Update from the PPO

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INQUEST Lawyers, 22 November 2016
Agenda

- Numbers
- Learning
- Pressures on the PPO
- Inquests
- Future
Statistics: 2015-16

PPO started investigations into 304 deaths in 2015-16

- +21% increase in investigations compared to 2014-15
- 170 natural cause deaths (+8% from 2014-15)
- 105 self-inflicted deaths (+36% from 2014-15)
  - 56% natural causes
  - 35% self-inflicted
  - 6% other
  - 2% homicide
  - 1% awaiting classification
Deaths investigated by type

- Natural causes
- Self-inflicted
- Other non-natural
- Homicide
- Awaiting classification

Data for different years from 2004-5 to 2015-16.
Statistics: 2016 half-year figures

Remorseless increases
182 new fatal incident investigations already between April – September 2016
  – + 22% on same time period in 2015
  – + 18% (natural causes)
  – + 12% (self-inflicted)
Explaining the increases

- Increase in natural cause deaths explicable (if unplanned)
- Hard to be definitive about cause of shocking increase in suicide:
  - **Staffing** cuts, crowding and regime restrictions must all play a part in reducing protective factors against self-inflicted deaths
  - So must troubling levels of **mental ill health**
  - And an epidemic of **new psychoactive substances**
  - But picture inconsistent and each tragic case is an individual crisis, an individual story and no simple, single explanation suffices
Tackling the increase in suicides

• In a complex context, effective efforts by staff using evidence based procedures are key to preventing self-inflicted deaths.
• Our investigations do illustrate some commendable work by staff but, in a strained prison system, too often suicide and self-harm procedures not being consistently applied.
• As a result, investigations often repeat the same lessons.
• This is not good enough and we frequently have to call on prison staff to redouble their efforts.
• Never been a more important time to learn lessons about preventing self-inflicted deaths
Learning Lessons publications

Recent publications:
- Deaths in segregation
- Dementia
- Homicides
- Prisoner Mental Health
- NPS
- Early Days

Future publications:
- Transgender prisoners
- Young prisoners
- Women prisoners
- Older prisoners
“Learning from PPO investigations: prisoner mental health”

Published January 2016

A thematic review of the identification of mental health needs and the provision of mental health care for prisoners, based on the learning from our fatal incident investigations.

Available online: http://www.ppo.gov.uk/?p=6737
Prisoner Mental Health

- Huge prevalence of mental ill health in prison – 70% of self-inflicted deaths
- Weaknesses in identification limits appropriate care and support
- Distress can be easily misinterpreted as bad behaviour
- Weaknesses in timely referrals and treatment
- Key Lessons:
  - mental health awareness training for staff
  - screening should consider documented risk as well as presentation
  - care should be equivalent to the community
  - compliance with medication should be monitored and encouraged
  - mental health teams should attend or contribute to all ACCT reviews
Case Study – Mr A

- Mr A was already prescribed antidepressants before arriving in prison and cut himself frequently.
- On arrival, a nurse conducted a reception screening and noted Mr A’s apparent mental health issues but did not make a referral for mental health assessment by relevant staff.
- The following day, Mr A said that he felt suicidal and asked to see the mental health team. No referral was made.
- At his suicide prevention (ACCT) case review, his case was discussed but again no referral was made.
- Mr A was discussed at the next mental health referral meeting but was not booked for an assessment.
- Shortly after, Mr A hanged himself in his cell without ever having been assessed.
“Learning lessons bulletin: new psychoactive substances”

Published July 2015

Examines the death of prisoners suspected to have been using NPS

Considers risks and behaviour related to NPS use

Available online: http://www.ppo.gov.uk/?p=6137
Learning: new psychoactive substances

• Now identified 64 deaths in prison between June 2013 and April 2016, where the prisoner or perpetrator of the death was known or strongly suspected to have used or possessed NPS before their death
• 44 self-inflicted, 9 natural causes, 6 drug-related, 3 not ascertained; 2 homicides
• Risks to physical and mental health, behaviour, bullying and debt.
New psychoactive substances (cont.)

• Key lessons:
  – supply needs to be reduced
  – staff awareness needs to increase
  – governors need to address the bullying and debt associated with NPS
  – drug treatment services need to address NPS
  – demand for NPS among prisoners must be reduced
Case Study – Ms B

- Ms B had several long term medical conditions and had frequent contact with the prison healthcare team.
- She had no history of self harm and had not shown any sign that she might hurt herself.
- Other prisoners said Ms B regularly taking NPS.
- One night, staff heard singing coming from her cell but this changed to a loud and aggressive noise, so officers went to investigate.
- The cell was dark and Ms B was in bed. She had made a deep cut in her arm, severed an artery and lost a lot of blood.
- She died in hospital later that day.
- Our clinical reviewer considered that NPS triggered a rapid onset psychotic episode which led Ms B to self harm.
“Learning lessons bulletin: early days and weeks in custody”

The bulletin examines the self-inflicted deaths of prisoners within the first month of custody.

Available online at:
http://www.ppo.gov.uk/?p=6855
Learning: early days in custody

• Sample of 132 self-inflicted deaths April 2012 to March 2014:
  – 1/3 occurred in first 30 days
  – Half of those in the first week
• Key lessons:
  – Risks factors: too much weight put on presentation of prisoner or statements made than on known risk factors
  – Induction: inadequate induction makes early days and weeks more stressful
  – Recalled prisoners: a high risk; in 1/5 of cases the prisoner was on recall
  – Mental health: continuity of mental healthcare is important, allowing prisoners to continue to receive the same support they did in the community
Case Study – Mr C

- Mr C was charged with serious violent offence against his partner
- A recent attempt at suicide was noted at court and in escort warning forms
- Despite this, no ACCT opened on reception
- Did not go to first night centre and had no induction
- That day, his partner and a probation officer both phoned to raise concern about Mr C’s risk of suicide with prison
- Staff spoke to Mr C, but accepted his assurance that he was ok and didn’t open an ACCT
- Next day, Mr C’s lawyer faxed a further expression of concern, but this was not urgently passed on to safer custody staff
- Mr C hanged himself two days after arriving in prison
Pressures on PPO

- Change at the top (not)
- Coping with demand
- Resources cut by 4.6% in 2016-17
- Performance still excellent
  - Initial reports issued within target:
    - 2010/11 – 15%
    - 2015/16 – 100%
    - 2016/17 - 100% (up to October 2016)
Stakeholder survey results

- **General stakeholder survey**
  - Nine out of 10 stakeholders, including all coroners, agreed that the quality of the work and services provided by the PPO was satisfactory or better

- **Bereaved families survey**
  - Around three-quarters of families who responded said that the PPO’s investigation had ‘fully’ met their expectations in this respect

- **Post-investigation survey**
  - Of all stakeholders, including all coroners, agreed that the fatal incident report met their expectations.
Efforts to get greater traction

• Focus on outcomes
  – SMART recommendations
  – All accepted
  – Action plans

• More joint working
  – HMIP follow up on all FII investigation recommendations.
  – New protocol with IMBs to undertake similar follow up.
  – Discussions with HMI Probation on similar role in APs

• Innovations
  – Third series PPO learning lessons seminars for custodial managers.
  – Regional NOMS action plans
  – NOMS SIDs project
Inquests

• Clinical reviews:
  – Coroner concerns about qualifications of clinical reviewers - but they are not expert witnesses.

• PPO investigator attendance at inquests:
  – Coroners still 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:
  – PPO has improved, inquests less so.
Future

- Demand – no sign of reduction, in fact
  - More older prisoners and rising number of natural cause deaths
  - Sharp, unexplained and continuing increase in self inflicted deaths
  - Particularly troubling rise in women killing themselves
- No foreseeable reduction in demand for independent PPO
- No foreseeable increase in resource to match demand
- High risk of impact on PPO performance
- That’s the cloth from which we’ll be cutting our coat
Future

• The state of prisons
• Prison and regulatory reform – White Paper
  – No progress without safety
  – Statutory footing?
  – Relationship with other scrutiny bodies
  – Status of PPO and its recommendations
• Legislation?
  – Governor autonomy
  – Future policy framework
  – Equity and consistency
Areas for discussion?

• Relationship with INQUEST
  – Liaison with Inquest about learning lessons
  – Training for investigators with Inquest lawyers

• Engagement with families
  – Signposting of sources of advice/support
  – Revised family leaflet (references Inquest)