

**Prisons &
Probation****Ombudsman**
Independent Investigations

Learning lessons bulletin

Fatal incident investigations | Issue 18

Self-inflicted deaths of IPP prisoners

Foreword

This learning lessons bulletin has been prompted by the worrying increase in self-inflicted deaths of prisoners serving Imprisonment for Public Protection (IPP) sentences in 2022. The PPO have continued to see self-inflicted deaths of IPP prisoners in 2023.

2022 saw the highest number of self-inflicted deaths among the IPP prison population since the sentence was introduced. More needs to be done by HM Prison and Probation Service (HMPPS) to ensure these high levels of self-inflicted deaths do not continue.

An IPP sentence should be considered as a potential risk factor for suicide and self-harm. IPP prisoners struggle with their uncertain status leading to feelings of hopelessness

and frustration. This can cause a lack of engagement with the parole process and sentence planning and create a lack of trust in the system. It is clear there are several risk triggers associated with IPP prisoners, including parole hearings, recall, prison transfers, change in security categorisation and upcoming release.

I hope this bulletin will provide useful insight and learning to HMPPS to ensure the risk factors associated with IPP sentences are identified and acted upon.

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Prisons and Probation Ombudsman

Context and data

IPP sentences were introduced in 2005. They were intended for high-risk prisoners who were considered dangerous, but whose offences did not merit a life sentence. Those sentenced to an IPP sentence are set a minimum term which they must spend in prison before the Parole Board can consider them for release. The Parole Board will only direct release if the prisoner has demonstrated that they have sufficiently reduced their risk to a level that can be managed in the community.

However, as of 30 June 2023 there were still 1,312 IPP prisoners who had never been released from custody in England and Wales. 51% of these prisoners have been held for at least 10 years beyond the end of their minimum term. In addition, there were 1,597 recalled IPP prisoners in custody, making a total IPP prison population of 2,909. The recalled IPP prison population has exceeded the number of IPP prisoners who have never been released. The recalled IPP prison population increased by 11% between June 2022 and June 2023.¹

In September 2022, the Justice Select Committee (JSC) published a report of its review of IPP sentences. The JSC found

that “the psychological harm caused by IPP sentences is a considerable barrier to progression for some IPP prisoners. The indefinite nature of the sentence has contributed to feelings of hopelessness and despair that has resulted in high levels of self-harm and some suicides within the IPP population. In addition to this, IPP prisoners distrust the people and services that are necessary to support their progression.”²

The Government responded to the review in February 2023, when they announced that they would not be resentencing those currently subject to an IPP sentence.³

In response to the JSC report, the Ministry of Justice (MOJ) and HMPPS published a new IPP action plan. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to “maximise their prospects of achieving a safe and sustainable release.”⁴

Provisional data from the MOJ shows that in 2022 there were nine self-inflicted deaths of IPP prisoners, the highest number of self-inflicted deaths among the IPP prison population since the sentence was introduced.⁵

1 Offender management statistics quarterly: January to March 2023 – <https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-january-to-march-2023/offender-management-statistics-quarterly-january-to-march-2023>

2 House of Commons Justice Committee, IPP sentences (parliament.uk), Third Report of Session 2022-23, p.58 – <https://committees.parliament.uk/publications/28825/documents/173974/default/>

3 House of Commons Justice Committee, IPP Sentences: Government and Parole Board Responses to the Committee’s Third Report, Ninth Special Report of Session 2022-23 (parliament.uk) – <https://committees.parliament.uk/publications/33927/documents/185861/default/>

4 Letter from the Lord Chancellor and Secretary of State for Justice on the Imprisonment for Public Protection Action Plan (parliament.uk) – <https://committees.parliament.uk/publications/39321/documents/192968/default/>

5 Quarterly update to December 2022 – <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2022>

IPP self-inflicted deaths between 2005 and 2022⁶



As of December 2022, there have been 78 IPP self-inflicted deaths, since the sentence was introduced in April 2005, which is 6% of all self-inflicted deaths during this period.

This bulletin focuses on the findings from 19 Prisons and Probation Ombudsman (PPO) investigations into self-inflicted deaths of IPP prisoners between 1 January 2019 and 30 June 2023.⁷

Assessment, Care in Custody and Teamwork (ACCT) management

ACCT is a multi-disciplinary case management approach used in prisons to support people at risk of suicide or self-harm. It focuses on identifying risks and triggers that might increase a person's risk of suicide and self-harm and provides extra support around these events.

Of the 19 self-inflicted deaths reviewed for this bulletin, only five of the individuals were on ACCT monitoring at the time of their death. This suggests that more needs to be done to recognise a prisoner's IPP status as a potential risk factor and to identify the triggers for suicide and self-harm that are associated with this status.

Case study A

Mr A was found hanged in his cell. He was serving an IPP sentence. He had been recalled a total of five times since his first release in 2013. Mr A had agreed to work with a therapy service to try to break the cycle of release and recall to prison. This work would start after his next parole hearing.

⁶ This graph uses MOJ data from this source: <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2022>

⁷ At the time of writing, MOJ have not yet published any figures for the number of self-inflicted IPP deaths for 2023. These cases have been confirmed using PPO investigation data available at the time of writing.

Mr A was placed on ACCT monitoring after he said he felt suicidal. He was aware that none of the reports requested by the Parole Board supported his release.

Overall, Mr A was managed well under ACCT during periods of crisis. Staff correctly identified that Mr A's IPP sentence and recalls to prison were significant issues that increased his risk of suicide and self-harm and they recorded this on the ACCT document. Mr A's parole hearing provided a focus for these issues and was therefore a time when Mr A might be at heightened risk of suicide or self-harm. The ACCT monitoring was stopped one week before the parole hearing and the post-closure review was set for the day after the hearing in recognition that it was a significant event for Mr A. At the post-closure review, Mr A said he felt hopeless and suicidal and therefore the ACCT was re-opened.

While closing the ACCT in advance of the parole hearing did not affect the outcome for Mr A, it left the possibility that he would ruminate in the week leading up to the hearing and overnight after the hearing and attempt to self-harm while he was not subject to extra checks.

Lessons to be learned:

- A prisoner's IPP status should be considered as a potential risk factor for suicide and self-harm.
- ACCT documents should not be closed in the run up to events associated with an identified trigger, such as parole hearings.
- Staff must consider known triggers when carrying out ACCT reviews or deciding whether to close an ACCT.

Recall

As well as referring to the harm that an IPP sentence can cause, the JSC also referred to the "recall merry go round".⁸

Following recall to prison, IPP prisoners are faced again with the uncertainty around their sentence and if they will be released.

Due to the licence aspect of the IPP sentence, prisoners can feel that the licence is never ending and therefore the sentence will never fully end. The case study of Mr A also refers to the cycle of release and recall. While the case study of Mr A focuses on ACCT management, his case also demonstrates the impact that the "recall merry go round" can have on an individual.

Case study A (part 2)

Mr A had a history of attempted suicide and self-harm, anxiety and depression. He was serving an IPP sentence imposed in 2008 and was first released in 2013. He was recalled to prison in 2016 and then released and recalled a further four times, the last time on 4 August 2021. He was recalled for failing to keep to the terms of his licence by maintaining contact with probation services. He did not re-offend. The investigation found that, despite strong multi-disciplinary input and a high standard of care in his last prison, Mr A was left traumatised and ultimately hopeless by the number of times he had been released and recalled to prison and his apparently endless sentence.

Lessons to be learned:

- Staff should be alert to potential triggers for suicide and self-harm, including: parole hearings, recall, prison transfers, recategorisation and return from open conditions.

8 House of Commons Justice Committee, IPP sentences (parliament.uk), Third Report of Session 2022-23, p.3 – <https://committees.parliament.uk/publications/28825/documents/173974/default/>

Provision of the key work scheme to IPP prisoners

The key work scheme is a key part of HMPPS' response to self-inflicted deaths, self-harm and violence in prisons. The aim is to reduce violence and self-harm in prisons by developing better relationships between staff and prisoners. Under the key work scheme, every male prisoner (in the closed prison estate)⁹ should have a dedicated prison officer key worker with whom they have weekly 1-1 contact.

We have found that the key work scheme is not operating as anticipated in all prisons due to factors including, staffing shortages and some prisons prioritising the most vulnerable prisoners for the key work sessions. The cases of Mr B and Mr C show that prisons need further guidance on how to identify and prioritise vulnerable prisoners for key work sessions.

Case study B

Mr B was found hanged in his cell. He was serving an IPP sentence with a minimum term that ended in 2008. He had been charged with a further offence in 2018. Mr B had disengaged with the parole process (including an upcoming Parole Board hearing) because he felt hopeless about the prospect of release. He did not engage with staff, isolated himself from other prisoners and withdrew from the regime.

In addition to his formal care plans, staff also put in place measures to try to reduce the impact of isolation on Mr B's wellbeing. An isolating individual's plan was put in place to monitor Mr B's wellbeing, but daily updates and weekly reviews did not take place as they should have done.

Staff made consistent efforts to engage with Mr B and encourage him to come out of his cell. However, staff shortages put significant limitations on the ability of the prison to run a meaningful, safe and decent regime. This meant that Mr B had very few key work sessions due to staff shortages, which when combined with the failures in isolation monitoring, meant that Mr B missed out on potential opportunities to build trusting relationships.

Lessons to be learned:

- IPP prisoners should be prioritised for key work to help with levels of engagement, build trust in the system and offer an opportunity for staff to identify any triggers or risks.

The case study below of Mr C shows the importance of key work in the run up to a release date. Release can be a time of heightened anxiety and stress for any prisoner, but particularly for IPP prisoners who have spent considerable time in prison. Lack of preparation for release can add to that anxiety and lead to recalls.

Case study C

Mr C was given an IPP sentence in 2007 with a tariff of four years. He was released in 2017 to an Approved Premises but was recalled to prison later the same day. Mr C was released again in 2020 and recalled to prison in 2021. Both recalls related to his licence conditions. He experienced mental ill health in prison and in the community.

⁹ Key work is only delivered in the closed male prison estate and to eligible women in the female estate. Not all women receive key work and key work is not delivered in the open male estate.

Mr C's mental health significantly declined when, in 2022, the Parole Board directed he should be released and reside in an Approved Premises. In that same week, he was found with a ligature and staff started ACCT monitoring. Mr C was still subject to these measures at the time of his death, four days later, when he was found hanged in his cell.

We found that staff had put supportive measures in place following the Parole Board's direction for release, and that staff had tried to reassure Mr C.

However, Mr C had not had a key work session for over seven weeks before he died. This included the period when he was informed of his release and when his mental health declined. While wing staff had a good rapport and provided a good level of care, Mr C might have benefitted from regular key work sessions and a consistent point of contact, particularly given the decline in his mental health in the run up to his release.

Lessons to be learned:

- The outcome of a parole hearing and the provision of a release date should be considered a significant risk factor for suicide and self-harm. This should be covered during regular key work sessions during the parole period and leading up to the release.

Sentence progression

Setbacks in sentence progression can increase a prisoner's risk of suicide and self-harm. Insufficient opportunities to participate in offending behaviour programmes can increase frustrations and create a sense of hopelessness, particularly for those serving an IPP sentence who may need access to interventions to help address outstanding risk factors and demonstrate their risk has reduced to a level where it can be managed in the community. The case of Mr D demonstrates not only how a lack of access to offending behaviour programmes can cause frustrations, but it also highlights another significant trigger – ongoing police investigations and potential for further charges.

Case study D

Mr D died after he was found hanged in his cell. He was serving an IPP sentence and had been recalled to prison. Mr D was anxious as a result of not knowing how long he would be in prison.

Mr D was transferred to a prison where his suitability to take part in offending behaviour programmes was assessed. The assessment concluded that Mr D's risk was not high enough to qualify for such programmes. However, Mr D's offender managers had said he needed to complete offending behaviour work in order for them to recommend release.

Mr D was understandably concerned that he was not able to take part in the programmes that he thought would enable him to progress. This left Mr D in an impossible situation where he was unable to complete the offending behaviour work to demonstrate his suitability for release to his offender managers. There was evidence that Mr D's sentence progression as an IPP prisoner and his inability to access offending behaviour programmes played on his mind in the months before his death and may have been a contributory factor.

Mr D was interviewed by police about alleged further offences. Following the police interview and in the months and weeks before his death, Mr D became increasingly anxious about being charged with further offences. There was no evidence that Mr D shared his concerns with prison staff. However, we were concerned that staff missed an opportunity to assess whether Mr D's risk of suicide had increased after the police interview. It was likely that Mr D's anxiety about further charges contributed to his decision to take his life.

Due to the restricted regime in place as a result of COVID-19, Mr D did not have meaningful engagement with staff in the months before he died. This significantly reduced their opportunity to identify that Mr D might have been at an increased risk of suicide or self-harm.

Potential further charges will impact on sentence progression and therefore should be considered as a risk factor. While Mr D did not tell staff about his anxieties, following up with Mr D after the police interview may have offered Mr D the opportunity to talk to staff and give staff the opportunity to assess whether he was at an increased risk of suicide or self-harm.

Lessons to be learned:

- Alternatives and opportunities must be provided to IPP prisoners who do not meet the threshold to participate in offending behaviour programmes, to help them progress through their sentence and demonstrate a reduction in risk.
- Prisoners' risk of suicide and self-harm should be reviewed after an interview with police.

Parole reviews are held by the Parole Board to decide whether to release an IPP prisoner on or after the end of their minimum term or to advise the Secretary of State for Justice whether an IPP prisoner should progress to an open (Category D) prison. If the Secretary of State for Justice accepts the Parole Board's recommendation for a transfer to an open prison, the prison can start making the arrangements for the transfer.

An IPP prisoner may feel a sense of hope if a Parole Board recommendation for a transfer to an open prison has been accepted by the Secretary of State for Justice. Therefore, it is important that transfer decisions are clearly explained to prisoners, particularly in cases where a transfer to an open prison has been approved by the Secretary of State for Justice but the prison have not been able to arrange such a transfer.

We are aware that there are occasions when a prison is unable to arrange a transfer to an open prison because the open prisons may refuse to accept the prisoner for a number of different reasons. While the prisons may have good reasons for declining the prisoner, this appears to undermine the parole process as it can make it difficult for Parole Board recommendations (that have been approved by the Secretary of State for Justice) to be implemented. These circumstances can leave IPP prisoners stuck in the prison system as they are not given the opportunity to demonstrate their reduced risk in open conditions. Once the Secretary of State for Justice has approved a recommendation for a transfer to open conditions, we do not believe the responsibility for the transfer should solely lie with the current (sending) prison.

The case study of Mr E highlights the above issues. Circumstances such as those experienced by Mr E should be considered as a potential trigger for suicide or self-harm.

Case study E

Mr E died after he was found hanged in his cell. He was serving an IPP sentence and was eight years over his minimum tariff. Mr E was in a high security prison and three months before his death, the Parole Board recommended that he could be moved to a Category D open prison to prepare him for release. His current prison was unable to locate a Category D prison who would accept Mr E. As Mr E was not a high security prisoner and he felt threatened at his current prison, staff decided to move him to a Category B prison.

On arrival at the Category B prison, Mr E said that he felt anxious as he had Category D status and had been expecting to go to a Category D prison. We found no evidence that Mr E was told why he was moved to a Category B prison, rather than to open conditions as recommended by the Parole Board. While there were other factors relevant to Mr E's death, the transfer was clearly a further source of anxiety.

Lessons to be learned:

- Decisions not to implement Parole Board recommendations (that have been approved by the Secretary of State for Justice) must be clearly communicated to the prisoner. Such circumstances should also be considered as a potential trigger for suicide and self-harm.
- HMPPS should consider introducing a national transfer process to ensure Parole Board recommendations can be implemented once approved by the Secretary of State for Justice.

Summary of lessons to be learned

ACCT management

- A prisoner's IPP status should be considered as a potential risk factor for suicide and self-harm.
- ACCT documents should not be closed in the run up to events associated with an identified trigger, such as parole hearings.
- Staff must consider known triggers when carrying out ACCT reviews or deciding whether to close an ACCT.

Recall

- Staff should be alert to risk factors and triggers for suicide and self-harm, including: parole hearings, recall, prison transfers, recategorisation, and return from open conditions.

Key work scheme

- IPP prisoners should be prioritised for key work to help with levels of engagement, build trust in the system and offer an opportunity for staff to identify any triggers or risks.
- The outcome of a parole hearing and the provision of a release date should be considered a significant risk factor for suicide and self-harm. This should be covered during regular key work sessions during the parole period and leading up to the release.

Sentence progression

- Alternatives and opportunities must be provided to IPP prisoners who do not meet the threshold to participate in offending behaviour programmes, to help them progress through their sentence and demonstrate a reduction in risk.
- Prisoners' risk of suicide and self-harm should be reviewed after an interview with police.
- Decisions not to implement Parole Board recommendations (that have been approved by the Secretary of State for Justice) must be clearly communicated to the prisoner. Such circumstances should also be considered as a potential trigger for suicide and self-harm.
- HMPPS should consider introducing a national transfer process to ensure Parole Board recommendations can be implemented once approved by the Secretary of State for Justice.

About the PPO's data

Data is based on when the PPO were notified of the death.

The PPO does not determine the cause of death. This is determined by a coroner following an inquest. Cases are separated into administrative categories, but these categories may differ from a coroner's conclusions. Classifications may change during an investigation. However, they are not altered following the conclusion of the inquest.

Our definition of a self-inflicted death is:
The death of a person who has apparently taken their own life and the circumstances suggest this was deliberate, irrespective of whether this would meet the legal definition of intent (i.e. suicide).

The PPO and HMPPS have different defining criteria for classifying cases. For this reason, the totals given here may differ from what is published by HMPPS.¹⁰

IPP sentence type is confirmed during the investigation process and uses documentation such as NOMIS reports, Death in Custody notification forms, PPO initial and anonymised reports.



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¹⁰ For further information on HMPPS data cited in this report, please see the release notes and guide at: <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-september-2022>