

The Investigator



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Ombudsman's opening

Welcome to the latest issue of The Investigator



Welcome to issue 12 of The Investigator which focuses on research carried out by the PPO's Research team. The PPO's Research team regularly analyses the data gained from our investigations as a means of identifying any themes and thematic learning. You can find our thematic publications on our website [here](#).

Our thematic publications include Learning Lessons Bulletins which summarise the learning from our investigations for services in remit (such as HMPPS). Each bulletin focuses on a specific theme, such as [post-release deaths](#) or [COVID-19](#), to name a couple of recent topics.

In Issue 12 we share our research into fatal incidents within the remand population. Given that in 2022, 35% of all self-inflicted deaths were of prisoners on remand, this is a very important subject. The research identifies some of the learning from our investigations that we hope can help address this worrying statistic.

As well as focusing on remand, this issue of The Investigator also includes an article about our post-release death investigations pilot and the PPO's year in numbers for 2022. This shows that we started 386 investigations into fatal incidents and completed 2,103 complaints investigations from 1 January to 31 December 2022.

I am pleased to be able to showcase some of our research and hope you find it interesting. I am also excited about future research projects and look forward to sharing further information about them.

Thank you for reading The Investigator, and as always, we welcome your feedback.

Kimberley Bingham, Acting Prisons and Probation Ombudsman

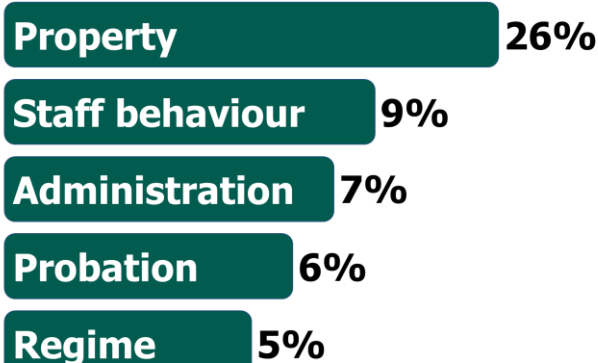
2022 in figures

These figures are subject to change as cases are ongoing but were accurate as of 5th January 2023.

Complaints from 1 January – 31 December 2022

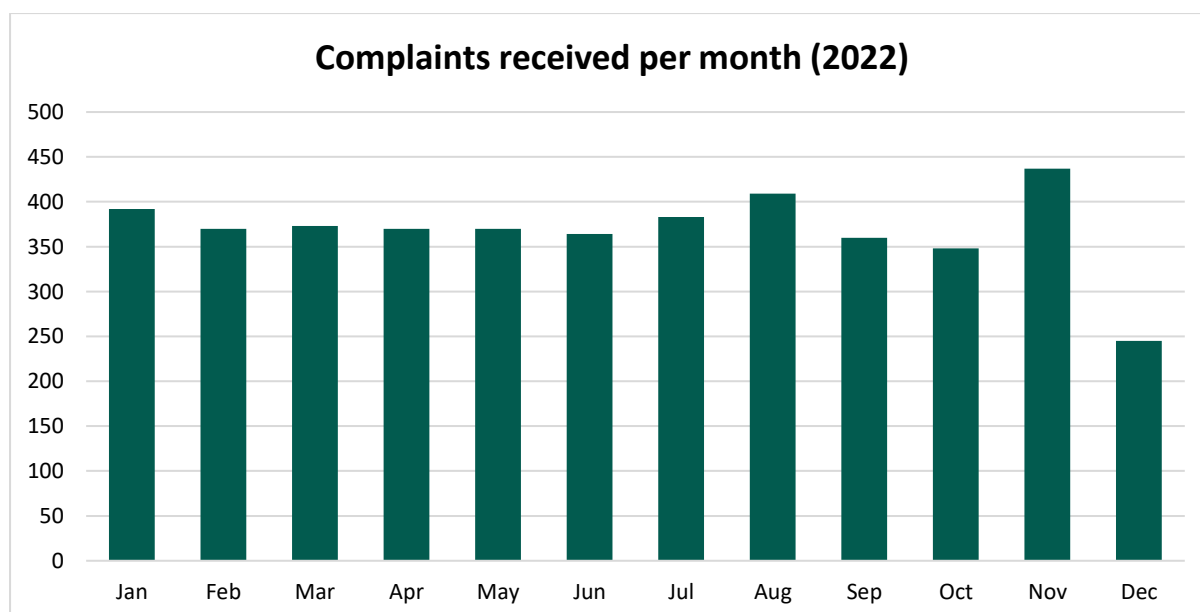
	2022	Compared to 2021
Complaints received	4,421	4,312 (109 more)
Complaints accepted	2,088	1,822 (266 more)
Complaints completed	2,103	1,860 (243 more)

Top 5 complaint categories (% of those received)



Outcomes

Complaints upheld/partially upheld: 573 (27%)



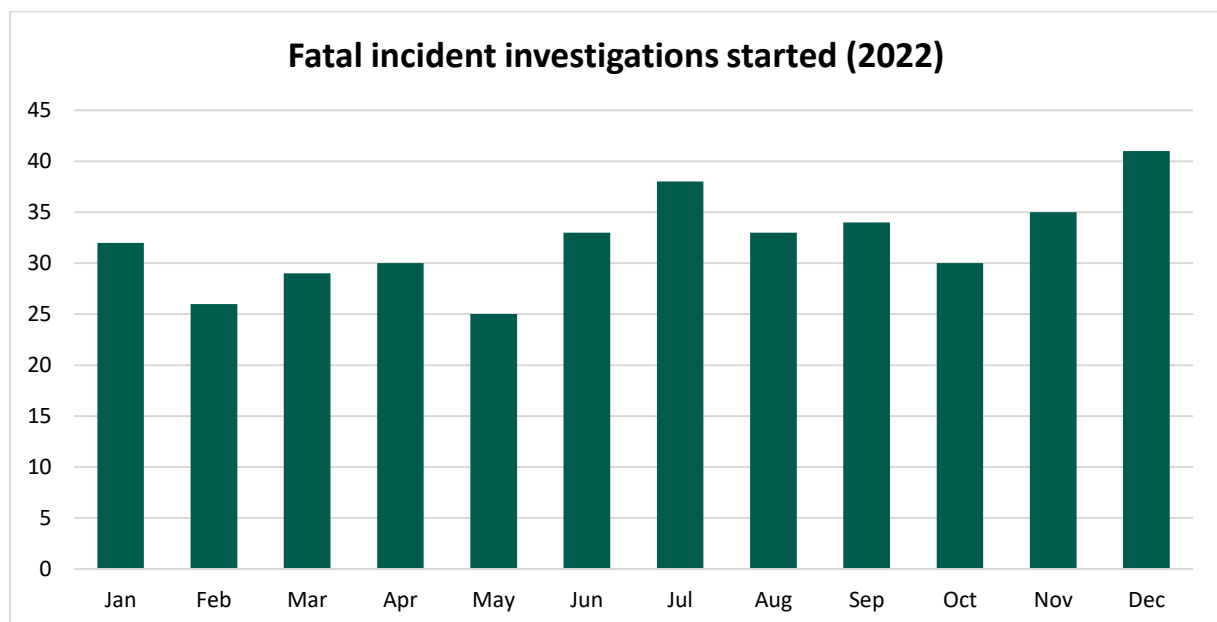
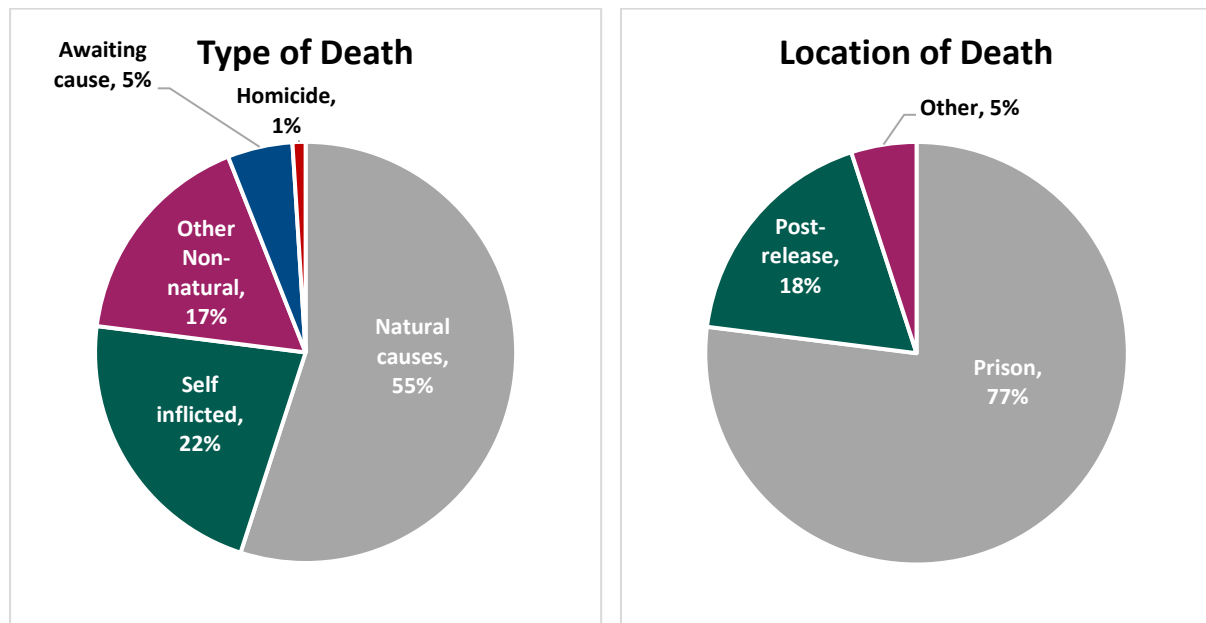
(Please note – There was a postal strike in December)

Fatal incidents from 1 January – 31 December 2022

	2022	Compared to 2021
Number of investigations started	386 investigations	406 (20 fewer)
Initial reports issued	321 reports issued	380 (59 fewer)
Final report issued	334 reports issued	326 (8 more)

2021 saw a greater number of deaths in custody than usual due to the COVID-19 pandemic, resulting in more investigations for the PPO.

Investigations started



Fatal incidents and remand

“in 2022, 35% of all self-inflicted deaths were of prisoners on remand.”

When we talk about the remand population in prisons, we are referring to individuals who are in prison until their trial begins or those who have been convicted but are awaiting sentencing. To give a full picture of remand prisoners as a proportion of the population, between July and September 2022, there was a total of 15,817 prisoners received into prison custody for the first time and of these, 10,295 were on remand¹.

The remand population has increased steadily since the start of the COVID-19 pandemic, largely due to disruptions in the court system. Recent statistics from the Ministry of Justice (MoJ) have indicated this trend has continued post-pandemic, with an 11% increase between 31 December 2021 and 31 December 2022. This has also been driven partly by the recent strike action of the Criminal Bar Association (now resolved). On 31 December 2022, the remand population was 14,143², the highest it has been for at least 50 years.

In their Safety in Custody quarterly update, MoJ have also stated that prisoners on remand had the highest rate of self-inflicted deaths and in 2022, 35% of all self-inflicted deaths were of prisoners on remand.³

What we know about the deaths of those on remand

At the PPO, we do not currently hold sentencing data on our case management system, however, our investigators usually record basic sentencing details as part of their reporting of a fatal incident. This may be relevant, particularly when making recommendations following an investigation. In the cases of deaths of individuals on remand, recommendations commonly related to issues around reception, initial assessment, and the identification of risk factors and potential triggers for self-harm or suicide (e.g., upcoming court appearances and/or sentencing).

Recommendations we have made in cases identified as remand can usually be grouped into the following themes:

Examining and recording all documentation (including ACCT documentation) that arrives with the prisoner and ensuring it travels with them on transfer

We have frequently made recommendations reminding reception staff to consider all documentation that arrives with a prisoner to properly assess their risk of suicide and self-harm.

¹ [Offender management statistics quarterly: July to September 2022 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-july-to-september-2022)

² [Offender management statistics quarterly: July to September 2022 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-july-to-september-2022)

³ [Safety in custody quarterly: update to September 2022 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2022)

For example, Mr A died of self-inflicted causes within a month of being remanded to prison for the first time. When he arrived, his Person Escort Record (PER) was not reviewed, meaning significant information about his risk of suicide and self-harm was missed. A reception nurse also gave too much weight to Mr A's presentation rather than his range of significant risk factors and staff did not start ACCT measures (the Prison Service suicide and self-harm prevention procedures).

Considering risk factors over how a prisoner presents

We have also made recommendations in remand cases that all risk factors should be considered and recorded when assessing a prisoner's level of risk – staff should not just rely on what the prisoner says or how they appear at the time.

Mr B, who despite telling the reception nurse he had attempted suicide several times (most recently the same month he was remanded into custody), stated he had no current thoughts of suicide. As a result, the decision was made not to start ACCT measures. Like Mr A, in the case of Mr B, we found that staff did not properly assess his risk of suicide and self-harm based on his known risk factors. We recommended that healthcare staff should not rely solely on the prisoner's stated intentions.

Flagged triggers for potential self-harm and suicide

In our investigations, we have also highlighted that court dates for trials and sentencing hearings are potential triggers for self-harm and suicide. These triggers should be identified and flagged to relevant staff and following court dates and hearings, prisoners should be re-assessed for their risk of suicide and self-harm.

For example, Mr C was attending court daily for his trial. Following the trial, he was convicted and was due to attend court the next day for sentencing. However, staff who saw him when he returned to the establishment were unaware of his change in status [from being on remand to convicted awaiting sentencing]. The following morning, during a roll check, Mr C was found dead on the floor of his cell. After Mr C's death, a prisoner told staff that Mr C had said he would take an overdose if found guilty at court. Mr C's change in status from a remand prisoner to a convicted prisoner should have triggered a reassessment of his risk of suicide and self-harm and a referral to healthcare staff based on this risk assessment.

In addition to the change in status from remanded to awaiting sentencing, court appearances more generally are potential triggers, and it is important that staff speak to prisoners following court appearances to assess whether their risk has changed and take appropriate action.

For example, Mr D was on remand and attending trial via video link. He was found, two days after his trial began, unresponsive with drug paraphernalia in his cell. There was no record that staff followed local practice and spoke to Mr D about any concerns he might have had following his court appearances in the days leading up to his death.

Conclusion

The remand population has increased since 2020, and it is important to acknowledge the impact this may have on cases investigated by the PPO. The case studies used in this article illustrate some of the issues experienced by prisoners on remand and recommendations we have made as a result of our investigations. They highlight the continuing need for thorough reception procedures, including examining of all documentation that arrives with the prisoner, identifying and assessing risk factors over how an individual may present, record-keeping and making appropriate referrals or application of ACCT procedures. It is also important to highlight triggers for self-harm and suicide specific to those on remand, such as court appearances and sentencing.

In the future, we hope to have access to more sentencing data as part of our ongoing case management improvement project and welcome future data sharing with HMPPS and MoJ. This will allow us to provide greater insight into trends that may be occurring around deaths in prisons and under probation supervision, particularly in relation to prisoners' sentencing status.

Author: Dr Sarah Welland, Research Officer, Research, Data and Analysis team

The PPO's post-release death investigations pilot: the importance of evaluation

"Evaluation... is not the icing on the cake, it is the egg!"

I recently read an article titled 'Evaluation: the icing on the cake?'⁴. This article described how sometimes evaluation is described as the 'icing on the cake' and a 'nice to have', when it is actually not the icing on the cake, it is the egg! The article explained that evaluation is a crucial ingredient. The PPO's recent evaluation of its post-release death investigations pilot demonstrates why evaluation is an important factor.

Why did the pilot start?

In 2020, at the PPO, we started to think more about our remit and the types of investigations we carried out. We were very aware of the high number of deaths following release from prison and started to have conversations with stakeholders and academics about this. We also carried out further research into the number of deaths and how long after release they occurred. Following this, we bid for additional funding to enable us to investigate more post-release deaths. This bid was successful and in September 2021 we started a 12-month pilot **to investigate all deaths (except homicide) that occurred within 14 days of release from prison.**

This pilot was a joint project between our Fatal Incident Investigation team, Research team and Strategy team. This project showed the benefits of thinking about the evaluation process from the start. As a result of this joined-up approach, our lead researcher on the project was able to advise from the start on what data to collect and how best to collate this.

As a project team we thought about what needed to be in place for the PPO to carry out these investigations. This included training for our investigators, an effective notification process so that the PPO would be notified of the deaths and an investigation methodology.

It was established that the post-release death investigations would focus on pre-release planning and post-release supervision. This included factors such as:

- identification of risk of suicide or self-harm,
- appropriate continuity of care on release for matters such as medication or follow up appointments,
- referrals to the appropriate services in the community; and
- appropriate handovers.

The pilot ran from 6 September 2021 to 5 September 2022. Although the pilot has ended, we have continued to investigate post-release deaths.

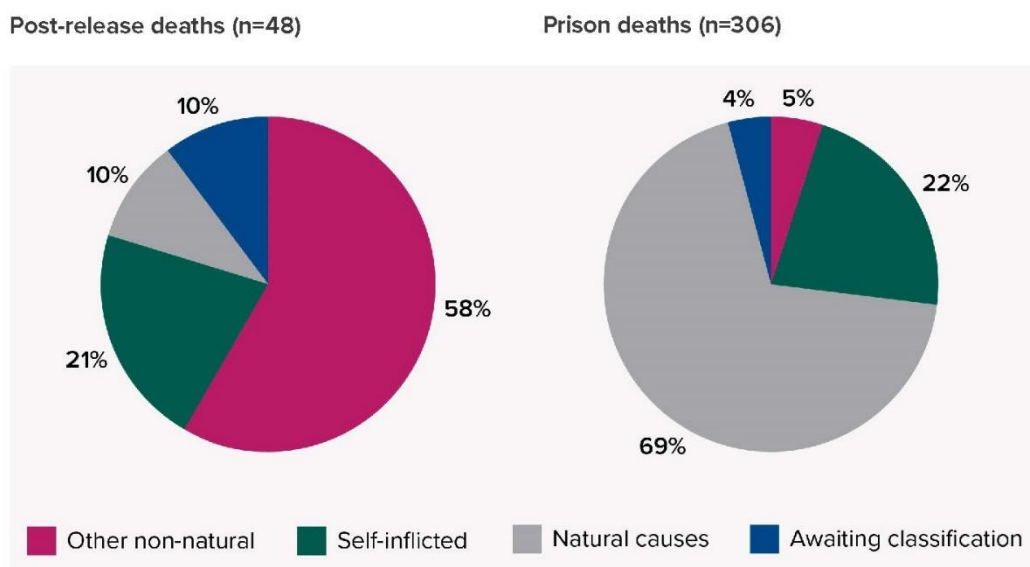
⁴ [Evaluation: the icing on the cake? - Civil Service \(blog.gov.uk\)](https://www.blog.gov.uk/2020/09/evaluation-the-icing-on-the-cake/)

What did the evaluation show?

The PPO's evaluation process looked at all areas of the pilot, including the notification process, the investigation process and the learning identified from the investigations.

During the 12-month pilot, the PPO were notified of 61 post-release deaths and started investigations into 48 of these cases. **50% of these investigations were into drug-related deaths.** There were also 10 self-inflicted deaths and 5 natural cause deaths.

The percentage of self-inflicted deaths that occurred in prison (22%) and within 14 days of release from prison (21%) were very similar. **This demonstrates that as much attention needs to be given to identifying risk factors on release as it does when the individual is in prison.**



Death classification breakdown for investigations started from 6 September 2021 to 5 September 2022 for post-release and prison deaths.

The evaluation of the pilot looked at the thematic learning from the investigations. The learning included findings about information sharing, homelessness, accommodation, substance misuse and mental health. **The evaluation identified the importance of strong partnerships and joint working across all sectors and services** to address these findings.

Importance of information sharing, detailed handovers and timely referrals

Information sharing, including detailed handovers and timely referrals are crucial. The evaluation showed that we made three recommendations about information sharing between prisons and probation. Two of these recommendations related to self-inflicted deaths. It is vital that prison staff give a full handover to probation staff so that the community offender manager is aware of any important risks or triggers.

The importance of detailed handovers and timely referrals was not just identified in self-inflicted death investigations, it is just as important in cases involving substance misuse. In one case we found that gaps in information sharing hindered release preparations and the prison resettlement team and substance misuse team only found out about the release the day before the release date.

The evaluation also identified that it can be difficult to establish exactly who is responsible for handing over key information from the prison to the community. It can also be difficult for those involved in release planning to identify who is or should be responsible for different aspects of care, for example substance misuse or mental health. The evaluation suggested this can become complex when there are a number of external agencies who might be involved.

As well as identifying the areas where the PPO had made recommendations, the evaluation also explored wider findings. For example, the issue of accommodation and homelessness emerged as a topic of concern. This relates to the challenges of multi-agency involvement and ensuring that staff understand who is responsible for making the relevant referrals.

The PPO will investigate whether the prison leaver left prison with accommodation arranged or homeless and whether appropriate referrals were made. However, some of the agencies involved in the process fall outside of the PPO's remit. Despite this, we have been recording our findings in relation to homelessness and accommodation so that the learning can be evaluated and shared more widely.

In this article I have demonstrated the importance of thinking about evaluation from the start of the project and shared some of the learning that the evaluation into the post-release death investigations pilot found.

You can read more about the learning from the PPO's post-release death investigations in our Learning Lessons Bulletin [here](#) and you can access the full pilot evaluation research paper [here](#).

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