Prisons & Probation Ombudsman
Independent Investigations

Bob Neill MP
Chairman
Justice Committee
House of Commons
London SW1A 0AA

15 January 2016

Dear Mr Neill,

Thank you for your letter of 9 December and your request that I provide observations about prison safety in light of the evidence given to the Committee by the Minister for Prisons and the Chief Executive of the National Offender Management Service (NOMS).

Background

As you are aware, I carry out independent investigations into deaths and complaints in custody. My detailed role and responsibilities are set out in my Terms of Reference and include two main duties:

- to investigate complaints made by prisoners, young people in detention, offenders under probation supervision and immigration detainees
- to investigate deaths of prisoners, young people in detention, approved premises' residents and immigration detainees due to any cause.

The purpose of these investigations is to understand what happened and to identify learning for the organisations whose actions I oversee. Individual investigation reports with recommendations for improvement are supported by a large and growing body of thematic "learning lessons" publications. Together, this learning is intended to ensure that my office can contribute to safer, fairer custody and offender supervision.

The attached paper provides observations based on this learning in the areas touched on by the Minister and Michael Spurr in their evidence on 1 December. However, you ask in particular about the implementation of lessons learned by the National Offender Management Service (NOMS), an up to date assessment of the reasons for both natural cause and self-inflicted deaths in custody and information on the current volume and nature of complaints.

Let me start with a few comments on reasons for deaths.

Natural cause deaths

In 2014-15, deaths in custody from natural causes made up around 62% of deaths notified to my office. The numbers of such deaths have been rising sharply over recent years (and rose 15% in 2014-15). In the year to date, numbers of natural cause deaths are broadly similar to the year before (see annex, section 3).

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The rise in natural cause deaths over recent years is largely explained by a rapidly ageing prison population and the age-related illnesses that, sadly but inevitably, attend such demographic change. Indeed, the scale of this growth in ageing is remarkable. The fastest growing segment of the prison population is prisoners over 60 and the second fastest those over 50. NOMS has projected continued increases in the numbers of older prisoners over future years.[1]

The explanation for this ageing is, in large part, longer sentences and more late in life prosecutions for historic sex offences.

Commendably, most of my investigations of natural cause deaths have found that the standard of healthcare was equivalent to that which the prisoner could have expected in the community, with a particularly noteworthy improvement in the provision of palliative care in prison. However, my investigations have also found that provision remains variable and occasionally unacceptable (for example, with missed opportunities to identify illness, delays in diagnosis, delays in calling an ambulance, unnecessary use of restraints, and delays in telling families that a prisoner was seriously or terminally ill).

Given this changing demographic, my investigations have also identified lessons which have not previously been of such widespread importance (for example, the need for improved health and social care for infirm prisoners; the obligation to adjust accommodation and regimes to the requirements of the retired and immobile; the need for more dedicated palliative care suites; and the call for better training and support for staff who must now routinely manage death itself).

While progress has certainly been made by prisons, variations in the care of the terminally ill remain and can sometimes be shockingly poor. I strongly agree with your Committee's conclusion to its report on older prisoners that, given the importance of the issue, the Prison Service badly needs a properly thought out and resourced strategy to manage this growing and needy population – a view I recently expressed to the Parliamentary All Party Penal Affairs Group.

Self-inflicted deaths

In 2014-15, the number of self-inflicted deaths (76) reported to my office actually fell 16%, but there were still 38% more than in 2012-13. In the year to date, there has been a troubling 29% increase (there have also been 5 homicides so far, compared to 4 in the whole of 2014-15).

You ask about causes and I must be honest and note that self-inflicted deaths are the culmination of personal crises in individual lives. Explanations, in so far as they can be made with any confidence, are as varied as the wide array of risks and needs that are presented by prisoners. Simple explanations are generally poor explanations.

However, themes do of course emerge, for example the pervasiveness of mental health needs (I am publishing a thematic study of mental ill health and death in custody on 19 January, which found at least 70% of those who committed suicide had one or more identified mental health need). Some new issues have also come to the fore, for example new psychoactive substances (NPS), about which the Committee is aware (see annex, section 1). Inevitably, given my role, I also continue to report on weaknesses in the response of prison staff to the myriad of risks that prisoners present and the missed opportunities to prevent deaths that my investigators' hindsight often identifies (see annex, section 5).

1 Please see section called 'Projection of over 50 and 60 year old population', and the tab Table A6. https://www.gov.uk/government/statistics/prison-population-projections-ns

While there are annual fluctuations, there is depressingly little sign that the rise in suicides in custody is abating (it is also rising in the community but not as rapidly). I have looked, in particular and some detail, at the very sharp rise in self-inflicted deaths that occurred in 2012-13 and 2013-14 to see what reasons can be discerned.

Unfortunately, no simple well-evidenced explanation was forthcoming. Staff reductions and strains in the system may well have played their part in reducing protective factors against suicide and self-harm but the picture was not consistent and increases in such deaths occurred even where these factors did not apply. New issues, such as NPS have emerged, but many familiar ones also recur (see annex, section 2), not least the need for better implementation of Prison Service suicide and self-harm prevention procedures (known as ACCT). Hence, my call, in my 2013-14 annual report, for a review of ACCT, which I am pleased NOMS has now completed but which requires robust action.

Implementation of lessons

You ask about the implementation of lessons from my investigations by NOMS. In some respects, this is not a matter for me and should be directed to NOMS. That said, I am very pleased by the comments to the Committee from both the Minister and Michael Spurr, which show how seriously they take my recommendations and thematic lessons (I was also delighted that the Minister found time to spend an entire morning at my office talking to my investigators).

However, it remains the case that I am frequently obliged to repeat recommendations and lessons and it can be depressing how little traction we appear to have on occasions, notwithstanding the strong commitment to implement identified improvements, at individual prisons and more broadly, signalled by Ministers and senior officials. The Committee will be aware that this is also a theme addressed by Lord Harris in his recent review and is a point he extends to the other independent scrutiny bodies dealing with deaths in custody. He makes various recommendations to further compel action.[2]

For my part, I am clear that my staff and I must continue to support improvement and continue to refine how my investigations and reports can achieve this, however slowly and incrementally.

On my arrival as Ombudsman, I set a new vision for my organisation that our independent investigations should contribute to making custody and offender supervision safer and fairer. An important part of fulfilling this ambition is the making of influential recommendations and broader thematic lessons for improvement. We may make recommendations in both individual fatal incident and complaint investigations and my staff are instructed to ensure that our recommendations are SMART (specific, measurable, realistic and time bounded) and therefore capable of auditable implementation.

The statistics relating to these recommendations are impressive. For example, 99% of fatal incident recommendations are accepted. NOMS, and the other bodies I investigate, are required to produce action plans after each investigation. In the very rare event that a recommendation is rejected, the Chief Executive of NOMS will write to me personally to explain why. At a regional level in NOMS, all Deputy Directors of Custody must now collate an area-wide action plan of all

2 The Harris Review, Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/439859/moj-harris-review-web-accessible.pdf. See pages 60, 71, and 97.

their respective recommendations from my office. These are indications of the seriousness with which the senior management of the Prison Service takes the search for improvement informed by my recommendations. Unfortunately, not all lessons appear to be learned or are learned only after repetition.

Influencing change in services under considerable strain is difficult and requires innovation. For the past two years I have held a series of autumn seminars for senior NOMS staff exploring self-inflicted and natural cause deaths as well complaints. In both years, the Chief Executive spent a whole day with me supporting the learning of lessons from my investigations among his staff. These seminars were well attended and well received and I hope to repeat them.

I should add that HM Inspectorate of Prisons routinely follow up progress on the implementation of fatal incident investigation recommendations during their inspections. I have also been in discussions with Independent Monitoring Boards about following up progress on the implementation of recommendations.

My commitment to supporting improvement in safety in custody and on offender supervision through my investigations and thematic reviews remains undiminished, but it clearly not an easy or linear process.

Complaints

You asked for an assessment of the current volume and nature of complaints received by my office. We have received 3561 complaints in the year to date, which is a 7% reduction on the same period last year. Care should be taken in making judgments about volume as there are time lags in collating the data and, in any case, only around 55% of these cases will be eligible for investigation. In particular, I do not believe this reduction in volume can be reliably interpreted as indicative of diminishing pressures within the prison system. Property remains by far the most common eligible complaint. We also receive a high volume of complaints about administration, categorisation and staff behaviour. Further details are provided in the annex (section 9). Detailed analysis on my complaints data for the year to the end of March will appear in my annual report.

The annex addresses the additional points raised in evidence from the Minister and Mr Spurr.

I am at the Committee's disposal.

Yours sincerely,

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ANNNEX

Key

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2. **ACCT review**
3. **Deaths in custody**
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    - **April-Dec 2015 deaths**
4. **Early days and weeks**
5. **Themes and learning from self-inflicted deaths**
6. **Transgender prisoners**
7. **Restricted regimes**
8. **Harris Review**
9. **Complaint statistics**

1. New psychoactive substances

Michael Spurr responded to Question 3 from the Chair with a reference to New Psychoactive substances (NPS), an issue which was followed up at Question 43 from Dr Huq MP.

We published, earlier this year, a Learning Lessons publication on NPS. The bulletin is necessarily cautious in drawing conclusions, given that NPS are proving difficult to detect and manage in prison, not least as there are hundreds of variations in chemical make-up. It is perhaps noteworthy that, even if a variety of NPS is legal in the community, possession in prison is outlawed under Prison Rules. Nevertheless, NPS still appear to be a significant problem in custody.

Examples of fatal incidents given in the bulletin include apparent fatal physical reaction to NPS, cases where NPS appears to have been a trigger to self-harm and cases where problems of debt and bullying associated with trading NPS may have led to self-harm among the vulnerable. The lessons identified for the Prison Service address these issues and call for better information for staff, effective prison drug and violence reduction strategies, appropriate access to drug treatment services, a proactive approach to bullying and education for prisoners about the risks of NPS.

The NPS bulletin was based on a search of final reports issued up to the end of February 2015. A search for all final reports issued between March 2015 and December 2015 produced the following findings:

- There were 19 cases where NPS or related words were found in the final report. These 19 deaths occurred between May 2014 and June 2015. While these 19 cases had mention of NPS in the report, this does not necessarily mean that the death was related to NPS use, only that the deceased was known or suspected of being involved in taking or selling NPS at some time prior to their death.

- In only 1 of these 19 cases was the post-mortem conclusive that NPS was the cause of death – in this case the post-mortem examination concluded that that the individual died of toxicity to a synthetic cannabinoid. That said, it is not possible to test for all variants of NPS, and in some cases blood was not tested at all.

- 3 of these 19 cases were natural cause deaths. In these cases, while there was evidence or suspicion of NPS use, there was no evidence that drugs played a part in the circumstances of the death.

- 1 case was a homicide, the motives for this and precise link to NPS are unclear. 2 were drug related deaths - one the toxicity to synthetic cannabinoid referred to above, in the other the post-mortem report concluded that the prisoner died from heroin toxicity but was known to also use NPS. The remaining 13 were self-inflicted deaths. All were known or suspected to have involvement with NPS, but we can't be certain how precisely this was related to the death.

We made a submission to NOMS' review of Prisoner Discipline Procedures (PSI 47/2011) and how this is managed across the prison estate, which provides an indication of how the Prison Service is managing the challenges from NPS, violence and vulnerable prisoners.

2. ACCT review

In response to Question 7, the Minister highlighted the NOMS review of the implementation of the ACCT process.

We made a number of written and oral submissions to the Review which drew on the learning from our investigation reports into self-inflicted deaths. Our submission was framed by the caveat that we see the ACCT processes which fail, i.e. after someone has taken their own life. We focused upon: the structure of the ACCT document itself, the need to tailor it to young people, the challenges of compliance, the need to involve Healthcare staff, the need to critically assess the prisoner and improve risk assessments, the culture within prisons toward the ACCT process, the need to improve training and learn lessons, more effectively, from the deaths of prisoners.

3. Statistics on deaths in custody

The Committee's Questions (7-16) were concerned with deaths in custody. Below are the PPO's most recent statistics on deaths in custody. As noted in our introduction, the increase in natural cause deaths is a result of an ageing prison population and thus set to steadily increase.

2014-15 deaths

There were 250 deaths in 2014–15, 11 (5%) more than the year before. The increase was predominantly among adult male prisoners. There were 7 deaths in approved premises, a decrease from 11 last year. Continuing the trend of recent years, we began 15% more investigations into deaths from natural causes (155 deaths). This is a consequence of rising numbers of older prisoners; on average the people who died of natural causes were 58 years old, compared to 37 years old for all other deaths. There were 76 self-inflicted deaths. This was a welcome decrease (16%) from 2013–14, but remains high relative to recent years. We were notified of 4 apparent homicides, the same number as the previous year.

April-Dec 2015 deaths

There were 211 deaths between April and December 2015, 25 (13%) more than for this time period the year before. The increase was among both prisoners and approved premises residents. There were 199 deaths in prison, an increase of 19 (11%) from the same period in the previous year. There were 10 deaths in approved premises, more than double than this time period the

previous year, when there were only 4 deaths. In both years, there were 2 deaths in immigration removal centres across this time period.

There was an increase in deaths among both men and women. There were 201 male deaths and 10 female deaths between April to December 2015, compared with 178 male and 8 female deaths in this time period in 2014. There was also an increase in deaths of over 60s. There were 69 deaths of over 60s between April and December 2015, compared with 58 deaths for this period the previous year.

Between April and December 2015, we began investigations into 108 natural cause deaths, 76 self-inflicted deaths, 4 other non-natural deaths, and 5 homicides. There are still 18 deaths awaiting classification, so these numbers are likely to increase. This should be taken into consideration when regarding the year on year comparisons.

There were 108 natural cause deaths between April and December 2015, compared with 115 for the same time period the previous year. There were 76 self-inflicted deaths between April and December 2015, compared with 59 for the same time period the previous year. There were 4 Other Non-Natural (ONN) deaths between April and December 2015, compared with 10 for the same time period the previous year. There were 5 homicides between April and December 2015, compared with 2 for the same time period the previous year. At this point, we can be certain that there has been an increase in self-inflicted deaths and homicides.

4. Early days and weeks

In response to Question 13, the Minister discussed early days in custody and the induction process. I commissioned a bulletin, to be published on 16 February, which explores the risks and vulnerabilities faced by prisoners during this period. The summary, set out below, should be considered embargoed until this date.

The 'Early Days and Weeks' bulletin follows up our review of self-inflicted deaths of prisoners in 2013/14, which found that a significant number of deaths occurred in the first month in custody. Looking at a sample of 132 of our investigations into self-inflicted deaths in prisons from April 2012 to March 2014, nearly a third of deaths (40) occurred in the first 30 days. Of these 40 deaths, half occurred during the first week in prison.

Looking specifically at these deaths in the first month of custody, a number of themes were apparent. The most common was the failure to identify, record and act on factors which are known to increase prisoners' risk of suicide or self-harm, when they first arrived in prison. Too often, our investigations have found that prison reception and first night units make decisions based on perceptions of prisoners' presentation and assurances that prisoners give that they do not have any thoughts or intention of suicide or self-harm, rather than known risk factors – which are much better predictors of future action, such as a history of suicidal behaviour, or the circumstances of an offence.

Another issue identified is that we often find that there are ineffective induction procedures. This means that new prisoners, particularly those who have never been in prison before and are likely to find the first days at the prison particularly daunting, do not have the information they need about the basics of prison life. Effective induction involves a lot more than simple provision of information. Regular contact with staff is important. Staff need to talk to the prisoner and check they are coming to terms with their situation.

Recall to prison after a breach of licence was a noticeable characteristic of several of the deaths within the first few weeks in prison. Recall can be distressing and is a known risk factor for suicide and self-harm. However, we found cases where little information about their recall was provided to prisoners, increasing their distress even further.

Inadequate consideration of mental health concerns was a common failing among deaths of prisoners in their first few weeks in custody. This included failure to recognise symptoms of mental illness, failure to review medication, and failure to make mental health referrals.

5. Themes and learning from self-inflicted deaths

Michael Spurr drew attention, in response to Question 16, to the challenges of establishing themes in and commonalities in self-inflicted deaths. In 2013-14, my Researchers examined, thematically, the investigation reports into these deaths to ascertain if there was any learning which could be drawn from these reports. The research found that there was no simple, well-evidenced, answer as to why self-inflicted deaths had increased so sharply in 2013-14. For example, there were self-inflicted deaths at 53 different prisons, which included prisons where there had not been self-inflicted deaths for many years, sometimes ever. However, the research extracted several key lessons, some of which are listed below.

- **Seek evidence of risk factors during reception.** Staff working in prison reception areas need to be aware of the known risk factors for suicide and self-harm. They must actively identify relevant risk factors from the information and documents available to them. Evidence of risk should be fully considered and balanced against the prisoner's demeanour. Reception staff should record what factors they have considered and the reasons for decisions.
- **Continuity and responsiveness in mental health care is essential.** Mental health referrals need to be made and acted on promptly. Care should be taken to ensure continuity of care from the community. Attention must be paid to potential increased risk when medication is changed, ended or otherwise disrupted.
- **The first month of custody is especially risky.** Prisoners are most at risk in the first month of custody. Those whose initial time may be more disrupted – for example due to court appearances – may need additional support.
- **Increased risk of suicide and self-harm must be considered when a prisoner is a suspected victim of bullying.** Reports or suspicions that a prisoner is being threatened, bullied, or is vulnerable due to debt need to be recorded, investigated, and robustly responded to. The potential impact on the victim's risk of suicide and self-harm must always be considered.
- **Effective and confident emergency response saves lives.** Uniformed and healthcare staff must understand their responsibilities during medical emergencies, including:
    - using the correct code to communicate the nature of a medical emergency;
    - arriving at the scene with relevant emergency equipment;
    - ensuring there are no delays in calling an emergency ambulance.

My office has published the following publications since April 2014 which may also be relevant to the Committee's assessment of self-inflicted deaths.

- Self-inflicted deaths of prisoners on ACCT
- Risk factors in self-inflicted deaths in prison
- Young adult prisoners
- Deaths of Travellers in prison

6. Transgender prisoners

The Committee tackles the issue of transgender prisoners at Questions 29-34. In October, we made a submission to the Parliamentary Women and Equalities Committee on the issues facing transgender prisoners. Since this submission, a further two transgender prisoners have died in custody. Their deaths are currently the subject of investigation. A summary of our submission is below.

Data

We have carried out a limited number of investigations into complaints made by, and the deaths of, transgender prisoners. The learning from these investigations is set out below. However, NOMS do not currently record if a prisoner is transgender so our own equality and diversity monitoring is stymied by this lack of information. As a result, we are only able to identify complaint investigations where the prisoner has disclosed to us their transgender status, which usually only occurs in cases where this status is relevant to their complaint.

Complaints

We identified 10 complaints relating to transgender issues from 2012-13 onwards, of which seven were eligible for investigation. These complaints came from four different male to female transgender prisoners and related to five prisons, spread across the prison estate: Frankland, Elmley, Wymott, Manchester and Maidstone. We upheld, and made recommendations, in three of these complaints.

Given the paucity of official information available, it is difficult even to know whether the small number of complaints to the Ombudsman from transgender prisoners is an issue in itself. It may be that the number is proportionate to the number of transgender prisoners within the prison system or that their gender goes unrecognised because it is not apparently relevant to the complaint or that complaints are being satisfactorily resolved at a local level. Without better data this will remain uncertain.

However, one theme that does appear to emerge from complaints from transgender prisoners was access to, or restrictions on, make-up or clothing which would help the prisoner to live in their acquired gender. Our recommendations were often specific to the nature of complaint, however in two of the three cases the prison was required to ensure that their local policy was compliant with the PSI or that staff be reminded of the requirements of both local and national policy regarding transgender prisoners. It should be added that it is not unusual for us to make recommendations that prisons should ensure that their staff are aware of, and feel confident in implementing, Prison Service Instructions, but perhaps this is all the more pertinent in the context of transgender issues about which many prison staff may lack awareness and training.

Deaths

We have identified four investigations into the deaths of transgender prisoners, three self-inflicted and one from natural causes. The transgender status of the prisoner was not a direct causal factor in any of these deaths, although an examination of these cases highlights the particular vulnerabilities of these prisoners and the need for the Prison Service to improve compliance with PSI 07/2011.

These cases were: a death at HMP Frankland in 2014, a death at HMP Belmarsh in 2013, a death at HMP Full Sutton in 2012, and a death at HMP Eastwood Park in 2006 (all may be accessed on our website).

7. Restricted regimes

The Committee explored, briefly, at Question 38, the issue of restricted regimes. We have highlighted previously the need to ensure that segregation is used within the appropriate guidelines and taking into account the heightened risk and vulnerabilities that segregation presents to some prisoners. The Committee may like to look at our PPO response to National Offender Management Service (NOMS) – Changes to Prison and YOI Rules and NOMS Policy - Review of Continuing Segregation, which commented on the structure of the segregation process and the use of segregation on children and vulnerable prisoners, and our Segregation Bulletin.

8. Harris Review

Questions 88 and 89 from the Committee's Chair refer to the Harris Review. My view is that the Harris Review made a number of important recommendations. However, particularly relevant to our work was the recommendation that my office should be placed on a statutory footing. The Committee itself (2011) has endorsed this idea, which has been the subject of various Ministerial commitments for over a decade, as well as being recommended by other Parliamentarians such as the Joint Committee on Human Rights (2013). Statutory footing would ensure unfettered access for my staff and full compliance from investigated bodies as well as more visible independence in compliance with Article 2 (ECHR).

9. Complaint statistics

Further to my comments in the introductory letter, details of the current status of the volume and nature of complaints can be found below.

Looking at the 9 month period April-December for each year, there has been a 7% reduction in the number of complaints received. Calculating the number of eligible cases for substantive investigation is subject to a time lag in the collection and processing of data and not all complaints so far received have yet been assessed. Current eligibility rates indicate that only around 55% of these cases will be eligible for investigation Fuller analysis of cases received, eligible cases and investigations completed in 2015-16 will appear in my annual report.

Separately, it is evident that productivity in my office has improved with an 8% increase in investigations completed. Fuller analysis of cases received, eligible cases and investigations completed in 2015-16 will appear in my annual report.

	April-Dec 2014-15	April-Dec 2015-16	% change
Complaints received	3828	3561	-7%
Investigations completed	1535	1653	+8%

Based on analysing those eligible cases which have been assessed, we can see from the table below that property remains by far the most common complaint. We also receive a high volume of complaints about administration, categorisation and staff behaviour.

Eligible cases received (excl 115 cases still to be assessed)	Apr-Dec 2015-16
Property	491
Administration	241
Categorisation	123
Staff Behaviour	113
Adjudications	105
IEP	103
Work and Pay	102
Regime	95
Money	64
Transfers	61
Letters	58
HDC	46
Accommodation	45
Visits	44
Probation	38
Prisoners	32
Equalities	29
Food	25
Phone calls	23
Security	21
Resettlement	13
Medical	10
Parole	3
Escorts	1
Legal	1
Awaiting categorisation	3
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