



**Learning from PPO investigations:
Self-inflicted deaths in prison custody
2007-2009**

June 2011

**Prisons and Probation Ombudsman
Ashley House, 2 Monck Street, London SW1P 2BQ**

Foreword

It is our public duty to share learning from investigations of deaths in custody with stakeholders and the services in remit. Since April 2004 when my office began investigating the deaths of prisoners, immigration detainees, and the residents of National Offender Management Service (NOMS) probation approved premises, over 1,100 investigation reports have been published. Each has been shared with the service in remit, HM Coroner and the bereaved family, as well as a wider audience in anonymised form on our website. A great deal of learning has been disseminated in this way, with most reports making recommendations for service improvement, or identifying good practice to be shared. We have recently begun to share our learning in a different way, by issuing reports that identify collective learning from a number of investigations, such as the report on deaths from circulatory diseases issued in November 2010, as well as a recent report from the complaints arm of my office.

This paper presents an overview of one of the higher profile aspects of my office's work, the investigation of self-inflicted deaths in custody. The key facts and figures from over 200 self-inflicted deaths are summarised, to provide stakeholders and the services in remit with a bigger picture of self-inflicted deaths in custody than that given in each individual report. Some of the facts and figures cited here confirm what we already know about deaths in custody, such as how remand prisoners and recently imprisoned prisoners account for the greatest proportion of self-inflicted deaths, and that those charged with violent offences (particularly against a loved one) are at a high risk of suicide. These are messages that cannot be repeated often enough. But there are new lessons to be learned as well, such as how frequently instances of bullying or intimidation from other prisoners have featured in our investigation reports, and how often we find that arrangements following Assessment, Care in Custody and Teamwork (ACCT) closure are less than robust. The subject of bullying is to be explored in more detail later in the year as a direct result of the analysis in this paper.

I would like to thank my colleague, David Ryan-Mills, for preparing this report. Until recently David's post was funded by the Department of Health, whose support I once more acknowledge publicly. I am very pleased that his post is now a permanent part of a small research team within my Ombudsman's office. It will ensure that the wider lessons from fatal incidents investigations are shared, as well as those arising from an individual death.

Jane Webb
Acting Prisons and Probation Ombudsman

June 2011

Contents

1. Demographic information	4
1.1 Age and gender	4
1.2 Ethnicity and nationality	4
2. Establishment details	5
2. 1 Type of establishment	5
2.2 Geography	5
3. Incident details	6
3.1 Timing and Location	6
3.2 Method	7
4. Offence and sentence history	7
4.1 Status and sentence type	7
4.2 Offence	8
4.3 Experience of custody	9
4.4 Transfers	9
5. Investigation findings	10
5.1 Reception	10
5.2 Substance misuse and detoxification	10
5.3 Mental health	11
5.4 Self-harm and attempted suicide	12
5.5 Segregation	13
5.6 Family contact	13
5.7 Significant events	13
5.8 Emergency response	13
5.9 Notifying the next of kin	13
6. Fatal incidents research: the next steps	14
Appendix 1. Fatal incident investigations	15
Appendix 2. Sample & methodology	16
Other PPO research and analysis	17

Self-inflicted deaths in custody 2007-2009

This is the third paper published by the PPO that has looked at a sample of fatal incident investigations in order to identify collective learning, and the first to look specifically at self-inflicted deaths in prison custody. The purpose of this paper is twofold: to provide stakeholders and services in remit with a bigger picture of self-inflicted deaths in custody than that given in each individual report, and to identify areas where more in-depth research is required.

This paper presents analysis of the available data from all PPO investigations into self-inflicted deaths in prison custody between 1 January 2007 and 31 December 2009. There were 208 self-inflicted deaths amongst prisoners in England and Wales during this period. Due to protracted investigations, there were two cases in 2009 that were not at the appropriate stage for data to be collected at the time of writing. This paper therefore presents analysis from the findings of 206 PPO investigation reports. Further details of PPO investigations and how the data for this analysis was collected are given in the appendices.

1. Demographic information

The demographics of the sample of prisoners were compared to the prison population using data provided by the Ministry of Justice from Offender Management Caseload Statistics 2009¹.

1.1 Age and gender

95% of those who took their lives were men. This is representative of the wider prison population where 95% of those in custody are men.

The average age at death was 34 years old. The youngest was aged 15 and the oldest aged 77 years old.

1.2 Ethnicity and nationality

82% of the prisoners were white, compared with 70% of the total prison population. More specifically, 73% of the prisoners were white-British.

19% of all the deaths were of foreign national prisoners, compared to 14% of the total prison population. This slight over-representation is largely explained by a spike in the number of self-inflicted deaths by foreign national prisoners in 2007, when 24 such deaths were investigated. The Ministry of Justice commissioned research into this area in 2008 in response and this was published in 2009².

The PPO identified concerns about policies to deal with foreign national prisoners in 22% of cases where the prisoner was non-British.

¹ Offender Management Caseload Statistics 2009, Ministry of Justice Statistics Bulletin <http://www.justice.gov.uk/publications/docs/omcs-2009-complete-210710a.pdf>

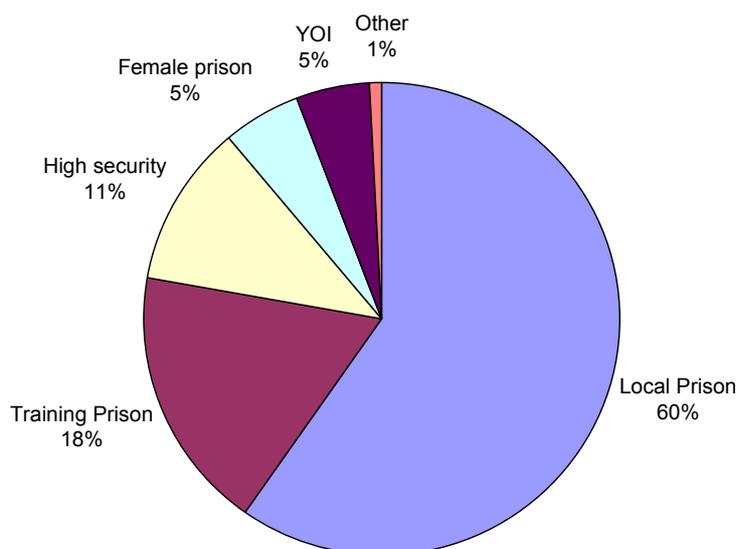
² Borrill, J. and Taylor, DA. (2009) *Suicides by foreign national prisoners in England and Wales 2007: mental health and cultural issues*. *Journal of Forensic Psychiatry and Psychology*, 20 (6). pp. 886-905.

2. Establishment details

2.1 Type of establishment

Over half of all the self-inflicted deaths in custody between 2007 and 2009 took place in local prisons:

Figure 2.1: Self-inflicted deaths: establishment type (N=206)



The proportion in local prisons is nearer to two-thirds if the core local prisons, which are managed by the High Security Estate, are included (HMP Manchester, Belmarsh and Woodhill).

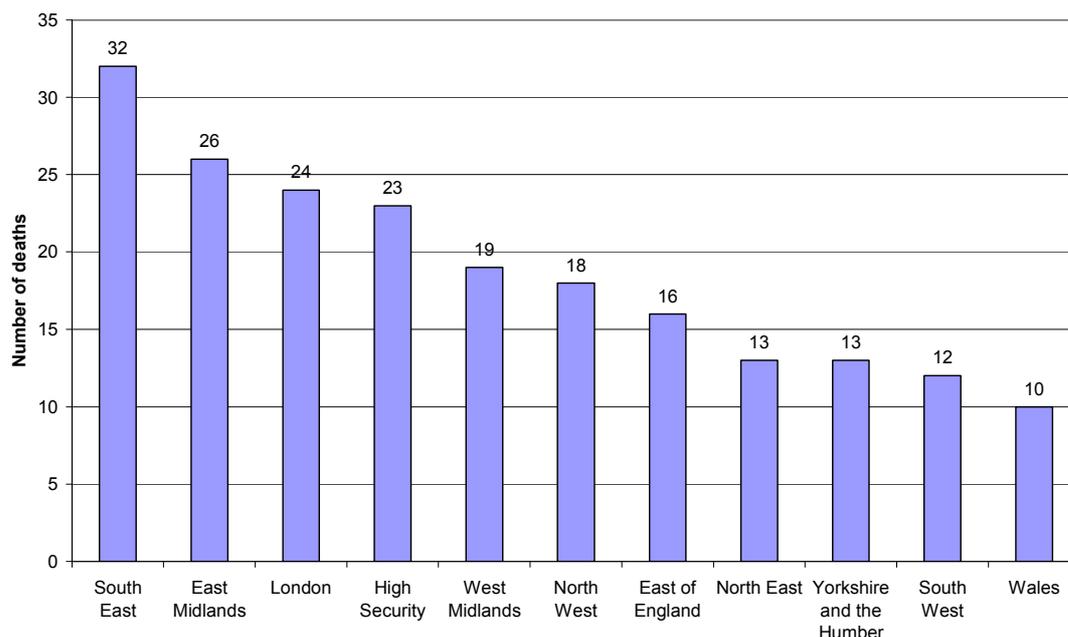
2.2 Geography

The greatest number of deaths occurred in the South East and the fewest in the Welsh NOMS region:

This distribution fits closely with the size of the prison population in each region, with the notable exception of London. The London region is predominantly formed by large local prisons - where risk factors for self-harm and suicide are at their most concentrated.

Less than 5% of the deaths occurred in privately contracted prisons. Such prisons, holding 11% of the total prison population (primarily in the local prisons of HMP Peterborough, Altcourse, Forest Bank, Doncaster, Parc and Rye Hill) are therefore under-represented in the PPO caseload.

Figure 2.2: Self-inflicted deaths: NOMS regions (N=206)



3. Incident details

3.1 Timing and Location

99% of the self-harm incidents leading to death took place in the prisoner's cell. The location of the cells varied. Two-thirds were on a normal prison wing with the rest located as follows:

- vulnerable prisoner wings or units (8%)
- first night or induction wings (9%)
- healthcare centres (6%)
- segregation or care and separation units (5%).

Most deaths or incidents leading to death were discovered on morning shifts (between 6.00am and 11.30am, 35%) or during the night shifts (from 10.00 pm to 6.00am, 28%).

Death was pronounced in cell in 84% of cases, and in hospital or in transit to hospital in 15% of cases. There were two deaths which occurred in a communal area.

The majority of deaths or incidents leading to death occurred in single cells (68%). When deaths or incidents leading to death occurred in double cells (29% of all cases), the deceased was the sole occupant in three quarters of these.

The PPO deemed the location of the cell to be inappropriate in 10% of all cases. Examples included:

- holding Rule 45 prisoners (those who were deemed to be too vulnerable to be housed on normal location) on normal location due to overspill or overcrowding
- prisoners progressing through induction units or wings too swiftly.

3.2 Method

The most common method was by hanging, in 91% of all cases. Cutting was the method used in 5% of cases. Other methods included self-strangulation, prescription overdose, food refusal, smoke inhalation and electrocution.

When the cause of death was hanging, the most common ligature points used were:

- windows or window bars (54%)
- beds or other furniture (20%)
- light fittings (5%)
- doors (5%)
- plumbing, conduits and air vents (5%)
- wall units or fittings (5%).

Ligatures were most commonly made of bedding (80%) and shoelaces (7%). Belts, clothing and a range of other materials were used in the remainder of cases.

4. Offence and sentence history

4.1 Status and sentence type

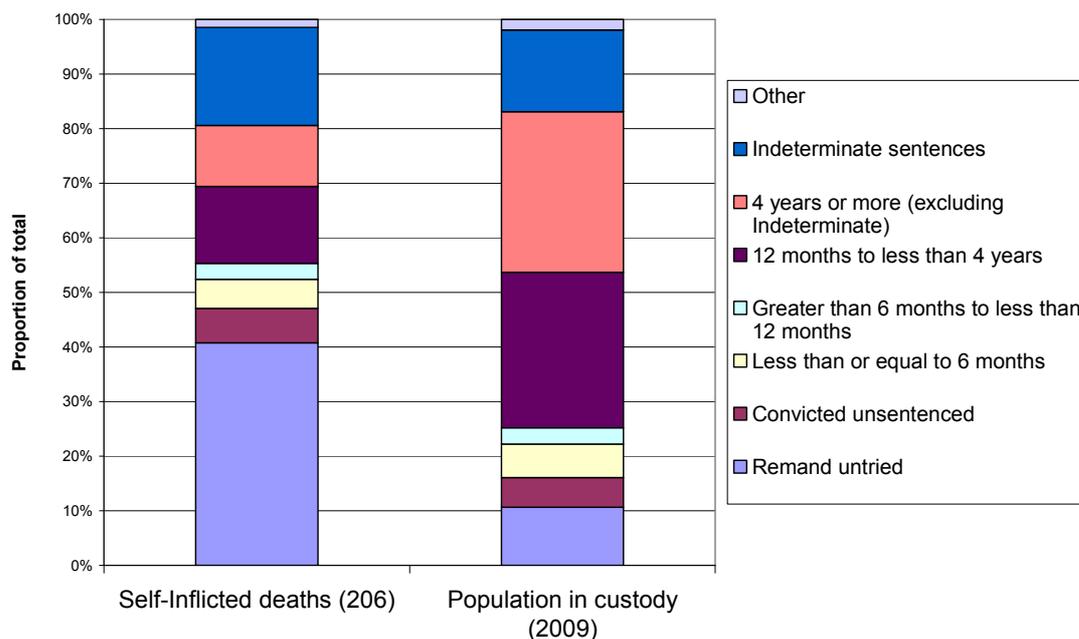
Nearly half of all the prisoners were not sentenced at the time of death (remand 41%, convicted unsentenced 7%).

Nearly a fifth were serving indeterminate sentences: life sentences in 13% of cases and indeterminate sentences for public protection (IPP) in 7% of cases.

Figure 4.1 uses prison population data to demonstrate how both unsentenced and indeterminately sentenced prisoners are over-represented in self-inflicted deaths when compared to the total population in custody³:

³ The status and sentence type of the sample of prisoners was compared to the prison population using data provided by the Ministry of Justice from Offender Management Caseload Statistics 2009, Ministry of Justice Statistics Bulletin <http://www.justice.gov.uk/publications/docs/omcs-2009-complete-210710a.pdf>

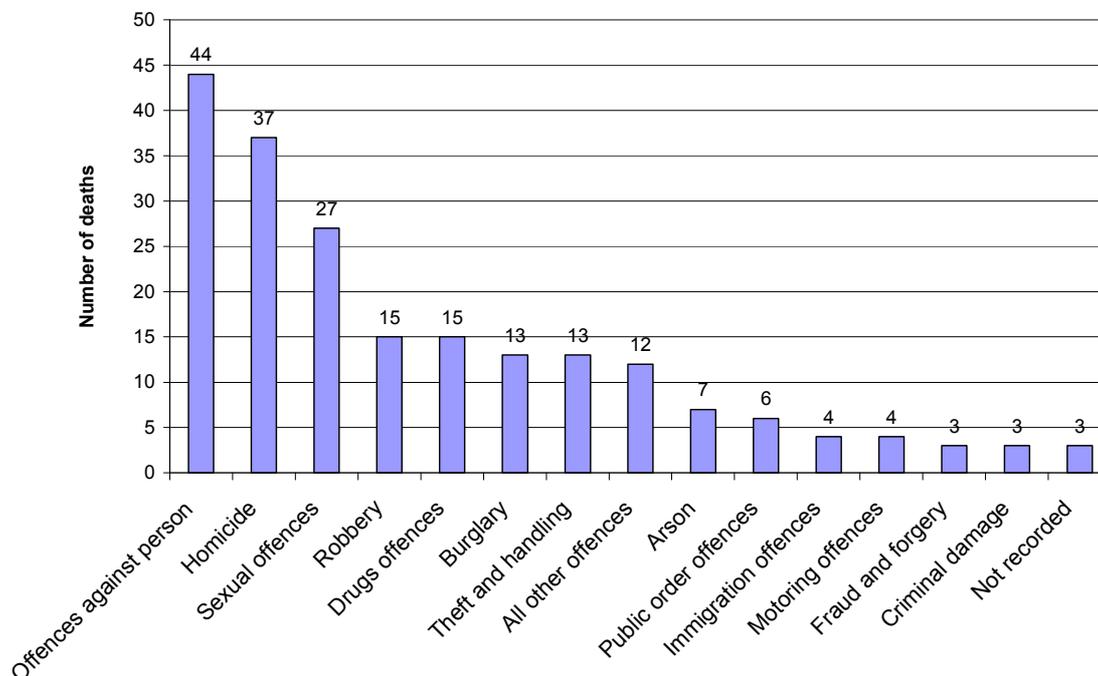
Figure 4.1: Self-inflicted deaths: Sentence (N=206)



4.2 Offence

The most common types of index offence (or alleged offence) were violent offences against the person (22%), homicide (18%) and sexual offences (13%):

Figure 4.2: Self-inflicted deaths: index offence (N=206)



When the offence involved a clear victim, and where details of offences were available, the victim could be described as intimate to or a family relation of the prisoner in 49% of cases.

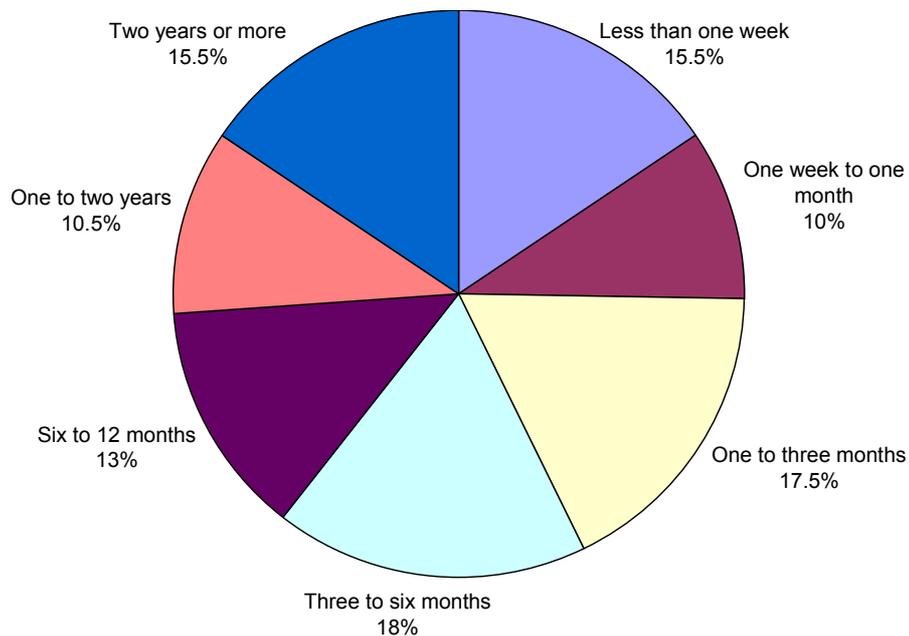
4.3 Experience of custody

39% of prisoners whose death was self-inflicted were in custody for the first time. 14% had been recalled to custody for breaching their release conditions.

Risk of suicide is particularly pronounced in the earlier periods of custody: 43% of all self-inflicted deaths during the period occurred amongst prisoners who had been in custody for three months or less.

However, a substantial number of the prisoners had been in custody for more than two years (15.5%).

Figure 4.3: Self-inflicted deaths - time in custody (N=206)

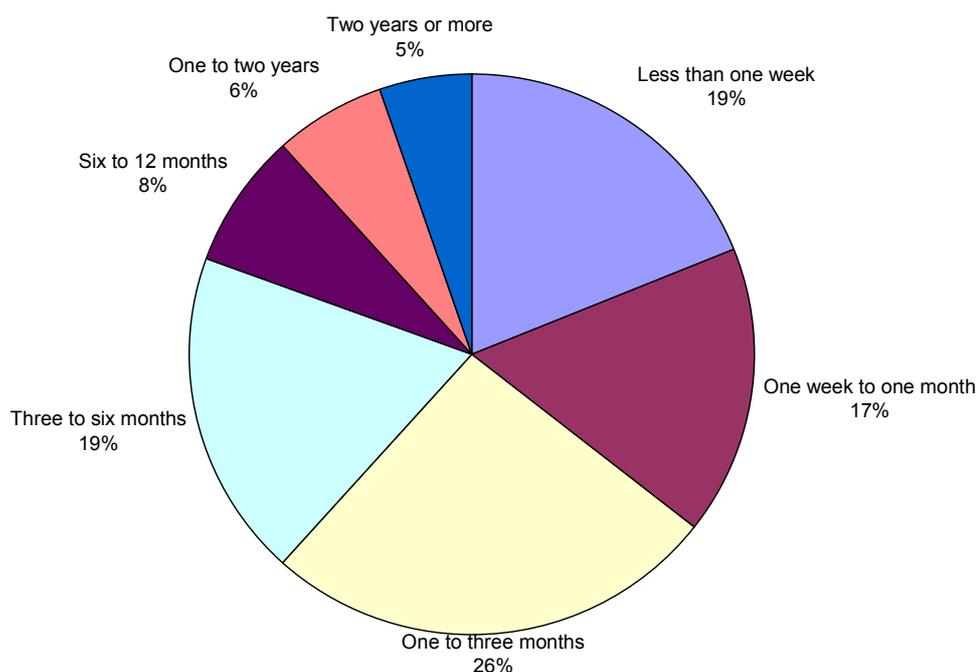


4.4 Transfers

Nearly half of all the self-inflicted deaths investigated were of prisoners who had been transferred at least once whilst in custody (49%).

When transfers are factored in, the risk of suicide in the earlier periods of custody becomes more pronounced: with nearly two thirds taking their lives within three months of reception into their final establishment.

Figure 4.4: Self-inflicted deaths - time in final establishment (N=206)



5. Investigation findings

5.1 Reception

62% of all the prisoners arrived at their final (or only) establishment within three months prior to death.

In these cases, PPO investigations identified concerns in a number of areas:

Area of concern	Percentage of cases
Reception	39%
First night	14%
Induction	14%
Escort services	5%

Concerns around the reception process centred upon:

- lack of attention to person escort records (PER forms)
- poor health screening
- failures in requesting medical records from community practices
- appropriate documentation from previous prisons not being shared.

5.2 Substance misuse and detoxification

Of those prisoners who stayed at one prison only and had not been transferred (105 prisoners), 28% were dependent on drugs or alcohol at reception.

Across the whole sample (including those who had been transferred between prisons whilst in custody), 20% were dependant on drugs or alcohol at reception into their final establishment.

Across the whole sample, 8% were being treated for withdrawal from drugs or alcohol at the time of death.

Across the whole sample, investigation found evidence that 13% had used illegal drugs or alcohol whilst in custody.

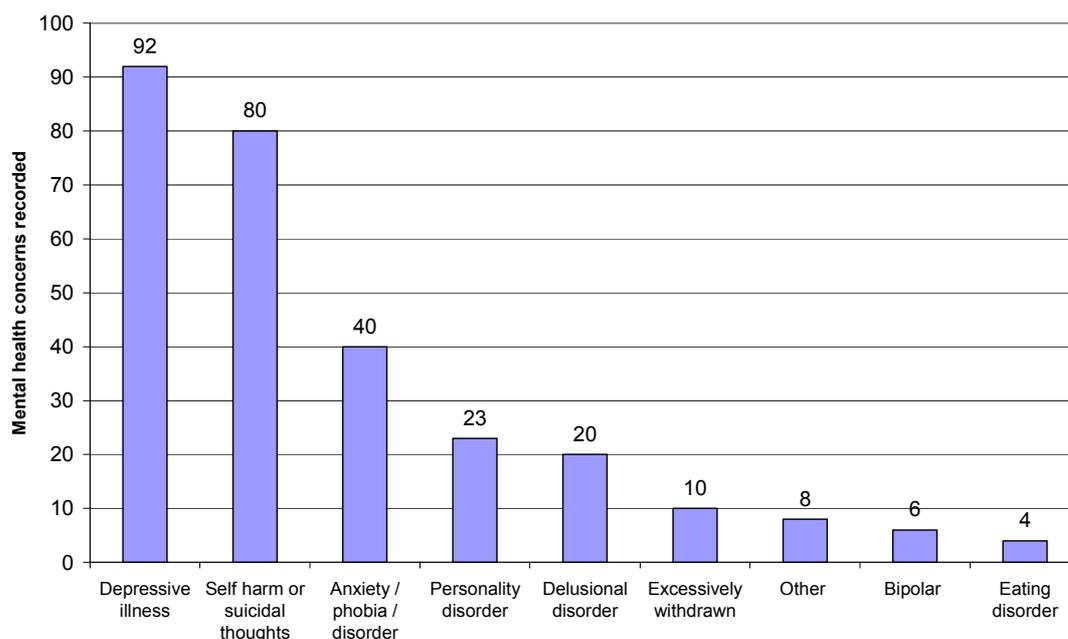
5.3 Mental health

There were mental health concerns recorded in 158 cases (77% of all cases).

Of these 158 prisoners who had mental health concerns recorded whilst in custody, a third had had previous psychiatric admissions prior to reception into prison (33%).

Figure 5.1 demonstrates the range and frequency of the types of mental health concerns recorded amongst these 158 prisoners:

Figure 5.1: Self-inflicted deaths: mental health concerns recorded (N=158: Multiple Responses)



The most frequent follow up to these mental health concerns was a referral to mental health in-reach (60% of cases).

The opening of Assessment, Care in Custody and Teamwork (ACCT) documents was the second most common follow up (52% of cases).

Over half of these prisoners were prescribed psychotropic drugs in the three months prior to death, including anti-depressant, anti-psychotic and mood stabilising medication (55% of cases).

However, nearly a third of these prisoners were not fully compliant with their prescription plan (31% of cases).

Few were considered for referral to psychiatric care or a secure mental health hospital (7% of cases).

Almost a third received no mental health treatment in the month before death (30% of all cases).

5.4 Self-harm and attempted suicide

There was a history or identified risk of self-harm or attempted suicide in 149 cases (72% of all cases).

Of those 149 cases:

- 50% had previously self-harmed whilst in custody.
- 32% had previously attempted suicide whilst in custody.

In the 149 cases where there was a prior history or identified risk of self-harm or suicide:

- ACCT documents were initiated in 70% of cases
- ACCT documents were in place at the time of death in 35% of cases
- ACCT documents were closed within a month prior to death in 28% of cases
- In 19% of cases the PPO found occasions where an ACCT had not been opened, but perhaps could have been.

The ACCT process helps monitor and support prisoners who are assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is observed at intervals determined by their perceived level of risk. The observations continue during the day and the night. Support can come from staff of all disciplines as well as from other prisoners through peer support schemes. The arrangements are reviewed regularly by a multi-disciplinary meeting, which includes the prisoner.

When ACCT documents were opened, the PPO deemed that monitoring and implementation was:

- correct on 40% of occasions
- partially correct on 34% of occasions
- incorrect on 26% of occasions.

Where an ACCT was open at the time of death, PPO concerns centred upon:

- poor recording of significant points which might trigger an act of self-harm
- absence of key staff at case reviews
- lack of family involvement in the process.

Where ACCT documents had been closed within the three months prior to the death (48), post-closure review arrangements were poor:

- nearly a third had no review date scheduled (15 cases)
- where reviews were scheduled, they were not held as scheduled in nearly a third of those cases (ten cases).

5.5 Segregation

Very few deaths (or incidents leading to death) occurred in segregation or care and separation units (5% of all cases).

Of those that spent some time in segregation or care and separation units in the week prior to death (15 cases), seven were awaiting adjudication, two were subject to cellular confinement, and two were segregated for good order or discipline reasons. Other reasons for segregation included dirty protest and their own protection.

5.6 Family contact

In 11% of cases, the family or friends of the deceased had contacted the prison to express their concerns about the prisoner in the three months prior to the death.

In 17% of cases, the deceased had no contact with family or friends in the three months prior to death.

5.7 Significant events

Common significant events that may have contributed in some part to the deaths included:

- bullying or intimidation from other prisoners (20% of cases)
- relationship breakdowns (20% of cases)
- impending court appearances (20% of cases)
- worries over childcare (5% of cases)
- debt to other prisoners (5% of cases)
- worries over immigration, asylum or extradition status (5% of cases).

Assessments of the significance of such events require a qualitative approach, in order to assess their impact on the individuals' state of mind prior to death.

5.8 Emergency response

Investigation found that there were unreasonable delays in entering the cell in 8% of all cases, and in healthcare staff attending the scene in 5% of all cases.

When radio code systems were used to communicate the nature of the emergency, the codes did not work effectively in 12% of cases.

Investigations found that access to defibrillators was unreasonable in 22% of all cases.

Rigor mortis was present on discovery of the incident in 27% of cases.

When rigor mortis was not present, concerns were expressed around delays in calling an ambulance or paramedics reaching the prisoner in 14% of cases.

5.9 Notifying the next of kin

In 13% of cases, up-to-date next of kin records were not held by the prison at the time of death.

Next of kin were notified of the deaths by the police in 19% of cases, and by prison staff by telephone in a further 19% of cases. In a number of instances, such methods of notification were appropriate, either due to police advice or where face-to-face contact with prison service staff was not feasible.

However, concerns around how the next of kin were notified were identified in 19% of all cases. Delay, the use of the police, and unnecessary use of the telephone were the most frequent concerns.

6. Fatal incidents research: the next steps

This paper has confirmed a lot of what is already known about self-inflicted deaths in custody, such as how prisoners on remand, in custody for violent offences and new to prison account for the greatest proportion of self-inflicted deaths. The figures presented have also highlighted areas that require further exploration and research, such as issues around the reception process, the availability of mental health services and the impact of what have been termed as 'significant events'.

The research team will publish a series of thematic reports in the 2011/12 reporting year, from both the fatal incidents and complaints functions of the office. These reports will be issued in order to further identify and share collective learning. As a result of the findings presented in this paper, the first area to be explored in greater detail is bullying or intimidation from other prisoners, a theme that features in 20% of our investigation reports.

Appendix 1. Fatal incident investigations

The Prisons and Probation Ombudsman's fatal incidents team investigate deaths of prisoners, residents of probation approved premises, those held in immigration removal centres and those subject to managed escort. At the Ombudsman's discretion, investigations have also been carried out into deaths of those who have been released from custody or detention, whether temporarily or permanently, where the case raises issues about the care provided. Investigations have also been undertaken into deaths of those in custody in the Channel Islands at the invitation of the authorities there. Investigation reports are issued to the bereaved families, to HM Coroners, to the services in remit, and to the relevant Primary Care Trust (or, in the case of deaths in Wales, Healthcare Inspectorate Wales).

Upon notification of a death in remit, an investigator will lead the investigation and a family liaison officer will liaise with the bereaved family. The investigator will find out as much as possible about the circumstances surrounding the person's death. This involves examining all the relevant documents and policies, together with interviews with relevant staff and prisoners or residents, if required. A clinical review is commissioned from the local Primary Care Trust (PCT) or, in the case of deaths in Wales, Healthcare Inspectorate Wales. In turn, they appoint a clinical reviewer (or reviewers) to assess the health care provided to the deceased and provide a report for evidence in the investigation. Once the PPO investigation is complete, a report is produced. The report outlines the investigation findings, including any clinical matters, and may also recommend changes to improve the quality of care given by the prison, approved premises or immigration removal centre in the future. Reports are issued in draft, giving the bereaved families and service provider an opportunity to comment on findings before the final report is issued.

Following inquest, the reports are anonymised and published on the PPO website⁴. Table 1 provides a summary of all investigations opened between April 2004 (the fatal incidents teams' inception) and March 2011:

Table 1: Fatal incident investigations 01/04/2004 - 31/03/2011- service in remit and PPO classification

PPO Classification	Prison	Approved Premises	Discretionary	Immigration	Secure Training Unit	Totals
Natural Causes	691	39	3	2	0	735
Self-Inflicted	487	24	5	4	1	521
Homicide	12	1	0	0	0	13
Illicit Drug Overdose	24	25	3	0	0	52
Accident	2	3	1	0	0	6
Unclassified ⁵	23	3	2	1	0	29
Totals	1,239	95	14	7	1	1,356

⁴ <http://www.ppo.gov.uk/>

⁵ Unclassified deaths include deaths not easily categorised as self-inflicted, natural causes, illicit drug overdose, accident or homicide. The classification of such deaths is currently under review.

Over 90% of all investigations opened have been in the prison setting, of which just over 40% were apparently self-inflicted⁶. Each investigation report contains detailed information on the circumstances surrounding an individual death. With over 1,100 reports now published, there is a large evidence base that can assist with the identification of learning and service improvement from these deaths.

Appendix 2. Sample & methodology

Since June 2009, PPO investigators have completed a pro forma for each finalised investigation, providing the source data for the fatal incident investigation full information system (FIIFIS). Pro formas for investigations published prior to June 2009 were completed by the research team. The pro forma captures quantitative information on the many issues that arise in a fatal incident investigation, from the offence and sentence history of the deceased through to emergency response and family liaison.

This paper presents analysis of the available data from all PPO investigations into self-inflicted deaths in prison custody between 1 January 2007 and 31 December 2009. There were 208 self-inflicted deaths amongst prisoners in England and Wales during this period. Due to protracted investigations, there were two cases in 2009 that were not at the appropriate stage for data to be collected at the time of writing. This paper therefore presents analysis from the findings of 206 PPO investigation reports:

Table 2: Sample overview

Calendar Year of Death	2007	2008	2009	Total
Self-inflicted deaths in custody	89	58	61	208 ⁷
PPO investigations available for analysis	89	58	59	206

It should be noted that these deaths occurred during a period of decline in the number of self-inflicted deaths in prison custody despite a rise in the overall prison population. In 2000, there were 81 self-inflicted deaths amongst a prison population of 64,602, a rate of 1.3 self-inflicted deaths per 1,000 prisoners. By 2009, there were 61 self-inflicted deaths amongst a prison population of 83,461, at a substantially lower rate of 0.9 self-inflicted deaths per 1,000 prisoners⁸.

⁶ Whilst deaths investigated are classified by the PPO, ultimately it is the coroner who determines the cause of death. This explains the use of the term ‘apparently self-inflicted’.

⁷ PPO figures for self-inflicted deaths differ slightly from those published by the Ministry of Justice. This is due in part to the NOMS definition of a self-inflicted death being more inclusive than that of the PPO - where illicit drug overdoses are categorised separately. NOMS official statistics are available at <http://www.justice.gov.uk/safety-in-custody-2009.pdf>. Both NOMS and PPO classifications are subject to change following inquest or as new information emerges.

⁸ Ministry of Justice (2010): *Safety in custody statistics 2008/2009: Ministry of Justice Statistics Bulletin 11* February 2010 <http://www.justice.gov.uk/safety-in-custody-2009.pdf>

Other PPO research and analysis:

All the reports below can be found on the PPO website <http://www.ppo.gov.uk/other-reports-and-publications.html>

Fatal incidents research

[Learning from PPO investigations: Deaths from circulatory diseases \(November 2010\)](#)

[Review of Fatal Incident Reports September 2008 to August 2009 \(March 2010\)](#)

[PPO Bereaved families report 2009 \(Feb 2010\)](#)

Complaints research

[Learning from PPO Investigations: Overview of complaints \(May 2011\)](#)

[PPO Complainants' Feedback 2009 \(Feb 2010\)](#)

[Report on effectiveness of PPO Publicity Materials \(Dec 2008\)](#)

Stakeholder feedback

[Perceptions of PPO 2009-2010 \(June 2010\)](#)

[PPO Stakeholder Feedback 2009 \(Feb 2010\)](#)

[PPO Stakeholder Feedback 2008 \(Feb 2009\)](#)