Prisons & Probation Ombudsman
Independent Investigations

PORSCH: Deaths of Offenders in the Criminal Justice System
A speech by the Prisons and Probation Ombudsman 22/02/17

Thank you for inviting me to speak to you today on the mournful subject of my investigations into deaths in custody.

Introduction

For those of you unfamiliar with the PPO, let me say a few words by way of introduction.

Essentially, my office has two roles:

- First, it acts as the independent complaint adjudicator for prisons, YOIs, immigration detention and probation;
- and, second, – and more relevant to today's discussions - it independently investigates all deaths in custody and in probation approved premises.

The purpose of these fatal incident investigations is four-fold:

- first, to establish the facts, including identifying good and bad practice
- second, to help the bereaved family understand what happened
- third, to support the inquest system and
- fourth, to identify learning for the organisations I investigate.

Since my appointment in 2011, I have also emphasised thematic learning – in other words, joining up the dots from our individual investigations to produce learning lessons publications looking across prisons.

I will lean on a number of these publications for today's event.

Statistics

However, to begin, it might be helpful to provide some national context in terms of statistics. In 2015-16, my office started investigations into 304 deaths. This was made up of:

- 170 (56%) deaths from natural causes
- 105 (35%) self inflicted deaths
- 7% other deaths, largely drug related
- 2% homicide

- 1% awaiting classification

Up to January this year, we have started 306 investigations - 28% up on the same last year:

- 177 natural cause deaths (up 36%)
- 97 self inflicted deaths (up 12%).

One particularly worrying increase occurred among women. In 2015-16, there were 12 deaths but already this year there have been 21. For the first time since 2007, there is now a higher number of self-inflicted deaths per 1000 prisoners among women than men. We will be exploring this sad development in a new Learning Lessons bulletin next month.

I also asked my analysts to look at the number of deaths we had investigated from the North East and Yorkshire region, to see if we could identify any trends but none emerged.

In essence, NE and Yorkshire accounts for 18% of the prison population and YTD had 19% of the self inflicted deaths and 17% of the natural causes deaths. Deaths in the region are therefore proportionate to the national picture – but this should be of little comfort as the national picture is unremittingly bleak.

Learning?

So those are a few statistics, but what learning can we draw from the many investigations I carry out?

I will focus mainly on self-inflicted deaths – not least because, in theory at least, they all preventable. But, I will add a few words on the huge increase in natural cause deaths, which also raises important questions for prisons.

For source material, I will refer, in particular, to my last annual report and 3 recent learning lessons publications:

- A 2016 bulletin on suicide prevention in the early days and weeks in custody
- A 2016 review of the pervasiveness of prisoner mental ill-health
- And 2015 bulletin on the impact of New Psychoactive Substances – for which my researchers have updated the data

Suicide prevention

In my last Annual Report, I described the increased numbers of suicides in prison as a “rising toll of despair”. But I also expressed doubts that this rise had an entirely simple explanation.

While I may risk not seeing the wood for the trees, in my view, each self-inflicted death is the tragic culmination of an individual crisis for which there can be a myriad of triggers.

Of course, some argue, perfectly plausibly, that financial cutbacks, staff reductions and regime restrictions in prison have reduced factors that protect against suicide and self harm, such as activity, time out of cell and interaction with others.

Unquestionably, many staff are under severe pressure and caring for the vulnerable may require time that is all too scarce. But, the evidence linking austerity and death is inconsistent.

For example, spikes in suicides also occurred in the high security estate and the private prison estate, neither of which have had the level of cut-backs suffered elsewhere. Maybe you know of some emerging research on the subject.

Whatever the explanation for the rise, suicide is just too prevalent in prison. Accordingly, effective suicide prevention efforts are absolutely essential. Unfortunately, too often my investigations identify repeated procedural failings – and failures to learn lessons from previous deaths – which hamper prospects for prevention.

Depressingly, I have been saying many of the same things about suicide prevention for much of my time in office. I know prisons are under enormous pressure, but it is not good enough that repeated findings on basic safety issues from my investigations, inquests, and inspection reports go unheeded – or, at least, improvement is not sustained.
It must be hoped that the Government's reform agenda addresses this issue and ensures both new resources for prisons AND accountability for ensuring much improved safety in custody.

However, it is important to add that I rarely identify a fundamental lack of care or compassion among staff who support the suicidal. But, too often, I do find weak procedures, failures of management, poor information sharing, a lack of joined up working, and gaps in training.

I could cite numerous cases and learning lessons publications, but I will refer simply to my bulletin on deaths in the early days in custody.

We know that early days in custody are particularly vulnerable times and prisons have invested heavily in safer custody arrangements to address this. But, too often, assessment by staff on reception or first night ignores known risk factors for suicide in favour of a prisoner's assurances or presentation. Professional judgment is, of course, key but ignoring known risk factors inhibits the chances of supportive monitoring and increases the prospect of failing to prevent future tragedies.

The bulletin offers a number of **case studies and that of Mr A** illustrates my argument.

Mr A was remanded to prison charged with a serious violent offence against his partner. He had left the same prison 6 months earlier. He had recently

attempted suicide in the community and was identified in court as a suicide risk.

This information was passed to the prison by the escort contractor. But, despite this, no ACCT was opened, nor did Mr A go the first night centre but returned to his old wing. He had no induction or secondary health screen, so further opportunities to assess his risk were missed.

Both his family and his probation officer contacted the prison fearful of his state of mind. A manager spoke to him, but accepted his assurances and didn't open an ACCT.

Next day his solicitor faxed concerns to the prison, noting his previous attempts at suicide. But no-one acted on the information or passed the fax to the safer custody team.

Two days later, he was found hanged.

Sadly, this case is not unusual – and the learning in the bulletin covers territory I have repeated many times.

Mental health

So what other themes emerge from my investigations?

Inescapably, one major theme is the pervasiveness of mental ill health in prison and its close association with self-inflicted deaths.

In January 2016, I published a learning lessons thematic review of prisoner mental health. The publication drew on learning from the deaths of 557 prisoners between 2012 and 2014. 199 deaths of these were self inflicted. Of the 199 prisoners, 70% had been identified as having mental health needs such as depression, anxiety and schizophrenia. This stark proportion is broadly in line with the literature.

So what issues did we identify?

1. First, that prisons need to be better at identifying prisoners with mental health needs. The early identification of mental heath issues, particularly on arrival, can be vital to ensuring that prisoners receive the care and support they need to help them cope with custody.

   Reception and healthcare staff, who carry out initial health screening, need to review all relevant information that arrives with a prisoner. A thorough review helps to ensure that warning signs are identified, and that referrals are made when further assessment or care is required.

2. The second issue was that effective sharing of information between prisons helps to ensure continuity of care and support for prisoners transferred from one prison to another or returned to prison after a

period in the community. This does not always happen and can mean vital information about a prisoner's mental health is missed.

3. The third issue was about accessing care. When there are concerns that a prisoner might be suffering from mental health problems, a referral should be made to mental health staff. Referrals can be made by other healthcare staff or by wing staff. Indeed, wing staff have the most day to day contact with prisoners and are best placed to notice changes in behaviour that might indicate a decline in the prisoner's mental wellbeing.

   Unfortunately, despite clear reasons to refer, such as a history of mental health treatment in the community or symptoms of mental health problems, too often prisoners are not referred for appropriate assessment.

4. The fourth issue was that, when a referral has been made, there should be an appropriate assessment. An assessor should make use of all available resources to reach an accurate understanding of the existence and severity of a prisoner's mental health condition. This includes using standard assessment tools, reviewing existing records and following NICE guidelines. Unfortunately, too often we find standard mental health assessment tools are not used and there is little guidance to support the selection of an appropriate tool for a prison setting.

5. The final point is about mental health awareness. While there are specialist mental health teams in prisons to assess prisoners and coordinate care when mental health problems are identified, residential staff have to manage mental ill health on the wings as part of their daily routine.

Prison staff awareness of mental health issues can be poor and many have received no relevant training. Without it, symptoms of mental ill health can go unrecognised and unusual or difficult behaviour can be interpreted solely as a behavioural problem. This can lead to a punitive response rather than to the care and treatment needed. Sometimes with fatal consequences.

The **case of Mr B** illustrates some of these points.

When Mr B arrived in prison, his Person Escort Record noted that he had made a number of previous suicide attempts.
This information was confirmed by his GP records and entered on his prison medical record.

Mr B transferred prison two months later. The reception nurse at the receiving prison noted that he had some family issues that were causing him distress and referred him to the mental health team. After the referral, it took more than six weeks before a mental health nurse assessed Mr B.

In the interim, a doctor saw Mr B about his diabetes. and noted that he was low in mood and not sleeping well. He was worrying about his family and had

not yet seen his baby who had been born after he was sentenced to prison. The doctor prescribed a course of anti depressants usually used for major depressive episodes, but did not use a standard tool for assessing anxiety or depression.
The nurse who later conducted his mental health assessment did not notice the previous suicide attempts on his medical record or that he had been prescribed anti-depressants. She also did not use a standard mental health assessment tool. She scored his risk of self harming as zero.

Later that day, Mr B was found hanged in his cell.

Clearly, more needs to be done both to effectively identify and then address mental ill health in prison and the attendant risk of suicide and self-harm.

New Psychoactive Substances

So onto my third theme, the destructive impact of the epidemic of new psychoactive substances in prison and its impact on death in custody.

NPS are made up of a wide array of relatively new and regularly changing substances, for which testing is still in its infancy. Many NPS are readily available in the community and most are cheap. This ready availability and low cost, means that in custody the profits to be made from NPS are attractive to organised and semi-organised crime.
These features compound the difficulty of reducing supply and demand for NPS in prisons. They also often make it difficult to draw definitive conclusions about their health impact and links to fatalities. But, against a back drop of rising numbers of suicides and increase in reported violence, I am clear that NPS have been something of a game-changer in terms of reducing safety in prison.

So with this background, I commissioned a learning lessons bulletin to look at the issue of NPS.

The bulletin focused on synthetic cannabinoids and adds to the evidence that NPS pose real dangers to both physical and mental health, including links to suicide and self-harm.

Staff and other prisoners may also be at risk from users reacting violently to the effects of NPS. There also cases of prisoners being given ‘spiked’ cigarettes by others to test new batches of NPS, before taking it themselves or sometimes just for the amusement of onlookers.

What are the numbers?

I only know of 4 deaths in prison that we have investigated where NPS was found by the inquest to be the cause of death. However, the link between NPS and deaths in custody is not always so explicit – and the scale of the issue should not be underestimated.

In fact, we have now identified 64 deaths in prison between June 2013 and April 2016 where the prisoner was known to have used NPS before their death. Of these deaths:

- 44 were self-inflicted
- 2 were homicides
- 9 were classified as natural cause deaths.
- In 3 cases, the cause of death was not ascertained - but NPS could not be ruled out as a possible factor.
- 6 deaths were the result of drug toxicity.

So what do these deaths tell us about the dangers posed by NPS?

1. First, they pose a risk to physical health. NPS use may hasten the effects of underlying health concerns. For example, leading to seizures, collapse or heart problems.
2. Second, as well as presenting a danger to physical health, NPS pose a risk to mental health. We have found repeated evidence of extreme and unpredictable behaviour and psychotic episodes from NPS use, sometimes linked to suicide and self-harm.
3. A third risk from NPS use are behavioural problems. We have seen many cases where the NPS user has presented violent or aggressive behaviour, which is often uncharacteristic for that prisoner, which put the individual and others at risk.
4. A fourth risk posed by NPS is its link to bullying. NPS use can result in prisoners getting into debt with prison drug dealers, with the potential for increased self-harm or suicide among the vulnerable - as well as adding hugely to security and control problems.
5. The final risk is drug toxicity, from NPS or from the combination of NPS and other drugs.

I could cite cases on all these dimensions, but let me offer the **case of Ms C**, which illustrates the emerging links and inter-relationships between NPS, mental health and self-inflicted deaths.

Ms C had served 19 months prison. She had several long-term medical conditions and had frequent contact with prison healthcare and hospital consultants. However, she had no history of self-harm, and had shown no sign that she might hurt herself.

Those who saw Ms C on the day of her death said she seemed her normal self, and had been joking with other prisoners. Early in the afternoon, officers said they heard singing coming from her cell, but this changed to a loud and aggressive noise. The officers went to investigate. At first, they thought she was having a bad dream but instead Ms C had made a very deep cut in her arm, severed an artery and lost a lot of blood.

Despite a swift emergency response, Ms C died in hospital later that day. After her death, other prisoners said that Ms C had been using NPS. Our clinical reviewer considered that NPS might have triggered a rapid onset psychotic

episode, which had led Ms C to self-harm. Otherwise, her actions were entirely out of character.

This is just one of many troubling cases we have investigated where NPS appears to have played a part in death in custody.

So what is to be done about NPS in prison?

- First, supply needs to be reduced. Trafficking in NPS needs to be tackled by effective local drug supply and violence reduction strategies. All known routes need to be addressed: from smuggling on or in the person, to post, to visits, to drones, to staff corruption and to all the innovative ways we have yet to discover.

- Second, staff awareness needs to be improved. Staff need better information about NPS, how to spot that a prisoner is taking them and what to do about it when they do spot it.

- Third, governors need to address the bullying and debt associated with NPS robustly. Bullying should be investigated, perpetrators challenged, victims supported and the impact of bullying fully taken into account when assessing the risk of suicide and self-harm.

- Fourth, drug treatment services need to address NPS use and offer appropriate monitoring and treatment. This should include working with mental health teams, to ensure appropriate dual diagnosis support is provided for prisoners with multiple needs.

- Fifth, demand for NPS among prisoners needs to be reduced. Cracking down on supply has its place, but ultimately it is only users recognising the risks and stopping that will be effective. This requires engaging education programmes for prisoners that persuasively outline the risks of using NPS. More fundamentally, prison regimes and purposeful activity need to be enriched so that there is less need to relieve boredom with bird-killers such as NPS.

Prison and health care services have begun to act on this learning and efforts to reduce supply and demand are underway - but staying one step ahead of the chemists and traffickers is a huge challenge.

Natural cause deaths

So, briefly, on to deaths by natural causes....

Unlike the rise in self-inflicted deaths, the reason for the sharp increase in deaths of prisoners from natural causes is more explicable: it is largely the result of the age related ill health that attends a rapidly ageing prison population.

This demographic shift has been dramatic, driven by increased sentence length and more late in life prosecutions for historic sex offences.

As a result, the number of prisoners over 60 has tripled in 15 years and is now the fastest growing segment of the prison population. The projections are all upwards – there will be more than 15,000 prisoners over 50 by June 2020.

The challenge to the Prison Service is clear: prisons designed for fit, young men must adjust to the largely unexpected and unplanned roles of care home and even hospice. Increasingly, prison staff are having to manage not just ageing prisoners, but the end of prisoners' lives and death itself.

Unfortunately, there has been little strategic grip of this major demographic change. Prisons and their healthcare partners have been left to respond in a piecemeal fashion. The inevitable result, illustrated in my investigations, is variable end of life care for prisoners and limited support for staff.

I have seen many examples of humane care for the dying and some excellent palliative care in prisons, not least in the North East. But the national picture is mixed. It remains astonishing that there is no properly resourced older prisoner strategy, to drive consistent provision across prisons.

Conclusion

I have covered quite a lot of territory this afternoon – largely because there is a lot of death in our prison system.

Sadly, the statistics are all in the wrong direction.

However, as I have tried to make clear, there is no lack of learning about how we might improve this picture – it is high time these lessons were learnt.

Thank you for your attention.