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**LESSONS NEED TO BE LEARNED FROM SUICIDES  
OF YOUNG ADULTS IN PRISON, SAYS OMBUDSMAN**

Young adults can be a difficult and challenging, as well as potentially vulnerable population in prison. They display varying levels of maturity and a wide array of risk and needs. These must be addressed if we are to reduce suicides among this age group, said Nigel Newcomen, the Prisons and Probation Ombudsman (PPO). Today he published a report on lessons that can be learned from his investigations into the self-inflicted deaths of 18 to 24-year-old prisoners.

Between April 2007 and March 2014, the Ombudsman investigated 89 self-inflicted deaths of young adult prisoners aged 18 to 24, two of whom were women. This report examines 80 of those investigations. Deaths among this age group are not disproportionate in relation to their representation in the prison population as a whole and over time the numbers of such deaths have been relatively stable, but they are a complex group some of whom have only recently left childhood behind.

The findings included:

- Bullying and suicide were linked. A fifth (20%) of 18 to 24-year-olds had experienced bullying in the month before their death, compared to 13% of other prisoners. Young adults were by turns both the aggressor and the victim and the potential impact of bullying on the risk of self-harm or suicide was too rarely considered;

- Many young adults exhibited challenging behaviour, being abusive and violent to towards prisoners and staff, and ignoring instructions. Prison staff tried to manage this using disciplinary charges and other sanctions, but needed to be aware that challenging behaviour can also mask vulnerability and mental health problems. A more balanced, consistent and holistic approach was needed;
- In too many cases, suicide risk assessments and monitoring arrangements were poor – repeating a finding in two other recent PPO reports. In a number of cases, concerns expressed by families were not acted upon by staff;
- Many young adults were distressed at being separated from their family and, in a crowded system; some could be transferred to prisons far from home. A particular risk requiring better management was the potentially intimidating transfer of a young adult from juvenile to adult prison as they turn 18;
- Overall 67% of the young adults had mental health needs, and 27% had previously been admitted for psychiatric care. A small number of young adults had been transferred between secure mental health hospitals and prison;
- A fifth of the young adults sampled were foreign nationals. For those serving longer sentences, the possibility that they would be deported was often a source of distress but communication with immigration authorities was often formal and bureaucratic.

The Ombudsman's recommendations included the need for prisons to act more robustly to allegations of bullying and consider the impact on the risk of suicide for victims of bullying. He also recommended that there should be better integration of the management of challenging behaviour and of risk of suicide; more timely referrals for mental health treatment; and recognition of the impact of transfers on already vulnerable prisoners.

Nigel Newcomen said:

“Young adults can be a difficult and challenging, as well as potentially vulnerable, population to manage. In our sample of 80 cases of self-inflicted deaths going back to 2007, challenging behaviour was common, with prison records detailing warnings for poor behaviour, formal adjudications and punishments for breaches of prison rules. Many had spent time in segregation or on the basic level of the incentives and earned privileges scheme (IEP), privations which inevitably reduced protective factors such as social interaction and activities. For the more challenging and complex individuals, it was also disappointingly rare for the different aspects of discipline, safety and healthcare to receive consistent and multi-disciplinary co-ordination.

“This bulletin draws out the potential lessons from self-inflicted deaths among young adults. I hope our findings make a significant contribution to greater safety in custody.”

- ENDS -

#### **NOTES TO EDITORS**

1. A copy of the report can be found on the PPO website. Visit [www.ppo.gov.uk](http://www.ppo.gov.uk).
2. The PPO investigates deaths that occur in prison, secure training centres, immigration detention or among the residents of probation approved premises. The PPO also investigates complaints from prisoners, young people in secure training centres, those on probation and those held in immigration removal centres.
3. This bulletin has been submitted as evidence to Lord Harris's Review of self-inflicted deaths of young adults in custody.
4. *Learning from PPO investigations: Risk factors in self-inflicted deaths in prisons* can be found here: [http://www.ppo.gov.uk/docs/Risk\\_thematic\\_final\\_web.pdf](http://www.ppo.gov.uk/docs/Risk_thematic_final_web.pdf)
5. *Learning from PPO investigations: Self-inflicted deaths of prisoners on ACCT* can be found here: [http://www.ppo.gov.uk/docs/ACCT\\_thematic\\_final\\_web.pdf](http://www.ppo.gov.uk/docs/ACCT_thematic_final_web.pdf)
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