BMA: Representing prison GPs conference
6 November 2014

Thank you for the invitation to speak to you.

Background – the office

I am not sure how much you know about my role, so let me offer a few words by way of introduction.

My office was created in the aftermath of the 1990 Strangeways riot and Lord Justice Woolf's report into its causes. One of his many recommendations to address evident prisoner frustrations was the creation of an Ombudsman to independently investigate complaints. This role came into being in 1994, with responsibility later extended to investigating complaints by those on probation and in immigration detention.

As a result, I receive about 5000 complaints a year mainly from prisoners. Of these complaints, about half are eligible for investigation and about 34% are upheld. Perhaps I should add that my remit excludes complaints about the clinical judgment of medical professionals, but I will

investigate contextual issues, such as access to healthcare.

In 2004, a significant new responsibility was added: that of independently investigating all deaths in prison or immigration custody and in probation approved premises. This investigative responsibility - when exercised in tandem with a coroner's inquest - enables England and Wales to comply with its obligations under article 2 of the European Convention on Human Rights – which has been interpreted as requiring independent investigation of all deaths in state custody.

I have assumed that it is my fatal incident investigations which are of most interest to this audience, but I can return to complaints in question time if that is wanted.

As to my own background, I have variously worked in academia, the probation service and the civil service, and I was Deputy Chief Inspector of Prisons for nearly a decade before being appointed Ombudsman in 2011.

Background - fatal incident investigations

Let me say a bit more by way of background about my fatal incident investigations.

Since 2004, my office has investigated around 2200 deaths in custody – the population of a small town. Last year, we began investigations into a staggering 239 deaths – 25% up on the year before. Of these, 136 were from natural causes, 90 were self-inflicted, 9 were drug related and 4 were homicides.

Every fatal incident investigation is led by one of my investigators, assisted by a clinical reviewer commissioned by the relevant NHS England Local Area Team. We have our own family liaison officers who explain our role to bereaved families and consult them about any issues that they wish our investigations to consider.

The objectives of the investigation are fourfold:

- First, to establish the circumstances of the death and the actions (or omissions) of the authority in remit;

- Second, to provide explanation and insight to families;

- Third, to assist the coroner;

- And, fourth, to identify any learning for improvement.

The investigation will also consider any relevant healthcare issues - and the basic assessment we seek from our clinical reviewers is whether there was equivalence with the care that could have been expected in the community.

Given scarce resources, investigations must be proportionate. So, for example, investigations into foreseeable deaths from long-term conditions look at a standardised set of topics and are brief and to the point, while those into self-inflicted deaths or homicides – with potentially most to learn - are much more open ended.

A draft report is produced - each of which I sign off personally - and this report is finalised and published anonymously after any inquest. I am pleased that, in a radical change from the past, virtually all reports are now on time.

The reports identify any good practice and make recommendations for improvement. Occasionally, I may also call for accountability and a disciplinary investigation. Recommendations are invariably accepted. Action plans are required and my old colleagues in the Inspectorate of Prisons follow up progress on my recommendations when they visit establishments.

The current picture

Unfortunately, the current picture when it comes to fatal incidents in custody is deeply depressing.

My focus in the past year has had to be on growth – a horrendous 64% increase in self-inflicted deaths, a 7% increase in natural cause deaths and even a doubling in the, thankfully, small number of homicides.

The rise in suicides – which reversed the fall in such deaths the previous year - is a tragic indicator of the level of personal distress and mental ill health in prisons. Some of these deaths may even evidence broader stresses and failures in the system.

My staff are still researching the patterns and thematic issues that may explain the increase and it is not yet possible offer a simple explanation. Indeed, last year suicides occurred in a perplexing array of prisons and among a wide range of prisoners and at all stages of detention.

Inevitably, it has been suggested that austerity and cuts are to blame for the rise in suicides, with prison staff so stretched - and the degree of need among some prisoners so high - that staff may no longer be able to provide adequate care and support for some vulnerable prisoners.

This is an entirely plausible hypothesis. Prisons are undeniably under pressure and cutbacks can reduce protective factors such as time out of cell and activities. But, while intuitive, the evidence for a causal link between cutbacks and suicide or self-harm still appears limited.

For example, it is noteworthy that deaths also increased significantly in high security prisons which have so far faced relatively few cut backs, and in open prisons which have few limits on time out of cell or interaction with others. Equally perplexingly, suicides increased in high performing prisons as well as poorly performing prisons,

private sector prisons as well as public sector prisons and so on. Simple answers for the increase in these deeply personal tragedies are probably false answers.

Moreover, every day prison and healthcare staff – and prisoner peer supporters - *do* save many prisoners from themselves – an achievement which goes largely unreported and without which the tragic number of suicides would be much higher.

Nor can we ignore the outside world. Suicide is not only a problem in prison and its incidence has also increased in the community.

We must also be honest about the limitations of what staff can do in the face of a really determined suicide bid. In one of the most extreme and tragic cases last year, a prisoner on constant watch in a healthcare unit, killed himself by deliberately jumping headfirst from his bed onto the cell floor before supervising staff could stop him. The level of mental ill health and despair shown by such cases is truly shocking.

However, even when faced with such cases, complacency is not an option. A rising suicide rate in prison reflects the state's evident difficulty in meeting its duty of care to some of the most vulnerable in its charge. And my office has a role to play in the urgent search for lessons that must be learned to reverse this growth.

Learning lessons – homicide and suicide

Let me say more about learning lessons.

Since my appointment, I have placed a great deal of emphasis on trying to identify learning from across my investigations, rather than only focusing on learning in individual cases. In this way, I hope to make a broader contribution to improving safety and fairness in prison. As a result, a substantial body of learning lessons material has been published using case studies and thematic learning to support improvement in prison.

For example, one publication looked at lessons to be learned from the small, but growing number of homicides in prison. All the victims were vulnerable prisoners and, among various findings, we identified the pressing need for a new strategy to manage vulnerable prisoners at risk

from other vulnerable prisoners, particularly in the high security estate. Appropriately, action to address this concern has now been taken by senior prison managers.

Similarly, to signpost the way forward in addressing weaknesses in suicide prevention arrangements in custody, I recently published two thematic reviews of the lessons to be learned from investigations into suicides by my office between 2007 and 2013 - just before the recent sharp increase.

These reviews found that there was already considerable scope for improvement in safer custody and ACCT procedures. The first review examined how well prisons identify and assess the risk of self-harm or suicide. The second, focussed on the next step: the quality of the ACCT processes that are put in place to support those prisoners identified as at risk.

Worryingly, we found recurring weaknesses in practice which illustrate the need for prisons to improve. When it comes to risk assessment, too often staff placed too much weight on how the prisoner seemed to be at the time, rather than known risks, such as previous instances of self-harm. The professional judgment of staff is crucial, but

known risks are the best predictors of future behaviour and should not be ignored.

And for those who were identified as at risk, we identified that, in around half the cases in our sample, the ACCT process was not well implemented, leaving some prisoners inadequately supported. A couple of cases illustrate these findings.

First, the case of Mr A.

When Mr A arrived in prison he told reception staff a number of things that can indicate risk of self-harm or suicide. He had mental health problems and drank alcohol to excess. Previous prison records showed he had self-harmed in custody. Although it was not his first time in custody, the beginning of a sentence can be a risky time particularly for those experiencing withdrawal from drugs or alcohol. Staff doing the reception screening did not feel Mr A was at risk of hurting himself and did not open an ACCT. He began an alcohol detoxification programme, but was placed on a standard wing rather than first night or healthcare accommodation (where he might have been more closely monitored). The staff seemed to have relied too much on their personal assessment of Mr A's

behaviour and demeanour, rather than the documented risk factors. The morning after he arrived in prison, Mr A was found hanging in his cell.

In the case of Mr B, his risk was identified, but the subsequent action to support him was poor.

Mr B was placed on remand after being charged with a serious offence. It was his first time in custody. Staff put Mr B on an ACCT on three different occasions. The third and final time was after he showed a ligature to a member of the healthcare team. The 'Triggers' section of the ACCT plan is meant to help staff identify events and circumstances likely to increase risk of self-harm or suicide. At no point were any triggers listed in the ACCT plan opened before Mr B's death. This was despite staff being aware he was desperately trying to get a deportation order approved so he could be closer to his ailing mother, that he was stressed about his relationship with his wife and children, and anxious about his current situation (particularly a parole application). A check of other ACCT documents at the prison suggested that this was not an isolated failing. One morning, Mr B telephoned his wife over 70 times before he got through to her. He was found dead later the same day.

In my view, ACCT procedures are in many ways impressive, supportive and well-designed. And having visited prisons in various countries, I am not aware of many better approaches. However, the real test is in the implementation of the procedures and my learning lessons reviews illustrate that this could often have been better. I also do not doubt the commitment, care and professionalism of most staff involved in safer custody work – and I also recognise the vital role of Listeners and other prisoner peer supporters.

Nonetheless, the reviews highlight a number of lessons that prisons need to learn, many involving better training for all those with a role in making custody safer.

First, risk assessment needs to be better and to take notice of all known risk factors. Officers and healthcare staff particularly in reception and in first night centres need to be better trained to identify risks and to share information between themselves and with those who need to know.

Second, when ACCT documents are opened, the procedures need to be adjusted to any significant changes and events affecting the prisoner. The staff who know the prisoner and the specialists caring for him or her need to be brought together. These multi-disciplinary reviews need to be consistently attended and chaired. Monitoring needs to be: supportive and effective; it needs to engage those at risk and, where possible, involve their families. Records should show clearly how risk was assessed and managed, and be regularly checked by managers to ensure things are done properly.

These are important lessons which often still need to be learned. With the recent and dramatic rise in the number of suicides in prison, the urgency of the situation is obvious. That is why I have called in my annual report for the Prison Service to review and refresh its whole safer custody strategy and ACCT procedures. I know that this call is being taken seriously by Prison Service managers, as well as the Ministry of Justice and Department of Health. I have been assured that a range of work is underway at local, regional and national level to try to improve safety in prison. We must hope that it succeeds.

Learning lessons – natural cause deaths

Learning lessons publications have also looked across our investigations into deaths in custody from natural causes. For example, studies have looked at palliative care and other aspects of the management of the elderly and infirm in prison.

This is a burgeoning subject. In an apparently unexpected and unplanned development - brought on largely by longer sentences and increases in the number of those convicted for historic sexual offences - a rapidly ageing prison population is leading sadly, but inexorably, to more deaths in custody from natural causes.

While by no means all natural cause deaths are of older prisoners, many are. And as age of the prison population is projected to continue to increase, so will age related deaths among prisoners. Indeed, it is quite remarkable that those over 60 are now the fastest growing part of the prison population. At the last count, there were over 100 prisoners over 80, including at least 5 over 90. In this context, it is no surprise that there was a 7% rise in deaths from natural causes last year.

As you will be aware, prisons essentially designed for young men are having to adjust to the challenging new roles of secure care home and even hospice. The implications for healthcare – but also for many other aspects of prison life - are significant. Fortunately, my learning lessons review of end of life care found that a number of prisons and their healthcare partners are making real progress towards better end of life care - but this varies from jail to jail.

It is also symptomatic of the lack of national strategic direction and slowness of prisons to adjust to the new geriatric penal reality that staff still struggle to achieve an appropriate balance between security and humanity when restraining terminally ill prisoners visiting hospitals and hospices. First and foremost the public must be protected, but this is not achieved by unnecessarily shackling the infirm and dying.

In this context I would make a particular plea to this audience: please encourage healthcare staff to be appropriately assertive when, in their clinical judgment, restraints may have a negative impact on the care of the terminally ill. Prison Service instructions and, indeed the law, require that the views of healthcare staff should be

fully taken into account in prison risk assessments. Too often, such crucial input is missing or overruled. And too often, terminally ill prisoners are restrained inappropriately - even at the point of death.

Conclusion

Let me draw matters to a conclusion.

I am grateful for your attention and I realise that have covered quite a lot of territory. This is a particularly challenging time for prisons and all those involved with them – including investigators like myself and medical practitioners like this audience. I hope that it is clear that I and my staff are keen to support improvement in custody and I wish you well with your own efforts to improve healthcare in prison.

[2748]