

Learning Lessons Seminar 2016

Self-inflicted deaths

Friday 2nd September, 2016

Nigel Newcomen

Prisons and Probation Ombudsman

Housekeeping

- Fire exits
- No fire drills
- Lunch at 1.15pm in the Dining Room
- Slides will be emailed
- Taxis

Agenda

- | | |
|-------|----------------------------------|
| 10.30 | Introduction by the Ombudsman |
| 10:40 | Response from Michael Spurr |
| | Q&A |
| 11:40 | Self-inflicted deaths |
| | What PPO investigations involve |
| | Learning lessons & |
| | recent case studies |
| 12.45 | Q&A |
| 13:15 | Lunch |
| 14:00 | Table discussion |
| | Feedback to panel and discussion |
| 15:30 | Next steps and close |

Introduction

- Delighted to welcome Michael Spurr CEO NOMS, delegates from prisons, senior NOMS staff and, of course, my own staff
- PPO created in 1994 to independently investigate prisoner complaints. Took on investigation of deaths in custody in 2004
- Our vision is to carry out independent investigations to make custody and community supervision safer and fairer
- This is the third annual series of seminars intended to use PPO learning from investigations to support prison staff to improve safety and fairness

Introduction

- PPO fatal incident investigations have 4 aims:
 - Establish circumstances of death, including good and bad practice
 - Provide explanation to the bereaved family
 - Assist the coroner
 - Identify learning for improvement
- Learning comes from individual investigations but increasingly also from thematic learning looking across investigations
- We will look at both these sources of learning and then discuss and debate

Introduction

- Never been a more important time to learn lessons about preventing suicide and self-harm
- Horrendous 34% increase in apparent suicides 2015-16 and 19% rise year to date in 2016-17
- Yet we are not clear why there has been such a surge:
 - Staffing issues, crowding and regime restrictions must all play a part
 - So must troubling levels of mental ill health
 - And epidemic of new psychoactive substances
 - But no simple, single explanation suffices
- In such a complex context, effective thoughtful efforts at prevention by staff are vital

Introduction

- Unfortunately, PPO reports often repeat the same recommendations, particularly the need for better risk assessment and better ACCT support
- Beyond procedural failings, it is rare for us to identify a lack of care. More often we find caring staff going to great lengths to support those in crisis, although not all staff contacts with those at risk are meaningful
- What is clear is that more can and should be done to improve suicide and self-harm prevention in prison
- Today is about learning lessons or at least understanding the obstacles to improvement, so that we can reverse the *rising toll of despair* in custody

Response from NOMS

Michael Spurr, Chief Executive Officer

What PPO investigations involve

Anita Mulinder, Senior Investigator

What PPO investigations involve

Types of investigation

- Natural Causes – (57% 2015/16)
- Self-inflicted – (34% 2015/16)
- Other - including homicide and drug overdose – (6% 2015/16)
- Awaiting classification (4% 2015/16)

Where?

- Prisons and YOIs
- Immigration Removal Centres
- Approved Premises
- Secure Training Centres
- Courts and Escort Vehicles

What PPO investigations involve

Advance Preparation in the office

- Notification and allocation of investigator
- Sending notices – establishment / coroner / NHS
- Previous deaths in establishment
- Contact establishment – appointment of liaison officer
- Request of records and other data
- Contact police and coroner
- Check HMIP and IMB reports
- Media interest
- Allocation of clinical reviewer

What PPO investigations involve

Opening Visit

- Meet with Governor or equivalent representative
- Prison tour and cell visit
- Meet with other members of staff
- Interview prisoners
- Collect / review documents / CCTV / radio transmissions
- Redacted copy of documents
- Obtain NOK details for FLO and funeral date
- Drawing of keys / Accommodation
- Case suspension?

What PPO investigations involve

Gathering evidence and identifying potential issues

- Examine documentation and other evidence
- Liaise with IMB and HMIP where relevant
- Liaise with police
- FLO contacts family
- Family visit?

- Construct timeline of events
- Identify and investigate potential issues
- Collaboration with clinical reviewer
- Case review with manager

What PPO investigations involve

Interviewing and providing feedback

- Interview prisoners
- Interview prison and healthcare staff
- Involvement of clinical reviewer
- Providing verbal feedback to Governor / representative

What PPO investigations involve

Completion of report

- Obtain clinical review
- Case review with manager
- Aim to write in parallel with investigation
- Recommendations
- Annexes
- Validation process:
FLO, Assistant Ombudsman, Deputy Ombudsman, Ombudsman

What PPO investigations involve

Issuing the report

- Advanced disclosure
- Issue of Interim report to prison, NHS, Coroner
- FLO contacts family and issues report to them
- Receive feedback and action plans (family and prison)
- Case review with manager
- Issue of Final report (including FLO input)
- Inquest
- Publication of anonymised report on website

Learning Lessons

Recent Case Studies

Early Days and Weeks

**Chauncey Glass, Research Officer
Anita Mulinder, Senior Investigator**

Learning lessons from fatal incident investigations

- Our investigations often identify areas for improvement and result in recommendations being made to a specific establishment or individual
- But there is also much to be learned from collective analysis of our investigations
- The learning lessons team work to collect standardised information about investigations, so that we can look for trends and identify common themes

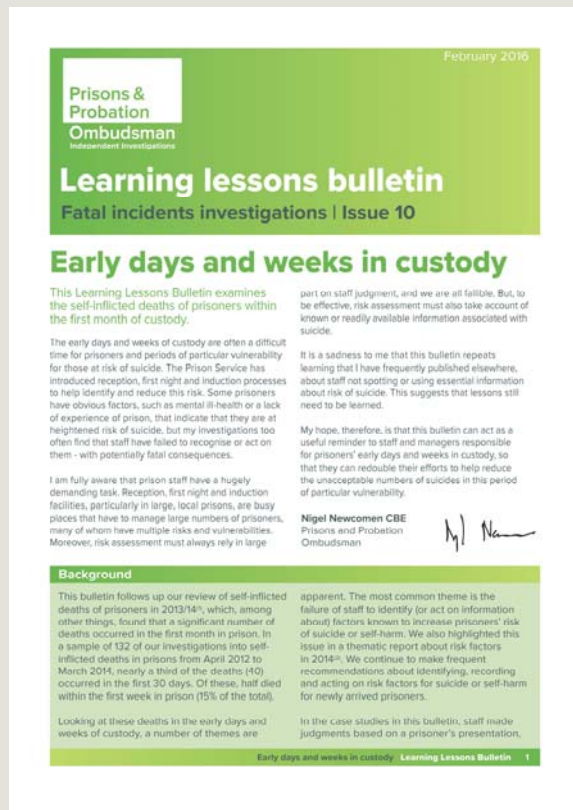
PPO Bulletin: Early days & weeks in custody

Published February 2016

E-copies supplied to all establishments

<http://www.ppo.gov.uk/?p=6855>

Each delegate should have copy.



Background

Data based on 132 investigations into self-inflicted deaths in custody, between April 2012 – March 2014

- 1/3 died within first 30 days
- 1/2 of these died within first week in prison

Most common theme: the failure to identify or act on information about risk factors.

Lesson 1: risk factors

- Investigations frequently find failure to identify risk factors
- Clear reception procedures required to ensure all staff understand their responsibilities
- **Lesson**
Staff need to identify, record and act on all known risk factors during reception and first night

Lesson 2: induction

- PSI 07/2015 sets out mandatory requirements for first arrival in custody
- Effective induction involves more than simple provision of information
- **Lesson**
All prisoners should receive an induction, regardless of location

Lesson 3: recalled prisoners

- Recall after breach of licence was a common characteristic – in 1/5 of cases studied the prisoner was on recall
- **Lesson**
Recalled prisoners can be especially vulnerable

Lesson 4: mental healthcare

- Inadequate consideration of mental health concerns during early days was a theme in investigations
- **Lesson**
Continuity of mental healthcare and responsiveness to a prisoner's mental health needs are essential

Case study One: early days

Background

- History of substance misuse
- February 2015: made a ligature and threatened to kill himself in prison
- March 2015: tried to suffocate himself in prison
- 28 August 2015: released on licence
- 3 September 2015: Arrested for a violent offence against his partner and licence revoked
- 5 September 2015: Remanded to prison
- PER: serious violent offence against partner

Reception

- Reception manager recognised the man from a previous prison, the man told him he had been recently released from another prison but did not think he had been on licence, the reception manager did not check this and took his word for it that the man had not been recalled, he did not notice the nature of the man's charge. Did note the man was polite and chatty.
- Reception officer noted previous prison number, did not look at PER because this was the reception manager's job, did not know the nature of the offence, did not record a history of attempted suicide. Said the man seemed comfortable in prison.

Reception (cont.)

- Reception manager recognised the man from a previous prison, the man told him he had been recently released from another prison but did not think he had been on licence, the reception manager did not check this and took his word for it that the man had not been recalled, he did not notice the nature of the man's charge. Did note the man was polite and chatty.
- Reception officer noted previous prison number, did not look at PER because this was the reception manager's job, did not know the nature of the offence, did not record a history of attempted suicide. Said the man seemed comfortable in prison.

Further events

- The man went to a cell on the first night centre. The induction officer spoke to him but did not note anything of concern.
- He was awake until around midnight and twice asked for paper.
- The nurse recorded checks at 12.54am and 4.00am but CCTV shows neither took place.
- At 6.44am he was found hanged in his cell.

Findings

- The man had the following risk factors for suicide and self-harm:
 - previous history of suicide and self-harm
 - licence recall
 - serious violent offence against his partner
 - potentially facing long sentence
 - opiate dependent
- However, reception staff knew little about the circumstances of his return to prison and had little understanding of the risk factors they needed to take into account when assessing the risk of suicide. They did not properly consider all available evidence and gave greater weight to his presentation and what he said.

Findings (cont.)

- We repeated a recommendation following a death in 2013 when we identified that reception risk assessments placed too much weight on staff perception and did not consider all relevant information.
- In response to that recommendation the prison said it would provide additional awareness training and local guidance for identifying and managing risk and a clear trail of notes identifying known risks and triggers.
- No evidence of any of these actions having been put in place in this investigation.

Prisoner Mental Health

Christine Stuart, Senior Research Officer
Catriona MacIvor, Senior Investigator

PPO thematic: prisoner mental health

Published January 2016

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>



Background

- Research has suggested that nine out of ten prisoners have one or more psychiatric disorders
- The prevalence of mental health issues in the prison population is considerably higher than in the general population
- A high proportion of the prison population need appropriate care and support for mental health problems
- The prison environment can be particularly tough for those with mental health problems

PPO thematic: Prisoner mental health

- The report considered the deaths of 557 prisoners who died in prison custody between 2012 and 2014
- This includes 199 self-inflicted and 358 natural cause deaths
- 70% of those who died from self-inflicted means had been identified with mental health needs
- 17% had been identified with a severe and enduring mental illness
- 42% had been identified with two or more mental health issues

Early identification

- Early identification of mental health issues when prisoners arrive can be vital to ensuring appropriate care and support is put in place
- The documentation that a prisoner arrives with may include important information about their mental health needs
- At the initial health screen this is often an over-reliance on the prisoners demeanour and presentation - documented risk factors should always be considered
- Information needs to be shared between community GPs and prisons, and from prison to prison

Mental Health Awareness

- Difficult or challenging behaviour might sometimes be the only way that distressed people with mental health problems are able to communicate when they need help
- This can easily be misinterpreted, and can lead to punishment, when what is required is care and treatment
- Prison and healthcare staff need to be aware of the warning signs of mental distress
- But staff often do not receive any training in mental health awareness

Treatment

- When mental health needs are identified, a referral should be made to the appropriate healthcare professional
- In 29% of self-inflicted deaths in the sample, a mental health referral was not made when it should have been
- When referrals are made, they often take too long or don't happen at all
- 19% of prisoners in the sample who had been diagnosed with a mental health problem had received no mental health care from a health professional while in prison
- 62% were prescribed drug treatments, but more than 1 in 4 were not fully compliant at taking their medication

ACCT

- 27% of the sample of prisoners who died from self-inflicted means were being monitored under ACCT procedures at the time of their death
- More than 4 in 5 of these prisoners had identified mental health problems
- Active participation in ACCT procedures by prison and healthcare staff is often an integral part of a prisoner's mental health care.
- Prison and healthcare staff should work together to develop an effective Care and Management Plan (care map), and to conduct reviews
- Too often there is not a multi-disciplinary approach and the opinions of healthcare staff are overlooked

Lessons

- Reception staff should review all the documentation that a prisoner arrives with, and pass on all relevant information as appropriate
- The health professional responsible for the reception health screen should give due consideration to all of the information they receive about a prisoner when making an assessment, including SystemOne records.
- Mental health awareness training should be mandatory for all prison officers and prison healthcare staff, to provide them with necessary guidance for the identification of signs of mental illness and vulnerability.

More lessons

- All prisoners should have access to the same care they would expect to receive in the community, including psychological and talking therapies
- Compliance with medication should be monitored and encouraged as part of an up-to-date care plan for prisoners with mental health problems.
- The mental health team should attend or contribute to all ACCT reviews for prisoners under their care, and should be fully involved in any important decisions about location, observations, and risk.

Mental Health: Case Study

Mr Saunders

- Rapid deterioration in mental health
- Sectioned under the Mental Health Act then released into the care of his family
- Charged with two counts of attempted murder after stabbing his brother, then his father while trying to stab himself
- Remanded to prison
- Prison alerted that he was at high risk of suicide
- Report recommended he should be transferred to hospital under the Mental Health Act

Key Events (1)

- Admitted to the inpatient unit under constant supervision.
- Three days later, staff reduced the level of observations from constant supervision to twice an hour. No clinician was involved in the decision.
- Psychiatrist assessed Mr Saunders but did not complete the first recommendation for transfer.
- Recognised that Mr Saunders was at a high risk of suicide but continued formal monitoring at twice an hour.
- First recommendation for transfer completed two weeks after arrival.

Key Events (2)

- Asked to speak to his family several times but could not remember their phone numbers and staff did little to help him.
- Continued to behave in a paranoid manner.
- Showed a mental health nurse some scratches he made on his arms on the day before he died. No investigation or discussion about increased risk.
- Mr Saunders was found electrocuted in his cell.

Findings (1)

- Failings in the management of ACCT procedures:
 - No clinical input into the decision to reduce the level of observations from constant supervision to twice an hour
 - Staff did not consider all of Mr Saunders's known risk factors when assessing risk of suicide and did not set observation levels that reflected his risk
 - Caremap not updated and reviewed at each case review and did not include actions designed to reduce his risk (family involvement)
 - Observations were at regular and predictable intervals and a mental health nurse took insufficient action when Mr Saunders cut his arms

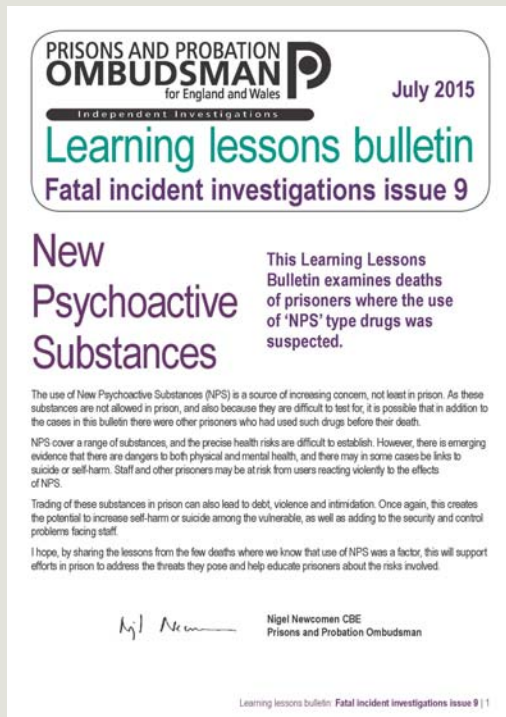
Findings (2)

- Prison healthcare staff did not properly understand the process for transferring Mr Saunders to hospital under the Mental Health Act:
 - staff did not follow the process
 - missed opportunity for earlier transfer
- Psychiatric cover insufficient to meet the needs of the population.

New Psychoactive Substances

**Christine Stuart, Senior Research Officer
Juan Diego Garzon, Senior Investigator**

PPO 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>

Background

- NPS have become an increasing problem within the community and in prisons
- “the most serious threat to the safety and security of jails”
– Nick Hardwick
- NPS were made illegal in May 2016 by the Psychoactive Substance Act
- Classified as a substance which *“is capable of producing a psychoactive effect in a person who consumes it”*

PPO Research

- Focused on synthetic cannabinoids: chemicals manufactured to imitate the effects of cannabis
- Synthetic cannabinoids are known by and sold under a range of 'brand' names, including 'Spice' or 'Black Mamba'. There are numerous compositions
- It is difficult to confidently identify NPS deaths
- Looked at cases where the prisoner was known or strongly suspected to use or supply NPS

PPO Research

We identified 58 deaths in prison between June 2013 and January 2016 where the prisoner was known or suspected of taking or selling NPS:

- 39 self-inflicted deaths
 - 2 homicides
 - 9 natural cause deaths
 - 3 cases where the cause of death was not ascertained
 - 5 the result of drug toxicity

In two of these cases the post-mortem was conclusive that NPS was the cause of death, and in one other the pathologist found that NPS was the most likely cause of death.

Difficulties

- **Detection:** NPS are mainly odourless. Work is being done to improve detection rates e.g. training dogs
- **Unpredictability:** NPS are inconsistent so identical packets may have differing strengths or side effects.
- **Toxicology testing:** Numerous variations of the composition of NPS means it may be untraceable in toxicology tests. Testing for NPS does not always happen.

Risks

- **Physical health:** may hasten effects of underlying health concerns, can lead to seizures, collapse or heart problems
- **Mental health:** users can experience psychotic episodes, sometimes linked to suicide and self-harm
- **Behaviour:** erratic, violent or aggressive behaviours. Incoherent or unable to stand. These may be misinterpreted as not linked to NPS use.
- **Vulnerability:** lead to debt and bullying, prisoners being used to test the effects of the substance
- **Toxicity:** From NPS or the combination of NPS and other drugs

Lessons

- **Educate staff:** Staff should be given information about NPS, and be aware of the signs that could indicate a prisoner is taking it.
- **Educate prisoners:** Offer education programmes for prisoners outlining the effects and risks of using NPS.
- **Strategy:** Address by using an effective local drug supply reduction and violence reduction strategies.
- **Treatment:** Drug treatment services should identify, treat and monitor prisoners with substance misuse issues arising from the use of NPS.
- **Challenging bullying:** Bullying should be investigated fully, perpetrators challenged, victims supported and the risk of suicide and self-harm should be fully taken into account.

NPS: Case Study

- Mr Ruslanas Ignatenka.
- Nationality: Lithuanian.
- Age: 35.
- September 2006 – Sentenced to life imprisonment for murder.
- Spent time in different prisons.
- Previous ACCT – August 2009.
- May 2014 – Transferred to Swaleside.
- Could speak English and communicate well.

Background

- **Initial health assessment:**
 - Seen by nurse and GP.
 - No history of drug and alcohol identified.
 - No previous ACCT noted.
- **No issues for over a year:**
 - Worked well in workshops.
 - Polite to staff.
 - Frequently attended gym.
- **23 August 2015**
 - **Barricaded in his cell.**
 - Mr Ignatenka was paranoid and incoherent.
 - ACCT did not start.
- **27 August**
 - **Smashed his cell.**
 - Mr Ignatenka said he was taking spice.
 - An officer noted Mr Ignatenka behaving bizarrely
 - No mental health referral.
 - No security information submitted re: use of spice.
 - ACCT did not start

- **1 October** - Engaged in RAPT programme
- **5 October**
 - **Damaged his cell / rip cloth of pool table**
 - Officers concerned behaviour was due to spice
 - An officer concerned about Mr Ignatenka's mental health and refers him to the mental health team for assessment the next day.
 - Use of spice was not reported.
 - ACCT did not start.
 - What happened with the referral? – Mr Ignatenka was never assessed.
- **Saturday, 7 November** - **Self-harmed** at 9.30pm
 - Mr Ignatenka moved to healthcare unit while his cell was cleaned.
 - ACCT started
- **Sunday, 8 November** - **Mr Ignatenka sent back to his cell**
- **Monday, 9 November** - **Mr Ignatenka found unresponsive in his cell** at 3.05am

Managing risk factors

- Missed opportunities to open ACCT procedures in particular on 23 Aug 2015.
- Failures in the management of the ACCT opened on 7 November
 - Failure of the ACCT assessor to carry out assessment based on all available information
 - First case review was not carried out
 - All checks/obs were conducted and recorded at regular hourly intervals.
 - Staff lacked training in managing ACCT

Emergency response

- Control room misunderstood when to call an ambulance – there was a delay in calling the ambulance.

Mental health

- No referral carried out after self-harm event on 23 Aug 2015 and missed opportunities to refer Mr Ignatenka to mental health services.
- Failures in the mental health referral process when an officer referred Mr Ignatenka for assessment on 6 Oct 2015.
 - Staff were not familiar with the mental health referral process.
 - Lack of a clear mental health referral process.
 - Lack of urgency for referrals of prisoners who self-harm
 - Staff lacked training in managing ACCT
- Effective exclusion of Mr Ignatenka (a prisoner with **dual diagnosis**) from mental health services.

NPS

- Availability of NPS in the prison
- Officers believed Mr Ignatenka's use of spice contributed to his self-harming and irrational behaviour, yet no one informed the security department by making security information reports about his illicit drug use.
- We found no evidence of a strategic approach to tackling the problem of NPS.

Afternoon Session

Please see the seating plan for which table you will be at for the afternoon session.

Discussion

- What are the barriers to implementing PPO recommendations and how can we overcome them?
- In the light of yet another dramatic rise in self-inflicted deaths, what more needs to be done?

Next Steps

- PPO will:
 - Share slides & contact lists
 - Collate the discussion and disseminate widely
 - Continue to investigate independently and robustly to identify learning in both individual cases and thematically
 - Learn from your feedback on this seminar
- What will you do?

Farewell

- Thank you for your attendance and participation
- Please complete an evaluation form
- The PPO wishes you well in efforts to improve safety and fairness in custody

Contact details

If you have any questions following the seminar please contact PPOcomms@ppo.gsi.gov.uk

Have you checked out our website? Our learning lessons publications and anonymised fatal incident reports are easily accessible at www.ppo.gov.uk