated or consistent and took little account of his vulnerability. On one occasion, he admitted to staff he had bought another prisoner's medication and said that he would like to kill himself. An ACCT was opened but at the same time he was given a written warning under the IEP scheme for concealing medication.

He received further warnings for poor behaviour, being abusive towards staff but also, again, for concealing medication. A few days before his death, he was placed on the basic regime – and despite continuing to be managed under ACCT as at risk of suicide – this left him to deal with enforced isolation for most of the day and few sources of distraction.

In a previous bulletin, the Ombudsman raised concerns about the apparently disproportionate numbers of self-inflicted deaths among prisoners on the basic regime. The bulletin found the removal of privileges needed to be considered on a case by case basis, in relation to the potential to increase risk of suicide or self-harm.

In November 2013, the IEP scheme changed. One major difference was the introduction of the 'entry' privilege level which was for all prisoners in their first weeks in prison. Entry level is more austere than the standard level, but less restrictive than basic level. Given that it was introduced late in 2013/14, and then took some time to be established in prisons, entry level affected very few of the prisoners considered in this report. However, the 2013/14 deaths raise concerns about the increased risks associated with early days and limited access to money or activity; in so far as the entry level combines these things it will need to be very carefully managed for vulnerable prisoners.

### **Lessons**

*The cumulative impact of restrictions due to segregation, adjudication punishments, IEP levels and access to work, should be considered for individual prisoners. Lack of activity or lack of income can leave prisoners vulnerable.*

#### **4.2.2. Segregation**

In 2013/14, seven prisoners killed themselves in prison segregation units. Although this is a small proportion of the overall deaths (8%), it is an increase from the year before, when there was just one such death.

It is of particular concern that a number of the prisoners, while undeniably difficult to manage, were suffering from mental ill-health. Others were being managed under ACCT procedures as at risk of suicide and self-harm.

For some, such as Mr J, both factors applied. Despite his known mental health difficulties, and being monitored through ACCT, his erratic behaviour was treated as a discipline issue.

Prisoners identified as at risk of suicide or self-harm are not expected to be segregated except in exceptional circumstances. This does not always seem to have been considered. In the case of Mr I, help finding a job might have been a more effective solution than segregation.

Prisoners in segregation, especially those held for their own safety, need to have something to do. This could be a book, a radio or some other activity: something to occupy them when they are unable to access the full prison regime.

### **Case study I**

Mr I was several years into an indeterminate sentence for arson when he allegedly seriously assaulted another prisoner. He was moved to a high security prison and was charged with attempted murder.

He had been receiving treatment for paranoid schizophrenia. The mental health nurse who had been co-ordinating his care contacted the new prison but the staff there never got back in touch for further information. This meant they were not aware of the importance of keeping him fully occupied for the sake of his mental health.

At the new prison, he had no job and little to keep him busy. He had no outside support and very little money to spend but was addicted to smoking cigarettes.

An ACCT plan was opened after he threatened to harm himself if he could not get any tobacco. He became a nuisance on the wing, pestering other prisoners for coffee and tobacco.

Staff moved him to the segregation unit, ostensibly for his own protection. There was no consideration of whether this was appropriate for a prisoner on an open ACCT plan and with mental health problems.

Although the move was originally intended to be for only a few days, there was no exit plan. He remained segregated for two weeks without tobacco, occupation or even a radio in his cell to distract him. His mental health deteriorated but no one questioned the appropriateness of his continued segregation. He hanged himself two weeks later.

### **Case study J**

Mr J was recalled to prison. He had a history of self-harm and had attempted suicide several times. He had been diagnosed with schizoaffective disorder, attention deficit hyperactivity disorder (ADHD), post traumatic stress disorder (PTSD), and depression.

His mental health problems were documented in reception but he was prescribed a lower dose of medication than previously. Soon after – and before mental health staff assessed him – he was transferred to a different prison. Information about his mental health problems was not shared with them.

When he arrived at the new prison, Mr J refused to leave the escort vehicle, became aggressive and smeared excrement over his body. He was forcibly removed to the segregation unit.

The prison was not able to provide the specialist care and medication Mr J needed, so decided to return him to the original prison. Once he was told this, Mr J calmed down.

When he returned the next day, he was taken straight to the segregation unit although he had been living on a normal wing without a problem the day before. The decision to segregate him appears to have been solely because he had been segregated for the brief time he was at the other prison. When he arrived back he was described as calm.

In the segregation unit, he made superficial cuts to his arm and staff began ACCT procedures. There is no evidence to explain why it was considered exceptional and therefore appropriate for him to remain in the segregation unit on an ACCT.

The level of required ACCT observations was set at one an hour. This meant he had no additional monitoring as hourly observations were required for everyone held in the prison's segregation unit. According to the prison's local policy, observations should have been set at five times an hour when, exceptionally, a prisoner on an open ACCT is held in the segregation unit.

An hour after he was last seen alive, an officer found him hanged in his cell. He was taken to hospital but never recovered.

### **Lessons**

*Monitor use of segregation for prisoners suffering acute mental illness or at risk of suicide and self-harm. Ensure the reasons are evidenced and that segregation is only used on vulnerable people when there are exceptional circumstances.*

*Ensure those least able to access regime activities still have opportunities to occupy or distract themselves.*

*Challenging and anti-social behaviour can be a sign of distress or mental ill-health; it should not only be viewed in isolation as a disciplinary issue.*

### **4.2.3. ACCT**

ACCT is the Prison Service's process for managing and supporting prisoners at risk of self-harm and suicide<sup>11</sup>. In 2013/14, 29% of the prisoners were being managed under ACCT procedures when they died. This was very similar to the previous year (27%), although there was a larger number due to the overall increase in deaths.

It was disappointing to see that fewer of the ACCT plans in 2013/14 had been implemented correctly. Just 64%<sup>12</sup> of the ACCT plans had the prisoner's triggers for self-harm or suicide correctly recorded on the document and only 68% had an appropriate CAREMAP<sup>13</sup> (objectives to help the prisoner manage or overcome their crisis). Only 40% had multidisciplinary case reviews. These were 79%, 86%, and 64% respectively the previous year.

These problems implementing ACCT are not new. Our recent thematic review of deaths of prisoners on ACCT<sup>14</sup> looked back to 2007 and that found half of all the ACCTs had not been implemented correctly.

Looking at the most recent deaths, it is concerning that the problems are, if anything, becoming more widespread.

It seems necessary to reiterate the learning from that report:

#### **ACCT plans:**

- must be approached as a holistic way to manage an individual
- all staff, from all departments, who come into contact with the prisoner are responsible for updating the plan
- training and refresher sessions for all staff should ensure that they are confident contributing to ACCTs.

#### **Triggers:**

- must be completed, including multi-disciplinary input, even to say no known triggers
- should alert staff and prompt further action or an immediate case review
- should be regularly reviewed and updated.

#### **CAREMAP:**

- goals should be realistic, achievable, and target the root cause of the prisoner's distress
- a named member of staff should be specified next to each goal
- a target date should be set for completing the goal
- a clear explanation is required if an ACCT is closed before the goals are achieved.

#### **Case reviews:**

- should be timely and multi-disciplinary
- the expectation should be that consistent staff attend the reviews
- invite staff from across the prison to attend and offer input into the individual's care. Explain what is needed and ask for written input if attendance is impossible
- involve families, and agencies working within the prison, where relevant.

More recently, we have investigated a number of self-inflicted deaths where the prisoner had such wide ranging and deep seated problems that there should at least have been consideration of the enhanced case review process. We have found that the failure to do so was at times detrimental to the prisoners' safety. The death of Ms K is one example, though the issues are not restricted to the female estate.



Too often, anti-social behaviour and other complex behaviours were not identified as signs of increased vulnerability which needed to be explored with the prisoner.

### **Case study K**

Ms K had a history of mental ill health. After a long period of stability she was admitted to a psychiatric hospital after a number of attempts to kill herself.

She was discharged to the care of the community team but was arrested almost immediately, when she threatened to kill her former partner.

She was remanded to prison after a doctor decided she would not benefit from further hospital treatment. It was her first time in prison.

A nurse immediately began ACCT procedures and recommended constant supervision. However, prison staff set four observations an hour.

She tried to hang herself twice in the first evening, and was moved to a safer cell and constantly supervised. Nearly two weeks after arriving in prison she was referred to a psychiatrist, who did not believe she should be in prison and immediately began to organise a transfer back to hospital. Tragically, Ms K died before this could take place.

Frequent ACCT case reviews were held and most were multi-disciplinary. However, there were several occasions when prison managers chose not to follow, and sometimes not to ask, the advice of clinical staff. Clinicians said that their opinion was not listened to, which was particularly troubling for a prisoner with such severe mental health problems.

Ms K was difficult to manage and her moods were unpredictable, extreme and liable to change quickly. She made a number of serious and determined attempts to hang herself.

An enhanced case review process could have helped ensure more consistency in the staff involved in her care, and made sure all input was given sufficient weight.

### **Lessons**

*Ensure that prisoners at risk of suicide or self-harm are managed in line with national instructions and guidance.*

*This includes:*

- *Ensuring that all staff receive training and are confident in the ACCT procedures;*
- *Holding multi-disciplinary case reviews involving all relevant people in the decision making;*
- *Completing ACCT documents fully and accurately, including triggers and realistic, relevant CAREMAP objectives;*
- *All staff to update the ongoing record. Ensure observations are following the prescribed level at irregular intervals;*
- *Conducting an ACCT review whenever there is a clear sign, or concerns raised, that risk has changed.*
- *Using enhanced case reviews for people who present complex issues and behaviours.*

#### **4.2.4. Bullying, drugs and debt**

Drug use in prison often goes hand in hand with issues of debt and bullying. Debt – whether for drugs or other items – can leave prisoners exceptionally vulnerable to pressure and bullying from other prisoners.

Prisoners who feel threatened can find it very hard to seek help from staff. Where drugs or debt are concerned this difficulty is multiplied. The prisoner would have to risk punishment by revealing that they – or perhaps worse, the bully – have been taking or trading drugs contrary to Prison Rules.

As a result, it can be very hard for the Ombudsman's investigators to uncover solid evidence of drug use, debt or bullying. It is almost certain such issues are under-reported, even after a death.

This is especially true of new synthetic drugs such as 'spice' or 'black mamba' (sometimes known as legal highs or new psychoactive substances). The chemicals used in such drugs vary too frequently for current tests to be effective. It is therefore hard to establish the extent of their use.

However, such substances seem to be an increasing problem within prisons. There was evidence in a small number of the investigations from 2013/14 that the prisoner had been involved with synthetic drugs.

A number of investigations found evidence that the deceased prisoner was under pressure from bullies, or was known to be taking drugs, or in debt. Although it is not possible to establish a direct link with their deaths, a few of the prisoners had raised these issues with staff in relation to acts or thoughts of self-harm.

Where staff were aware of the problems, too often the only action taken was to move the prisoner who felt threatened to a different wing or even to the segregation unit. For example, Mr L moved six times within a short period and each time the bullying continued. No further action was taken despite a serious suicide attempt which he indicated was a result of bullying.

Frequently in these cases, staff did not consider that bullying, drug and debt issues made prisoners more vulnerable. They rarely noted that a prisoner feeling under threat from others was at increased risk of suicide and self-harm. This was true even when those who reported bullying and threats were being managed under ACCT procedures.

#### **Case study L**

Mr L was a young man who had been recalled to prison. His records showed he had a history of self-harm related to being bullied, including during a previous time in custody.

He was being transferred to a new establishment when staff discovered he had a quantity of tablets and mamba (a synthetic cannabis). He had been persuaded to smuggle the drugs for another prisoner.

After his transfer, prisoners at the new prison demanded he pay them for the 'lost' drugs. He received a disciplinary punishment for possession of the drugs which stopped most of his earnings and prevented him from ordering items from canteen (the prison shop) for two weeks. He moved wings twice within the first few weeks but the bullying continued. Staff found him

hanging in his cell and were able to save his life. ACCT procedures were started but, despite the seriousness of his suicide attempt, ended just a week later.

Mr L continued to report that he was being threatened, and he moved within the prison a further four times. Each time he reported being under threat it was treated as a separate, isolated incident. Staff did not challenge the alleged perpetrators.

Mr L was too frightened to attend activities so he spent a lot of time alone, locked in his cell. No one identified either the bullying or the isolation as increasing his risk of suicide and self-harm.

Around two months after his first suicide attempt, a prisoner found him hanged in his cell.

Synthetic drugs are an increasing problem in prisons and difficult for prisons to detect. However, many of the issues that arise are similar to those caused by misuse of other substances and related prisoner debt.

Mr M had a history of tobacco debts, which he indicated were related to a couple of incidents of self-harm. Later it seems he again incurred debts, this time through drug use. It does not appear that staff spotted the signs of this vulnerability before his death and he did not confide in them.

#### **Case Study M**

Mr M had spent over two years in prison when he died. During his sentence he had self-harmed, and had once threatened to jump from the landing because he was in debt to other prisoners. He was managed under ACCT procedures but continued to get into debt, particularly by borrowing tobacco.

When he moved to a prison nearer his family a year later, the reception nurse mistakenly recorded that he had no history of self-harm. This suggested that she had not seen his escort record or read his medical record. However, there was no reason to consider him at particular risk at that time. In fact for the next two months he appeared to settle well and participate in the prison regime. After his death the investigator received information that Mr M had been in debt. It was

said that he had been taking illicit drugs and other prisoners' prescription medications.

Although the investigator was unable to find definitive evidence of debts, post-mortem tests found tramadol and codeine (which can have euphoric effects) present in his blood. He had not been prescribed either medication.

One afternoon an officer unlocked Mr M's cell but did not check on him. Several minutes later a prisoner discovered him hanging and raised the alarm.

It was a further five or six minutes before an ambulance was called and none of the officers present attempted resuscitation. Instead they waited for a nurse to arrive. Mr M was pronounced dead soon after.

### **Lessons**

*Reports or suspicions that a prisoner is being threatened, bullied, or is vulnerable due to debt need to be recorded, investigated, and robustly responded to.*

*The potential impact on the victim's risk of suicide and self-harm must always be considered.*

### **4.3. The prison's emergency response**

There are a number of indications that the quality of emergency response declined in 2013/14. This was despite a new instruction<sup>15</sup> in February 2013 aimed at improving the speed and effectiveness of responses to medical emergencies.

There was at least one member of staff trained in first aid in only 76% of the incidents compared to 87% the year before. This possibly reflects the increasing difficulties governors have releasing staff for training while managing with fewer staff.

In an emergency, such as when a prisoner is found hanging (or collapsed from natural causes) just a few minutes lost waiting for trained staff can be crucial. It can also be extremely distressing for staff first on the scene to feel ill-equipped to help and not know what to do.

In nearly a third of cases in 2013/14, our investigations found there had been an unreasonable delay in calling an ambulance (32%, from 12% in 2012/13). This increase was statistically significant.

An emergency radio code was not used in 29% of the incidents (similar to 2012/13). At other times, a general call for emergency assistance was used instead of the correct code (emergency codes are supposed to also communicate the nature of the injury). Other times, correct codes were used but were not responded to effectively: ambulances were not called, or the staff attending did not bring necessary equipment such as the emergency bag and a defibrillator.

### **Case study N**

Mr N told his cellmate he had a headache, and did not want to join him in the exercise yard. When his cellmate returned, he found Mr N hanging from the bunk bed.

He called an officer. The officer was not carrying a radio, so he shouted to colleagues for assistance. He went into the cell and cut the ligature. Mr N was not breathing so the officer began cardio pulmonary resuscitation.

A few minutes after Mr N was found, the wing manager radioed the prison's communications room to request medical assistance. He did not use an emergency code.

The nurse who was the first to respond said the word ligature had been used in the message so she understood the nature of the emergency. She was closely followed by a colleague who had collected an emergency bag and defibrillator.

The nurse requested that an ambulance be called. This was about six minutes after Mr N had first been found hanged.

Paramedics happened to be at the prison attending a separate incident. They were able to reach Mr N before the ambulance. However, they were unable to save him.

The investigation found that the prison's local policy was not in line with national instructions to prisons as it stated that a specific request for an ambulance must be made, in addition to an emergency code.

It was a concern that the emergency code system was not used and that, almost a year after the issue of the national instruction, the prison had not updated their emergency code protocol to reflect mandatory requirements.

### **Case study O**

The evening after an ACCT case review, a patrol officer discovered Mr O hanging from an upturned bed in his cell.

Code blue is used in life-threatening circumstances such as when prisoners have trouble breathing or are unconscious. The officer should have used this. Instead he initially radioed "assistance required".

The designated response team were dealing with another incident. After a few minutes, when help did not arrive, the officer called code blue.

The officer who found Mr O correctly entered the cell immediately but there was a delay of seven minutes before another officer arrived to help which was unacceptably long.

It is usual to take a defibrillator to a code blue incident. However, none of the officers knew where the defibrillators were kept, and had not been trained to use them.

The officers attempted resuscitation, although they had no up to date first aid training. It took 15 minutes before an ambulance technician (who was already in the prison dealing with the other incident) arrived at the cell.

### **Lessons**

*Uniformed and healthcare staff must understand their responsibilities during medical emergencies, including:*

- *using the correct code to communicate the nature of a medical emergency;*
- *arriving at the scene with relevant emergency equipment;*
- *ensuring there are no delays in calling an emergency ambulance.*

*There should be sufficient staff trained and confident in first aid, including use of defibrillators.*

## 5. Lessons to be learned

- **Seek evidence of risk factors during reception.**

Staff working in prison reception 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.

- **Ensure all prisoners receive an induction, regardless of location.**

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

- **Continuity and responsiveness in mental health care 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 potential increased risk when medication is changed, ended or otherwise disrupted.

- **The first month of custody is especially risky.**

Prisoners are most at risk in the first month of custody. Those whose initial time may be more disrupted – for example due to court appearances – may need additional support.

- **Restrictions on contact with family can be a trigger for self-harm or suicide.**

Relationship breakdown and violent offences against family members are known risk factors for suicide. Being subject to a restraining order can be a sign of increased vulnerability.

- **Increased vulnerability of prisoners with limited access to the main prison regime must be taken into account.**

The cumulative impact of restrictions due to segregation, adjudication punishments, IEP levels and access to work, should be considered for individual prisoners. Lack of activity or lack of income can leave prisoners vulnerable.

- **Prisoners on open ACCT documents must only be segregated in exceptional circumstances.**

Monitor use of segregation for prisoners suffering acute mental illness or at risk of suicide and self-harm. Ensure the reasons are evidenced and that segregation is only used on vulnerable people when there are exceptional circumstances.

Ensure those least able to access regime activities still have opportunities to occupy or distract themselves.

Challenging and anti-social behaviour can be a sign of distress or mental ill-health; it should not be viewed in isolation as a disciplinary issue.



- **Ensure ACCT focuses on the prisoner as an individual, and that the processes are correctly implemented.**

Ensure that prisoners at risk of suicide or self-harm are managed in line with national instructions and guidance.

This includes:

- Ensuring that all staff receive training and are confident in the ACCT procedures;
- Holding multi-disciplinary case reviews involving all relevant people in the decision making;
- Completing ACCT documents fully and accurately, including triggers and realistic, relevant CAREMAP objectives;
- All staff to update the ongoing record. Ensure observations are following the prescribed level at irregular intervals;
- Conducting an ACCT review whenever there is a clear sign, or concerns raised, that risk has changed.
- Using enhanced case reviews for people who present complex issues and behaviours.

- **Increased risk of suicide and self-harm must be considered when a prisoner is a suspected victim of bullying.**

Reports or suspicions that a prisoner is being threatened, bullied, or is vulnerable due to debt need to be recorded, investigated, and robustly responded to.

The potential impact on the victim's risk of suicide and self-harm must always be considered.

- **Effective and confident emergency response saves lives.**

Uniformed and healthcare staff must understand their responsibilities during medical emergencies, including:

- using the correct code to communicate the nature of a medical emergency;
- arriving at the scene with relevant emergency equipment;
- ensuring there are no delays in calling an emergency ambulance.

There should be sufficient staff trained and confident in first aid, including use of defibrillators.

## End notes

- <sup>1</sup> These are financial years: April 2012 to March 2013 (2012/13) and April 2013 to March 2014 (2013/14).
- <sup>2</sup> Reports of the Ombudsman's fatal incident investigations are available online at [www.ppo.gov.uk](http://www.ppo.gov.uk).
- <sup>3</sup> The test used was 2 sample Z-tests for proportions. This compares difference in proportions between two populations (in this case between 2012/13 and 2013/14). Because this test can be sensitive to small numbers, and there were a number of measures where less than 10 cases were observed, we also tested using Fischer's Exact test. Both identified the same differences as significant to 95%.
- <sup>4</sup> Review: Fatal Incident Reports. Prisons and Probation Ombudsman, March 2010. This found 69% of the self-inflicted deaths occurred in local prisons. [www.ppo.gov.uk](http://www.ppo.gov.uk).
- <sup>5</sup> These can be found at: <https://www.gov.uk/government/collections/prison-population-statistics>
- <sup>6</sup> Learning from PPO investigations: Risk factors in self-inflicted deaths in prison. Prisons and Probation Ombudsman, April 2014. [www.ppo.gov.uk](http://www.ppo.gov.uk)
- <sup>7</sup> The median (middle value) has been used because a minority of very long-term prisoners in the sample skews the mean number of weeks upwards. However the same trend is displayed by the mean which fell from 117 weeks to 84 weeks. The time in custody is that spent on their final prison sentence.
- <sup>8</sup> ACCT is the Prison Service process for monitoring and supporting prisoners at risk of self-harm or suicide. It stands for Assessment, Care in Custody and Teamwork (ACCT).
- <sup>9</sup> The PER is a multi-agency document that travels with prisoners whenever they are escorted outside of prison. It contains information that is intended to alert staff – including prison officers, healthcare, escorts, court employees, and police – to the risks posed by the prisoner. This includes the risk of self-harm or suicide.
- <sup>10</sup> IEP (Incentives and Earned Privileges) was introduced to promote pro-social behaviours, and sanction anti-social and rule-breaking behaviours. Behaviour is assessed over time, taking into account positive comments as well as issued warnings, and prisoners are assigned to one of a number of levels. Privilege level determines benefits and privations: for example those on higher levels have access to televisions, can spend more of their money on goods and telephone calls, and can have more visits.
- <sup>11</sup> The policy information can be found in Prison Service Instruction 64/2011 'Management of prisoners at risk of harm to self, to others and from others (Safer Custody)'
- <sup>12</sup> The percentages in this section are of prisoners who died while on an ACCT (14 in 2012/13 and 25 in 2013/14).
- <sup>13</sup> CAREMAP stands for Care and Management Plan. It is a central part of the ACCT plan which identifies the most pressing issues facing the individual at risk, and sets objectives for how this risk will be reduced.
- <sup>14</sup> Self-inflicted deaths of prisoners on ACCT. Prisons and Probation Ombudsman, April 2014. Available at [www.ppo.gov.uk](http://www.ppo.gov.uk)
- <sup>15</sup> Prison Service Instruction 03/2013 Medical Emergency Response Codes







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