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

Nigel Newcomen
Prisons and Probation Ombudsman

16 November 2016
Agenda

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

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

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

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

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

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

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

• New emphasis on thematic analysis across investigations to encourage services to learn lessons and avoid preventable deaths

• Thematic studies 2015-16:
  – Homicides
  – Suicides in segregation
  – Dementia
  – *Prisoner mental health*
  – *New psychoactive substances*
  – *Early days and weeks in custody*
“Learning from PPO investigations: prisoner mental health”

Published January 2016

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

Available online: [http://www.ppo.gov.uk/?p=6737](http://www.ppo.gov.uk/?p=6737)
Learning: prisoner mental health

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

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

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

Published July 2015

Examines the death of prisoners suspected to have been using NPS

Considers risks and behaviour related to NPS use

Available online: http://www.ppo.gov.uk/?p=6137
Learning: new psychoactive substances

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

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

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

Published February 2016

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

Available online at: http://www.ppo.gov.uk/?p=6855
Learning: early days in custody

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

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

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