

Young adult prisoners

This Learning Lessons Bulletin examines learning from investigations into the self-inflicted deaths of 18 to 24 year old prisoners.

In 2013, I had the mournful responsibility of publishing a learning lessons bulletin into three self-inflicted deaths of children¹. It is disheartening and tragic to see a number of the same issues recur in my office's investigations into the sadly more frequent self-inflicted deaths of young adults in prisons. While deaths among this age group are not disproportionate in relation to their representation in the prison population as a whole, their youth, behaviour and often traumatic lives can leave them vulnerable and isolated in custody. Although some issues, in particular frailties in risk assessment and in support for those at risk of self-harm, are similar to those encountered in the deaths of older prisoners, the needs of 18 to 24 year olds may well have more in common with those of the younger age group.

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 and explores themes of bullying, anti-social behaviour, the assessment and management of risk of suicide and self-harm, disruption from transfers, mental ill health and young foreign national prisoners. As with all our learning lessons materials, it is my ambition that our findings make a significant contribution to greater safety in custody.

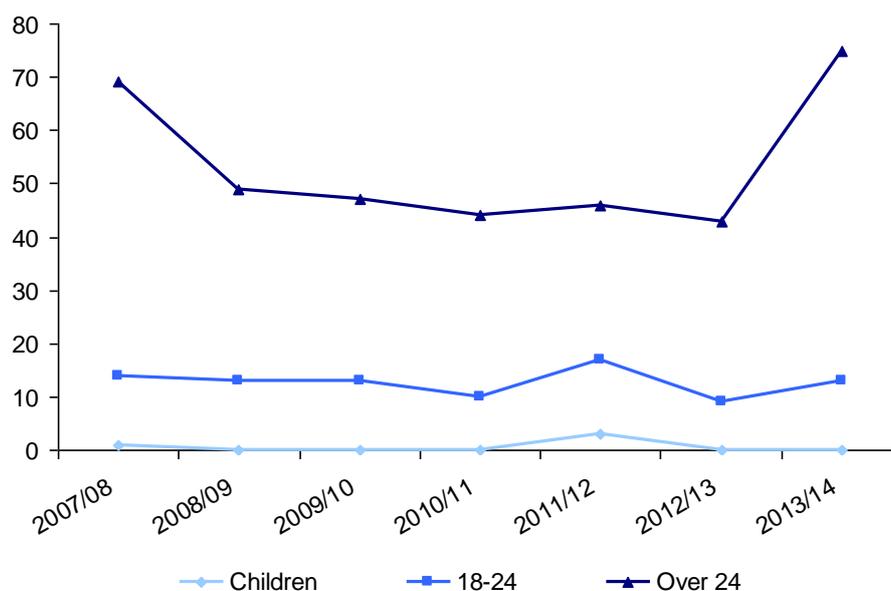
I am also pleased to submit this bulletin as evidence to Lord Harris' Review of self-inflicted deaths of young adults in custody.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

Deaths of young adults

Between April 2007 and March 2014, the Ombudsman investigated 89 self-inflicted deaths of young adult prisoners aged 18 to 24. Two were young women. In the same period, there were 373 investigations into self-inflicted deaths of adult prisoners (over 24 years old) and 4 deaths of children. This means that, while 19% of self-inflicted deaths in prison were of young adults, prison population data for December 2013 indicates that they made up 22% of the prison population². Over time the numbers of such deaths have been relatively stable. For example, the sharp rise in self-inflicted deaths in 2013/14 was primarily in the over 24 age group.

Figure 1: Self-inflicted deaths in prison, by financial year and age group



This bulletin examines learning from 80³ investigation reports into the self-inflicted deaths of young adults in prison between April 2007 and March 2014. In addition to the investigation report, investigators complete a detailed data collection form for each investigation. These forms cover most aspects of prison life and allow some standardisation of information to enable cases to be compared. This provided further information in 75 of the young adult deaths and in 333 self-inflicted deaths of prisoners over 24 in the same period⁴.

Bullying

Bullying encompasses a broad spectrum of behaviour including violence, harassment, intimidation, ostracising and abuse. It is not age-restricted and, while a direct causal relationship with self-inflicted deaths may be hard to establish, the effect on the well-being of the recipient can be devastating, particularly within the closed confines of custody. Given the vulnerabilities of many of the young adults in our sample, it is surprising how rarely bullying was considered as increasing the risk of self-harm and suicide.

A previous PPO publication⁵ looked at bullying and violence in self-inflicted deaths of prisoners of all ages and noted that it was especially common in deaths in Young Offender Institutions. Ministry of Justice statistics⁶ on prison assaults, although just one potential form of bullying, also suggest a higher prevalence in the young adult population. Our analysis for this bulletin reaffirms this: a fifth (20%) of the 18-24 year olds in our sample were recorded as having experienced bullying from other prisoners in the month before their death, compared to 13% of other prisoners. From the investigation reports it is striking how many young adults told of, or were believed to have experienced, bullying from prisoners at some point during their time in custody.

Poor behaviour is discussed in more detail in the next section but it is important to recognise that this is not a simple dichotomy between strength and vulnerability⁷. Frequently, young adults were, by turns, both the aggressor and the victim. Perhaps understandably, both staff and the policies that guide anti-bullying can struggle with how best to manage this apparent contradiction. Mr A, for example, reported threats from other prisoners on at least two occasions. However, he was also implicated in a violent assault on another prisoner and received warnings about his behaviour. At the time of his death he was on the lowest level of the Incentives and Earned Privileges (IEP)⁸ scheme and was being monitored as a suspected bully. At no point was Mr A considered a risk to himself. This was despite documented vulnerabilities, including a recent suicide attempt, relationship problems, a history of mental health problems, and on-going depression. In particular, the Ombudsman was critical that these pre-existing risk factors were not given more consideration when a decision to segregate him was made. The need to take into account static risk factors when assessing risk of suicide or self-harm was highlighted in a recent thematic review of the Ombudsman's investigations into self-inflicted deaths⁹.

Case study A

Mr A was recalled to custody after being charged with a new offence. When he returned to prison, he alerted the staff on reception that he had recently taken a drug overdose, and was receiving treatment and medication from community mental health services. However, he said he had no current thoughts of suicide or self-harm and staff assessed him as not being at risk. Later, he told a mental health nurse about the recent overdose, that he was feeling down due to being in prison and about stress due to his relationships outside prison. He continued to be prescribed anti-depressants throughout his stay in custody, but declined additional mental health support.

Soon after his arrival, a Security Information Report (SIR) recorded that Mr A had been threatened by his cell mate and, as a result, had to move to a new cell. He also received warnings for his behaviour, including for threatening behaviour towards an officer. After around a month in custody Mr A was part of a group who allegedly seriously assaulted another prisoner. No disciplinary charge was brought, but he was placed on the basic (lowest) level of the IEP scheme and officers opened an anti-social behaviour scheme booklet to monitor him as a suspected bully. He was moved to a new wing, away from the victim.

The next day Mr A refused to return to his cell and told staff that this was because he was being threatened by other prisoners. Little was recorded about the threats, but Mr A was then segregated from the other prisoners (although he remained on the same wing). He was apparently satisfied with the arrangement, but the combination of segregation and the restrictions of the basic IEP regime meant he was locked in his cell for long periods with little to occupy him. In a phone call to relatives, he mentioned the lack of television, although he gave no indication of particular distress. On the third night of segregation, he asked an officer for a book, and another prisoner if he could borrow their radio, but was unable to get either. The next morning he was found hanging in his cell. He was 20 years old.

Case study B

Mr B was 19 and had no previous convictions. He told reception staff he had dyslexia, no history of mental health problems or thoughts of self-harm and that he was scared about being in prison.

After a week, and to be closer to home, he was transferred to a new prison, but a newspaper article was passed round his new unit which identified him and gave details of his offence. This led to him being verbally abused by other prisoners and physically assaulted. The next day, he was moved to another unit and a transfer arranged to a different prison. He was found hanged in his cell before the transfer could take place. He left a note indicating he felt unable to bear the verbal abuse.

Mr B was new to custody and had moved prisons, then between units, in quick succession. After he was attacked, no-one had specifically checked on his welfare or asked if the move had helped stop the bullying. It would appear likely, given his note, that the verbal abuse had continued. Although disciplinary action was taken against his immediate assailant, the Ombudsman was concerned that there was little further investigation and no action was taken about the prisoners who were verbally abusive.

While staff took the risk he faced from other prisoners seriously, they did not consider whether he was at risk of suicide or self-harm as a result. This case bears a striking and depressing resemblance to another death, the lessons from which were highlighted as a case study in our previous report about bullying in prison¹⁰. The need for staff to give fuller consideration to the implications of bullying for the safety of the individual victim was one of the main lessons to come from that review and we must highlight it again here.

Mr A told staff when he was being threatened and may have identified one of the prisoners involved. In that case, prompt action was taken to help keep him safe. It is important that when prisoners report bullying they feel supported and taken seriously. Prisoners in other investigations had reported being harassed by prisoners shouting abuse out of their cell windows, a form of bullying common in young offender institutions. Often the prisoner cannot (or will not) identify those responsible, so the issue is taken no further and the behaviour continues unchallenged.

However, some young adults are more reluctant to seek help and, in a number of cases, information which could have indicated bullying was missed. Intelligence about prisoners being in debt, prisoners giving away property or those suddenly withdrawing from participation in work or association can indicate vulnerability to bullying. One prisoner, previously described as a model student, began repeatedly to refuse to attend education and said this was because he had a 'beef' down in education. He was placed on the basic level of IEP as a punishment which meant for an extended period he had limited time out of his cell and no television. The possibility that he was at risk from others in education was not investigated further. Withdrawing from the regime can itself be a sign that an individual is at heightened risk of suicide or self-harm, so it was a concern that this out of character pattern of behaviour was not picked up sooner.

Lesson: Indications and allegations of bullying should be recorded, investigated and, acted upon to protect the apparent victim and address the behaviour of the alleged bully or bullies. The impact on the risk of suicide and self-harm for victims should always be considered.

Challenging behaviour

IEP is designed to reward positive behaviours and attitudes, and sanction negative ones. A previous bulletin raised concerns that fatal incidents occurred disproportionately among prisoners on the lowest ("basic") level of privileges, which reduces protective factors against suicide and self-harm such as association, activities and access to television. The bulletin found that prisons needed to improve the balance between managing poor behaviour and managing vulnerability¹¹. It is telling that, at the time of death, 16% of the 18 to 24 year olds were on basic level. This compares to 6% in other self-inflicted deaths of older prisoners.

In a number of these investigations, young adults exhibited challenging behaviour: being abusive and/or violent towards both prisoners and staff, getting into fights, ignoring instructions, together with lower level misbehaviour, such as misusing cell bells. Prison staff attempted to manage this in a number of ways, most often using the IEP system and formal disciplinary charges. In some cases segregation, anti-bullying and violence reduction measures were used. It was also common for the young adults to be transferred between establishments, in the hope that a 'fresh start' would lead to improved relationships with staff and better behaviour. In a minority of cases prisoners were transferred between segregation units at different establishments when their behaviour became overwhelming. At the

extreme, one prisoner who had transferred back to prison after assaulting staff in a secure hospital, spent time in several segregation units and was waiting to be assessed for a Close Supervision Centre – a specialist unit which manages the most disruptive and dangerous adult prisoners in the estate. Staff should be aware that challenging behaviour can be a mask for vulnerability and mental health problems.

Case study C

Mr C was a troubled young man who was remanded into custody on an attempted murder charge. In his first few months in custody he was subject to a number of adjudications and segregated for fighting and refusing officers' orders. He was referred for a mental health assessment because staff were concerned he could be psychotic.

He twice started fires in his cell and both times was subject to disciplinary punishments as a result. After the first fire, he spent most of the next month in segregation. He was then convicted of the attempted murder and indicated to court staff he intended to kill himself. When he returned to prison he was managed through Assessment, Care in Custody, and Teamwork (ACCT), the Prison Service's suicide and self-harm prevention procedures. He was located in the healthcare unit for observation due to the high risk he was believed to pose. After he returned to a standard cell, he set a second fire. Recognising this time that the fire was an act of self-harm, ACCT procedures were re-started. Despite this, and against guidelines (paragraph 2.55 of Prison Service Instruction 47/2011), he was charged with a disciplinary offence for the fire and segregated. Later, after he was sentenced, he used a ligature to attempt suicide.

Mr C appealed against his conviction but, before this was heard, he transferred to a different prison. The sending prison got in contact, both on his arrival and later when his appeal was refused, to warn the new prison that the court proceedings were a trigger for suicide and self-harm and he would be at heightened risk in the event the appeal was unsuccessful. On both occasions, the prison assessed Mr C as not being at risk and did not begin ACCT procedures. The fourth morning after his appeal had been refused Mr C was found hanging in his cell. He was 24 years old.

Case study D

Mr D appeared in court where he was remanded into prison custody. He said he would kill himself and this was recorded – but not prominently – on the records handed over to the prison on his arrival. Reception staff did not consider him at risk of harming himself, though his prescription for anti-depressants he had been taking in the community was continued. Over the next month he received two warnings about his behaviour.

One day he spoke to his partner and two members of staff, and said he was upset because he had heard that his brother had died. His partner had not heard about this and unfortunately he ran out of credit for the phone so could not contact other relatives to confirm the news. Neither member of staff took any action and they did not share the information more widely. Between the two conversations with staff, he was taken to the segregation unit under restraint after it was alleged that he had attempted to assault another prison officer.

The next night, still in segregation, Mr D used his cell bell to call for staff on a number of occasions. He had previously received warnings for misusing the bell. However, it appears that a number of cell bells that night, including that of Mr D, were not answered for extended periods or cancelled without the officer on duty checking the prisoner. The last time he pressed the bell for assistance was just before midnight. He was not checked until almost three hours later by which time he was dead. He was 22 years old.

The cases of Mr D and Mr C illustrate the difficulties posed for staff in having to simultaneously address the management of poor behaviour as well as vulnerability and risk of self-harm. Staff were concerned that Mr C was mentally unwell, yet when he set a fire the

same action was treated both as a disciplinary matter and as an act of self-harm. It is difficult to reconcile the punitive response of being placed in segregation with the aim of the ACCT procedures to help support an individual in crisis. For this very reason, Prison Service guidance requires that prisoners being managed on ACCT procedures are placed in segregation only in exceptional circumstances. In such rare instances, the grounds for this should be clearly documented on the ACCT record. Likewise, Mr D had received some distressing news about his family. Soon after he was allegedly aggressive to staff and was segregated as a result. Although he told a doctor and the chaplain about his brother, they did not open an ACCT, help him contact his family to confirm the information or alert the officers in the segregation unit about his vulnerability.

In our review of self-inflicted deaths of children¹² we highlighted similar concerns. The children's behaviour was often challenging: damaging their cells, disobeying orders and being aggressive towards staff. However, these acts were too often considered only as security concerns and, even for one child who was being monitored under suicide and self-harm prevention procedures, with little consideration that the challenging behaviour might also indicate underlying emotional distress. We recommended that the discipline and care aspects of custody needed to be more closely aligned, we find the same can apply to young adults.

One way to achieve an appropriate balance, particularly in the most complex cases, may be through greater use of enhanced case reviews. These are designed to help manage individuals with multiple and challenging issues through a co-ordinated, multidisciplinary and holistic approach overseen by senior staff. This would seem an appropriate response to the mixture of poor behaviour, aggression and vulnerability (including mental illness and repeated acts of self-harm) evident in a number of young adult deaths.

Lesson: Managing risk, treating mental health and managing behaviour need to be better integrated to ensure a balanced, holistic and consistent approach to prisoners in emotional turmoil.

Identifying and managing risk

The issues around identifying and managing risk of self-harm and suicide have been covered in detail in two recent PPO reports¹³. Both reports looked at self-inflicted deaths in prison investigated by the Ombudsman. Although different groups of prisoners were looked at, the findings about the assessment and management of their risk were broadly similar. Too often prison staff placed too much weight on judging how the prisoner seemed or 'presented', rather than on known risks, even when there had been recent acts of self-harm. Other key lessons were that prisons needed to respond quickly and effectively when concerns were raised by friends and family; that risk changes over time and can increase sharply in response to events and circumstance; that remand prisoners appear to over-represent; and that risk assessments need to consider fully information provided by police, escort services and the courts.

The ACCT report looked at deaths where the prisoner was being monitored under the Prison Service suicide and self-harm prevention procedures at the time of their death. At any one time around 2% of the prison population are on ACCT monitoring. When implemented properly, ACCT provides a comprehensive, multi-disciplinary framework to address the underlying cause of a prisoner's distress. However, to be effective, ACCT requires a concerted, joined-up and holistic approach. The report found that the ACCT process was not correctly implemented or monitored in half the cases. There were cases where 'objectives' set to help lower the risk were not realistic, achievable or relevant. In other cases the ACCT documentation was incomplete or poorly completed, leaving out important information about potential triggers for self-harm and patterns of behaviour. There were prisoners being monitored under ACCT who were not reviewed regularly or whose care was not assessed in light of changed circumstances. Many reviews which did take place were not multi-disciplinary, often lacking important input from healthcare professionals.

The report found staff in contact with prisoners needed to have up to date ACCT training and they did not always update ACCTs with relevant information.

The issues raised in both reports are highly relevant for the 18-24 age group. In a number of cases, concerns from family were missed; prisoner's withdrawal from the regime was not considered as a possible indicator of raised risk; and risk assessments often relied too heavily on a young person's eye contact and assurances that they had no thoughts of harming themselves. Implementation of ACCT sometimes fell short, including cases of actual or threatened self-harm which did not prompt any case review or use of ACCT. The potential for conflict between care plans for support under ACCT and systems for managing poor behaviour was discussed earlier but this need for a holistic approach would appear to have particular relevance to younger age groups.

It is also noticeable how frequently distress at separation from family is mentioned in the reports, in particular parents and partners. Although in a crowded prison estate, this is clearly not just a problem for young adults it may be that given their age, few may have had much experience of living independently and may, therefore, find the sudden isolation harder to bear. A minority had very young families of their own, for whom lack of contact was a source of considerable pain. The possibility of receiving visits was central to some; transfers to prisons far from home caused readily apparent distress, even in cases where they were able to remain in relatively frequent telephone contact with family. For young adults known to be already vulnerable, particularly those being managed under (or recently on) ACCT procedures, moves that take them away from support networks may pose significant issues with regard to their level of risk and such moves need to be carefully considered. At a minimum the receiving prison needs to be aware of these risks and ready to safeguard the young adult.

Although family often offered a central point of support, there were examples of sudden and devastating impact when this was withdrawn. In a number of cases, the most significant events in the final weeks or days of prison were arguments with partners and, especially, the ending of relationships. One man with a history of mental health problems and previous suicide attempts was placed on ACCT monitoring after he deliberately burned himself. However, despite being very upset that his girlfriend had ended their relationship and, on the same afternoon, being told that a close relative had died, his level of risk was not reviewed. Days later, when an officer found he had cuts on his legs there was still no further review. The next day he was found hanging in his cell. While in some cases, relationship problems only became known following the death, there were instances – as with Mr E – when the dispute with his partner and the likelihood of detrimental impact were both known, yet did not lead to additional support.

Case study E

Mr E was in prison for the second time. He had been subject to monitoring under ACCT twice during his previous sentence (once was after a serious suicide attempt). During the Ombudsman's investigation staff consistently described him as an able, motivated, intelligent and articulate young man who liked to be in control of his life. These qualities, and his willingness to disclose his troubles, led him to seek support from a wide range of prison staff.

In his second sentence, he was preoccupied, to the point of obsession, with his partner. Initially they were in daily telephone contact but this began to dwindle. An ACCT was opened after he took an overdose of tablets, explaining later that he had done it to get his partner's attention. There was no evidence that anything other than his relationship distressed him. Although the ACCT was later closed, one of the objectives was to have a family visit and this took place shortly after.

By all accounts the family visit went well, but, later that day, his partner told a social worker she wanted to end the relationship. When he found out, Mr E was distraught. Staff were

aware of the situation; he was checked and supported by a number of them but no one thought that re-opening the ACCT was necessary. In the early hours of the morning, his observation panel was seen to be blocked. Despite this an officer did not check him for another hour. By this time he had hung himself and it was too late to attempt resuscitation. He was 23 years old.

Lesson: Young adults often have strong attachments to their families and partners and their lack of life experience can mean they are more emotionally affected by the break up of relationships and family bereavements. Prisons need to take this into account when assessing their risk.

Transfers

Moving prisoners around the prison estate can be an appropriate part of sentence progression, but also an unfortunate consequence of a crowded prison system. Inevitably, it can be very disruptive. In the cases in our sample, there were a number of recurring issues with moves taking people further away from families, loss of important information in the transfer or – as already shown in the case of Mr C – information not being acted on by the receiving prison and disrupting participation in activities which can be an important diversion for individuals in emotional crisis. Moves between prisons can be unavoidable and even desirable but there were a number of occasions when the investigation raised concerns about the way moves were decided and handled with regard to vulnerable young adults at risk of self-harm.

In an extreme example, a young man with disabilities was told at short notice that he would be transferred. The move would take him far from home and away from the support he relied on from two other prisoners who helped him with his disability. His cell mate was so concerned about the man's risk of self-harm that he alerted staff. The day he was transferred he was apparently tricked into leaving his cell by officers, who then restrained him when he tried to return. The receiving prison was not told of this and he hanged himself just under a week after arriving there. In addition to the concern raised by his cell mate, the man had a history of self-harm and had been monitored several times under ACCT procedures. Only a month before the transfer, the young man had made a cut to his wrist. In other cases, although vulnerability may have been less apparent, some of the young adults were transferred while subject to, or soon after, the closure of suicide and self-harm prevention procedures without apparent consideration of how the disruption and uncertainty of a transfer might impact on that risk.

Mr F, a troubled and very vulnerable young man, found it difficult to be apart from his family. He had received intensive support in a small unit dedicated to the most vulnerable young people but was required to move after his 18th birthday. There were significant problems finding an establishment suitable for his complex needs. Care was taken to try not to disrupt his continuity of care through frequent transfers, but he ended up at a prison a long way from home which was poorly equipped to help him address his offending. Staff made considerable efforts to support him, but ultimately struggled with the extent of his vulnerability.

Case study F

Mr F was a young man who had been held, firstly, in mental health secure accommodation and then, in a specialist unit of a Young Offender Institution (YOI) for the most vulnerable and complex young offenders. He had been diagnosed with a range of issues including Asperger's Syndrome, learning disabilities and behaviour disorders, in addition to physical health problems.

He seemed to make progress at the unit, including in education, although there were occasions where he was bullied and others where he was the perpetrator. Mr F remained at the unit for 10 months after his 18 birthday as the unit found it difficult to find a suitable

establishment for him and did not want to disrupt his care with frequent moves. They referred him to a particular prison because it offered a relevant offending behaviour course suitable for his learning disabilities. However, the transfer request was turned down as the prison felt he needed a prison with a dedicated unit for vulnerable prisoners or 24 hour healthcare. Instead, he transferred to a prison unable to offer appropriate offending behaviour work, yet with a similar healthcare regime to the establishment that had turned him down. He was not on a Vulnerable Prisoner wing, though his wing was designated as for 'poor copers' (prisoners who are considered likely to experience problems living and integrating well in the main prison).

Over his months at the prison he built up positive relationships with the chaplaincy who encouraged his interest in music. However, his time there was also turbulent: he was sometimes violent and staff found it difficult to manage his frequent, worrying incidents of self-harm. A repeated trigger was a lack of tobacco or coffee, but more deeply he suffered feelings of loneliness and isolation. He missed his family who lived a long distance away. He was frequently monitored under ACCT, but some were closed too early and there were occasions he harmed himself and no ACCT review was held. The Ombudsman considered that, because of his complex needs, the enhanced case review system should have been used. At the time of his death he was being monitored under ACCT. He had performed at a concert in the chapel that evening, but during ACCT checks that night was found hanging in his cell. He was 19 years old.

Wing officers had given him time and attention and tried to manage his behaviour with rewards and sanctions. They genuinely seemed to care about his well-being. However, they could not meet his significant needs and manage his frequent but unpredictable outbursts and acts of self-harm. The investigation identified a need for better planning and care for young prisoners with learning disabilities, more effective information sharing and improved procedures to support extremely vulnerable young men subject to ACCT monitoring.

A small, but concerning, number of other cases highlighted difficulties in the transition to the young adult (like Mr F) or adult estate and services for young adults in custody. One young man, sentenced days after his 18th birthday, had previously spent time in custody in a YOI close to London. The investigation found that it was likely he had expected to be placed in the unit for young adults there, so his placement at an unfamiliar prison far from his family and girlfriend was judged to be a significant factor in his death. At the same time, he moved to having to work with the probation service rather than the youth offending workers he was familiar with. Similarly, Mr G was convicted when he was child of 17 and was sentenced to detention for life a few weeks later, when he had turned 18. He should have returned to the YOI to be assessed and an appropriate placement determined. Due to a lack of planning, and poor communication between the different agencies and establishments involved, he was inappropriately placed in an unfamiliar, adult local prison which failed to recognise or act on the (previously identified) risk he posed to himself.

Case study G

Mr G was remanded into custody aged 17 charged with a very serious crime. Apart from his young age he presented with a number of risk factors: he had received an indeterminate sentence with a minimum term of 18 years, he had a history of mental health problems and had self-harmed. He was considered to have suffered some brain damage, personality changes and learning disabilities resulting from an earlier head injury.

He spent time at a Secure Training Centre and then at a psychiatric hospital before he transferred to an under 18's unit of a YOI where he settled well. Between conviction and sentencing Mr G turned 18. On the day he was sentenced, he should have returned to the YOI. However, there had been no effective planning for his transition to the young adult estate and there were significant communications failures among those responsible for Mr G which led to his inappropriate transfer to an unfamiliar, adult local prison. The prison had only recently begun to take young adult men aged 18-21 in an addition to its main function

and did not seem well prepared for this new responsibility. Staff failed to recognise Mr G's vulnerability. Despite arriving with a suicide and self-harm warning form from the court and being forewarned about his vulnerability in a telephone call, reception staff and others did not identify him as at risk of suicide and self harm. ACCT procedures were therefore not used.

Due to his offence, and the media coverage it had attracted, he was designated as a vulnerable prisoner who needed protection from others. However, there was no space available on the Vulnerable Prisoner wing and he was held on a standard wing. The need to keep him apart from the other prisoners meant he was isolated in his cell for extended periods during the particularly risky early days in custody, without even the safeguards that exist in segregation units. The investigation found that he was effectively forgotten during the four days he spent at the prison: very little staff interaction with him was recorded, and no manager checked on his welfare. Mr G hanged himself and was found dead by an officer unlocking prisoners in the morning.

A fifth of the young adults (20%) had moved cells in their last 72 hours. Sometimes moves between cells or wings in the same prison occurred very shortly before the prisoner took their life. As above, these were often very vulnerable young men, frequently with a history of recent self-harm. A move between wings can mean losing the support of a friendly cell mate or familiar faces on the wing. Moving from a healthcare unit to a standard prison wing sometimes meant loss of location in a safer cell combined with a reduction in observation and support. Greater consideration was needed of how such changes could impact on the individual's level of risk – particularly, but not exclusively, for those young adults recently or currently being managed on ACCT. Around 10 days into his sentence one young man was placed on ACCT monitoring and moved to a safer cell after he had tried to hang himself. Four days later he was moved to a standard cell. Although the ACCT observations were increased, he was found hanging the same day. The increased observations to some extent took into account the impact of the move but it was not clear why it was decided to move him from the safer environment. Before the move, he had not had a sustained improvement in his mood and he had just been assessed as needing an urgent transfer to a mental health facility.

Lesson: The impact of significant disruption on the well-being and safety of already vulnerable prisoners should be fully considered in decisions to relocate them within or between establishments (particularly when this places them far from family support) and especially during the transition between the juvenile and young adult estates.

Mental health

Overall 67% of the young adults in our sample had mental health needs, and 27% had previously been admitted for psychiatric care. While this is similar to the other prisoners in the sample (72% with mental health needs, 23% with previous psychiatric admissions), it is a high level of need and the investigation reports reveal just how acutely unwell some of the young adults were before they died. In addition to those with severe and enduring mental illness, there were others who may not have had a specific mental illness but were having to cope with a range of issues such as bereavement, traumatic childhood events and abuse, in addition to the stress of incarceration or on-going legal proceedings. Although the needs of the two groups differ substantially, on the whole the lessons from the cases are similar.

Referrals, whether for mental health assessment or to transfer a prisoner to a secure mental health bed, need to be made and actioned promptly when there are concerns. In several cases mental health teams could not provide prompt care for individuals in crisis; it is a reflection of resources available to mental health teams that when one young man's referral was changed to 'urgent' it reduced the waiting time, but only down to two weeks. When Mr C transferred to a new prison he was referred to the mental health team but not seen. The mental health team at his previous prison were sufficiently concerned to get in touch with

their counterparts and an appointment was made but later cancelled. In addition, the records of his medication were not reviewed so his treatment stopped abruptly after the move. Ceasing medication can have a significant impact on mood, thereby increasing risk, so should be undertaken carefully and with support.

A small, but worrying number of young adults transferred between secure mental health hospitals and prison. In such cases, there were not always good arrangements to ensure a smooth transition of management and continuity of care. In the case of Mr H, despite leaving the prison under constant supervision due to his risk of suicide, management of his risk and support for mental health was all but absent when he returned from a secure hospital. Mr F's move to prison was one of the better handled. He was initially considered unfit to plead and held in a mental health hospital as an in-patient. When he improved sufficiently to return to prison, at least at first, he was placed in a specialist unit equipped to support the most vulnerable and troubled young people in custody. Others, due to slow referrals or their level of violence to others, remained in prison managed by non-specialist staff, despite assessments that they were too unwell to be in prison.

Case study H

Mr H was a challenging 23 year old who frequently self-harmed, most often out of frustration at the difficulties he had in maintaining contact with his partner. A few months before he died, he staged a rooftop protest and threatened to kill himself after arguing with her. He was rescued from hanging in his cell, moved to the healthcare unit and was observed constantly to prevent him harming himself. His behaviour was disturbed and disruptive at this time – he covered his face in ink, spread food round his cell and refused to wash. He often blocked his observation panel or hid from staff view when he was in his cell. While many staff were involved in trying to help Mr H, his risk of suicide and the underlying causes should have been more proactively addressed, rather than contained. The ACCT Caremap did not address the causes of Mr H's distress.

He remained subject to constant supervision for almost two months until he transferred to a medium secure mental health unit. In those two months, he repeatedly refused his medication and, as he made nooses from his clothes, at times he was required to wear protective clothing (a basic smock type clothing made from rip proof fabric). It was unclear from the records exactly how often and for how long this clothing was used. At the secure hospital, he informed staff that he had made up his symptoms to get out of prison and, after six weeks, he was discharged back to prison. It is a particular concern that, after so many close interventions, monitoring and mental health input appeared to stop altogether after he returned to the prison from the secure mental health unit. Despite the fact he had left the prison after two months subject to constant observations, the ACCT monitoring was neither continued nor formally closed on his return. A month after returning to prison, a routine roll check discovered Mr H hanging in his cell.

Case study I

After four years of mental health treatment following his offence, Mr I was found fit to enter a plea in his criminal trial and was remanded to prison. His behaviour quickly deteriorated and he spent increasing periods in segregation. He was so difficult to manage that he was transferred between segregation units at different prisons, spending time in five different segregation units in a very short period. Such regular moves cannot have helped his already unsettled mental state and there was a lack of handover between healthcare teams to ensure appropriate care continued – including arriving at a prison without medication and without the extent of his needs being communicated in advance. At his final establishment, Mr I was located in a high control cell and subject to a security protocol which required four officers and a senior officer to be present when his cell was unlocked. Within five days, his erratic behaviour concerned staff so much that they identified him as in need of suicide and self-harm prevention procedures and moved him to a safer cell.

Mr I's life in the unit was extremely restricted. He was disorientated whenever he was brought out of his cell and he was described as rarely making sense when he talked. Staff found it difficult to engage him in the most basic of activities, such as taking a shower, yet efforts were made to provide him with some routine. This was despite his abusive, unpredictable and violent behaviour – one alleged assault on a member of staff was subject to criminal investigation at the time of his death. However, Mr I's mental health supervision was well co-ordinated with the suicide prevention procedures. A member of the primary mental health team saw him several times daily, but unfortunately Mr I was rarely, if ever, in a well enough state to recognise or respond positively to this.

The prison's psychiatrist recommended a transfer to a secure mental health setting. A referral was turned down as the hospital psychiatrist disagreed over the diagnosis, considering that he had a number of personality disorders rather than a severe mental illness. The psychiatrist believed that because of this, and the four years in hospital, further treatment would not improve Mr I's mental health. This left the prison in an impossible position as officers and healthcare staff all considered that Mr I was too acutely unwell for a prison setting. This was especially pressing as he had now been in segregation for an extended period, which could not have helped his mental state, yet he posed too high a risk to others to be located elsewhere. The Governor of the prison intervened to ask the hospital to reconsider but was unsuccessful. In the early hours of the morning, while carrying out an ACCT observation, an officer found Mr I hanging in his cell. His exact date of birth could not be confirmed but he was either 23 or 26 years old.

Lesson: Mental health care and referrals need to be made and acted on in a timely fashion. Effective arrangements for medication and information sharing should be in place to ensure consistent and continuous care and minimal disruption in the event of transfers – whether involving other prisons or hospitals.

Foreign national prisoners

In the last decade the number of foreign nationals in prison has doubled to around 14% of the prison population¹⁴. A fifth (20%) of the young adults in the sample were recorded as foreign nationals. In many respects, foreign national prisoners are a disparate group representing a huge range of nationalities, languages, culture and familiarity with the UK. Specialist needs such as interpretation, translation and support to stay in contact with family abroad are neither universal nor restricted to the group. For example there are naturalised British citizens with greater language difficulties and many British citizens have close family members living or working in other countries. In spite of this, there were some common themes among the young adult foreign national prisoners.

Most had been in the UK for over a year, often much longer, and were reasonably proficient in English. For those serving longer sentences the possibility that they would be deported was often a source of distress. Some had been in the UK since childhood and, if deported, faced 'returning' to a country and culture they were unfamiliar with. Others, like Mr J, faced being separated from their family, and in some cases their young children, if deported.

Case study J

Mr J had lived in the UK for a number of years with his family. He had no close relatives remaining in the country of his birth. He reacted to the thought of his first time in custody by attempting to tie the sleeve of his sweater round his neck when still at court. However, while this information was on the record received by the prison, during reception screening he denied any thoughts of self-harm and was not assessed as being at risk.

The first few months of his time in prison were characterised by outbreaks of anti-social behaviour. Mr J often challenged authority and his manner was described as confrontational. He was shocked to receive a long sentence and at this point his behaviour changed; he publicly doubted his ability to cope and began to confide in staff that he was

having thoughts of self-harm. A month later he received written notice that he could be deported when his sentence ended. He became increasingly distressed and he remained subject to the close observation and enhanced support provided by ACCT until his death nearly two months later. He was just 19 when officers discovered him hanging in his cell

The investigation found that healthcare and officers worked hard to help Mr J manage his feelings of despair. He was allowed to share a cell with a prisoner who spoke the same language and was encouraged to keep busy through a range of leisure and educational activities. He was also prescribed anti-depressant medication. The possibility of deportation on release clearly preyed on Mr J's mind to a significant degree. Mr J's English was good but he was by no means fluent. The letter he received about the possible deportation used complex, bureaucratic language; while this might be necessary for a document with legal status no thought seemed to have been given to providing a translated version. Although he was told that he would be allocated a caseworker, it does not appear that Mr J saw anyone with specialist immigration knowledge before his death.

The idea of deportation was clearly distressing and the process appeared to exacerbate this. Communication was in English, and written in a formal and bureaucratic style that even someone with a reasonably good grasp of the language would find difficult to follow. Several of the young adults in our sample received notices that they were being considered for deportation, leaving them to face an uncertain time while their case was assessed. This was often, as in Mr K's case, just before their release date and in some cases after the end of their sentence. One man had been expecting to be released back into the community, but 13 days before the end of his sentence he was handed a notice of deportation. While he could communicate in English he was not fluent and appeared not to understand when a prison officer tried to explain that he could appeal against deportation. He had apparently left his country to escape violence and religious persecution and feared for his life should he return. The morning after receiving the notice he was discovered hanging in his cell.

Case study K

Mr K was 24 years old and was in prison for a number of immigration-related offences. After his death, it was discovered he had been using a false name and nationality. His fiancée, who was expecting their child, lived in the UK and only knew him by the name he gave in court. He was concerned that the court case for further charges he was facing would uncover his true identity. Shortly after he arrived in prison, staff who were monitoring his letters were alerted to the risk of harm he posed to himself and ACCT processes were put in place to help support him. The ACCT document was closed five days later.

Around a month before his conditional release date he was served with a notice of the liability to deport. In response, he indicated his intention to appeal against the deportation. Just days before his release date he received a notice that the decision had been taken to deport him. Mr K wrote a letter in reply in which he said he had decided to take his own life as he could not continue to live in prison after his release date. For a second time, ACCT monitoring was put in place. This ended a few days after his release date had passed. The next day it was re-opened when his cell mate found Mr K attempting to hang himself.

Mr K's appeal hearing against the deportation was postponed and he was refused temporary release to the UK. He was on remand facing further charges, so was to remain in prison custody until the crown court heard the case. A few weeks later, a fellow prisoner had seen Mr K waiting for a visit from the immigration authorities. The meeting did not take place and he was described as being very frustrated about this. Two nights later he hung himself from the bars in his cell. He left a note of apology for his fiancée, explaining he could not go on in prison.

Lesson: Prisoners and detainees subject to, or under threat of, deportation can experience significant distress. Even those proficient in English can find it difficult to understand and come to terms with their situation. Attention should be paid to the

possibility that their risk of suicide and self-harm is raised and they should have access to interpretation and translation services, immigration advice or legal representation as needed.

Lessons

- Indications and allegations of bullying should be recorded, investigated and, acted upon to protect the apparent victim and address the behaviour of the alleged bully or bullies. The impact on the risk of suicide and self-harm for victims should always be considered.
- Managing risk, treating mental health and managing behaviour need to be better integrated to ensure a balanced, holistic and consistent approach to prisoners in emotional turmoil.
- Young adults often have strong attachments to their families and partners and their lack of life experience can mean they are more emotionally affected by the break up of relationships and family bereavements. Prisons need to take this into account when assessing their risk.
- The impact of significant disruption on the well-being and safety of already vulnerable prisoners should be fully considered in decisions to relocate them within or between establishments (particularly when this places them far from family support) and especially during the transition between the juvenile and young adult estates.
- Mental health care and referrals need to be made and acted on in a timely fashion. Effective arrangements for medication and information sharing should be in place to ensure consistent and continuous care and minimal disruption in the event of transfers – whether involving other prisons or hospitals.
- Prisoners and detainees subject to, or under threat of, deportation can experience significant distress. Even those proficient in English can find it difficult to understand and come to terms with their situation. Attention should be paid to the possibility that their risk of suicide and self-harm is raised and they should have access to interpretation and translation services, immigration advice or legal representation as needed.

¹ [Learning lessons bulletin: Fatal incidents investigations issue 3 - Child deaths](http://www.ppo.gov.uk/other-reports-and-publications.html). Prisons and Probation Ombudsman, March 2013. Available at <http://www.ppo.gov.uk/other-reports-and-publications.html>

² Offender Management Statistics Quarterly (December 2013). Ministry of Justice. Available at <https://www.gov.uk/government/collections/offender-management-statistics-quarterly>

³ These are the cases where the investigation report has been issued before 31/05/2014. In 3 cases the report has only been issued in draft form.

⁴ Forms are requested from the investigator following their investigation. Information on some cases is not available due to on-going investigations.

⁵ [Learning from PPO investigations: Violence reduction, bullying and safety](http://www.ppo.gov.uk/other-reports-and-publications.html). Prisons and Probation Ombudsman, October 2011. Available at <http://www.ppo.gov.uk/other-reports-and-publications.html>

⁶ In 2013 45% of assailants in prison assaults were aged 18-24 (and a further 15% were aged under 18). Safety in custody statistics (December 2013). Ministry of Justice. Available at <https://www.gov.uk/government/collections/safety-in-custody-statistics>

⁷ Throughout this report, unless specifically referring to Vulnerable Prisoner status or units, we use 'vulnerable' to refer to a broad range of factors including (but not limited to) traumatic childhood experiences, mental illness, learning disability or low problem solving abilities, physical disability, (appearing) especially young or immature, and type of offence.

⁸ 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.

⁹ [Learning from PPO Investigations: Risk factors in self-inflicted deaths in prisons](http://www.ppo.gov.uk/other-reports-and-publications.html). Prisons and Probation Ombudsman, April 2014. Available at <http://www.ppo.gov.uk/other-reports-and-publications.html>

¹⁰ Case study 4, [Learning from PPO investigations: Violence reduction, bullying and safety](http://www.ppo.gov.uk/other-reports-and-publications.html). Prisons and Probation Ombudsman, October 2011. Available at <http://www.ppo.gov.uk/other-reports-and-publications.html>

¹¹ [Learning lessons bulletin: Fatal incidents investigations issue 4 - Basic regime](http://www.ppo.gov.uk/other-reports-and-publications.html). Prisons and Probation Ombudsman, March 2013. Available at <http://www.ppo.gov.uk/other-reports-and-publications.html>

¹² [Learning lessons bulletin: Fatal incidents investigations issue 3 - Child deaths](http://www.ppo.gov.uk/other-reports-and-publications.html). Prisons and Probation Ombudsman, March 2013. Available at <http://www.ppo.gov.uk/other-reports-and-publications.html>

¹³ [Learning from PPO Investigations: Risk factors in self-inflicted deaths in prisons](http://www.ppo.gov.uk/other-reports-and-publications.html) and [Learning from PPO investigations: Self-inflicted deaths of prisoners on ACCT](http://www.ppo.gov.uk/other-reports-and-publications.html). Prisons and Probation Ombudsman, April 2014. Available at <http://www.ppo.gov.uk/other-reports-and-publications.html>

¹⁴ Foreign national prisoners. Ministry of Justice, January 2013. Available at <http://www.justice.gov.uk/offenders/types-of-offender/foreign> [accessed May 2014]