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PRISON SERVICE NEEDS TO ACT TO REDUCE SUICIDES, SAYS OMBUDSMAN

Prisons must improve how they risk assess, monitor and care for prisoners to help prevent suicides, said Nigel Newcomen, the Prisons and Probation Ombudsman (PPO). Today he published two reports on the lessons that can be learned from PPO investigations into self-inflicted deaths in custody.

There has been a sharp and troubling increase in self-inflicted deaths in custody in recent months. In 2013-14 there were 89 self-inflicted deaths in prison, an increase of 37 (71%) on 2012-13 when there were 52. The PPO independently investigates the circumstances of all deaths that occur in prisons in England and Wales and identifies lessons that need to be learned to improve safety. The PPO also investigates complaints from those held in prison.

The first report, *Learning from PPO investigations: risk factors in self-inflicted deaths in prisons*, uses information from investigations into 361 such deaths investigated between 2007 and 2013. It examines the characteristics of those who died, the events in the 72 hours leading to their deaths, and the prisons' approaches to assessing and managing risk. Although various different groups of prisoners were looked at, the findings about the assessment and management of their risk were broadly similar. Too often prison staff placed too much weight on judging how the prisoner seemed, or 'presented' rather than on indications of known risk, even when there had been recent acts of self-harm.

Other findings include:

- risk changes over time and in response to context and events;
- contact with health services was common in the final 72 hours and represents a key opportunity for suicide prevention;
- prisoners often withhold their distress from staff and other prisoners, and processes must be in place to respond effectively when family or friends raise concerns;
- reception screening needs to take fully into account concerns raised by police, escort services or the courts; and
- Prison Service Instructions should list being held on remand as a risk factor and the risk factors for suicide and self-harm should be presented clearly and concisely.

The second report, *Learning from PPO investigations: Self-inflicted deaths of prisoners on ACCT* looks at 60 investigations where the prisoner was being monitored under the Prison Service suicide and self-harm prevention procedures, the Assessment, Care in Custody and Teamwork Plan (ACCT), at the time of their death. At any one time around 2% of the prison population are on ACCT monitoring. When implemented properly, ACCT provides a comprehensive, multi-disciplinary framework to address the underlying cause of a prisoners' distress. To be effective, ACCT requires a concerted, joined-up and holistic approach. The report finds that the ACCT process was not correctly implemented or monitored in half the cases in the PPO sample.

Other findings include:

- the goals in ACCT plans should be realistic, achievable and relevant;
- the trigger and warning signs section should be completed on all ACCT plans and reviewed and updated as and when necessary;
- staff from across the prison and agencies working within it should be encouraged to attend ACCT reviews and offer input into an individual's care;

- all staff who come into contact with an individual should be responsible for updating the ACCT plan if they feel that their risk of self-harm or suicide is heightened; and
- all staff should be up to date on their ACCT training.

Nigel Newcomen said:

“While I recognise the challenges facing busy prison staff and that my investigations have the benefit of hindsight, too often we find that assessments of risk of self-harm place insufficient weight on known risk factors and too much on staff perceptions of the prisoner’s behaviour and demeanour. While the professional judgment of staff is an essential ingredient in ensuring safety in custody, better staff awareness, consideration and training about risk factors could improve safety in custody.

“Nearly a decade after the introduction of ACCT (and a range of other safer custody measures) which saw self-inflicted deaths in custody fall, such deaths have risen sharply in recent months. It is too early to be sure why this rise is occurring, but the personal crisis and utter despair of those involved is readily apparent, as is the state’s evident inability to deliver its duty of care to some of the most vulnerable in custody.

“Learning the lessons from these two reports ought to help the Prison Service improve the implementation of ACCT and ensure greater safety in custody. However, given the repeated weaknesses in practice we identify and the rising toll of self-inflicted deaths, I believe it is also now necessary for the Prison Service to review and refresh its safer custody strategy in general and ACCT in particular.”

- ENDS -

NOTES TO EDITORS

1. A copy of the reports can be found on the PPO website. Visit www.ppo.gov.uk.

2. The PPO investigates deaths that occur in prison, secure training centres, immigration detention or among the residents of probation approved premises. The PPO also investigates complaints from prisoners, young people in secure training centres, those on probation and those held in immigration removal centres.
3. Prison Service Instructions provide a detailed guide to suicide and self-harm prevention through assessment, monitoring, staff and peer support. First night and induction procedures are intended to provide extra support for prisoners who are newly arrived in custody. The instructions also specify a non-exhaustive list of factors and triggers that indicate prisoners are at heightened risk. This includes having a history of self-harm, mental health issues, substance misuse problems, certain offence types, receiving a life sentence and being in the early days of custody.
4. Assessment, Care in Custody and Teamwork plan (ACCT) was introduced in 2005-06 and built on a previous monitoring system known as F2052SH, introduced a decade earlier.
5. Contact us: Please contact Jane Parsons, PPO Press Office, on 020 3681 2775 or 07880 787452 if you would like more information, or email mail@ppo.gsi.gov.uk