

Update from the PPO

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INQUEST Lawyers, 11th November 2015

Agenda

- Update since 2012
- Stats 2014-15
- Stats 2015-16
- Performance
- Coroners and stuff
- Learning lessons
 - Self-inflicted deaths 2013-14
- Outcome focus
- Future

PPO 2012 talk to Inquest lawyers

Key challenges:

- Demand
- Resources
- Focus on identifying and disseminating learning
- Focus on investigation timeliness and quality
- Focus on outcomes
- Considerable progress internally but troubling increases in deaths in custody

Statistics: 2014-15

PPO investigated 250 deaths in 2014-15:

- + 5%
- 155 natural cause deaths (+ 15%)
- 76 self-inflicted deaths (- 16%)
- 62% natural causes
- 30% self-inflicted
- 2% homicide
- 6% other

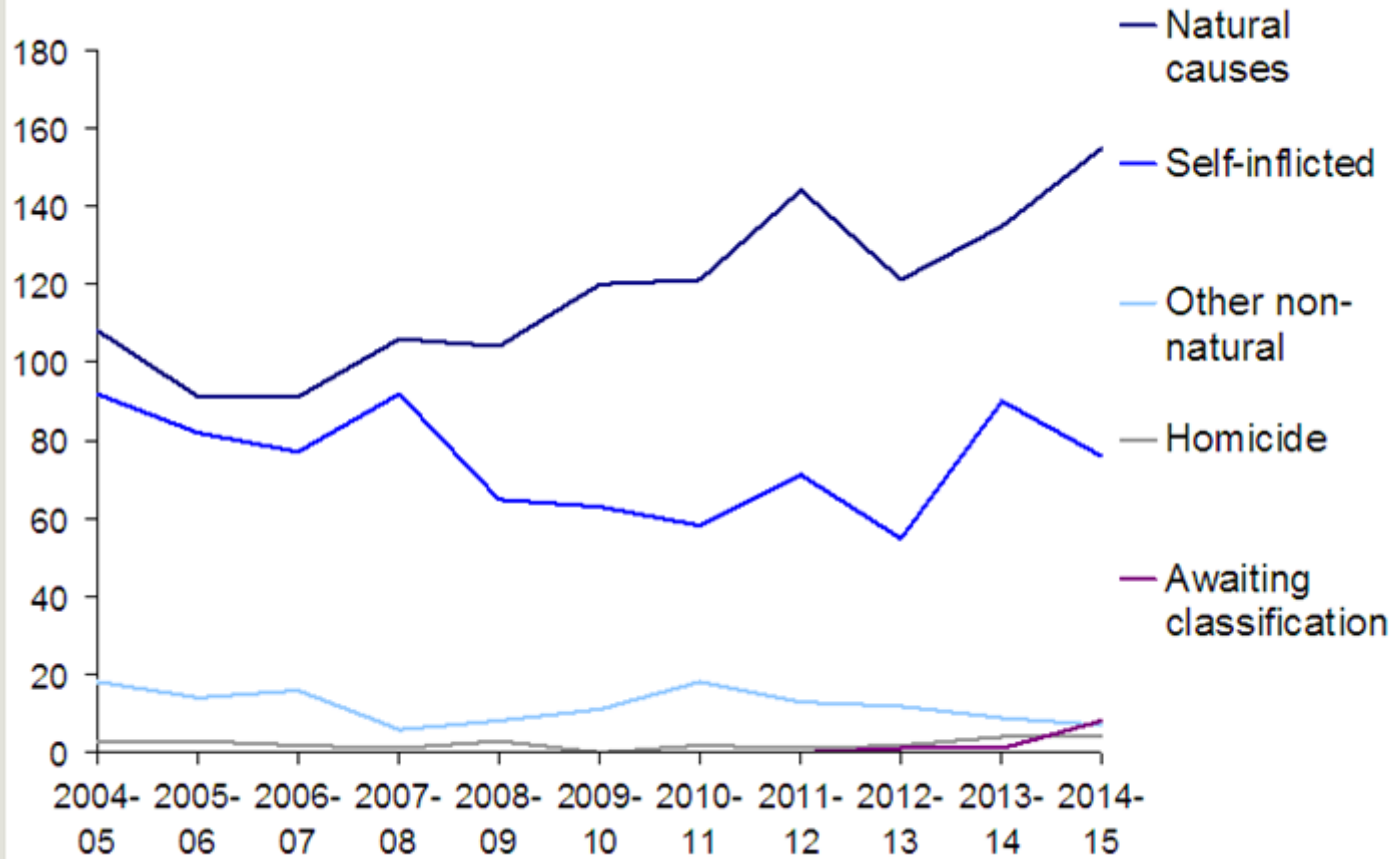
Statistics: 2015-16 (half-year)

153 new fatal incident investigations already

- + **29%**
- + **8%**(natural causes)
- + **59%** (self-inflicted)

- 50% natural causes
- 39% self-inflicted
- 2% homicide
- 9% other and not yet classified

Deaths Investigated By Type



Learning Lessons publications 2014-15

- Risk factors in suicide
- Suicide monitoring
- Self-inflicted deaths 2013-14
- Deaths of young adults
- Deaths of Travellers
- Deaths in segregation
- Deaths related to NPS
 - Complaints about maintaining family ties
 - Complaints from women and young people
 - Complaints about Rule 39 mail

Self-inflicted deaths in 2013/14

89 in 2013/14, a 64% rise on 2012/13.

What lies behind this rising toll of despair?

- Must be some impact from 28% reduction in prison staff and sustained prison population
- But no clear evidence – and some settings without reductions (HSE, private sector) also suffered increased suicides
- Also need to note rise in suicide in the community
- Instead, some new variables and, worryingly, many familiar ones

Self-inflicted deaths in 2013/14

- More deaths in first month
- More had less than two hours out of cell
- Fewer charged with violent or sexual offences
- Significant number of restraining orders
- Weaknesses in risk assessment and ACCTs
- Impact of disciplinary sanctions not recognised
- Links to bullying and intimidation not made

Self-Inflicted Deaths in 2013/14 - Lessons

- **Actively** look for risk factors during reception
- All prisoners should receive an **induction**
- **First month** in prison especially risky
- More responsive **mental healthcare**
- Minimise restrictions on contact with family
- Limited regime increases vulnerability
- Avoid use of segregation – should be exceptional
- ACCT should be holistic properly implemented
- Bullying can increase the risk of suicide
- Effective emergency response

Performance

Initial reports issued within target:

2010/11 – 15%

2011/12 – 21%

2012/13 – 56%

2013/14 – 92%

2014/15 – 97%

2015/16 – 100%(ytd)

Coroners

Clinical reviews:

- Training with NHS England
- Coroners concerns about qualifications of clinical reviewers.

PPO investigator attendance at inquests:

- Coroners unnecessarily calling PPO investigators to inquest and pre-inquest hearings. Difficult to resource.

Post-mortem and toxicology reports:

- Increasing delays – sometimes leading to suspension of investigation.

Timeliness:

- Improved but coroners want them earlier. Not usually possible.

Evaluation:

- Stakeholder feedback.
 - 84% said reports good or very good
 - Only 71% said they received adequate communication during investigation.

Focus on outcomes

- PPO refocused on outcomes
 - Carry out independent investigations to make custody and community supervision safer and fairer.
- New communication strategy to increase impact.
- Development of policy function.
- Joint working
 - HMIP follow up on all FII investigation recommendations.
 - Discussions with IMB's to undertake a similar role.
- Innovations
 - National learning lessons seminars for custodial managers from NOMS\HO to discuss best practice and areas for improvement.

Challenges

Deaths increasing

- More older prisoners
- Sharp and unexplained increase in suicide 2015-16
- No let up in demands on PPO and some new ones
 - Extension of PPO remit:
 - Complaints from secure training centres
 - Deaths in local authority children's homes
- No progress on statutory footing
- Significant pressure on resources expected
- No foreseeable reduction in demand for independent PPO