HER MAJESTY'S INSPECTORATE OF PRISONS FOR ENGLAND AND WALES

Suicide is Everyone's Concern

A Thematic Review by HM Chief Inspector of Prisons for England and Wales

May 1999

Thematic Report

READERS GUIDE

Layout of the report

Major recommendations to the Secretary of State and Director General of Prison Service to be found in Chapter Eight. Other recommendations are emboldened in normal font in the text, where they can be understood in context.

Commendations and references to examples of good practice are in italics.

Quotations are emboldened in purple italics.

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Terms of Reference:
To offer informed advice to the Prison Service to enable it to maintain, in every establishment, the best possible practice in order to assist and support:

- prisoners who may be at risk of self-harm and suicide
- the next of kin of prisoners who appear to have committed suicide
- staff and prisoners affected by the above.

PREFACE

In December 1997, the then Minister for Prisons, Ms Joyce Quin, asked me to carry out a thematic review of Suicide and Self-Harm in Prison Service establishments in England and Wales, to follow up that undertaken by my predecessor, Sir Stephen Tumim in 1990. This was in response to concern expressed by the Director General of the Prison Service, Mr Richard Tilt, to both her and me, about the number of deaths in custody and whether everything possible was being done to prevent them. There had been 68 suicides in 1997/1998, since when they increased to 83 in 1998/1999. Subsequently Ms Quin's successor as Minister for Prisons, Lord Williams, has maintained deep Ministerial interest in the progress of our work, being patient when I delayed completion not solely because the scope of our work was more extensive than I thought initially, making extra demands on an already busy Inspectorate, but because I wanted to evaluate evidence gleaned from the United States, which I mention below.

I must begin by giving a reminder of what a thematic review is and what it is not. It is not a piece of systematically conducted academic research, although we undertook a relevant literature review. It is an exercise based on information gathered from and consultation with any parties who are expert or have a particular interest in a subject, designed to produce practical recommendations aimed at improving policy and practice.

The particular significance of this review is that it affects every person every time they come into custody. Death and bereavement inevitably touch us all in some way, and, when a prisoner dies in prison, his or her family and friends are bereaved in the same way as anyone else. But there is an added dimension to a death in prison. Firstly family and friends do not just lose a loved one, they lose him or her in very painful circumstances, separated from them and in conditions that they do not fully appreciate. In addition staff and prisoners, living and working with the person, are also deeply affected, and have to come to terms with their bereavement as well as that of the family. Thus the impact of a death in custody is compounded by a number of additional factors and emotions, which must be acknowledged, but are difficult to understand objectively. One suicide is one too many, but, regrettably, there will always be deaths in prison, however professional and caring the prison staff, and however efficient a reduction strategy and systems for observing prisoners.

The starting point of the review was to look closely at the current Prison Service Strategy, 'Caring for the Suicidal in Custody', introduced in 1994, which seemed to us to be fundamentally sound. However, on examination, as set out in Chapter Five, we concluded that the policy did not take sufficient account of the needs of different groups of prisoners. For example although the vast majority of suicides are adult males, self-mutilation is the more prevalent issue with females and young offenders. This suggests the need for different strategies for females and young offenders. It was also clear to us that a fresh approach to suicide prevention in local prisons was necessary.

We found that the current strategy had only been partially implemented. There were serious deficiencies in the application of the policy, for example ignoring the need for case reviews, the absence of quality checks on vital documentation and inadequate training of staff. But above all was the absence of total ownership of the

strategy by some senior managers. What is abundantly clear is that, whatever systems are devised, they will be useless unless accompanied by total ownership of, and commitment to, their implementation throughout the Prison Service.

In the course of our work it became very clear that the vast majority of self-inflicted deaths occur in local prisons, which contain a very wide mixture of prisoners – remand, convicted but unsentenced, life, long, medium and short sentenced, mentally disordered, and, in some, women, young offenders and children. They are massively overcrowded, holding, on average, 126% of their Certified Normal Accommodation (CNA), with an average throughput in excess of four times their population every year. On top of this they are not resourced to provide full, purposeful and active regimes for each prisoner, with the result that too of them are left locked in their cells for far too long. In Chapter Six I put forward principles on which a revised strategy for suicide prevention in local prisons should be built.

During 1999 I shall be conducting a review of unsentenced prisoners, which will include an examination of available regimes in local prisons. There is no doubt that fear, uncertainty, enforced idleness and boredom are factors which cannot be disregarded when considering the reasons for suicide, and so that review will be a natural follow-on to this.

From my predecessor's review, I cannot stress too strongly the importance he paid to relationships between prison staff and prisoners. Time has shown how wholeheartedly and positively some staff have grasped the need to concentrate on this aspect of their work, which should influence and underlie everything that they do. However the quality of these relationships still varies, often appearing to rely more upon the goodwill and inclination of individual governors and staff than a consistent, professional culture, that runs throughout the Prison Service.

In many recent inspection reports I have stressed the importance of challenging a negative culture. I refer to this in my annual report to Parliament as follows:

"Culture is not written down, and is made up of a number of intangibles – an approach to prisoners that sees them as subordinates, not as people who may have broken the law but who have been entrusted to the care of the Prison Service. Some staff exhibit a cynicism for positive programmes for prisoners, oppose the need to change long established work patterns, and continually challenge the legitimate authority of the Prison Service."

All of us in the Inspectorate are struck by the immediately apparent difference between the atmosphere in prisons which have healthy cultures and those in which alternative cultures rule. Thinking this through we have adopted the term 'A Healthy Prison', a phrase taken from the title of a Prison Service Conference[1]. The phrase is also in use in one or two prisons, although the definitions, which we give in Chapter Seven, are our own. Care for and awareness of others are at the heart of what healthy relationships between staff and prisoners are all about. When we looked at reducing suicide and self-harm we concluded that exactly the same applied to any successful strategy. I hope, therefore, that the 'Healthy Prison' concept will catch on, because it exactly describes the outcome of successful delivery of the Prison Service's Statement of Purpose, namely that it will keep prisoners safely in custody, and treat them with humanity, while preparing them to live a law-abiding life in prison and on release.

In order to obtain as broad a picture as possible about the operation of the Prison Service's strategy, and wider related issues, I wrote to all Prison Service prison Governors and all private sector prison Directors, 101 of whom responded. I invited them to assemble the views of staff and prisoners, Suicide Awareness Teams and, where they had them, Listeners, who

[1] First International Conference on Healthy Prisons Liverpool 24-27 March 1996.

are prisoners trained by the Samaritans, and, operating in that capacity. Subsequently structured discussions were arranged with separate groups of staff and Listeners in 23 establishments. Staff and Listener training sessions were also observed. The records, held in Prison Service Headquarters, on self-inflicted deaths in 1996 and 1997 were thoroughly examined, as were records of attempted suicides during the same period. I also wrote to all managing medical officers, of whom only 37 replied.

Throughout the review we have worked closely with Mr Martin McHugh, Head of the Prison Service Suicide Awareness Support Unit (SASU), and are grateful to him for sharing his own concerns with us.

Later in the review, with the agreement of the Director and the National Advisory Council, I wrote to the Chairmen of every prison Board of Visitors, inviting them to complete a questionnaire, to give us a detailed snapshot of the situation in their prison on one particular day. I know that this required a considerable amount of additional work, and I am enormously grateful to them for the care and attention they paid to my request, demonstrating their individual and collective interest in the issues. The results of our analysis of the returns from 113 Boards, are contained in a separate Annex.

Outside the Prison Service I wrote to every Coroner, met with the Coroner's Advisory Group in the Home Office, and members of the team attended a number of inquests. We had a most moving and informative meeting with the relatives of nine prisoners who had died in prison, whose courage in coming to meet with us I recognize and admire. We also met with interested organizations such as Inquest, Death on Remand and CRUSE, and both the Prison Reform Trust and the Howard League were approached and contributed.
The first three chapters of the review are devoted to examining suicide in the context of imprisonment, including statistics setting out the scale of its incidence in prisons as opposed to society as a whole, and the responsibilities that are incumbent upon staff. Chapter Four includes aspects of care, particularly for relatives of the deceased, to which I believe that the Prison Service must devote much more attention. As has been mentioned above, Chapter Five examines the effectiveness of current practice, and Chapter Six is concerned with a separate strategy for local prisons, in which the large majority of suicides occur. Finally I hope that considerable attention will be paid to Chapter Seven, and the concept of the 'Healthy Prison', because of its relevance to the role and purpose of the Prison Service as a whole.

The purpose of this review has been to address a problem for which there are no easy solutions. Any successful reduction strategy must be broadly focussed, requiring the development and maintenance of high, professional standards of care, supported by basic care practices that are seen as an essential part of the every day work of all staff working in prisons. There are no shortcuts to a culture of responsibility, in which managers, at all levels, constantly reinforce staff in the maintenance of consistently high standards of performance of which they can be proud; it must be deliberately introduced. In addition, in our view, prisoners have a more proactive part to play, particularly in local prisons.

But no one should fail to recognize that what is a tragic prison incident for those with professional responsibilities, is also a personal loss for families and friends, who will carry their loss for ever. Sparing them from such tragedy is what this whole exercise is all about. Should one occur, I trust that all those with such responsibilities will treat families and friends as they would expect to be treated were they to be in similar circumstances.

I set out in this report essentially, a suggested stronger framework within which the Prison Service can better implement its current strategy. **Central to my recommendations is the need for a ringing declaration from the Home Secretary, through the Director-General, to everyone in the Prison Service, that**

suicide and self-harm can and will be reduced, and that accountability for delivering that reduction begins at the top and goes right down to the bottom. If this needs resources these must be made available, but personal commitment does not cost money. The Prison Service has already demonstrated that such total commitment, from Ministers down to individual prison staff on landings, can work, in its success in reducing the number of escapes from prison.

I have yet to meet anyone, Minister, senior official, Governor, manager or member of a prison staff who does not care about suicide. I am confident that, given consistent leadership, and the proper management of procedures and resources, designed and allocated to reduce suicides and self-harm, the Prison Service can emulate the outstanding success that it has enjoyed in improving security. That is why I call this review ***Suicide is Everyone's Concern.***

ACKNOWLEDGMENTS

In order to ensure that we kept pace with outside thinking and experience, I invited four distinguished practitioners to form a consultative and advisory board. Dr Robert Hale, Director of the Portman Clinic in the Tavistock and Portman Trust, is well known for his work with the mentally disordered. Professor John Gunn, at the Department of Forensic Psychology, the Institute of Psychiatry, the Maudsley Hospital, has, amongst other achievements, written a masterly study on the subject for the Scottish Prison Service, which is, as yet, unpublished. I am glad to have been able to draw on its contents and conclusions. Mrs Sheila Coggrave, National Prison Support Co-ordinator of the Samaritans, already has extensive experience of working in prisons. Mrs Juliet Lyon, of the Trust for the Study of Adolescence, has published material on self-harm and suicide prevention amongst women and young offenders. Their wise advice has been invaluable. All of them are busy people, and I am particularly grateful to them for giving so much of their time, so readily, to us.

I was fortunate that Ms Ann Hair had recently retired from the Suicide Awareness Support Unit (SASU) in the Prison Service, and that I was able to employ her as a Consultant for the period of the review. She had worked on the Prison Service strategy and so brought a wealth of knowledge of the issues with her. Because so many of the Inspectorate are occupied with other tasks, she led the fieldwork and dealt with all the correspondence, in a way that demonstrated that the commitment to the subject, that she brought with her, was and is total. If this report results in the hoped for reduction of the number of suicides in prisons, it will be a fitting reward for her dedication and her sustained efforts.

Within the Inspectorate I must once again pay tribute to both Mr Colin Allen, my Deputy, and Mr Rod Jacques, Leader of the Alpha team, whose deep humanity shines through everything they do. Being long experienced in the Prison Service, they know just how much this issue affects all those touched by the tragedy of a suicide in prison, and they have edited the report, with sensitivity allied to an innate understanding of what is practical. Throughout its progress they have devoted long hours to it, in addition to their other tasks, and their wisdom and advice are reflected in the recommendations.

Mrs Monica Lloyd, Team Leader Research and Development put an immense amount of time and effort into gathering and testing the data contained in the report, and submitting the text to the discipline of acute psychological scrutiny. During the period of the review she was helped first by Miss Susan Davies and Miss Helen Arnold, two Research Officers who have now left the Inspectorate, who conducted many of the interviews and studied all the records, a long and sometimes harrowing experience. Other interviews, and the collection of much of the evidence, were conducted by their successors Dr Louise Falshaw and Miss Victoria Richardson and particularly Mrs Linda Durie, who spent long hours tabulating and presenting the data. Individually and collectively they have completed a huge amount of high quality work, all of which has been passed on to the Prison Service for their further use.

Last but not least, in the United States I must thank Miss Faye Pollard, External Liaison Co-ordinator of the Federal Bureau of Prisons, US Department of Justice, Mr Bernard Kerik, the Commissioner, Mr Roger Parris, Assistant Commissioner for Health, Substance Abuse and Forensic Services, of

the City of New York Department of Correction and Mr Juan Pietri who made sure we were able to make best use of our time. The briefings that they arranged for me, and the care and attention that they gave to my team, made a deep impression on us. I hope that they recognize that any resulting reduction in the numbers of self-inflicted deaths in prisons in England and Wales will owe much to their achievements, which they so willingly shared with us.

Sections

BACKGROUND AND CONTEXT

Summary

- suicide in prison custody has to be understood in relation to suicide in the community
- the overall suicide rate in England and Wales is reducing, except for men aged 25-34 and women 15-24. For these groups the rate continues to rise. Suicide rates are significantly higher in those local authority areas with high levels of deprivation
- the rate of self-inflicted deaths in prison more than doubled between 1982 and 1998
- the Psychiatric Morbidity Survey of Prisoners 1998 demonstrated that 12% of men and 23% of women reported suicidal thoughts in prison during the week prior to them being questioned
- the increase in the rate of self-inflicted deaths in prison is larger than would be expected from the rise in the prisoner population
- a significant proportion of self-inflicted deaths are by those with violent offences
- there appears to be an over-representation of white prisoners among those who commit suicide
- about 60% of self-inflicted deaths take place in the first three months after arrival in an establishment
- most people who attempt suicide in prison have experienced a variety of adverse life events particularly violence and sexual abuse
- about three quarters of people who take their own lives in prison have a history of substance misuse.

Suicide trends in the community

1.1 There are two most difficult questions. Who commits suicide? And why? Later chapters explore some of the wider understanding about what might cause people to end their lives, but first it is vital to have some idea about patterns of suicide in the general community, before looking into the nature of prison suicides. Suicide happens to all sorts of people in all walks of life. It is therefore an issue for the whole community and not just the Prison Service.

1.2 Figures for rates of suicide in the community are taken from the Office for National Statistics which has published an analysis of the trends for suicide in England and Wales from 1982 to 1996.[2] The analysis includes all suicide and open verdicts where the harm was self-inflicted but there may have been insufficient evidence to prove that the intention was death. In this sense they correspond with the Prison Service category of self-inflicted death.

1.3 This analysis indicates that there has been a clear trend in the community for suicide rates to fall, for men by 9 per cent and for women by 43 per cent since 1982. In 1996 there were a total of 4,872 recorded suicides, three quarters of which were men and one quarter women. This represents 1.4 per cent of all male deaths in 1996 and 0.4 per cent of all female deaths in the same

[2] Office for National Statistics (Summer '98). Population Trends No 92. London: The Stationery Office

Table 1: Self-inflicted deaths for the years 1988-1998 by custody status*

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Sentenced	16	21	22	26	17	20	31	33	28	34	27
Remand	19	25	24	12	14	18	23	22	31	26	40
Convicted/ unsentenced	2	2	4	4	10	9	7	4	5	8	15
Missing data							1				
Total	37	48	50	42	41	47	62	59	64	68	82

* figures from Suicide Awareness Support Unit Prison Service HQ

year. The Department of Health's suggested target published within the government's Green Paper "Our Healthier Nation" is to achieve a further reduction of 17 per cent on the 1996 rates by the year 2010.

1.4 Closer examination of the figures for this period, 1982 to 1996, indicates that although there were overall decreases in rates for both men and women, there were marked rises in the younger age groups over the same period. For men there was a 30 per cent increase in the 25-34 age group and for women there was a 16 per cent increase in the youngest 15-24 age group, although this latter group remained the category with the lowest rate of suicide of all other groups, either male or female. Much of the increase in the rate for young men is likely to be associated with their single marital status as further analyses show that this is the only group of men for which the rate is increasing. This data confirms the literature which stresses the protective effect of partnership for men.

1.5 A further analysis by the Office for National Statistics[3] examined regional variations in the constituent countries of the United Kingdom. These indicate that the rates of suicide are higher in those areas characterized by generally poor socio-economic circumstances, and that the rate of suicide in Scotland was 50 per cent higher than that of the United Kingdom as a whole in 1994-96.

Suicide trends in prison

1.6 In contrast with the falling rate of suicide in the community, the rate in prison has increased dramatically. Figures per 100,000 of the average annual population rose from 54 in 1982 to 128 in 1998. The number of self-inflicted deaths for the years 1988-1998 by Custody Status are given in Table 1.

1.7 It is clear that there has been a significant rise in the number of self-inflicted deaths over the last ten years and a marked increase between 1997 and 1998 which has taken place within the unsentenced prisoner population. However, the prison population has also increased and it is necessary to take this into account in order to calculate whether the increase is in proportion to the increase in the population. Figures for both the rate per 100,000 of the average annual population and per 100,000 receptions are displayed below in Table 2 for 1996, Table 3 for 1997 and Table 4 1998. The rate calculated by receptions rather than the average annual population produces a lower rate which reflects the occurrence of suicide in proportion to the impact of entering prison either as a remand or sentenced prisoner, although the true figure will be somewhat higher because a proportion of prisoners who come into prison on remand are counted again when they return as convicted receptions.

[3] Office for National Statistics (Autumn '98). Population Trends No 93. London: Stationery Office

Table 2: Rates of self-inflicted deaths for 1996* per 100,000 average population and per 100,000 receptions**

	Number of self-inflicted deaths *1996*	Average prison population *1996*	Rate per 100,000 average population *1996*	Receptions *1996*	Rate per 100,000 receptions *1996*
Sentenced	28	43,043	65	82,861	34
Remand (untried)	31	8,374	370	58,888	53
Convicted unsentenced	5	3,238	154	34,987	14
Total	64	54,655***			

* from records held by Suicide Awareness Support Unit, Prison Service HQ

** data from Home Office Research Development & Statistics Directorate

***figure of 54,655 does not include civil prisoners (55,300 average population)

Table 3. Rates of self-inflicted deaths for 1997* per 100,000 average population and per 100,000 receptions**

	Number of self-inflicted deaths *1997*	Average prison population *1997*	Rate per 100,000 average population *1997*	Receptions *1997*	Rate per 100,000 receptions *1997*
Sentenced	34	48,412	70	87,168	39
Remand (untried)	26	8,453	308	62,066	42
Convicted unsentenced	8	3,678	218	36,424	22
Total	68	60,543***			

* from records held by Suicide Awareness Support Unit, Prison Service HQ

** data from Home Office Research Development & Statistics Directorate

***figure of 60,543 does not include civil prisoners (61,114 average population)

Table 4. Rates of self-inflicted deaths for 1998* per 100,000 average population and per 100,000 receptions**

	Number of self-inflicted deaths *1998*	Average prison population *1998*	Rate per 100,000 average population *1998*	Receptions *1998*	Rate per 100,000 receptions *1998*
Sentenced	27	52,176	52	86,800	31
Remand (untried)	40	8,157	490	64,600	62
Convicted unsentenced	15	4,411	340	42,200	36
Total	82	64,744***			

* from records held by Suicide Awareness Support Unit, Prison Service HQ

** data from Home Office Research Development & Statistics Directorate

***figure of 64,744 does not include civil prisoners

1.8 These figures show that, in comparison with the rate of male suicide in the community which was 17.4 per 100,000 in 1996, the rate in prisons is much higher and that *the increase in the rate of suicide for unsentenced prisoners is larger than would be expected by the influence of population alone.* The largest single rise in the rate per 100,000 receptions for self-inflicted deaths between 1996 and 1998 has been in the

Table 5. Suicides in 1995 in other European prison systems (rate per 100,000)

Country	Rate per 100,000	Country	Rate per 100,000
Austria	148	Greece	57
Belgium	196	Ireland	142
Denmark	115	Italy	101
England & Wales	116	Netherlands	145
Finland	92	Portugal	106
France	185	Scotland	284
Germany	153	Sweden	73

convicted/unsentenced population which has increased by over 250 per cent.

International comparisons

1.9 Comparative data for suicides in other European prison systems are given in table 5, in rate per 100,000 for 1995.

1.10 There are some difficulties in drawing firm conclusions from these figures as they are affected by the method of classifying self-inflicted deaths in different countries and by the method of recording the populations of prisons. The high rate for the Scottish Prison Service may be affected by the high rate in the community referred to earlier.

Suicidal thoughts in prisons

1.11 The psychiatric morbidity survey of prisoners in England & Wales carried out by the Office for National Statistics in 1998[4] (hereafter referred to as the prison morbidity survey) asked prisoners these questions:

i. Whether they had ever thought of taking their own lives even if they would not actually do it?

1.12 The proportion of unsentenced prisoners who reported suicidal thoughts in the previous week was 12 per cent for men and 23 per cent for women and for sentenced prisoners was 4 per cent and 8 per cent respectively. This indicates that the idea of suicide is three times as prevalent in the minds of unsentenced than sentenced prisoners, and twice as prevalent in the minds of female prisoners than in male prisoners at both stages, even though in practice statistics demonstrate that they are less likely to make a suicide attempt in prison.

ii. Whether they had ever made a suicide attempt?

1.13 15 per cent of male unsentenced prisoners and 27 per cent of female unsentenced prisoners claimed to have made an actual suicide attempt in the previous year. The proportion was less for sentenced prisoners with 7 per cent of male and 16 per cent of female prisoners claiming to have made a suicide attempt in the previous year.

iii. Whether they had ever deliberately harmed themselves without the intention of killing themselves?

1.14 In answer to this question, the proportions claiming to have injured themselves in this way were lower than for serious suicide attempts for both men and women. Five per cent of male unsentenced and nine per cent of female unsentenced prisoners reported that they had injured themselves without the intention of killing themselves during the current prison term. Interestingly this rose slightly in sentenced prisoners to 7 per cent for men and 10 per cent for women. This indicates that whereas suicidal thoughts as measured by the first question decreases with change of status from unsentenced to sentenced, the impulse to self injure as measured by the third question does not.

[4] Office for National Statistics (1998). Psychiatric Morbidity among prisoners in England & Wales. London: Stationery Office.

Table 6. Self-inflicted Deaths in HM Prison Service Establishments in England & Wales for the period 1st January 1990 – 31st December 1998*

	Males				Females				
	Juveniles	Y.O.	Adults	Total	Juveniles	Y.O.	Adults	Total	Grand Total
Year	*15-17*	*18-20*	*21 yrs+*		*15-17*	*18-20*	*21yrs+*		
1990	3	7	39	49	0	0	1	1	50
1991	1	4	37	42	0	0	0	0	42
1992	1	5	33	39	0	1	1	2	41
1993	1	2	43	46	0	0	1	1	47
1994	2	8	51	61	0	0	1	1	62
1995	1	7	49	57	0	0	2	2	59
1996	1	11	50	62	0	0	2	2	64
1997	1	8	56	65	0	1	2	3	68
1998	3	11	65	79	0	0	3	3	82

* Figures from Suicide Awareness Support Unit, Prison Service HQ

Actual suicides and self injury in prisons

1.15 Deaths from suicide represent about half of all deaths in prisons. The following table provides figures for the actual occurrence of suicide in different groups of prisoners from 1990 to 1998.

1.16 The occurrence of suicide for women in prison is considerably lower than for men at about 3.5 per cent of the total, although it accords with their proportion of about 4 per cent in the prison population over the same period (although, in the community female suicides constitute only 0.4 per cent of the total number). During the eight years covered by the table there have been no suicides at all of girls aged 15 to 17 and two in the age category 18 to 20. In contrast there have been 14 suicides of boys aged 15 to 17 and 63 of young men aged 18 to 20.

1.17 Self-inflicted deaths for violent and sex offenders are higher than would be expected from their proportion in the prison population and acquisitive offenders and drugs offenders are lower than would be expected. A link between violence against others and violence to self is consistent with the findings of Dooley (1990)[5] that those convicted of murder constituted 16 per cent of a sample of 295

Table 7. Proportions of self-inflicted deaths by offence type charged 1996-1998*

Offence type	Self-inflicted deaths 1996 %	Prison Population 30.6.96 %	Self-inflicted deaths 1997 %	Prison Population 30.6.97 %	Self-inflicted deaths 1998 %	Prison Population 30.6.98 %
Violence against the person	30	22	28	21	34	21
Acquisitive offences – Burglary/robbery/theft	34	41	38	42	38	40
Sexual offences	12	8	12	8	10	8
Drugs offences	8	13	7	14	8	16
Other offences	16	15	15	15	10	15

* figures from Suicide Awareness Support Unit, Prison Service HQ

5 Dooley, E. ('90). Prison Suicide in England & Wales 1972-87. British Journal of Psychiatry, V, 156.

Table 8. Proportions of self-inflicted deaths by ethnic group

Ethnicity	Self-inflicted deaths in 1996* %	Prison population as at 30.6.96 %	Self-inflicted deaths in 1997* %	Prison Population as at 30.6.97 %	Self-inflicted deaths in 1998* %	Prison Population as at 30.6.98 %
White	91	81	93	82	89	82
Black	5	13	6	12	9	12
Asian	2	3	-	3	2	3
Other	-	3	1	3	-	3
Not recorded	2					

* figures from Suicide Awareness Support Unit, Prison Service HQ

Table 9. Distribution of self-inflicted deaths by age 1994-95* and 1996-1997*

Age	Self-inflicted deaths 1994-95 %	Prison Average population 1994 %	Self-inflicted deaths 1996-97 %	Prison Average population 1997 %
15-17	3	3	2	4
18-20	12	14	14	12
21-24	18	21	17	19
25-29	26	22	24	22
30-39	26	25	24	27
40-49	12	10	12	10
50-59	3	4	5	5
60+	0	1	2	1

* figures from Suicide Awareness Support Unit, Prison Service HQ

suicides between 1972 1987 although they constituted only 4 per cent of the sentenced population.

1.18 Table 8 shows that for the years that data is available there appears to be an over-representation of white prisoners among those who committed suicide and an under representation of black prisoners.

1.19 Table 9 presents the percentage of self-inflicted deaths occurring in each age group in comparison with their proportion in the prison population for 1994-1997. Overall, these figures suggest that the age distribution of self-inflicted deaths is broadly in proportion with that of the prison population as a whole. Table 10 indicates that this also applies to the incidence of self-harm and attempted suicide, except for the 21-29 year age group where the incidence of self-harm is higher than might be expected.

1.20 Table 11 shows the time at the establishment that elapsed before the suicide occurred.

Table 10. Attempted suicides/incidents of deliberate self-harm - 1996/97 by age*

Age Group	Number of people	Percentage	Prison Average Population 1997 %
15 - 17 years	73	4	4
18 - 20 years	277	14	12
21 - 29 years	960	48	41
30 - 39 years	506	25	27
40 - 49 years	114	6	10
50 - 59 years	23	1	5
60 - 69 years	2	-	1
Missing data	30	2	
Total individuals	1,985	100%	

* analysed from records held by Suicide Awareness Support Unit, Prison Service HQ

Table 11. Time at establishment prior to self-inflicted death - 1994 to 1997

Days at establishment	Cumulative frequency of self-inflicted deaths1996-1997**			
	1994	1995	1996	1997
Up to 1 day	11%	4%	8%	9%
Up to 7 days	27%	20%	29%	27%
Up to 14 days	35%	25%	36%	36%
Up to 21 days	46%	27%	43%	41%
Up to 28 days	49%	31%	43%	43%
Up to 2 months	53%	36%	55%	48%
Up to 3 months	67%	42%	64%	54%
Up to 4 months	71%	49%	71%	56%
Up to 5 months	78%	53%	78%	62%
Up to 6 months	82%	53%	78%	65%
Up to 12 months	93%	80%	89%	80%
Up to 24 months	93%	94%	96%	91%
More than 24 months	100%	100%	100%	100%
Time not recorded	7 cases	9 cases	1 case	2 cases
Total numbers of SIDs	62	59	64	68

* figures from Suicide Awareness Support Unit, Prison Service HQ

1.21 One feature of this data is its relative stability over the years, although the data for 1995 seems to be somewhat out of step with that of previous and subsequent years. The proportion of suicides occurring within the first 24 hours of custody remains around 10 per cent, the proportion of suicides that occurred within the first month remains at 43 per cent and the proportion which occurred within the first year amounts to 80% or more. *These figures confirm that the first 24 hours is a very high risk time, that the whole of the first year is a medium risk time for suicide and that after the first year has past the risk of suicide is substantially reduced.*

1.22 Table 12 shows the proportion of self-inflicted deaths which in 1988-1990 and 1996-1997 were classified from their records as having had any psychiatric contact.The figures for 1994-1995, however, refer to a clinical diagnosis of mental disorder within the meaning of the Mental Health Act 1983 by an approved practitioner under Section 12. This is a more stringent criterion than psychiatric referral and may account for the lower figure given for 1994-95.

Table 12. Previous psychiatric history of prison suicides

Psychiatric History	1988-1990* %	1994-1995* %	1996-1997 %
Yes	38	23	40
No	62	77	60

* from Crighton & Towl (1997[6]

1.23 There are some difficulties in defining psychiatric disorder which means that comparisons between different studies have to be made with some caution. However, the figures suggest that about a third of prisoners who commit suicide have some form of mental disorder. In the community there is a much clearer link with mental illness and suicide where over 90% are reported to have such a history. The dominant diagnosis in the community is depression which is made in 70 per cent of cases with alcoholism accounting for 15 per cent and schizophrenia and phobic anxiety accounting for a further 6 per cent.[7] A report by the Office for National Statistics 'Non-Fatal Suicidal Behaviour Among Prisoners' based on the prison morbidity survey indicated that previous psychiatric treatment before entering prison was four times as common in male prisoners and three times as common in female prisoners who had attempted suicide in the previous year than in those who had not. This suggests that the levels of psychiatric disturbance in prison suicides are higher than average for a prison population but not so clearly linked with psychiatric disturbance as for community samples. The reason for the lack of clarity is likely to be that the prison population as a whole is very disturbed. *The morbidity survey indicated that only 10 per cent of the population were free from any form of mental disorder at all.* Against a background of this level of disturbance it seems that medical help-seeking behaviour does not discriminate clearly between those who are at risk of suicide and those who are not.

1.24 Figures for previous substance misuse in prison suicides, however, show high levels with about three quarters of those who commit suicide in prisons having a history of single or multiple substance abuse. This contrasts with the community figures referred to above where 15 per cent had a diagnosis of alcoholism and only one per cent of barbiturate dependence.

Table 13. Previous history of substance misuse

	1996		1997	
	No	%	No	%
Multiple substance misuser	25	40	28	43
Single substance misuser	24	38	19	29
No substance misuse listed	4	6	11	17
Not known	10	16	7	11
Missing cases	1		3	
Total	64		68	

* analysed from data held by Suicide Awareness Support Unit, Prison Service HQ

6 Crighton, D. and Towl, G. (1997). Self-inflicted deaths in England and Wales: an analysis of the data for 1988-90 and 1994-96. In Suicide and Self-injury in Prisons, Issues in Criminological and Legal Psychology, no 28.

7 Barraclough, B. and Hughes, J. (1987). Suicide: Clinical and Epidemiological Studies. USA: Croom Helm.

UNDERSTANDING SUICIDE

Summary

- suicide is a means of escape from unbearable emotional pain when there seems to be no other option
- unimaginable circumstances might be bearable to one person but may bring overwhelming feelings upon another. This could be any one of us
- most suicidal people give some signs of their intentions
- those close to the person find such depth of despair very difficult to comprehend
- ambivalence is a known feature of being suicidal i.e. wanting to die and at the same time wanting to be rescued
- background history may make someone vulnerable to suicide. A range of events may trigger suicidal feelings. There is no foolproof means of predicting who will commit suicide or when
- listening and encouraging exploration of suicidal feelings with a sympathetic person, in a safe environment, reduces distress
- on current prison populations an average of 640 men and 37 women are likely to kill themselves at some point in their lives.

"It is the words that suicidal people say – about their psychological pain and their frustrated psychological needs - that make up the essential vocabulary of suicide. Suicide prevention can be everyone's business."
Edwin Shneidman (February 1996) in his Preface to his book "The Suicidal Mind". Professor of Thanatology Emeritus at the University of California at Los Angeles School of Medicine, and Founder of the American Association of Suicidology.

The experience of the suicidal

"Suicidal death is an escape from pain …. Pain is Nature's great signal …. it both mobilizes us and saps our strength; pain, by its very nature, makes us want to stop it or escape from it."
"Everyone who commits suicide feels driven to it – indeed feels that suicide is the only option left."
Edwin Schneidman, 1996[8]

2.1 The above analysis of suicide identifies a range of characteristics which illustrate the complexity of the suicidal state and the need to understand it at several levels.[9] In short, suicide is the result of a decision which may feel entirely rational to the perpetrator but which is made at a time of acute emotional distress when focus is narrowed and the individual is unable to see alternative options. The overwhelming need is to escape from intolerable pain or despair and from the burden of being conscious. There is evidence to suggest that some individuals may injure themselves as a regular means of coping with emotional pain and that such individuals are high risk for

9 Schneidman, E.S. (1996). The Suicidal Mind. New York: Wiley.
10 Schneidman, E.S. (1997). definition of suicide. New York: Wiley.

completing suicide when pain becomes overwhelming.

2.2 In 1996/1997 the Prison Service and The Samaritans organized three conferences on Listener Schemes. In her address on confidentiality Sheila Coggrave, National Prison Support Co-ordinator for The Samaritans, spoke about the feelings of hopelessness and powerlessness which grow until someone feels that the escape routes and options have all disappeared, and that the only way of easing pain is death.

"The situation was so unbearable. I had to do something and I didn't know what else to do".
A prisoner

Those at risk of suicide

2.3 Anyone can become suicidal. Any one of us could find ourselves at risk, given unimaginable combinations of circumstance, which become overwhelming. In August 1994 Di Stubbs said in her foreword on behalf of The Samaritans to "Waking Up Alive" by Richard A Heckler, a Professor of Counselling Psychology and Director of the Hakomi Institute of San Francisco:

"Suicide is caused by feelings not facts – a similar event may be borne by one person and may lead another to suicide or attempted suicide. Events, feelings and experiences add strands to a net that can drag you under. The final straw can be the weight of gossamer but the combined effect can be devastating. Or the final straw can weigh like an iron girder."

2.4 Most commentators now agree that there are links between self injury and suicide, and statistics indicate that half of those who die from suicide in prison have injured themselves before. Liebling (1992)[10] stresses the similarities rather than the differences between those who self injure and those who complete suicide in prisons. Williams (1997)[12] describes those at risk of suicide in the community as pessimistic about themselves and their capacity to make anything better. Much of this is because of early life experiences of loss, abandonment and hurt. They are vulnerable to acute sensations of pain and despair because these signal another episode of agony over which they expect to have no control.

2.5 Williams (1997) also points out that individuals suffering from borderline personality disorder are especially at risk of self mutilation and suicide with between 4 and 10 per cent eventually killing themselves. The prison morbidity survey indicated that 23 per cent of male unsentenced, 14 per cent of male sentenced and 20 per cent of all female prisoners were diagnosed as suffering from this disorder, whereas the prevalence in the community is in the region of 1.8 per cent.[12] Based on the average annual population of prisoners in these categories in 1997, this translates into an average of 640 men and 37 women in prison in 1997 who will kill themselves at some point in their lives. The risk of this happening during their time in prison is likely to be high given the level of stress associated with their prison experiences.

2.6 Our own work during this review and from inspections supports Liebling's (1992) study of young prisoners. She demonstrated that the backgrounds and criminal justice histories of both those who attempted suicide and those who did not were characterized by the same multiple disadvantages, although there were significant differences of degree. Suicide attempters were more likely to have experienced:

- multiple family breakdown
- sexual abuse
- frequent violence leading to hospitalization

10 Liebling, A. (1992). Studies in prison. London: Routledge.
11 Williams, M. (1997). A cry of pain. London: Penguin.
12 The average from 8 community surveys in the USA from 1980 to 1990

- local authority placement as a result of family problems (rather than offending)
- truancy as a result of bullying (as opposed to boredom or peer pressure)
- very short periods spent in the community between periods in custody.

2.7 Once in prison the suicide attempters were:

- considerably worse off than their peers
- more socially isolated
- less likely to have a job or anything to occupy them in the day or when locked up in their cells
- less likely to be in contact with anyone outside, either family, friends or probation officer
- find it difficult to express themselves and communicate with either prisoners or staff.

2.8 These characteristics can predispose prisoners to a suicidal response triggered by such experiences of custody as being isolated, bullied, subject to violence and intimidation and from being ignored by staff.

A typology of prison suicide

2.9 Liebling (1997)† suggests that there may be three broad types of prisoners at risk of suicide who can be distinguished from one another by several features and who may have different motivations for taking their lives. The first is the group described above who are younger with a history of previous self-injury, whose distress is acute and who are particularly vulnerable to the impact of imprisonment. The second is an older group of long sentenced prisoners who are often at the beginning of their sentences and who feel guilt and shame at their offences and hopeless about their future. The third is the psychiatrically ill whose mental state is confused and who are socially isolated and poorly equipped to cope with imprisonment. The differences are described in Table 2.

Table 2: A Typology of Prison Suicide†

	1. Poor Copers	2. Long Sentence Prisoners	3. Psychiatrically Ill
Possible Motivation	Fear Helplessness Distress/isolation	Guilt/no future	Alienation, loss of self-control fear/helplessness
Age	16-25	30+	30+
Proportion of total number who committed suicide	30-45%	5-20%	10-22%*
Relevance of Situation	Acute	Chronic	Varied
History of previous self-injury	High	Low	Medium
Features	Often more typical of prison population i.e. acquisitive offences	Often (76%)**on remand, after midnight; some well into sentence	Psychiatric history present Single NFA

† Taken from Liebling, A. (1997). Risk and prison suicide. In H Kaushall & J Pritchard (eds), Good practice in risk assessment and risk management

* 13% for young offenders under 21

** Dooley (1990)

2.10 These categories allow some interesting comparisons between suicides in prison and in the community. In almost 90 per cent of studies of suicide in the community a history of psychiatric treatment or illness was evident.[13] Those with a known history of psychiatric illness accounted for only between 10 and 22 per cent of suicides in prisons between 1987 and 1993, and amongst young prisoners the proportion was only 13 per cent. This finding is particularly surprising given the higher levels of psychiatric disturbance within the prison population. The research of Liebling (1992) which first identified the vulnerable typology was carried out on young prisoners and it is likely that the risk of suicide in this group is far more a function of vulnerability than of psychiatric illness. Furthermore the category of long sentenced prisoners is entirely specific to prisons. The main implication for the management of the suicidal in prisons is that the solution does not reside in the provision of psychiatric care alone but in a prison wide approach in which suicide is indeed everyone's concern.

Ambivalence about living

2.11 We began this chapter by describing the experience of the suicidal as being unable to identify any other way of shutting off pain than by shutting out consciousness. This over focussing on one solution and an inability to identify alternatives is associated with the narrowing of vision which itself is a function of stress. Suicidal people are therefore not so much intent on dying as ambivalent about living and unable to identify an alternative way to end their pain. This indicates that there is a crucial role for staff in helping the suicidal expand their awareness of the alternative options available to them. The role of staff must be to understand the complexity of this experience, to empathise, to alleviate the pain of isolation and to help the individual to take small steps that will bring about an end to their pain through more effective means.

2.12 The most important question of a potentially suicidal person should not be about family history but should be "where do you hurt?" and "how can I help you?". This is where suicide prevention in prison should begin and all staff have an obligation and should therefore have the courage to talk openly about despair and suicide to those who seem to be at risk.

13 See footnote 8.

THE IMPACT OF IMPRISONMENT

Summary

- the belief that imprisonment and punitive regimes will cure crime and make society safer misjudges the impact of custody
- imprisonment has to achieve different objectives for different groups of prisoners
- the Prison Service's duty of care requires staff to sustain prisoners' mental well-being and to protect them from themselves and from others
- the prison population includes many groups at high risk of suicide
- some suicides will always happen despite the best efforts of staff
- many distressed prisoners are supported by staff every day as part of their regular work
- self-mutilation can be a sign of distress and potential suicide so staff must persevere to help prisoners find better ways of coping
- there are combinations of many issues which can cause prisoners to consider suicidal behaviour
- the blame culture confuses staff about how they should work with the suicidal.

3.1 Two views about suicide in prison are widely held in the community. The first is that suicide should be easy to prevent in a total institution which controls all aspects of prisoners' lives but this ignores the reality that many prisoners have ample opportunity to kill themselves away from the eyes of staff and other prisoners. The second is that the treatment and conditions of prisoners should not be so punitive so as to cause despair and suicide. Regrettably, while conditions in many prisons are not designed to be punitive, overcrowding, poor facilities and impoverished regimes make them so. To some extent these views of the way that prisons should operate exemplify the limited nature of the popular understanding of prison regimes, how control is exercised, the impact of imprisonment and the background level of mental disorder among prisoners.

What is imprisonment for?

3.2 There are deep confusions in our society, as in other civilized societies, about imprisonment, what it means, what it takes to make it a useful punishment and whether it can serve to reform and rehabilitate. These confusions inevitably touch the staff engaged in the complex work of custody on our behalf, and pose many conflicts for them. Imprisonment has to achieve different objectives for different groups of prisoners; for example hold unconvicted prisoners on remand for court, ensure that dangerous prisoners do not escape, tackle criminal behaviour to try to prevent reoffending etc. Different groups require different regimes; for example women, juveniles, the elderly and the mentally disordered. Furthermore, the emphasis is ever changing, between punishment and deterrence on the one hand and rehabilitation on the other, according to the times we live in.

3.3 For most people, prisoners are out of sight and out of mind but prison staff are daily face to face with people whom society has discarded, albeit temporarily. In their professional role they have to

reconcile these shifting expectations and attitudes of society, and to regulate their relationships with prisoners accordingly. They also have to work out their personal views as members of society and manage them in relation to their public duty. The media plays a highly visible part and often inflames attitudes. While fashions come and go, prisons do not. While sympathies towards prisoners rise or fall, the staff continue their work. The dynamics of life in the total institution of a prison are not easy to convey to the general community, which has little comprehension of the pain of imprisonment.

3.4 Understandably perhaps, many ordinary people have little inclination to understand it. The common belief that more imprisonment and more punitive regimes will cure crime and make society safer seriously misjudges the impact of custody on people who are imprisoned. Unless the prison experience helps to make prisoners less likely to reoffend on release there is a real danger that society will be at greater risk from offenders who have been corrupted in custody.

The pains of imprisonment

3.5 It is broadly accepted that imprisonment is painful although this is not greatly explored in the literature on suicide within prison which focuses on average populations rather than individuals and uses quantitative rather than qualitative methods. It is hard to measure individual pain and much of the research fails to capture it. Alison Liebling (1992) talks of the importance of "sitting where the prisoner sits" to better understand the pains of imprisonment. For this reason *we commend the initiative that has been taken by a probation officer at HMP Liverpool*[14] where those harming themselves are interviewed, if possible within 24 hours of the incident, to determine what triggered the behaviour and how it could have been prevented (see also Chapter Five).

3.6 The prison morbidity survey asked a few simple questions of prisoners to separate out self-harm from serious suicide attempts and the light that this has shed on the prevalence of these two functionally different behaviours has been enormous. We need to ask more questions of prisoners to determine why they harm themselves and how this behaviour differs from serious suicide attempts.

3.7 Moreover, given that the risk factors for suicide are shared by so many prisoners and that the experience of coming into prison itself is likely to be a risk factor in its own right, then **greater understanding of what triggers actual suicide in the individual case will only come from this sort of in depth individual analysis. We recommend therefore that more research of this kind is undertaken.**

The significance of self-harming behaviour

3.8 It is known that most prisoners who injure themselves, many repeatedly, do not go on to kill themselves. However a significant proportion of those who commit suicide do have a history of self-mutilation. It is also known that in the community those who harm themselves are 100 times more likely to kill themselves than the general population and that 10 per cent of this group do eventually carry this out.[15] Thus although self-mutilation may become established as a coping device or a way of dealing with pain and staying alive, it may develop into a method of achieving complete release in death.

3.9 Therefore, aside from the importance of responding to self-injuring behaviour on humanitarian grounds as it signals acute distress in a fellow human being, it is also important that it is responded to because of the possibility that it may develop into fatal self injury in the future. *We commend the self-help group, facilitated by staff at HMP Durham where women with a history of self-injury meet together weekly to share their feelings and talk about their impulses to self injure.* There is some evidence that this is effective in controlling the behaviour and allowing more adaptive coping mechanisms to develop.

14 Paul Fenning, Probation Officer, HMP Liverpool.
15 Morgan, H. and Owen, J. (1990). Persons at Risk of Suicide: Guidelines on Good Clinical Practice. Nottingham: Boots

The impact of self-mutilating behaviour on staff

3.10 We do not underestimate the difficulty for staff in managing the persistent self-mutilating behaviour of some prisoners, particularly children, young adults and female prisoners. However, what is always important is to take their behaviour seriously. There is a natural defence on the part of staff against seeing acts of self-mutilation as genuine cries for help and signs of potential suicide risk. They are frequently bewildered by this behaviour. The correct response of staff should be to understand the distress and the cause of the behaviour in order to help the individual replace it with more effective coping strategies. The charity 'Inquest' which supports bereaved families has drawn attention to what it calls an apparent "blindness to distress" on the part of some prison staff in cases which ended in suicide. Not all unhappy people are able to admit or express their feelings in a constructive way. This may be particularly so for young people and those on remand. To some extent their actions are "attention-seeking" but labelling the behaviour in a dismissive way is likely to increase the distress. The real task for staff is to persevere to reach what is bothering prisoners and find out what they need in order to help them to cope better.

The inevitability of suicidal behaviour

3.11 We have already described the vulnerability of the prison population in general and the special difficulties of those whose experience of severe adversity in the past has rendered them particularly ill-equipped to cope with the fracturing of relationships, the isolation and the harshness of the prison experience. As Professor Gunn has written[16]

"Prisons collect individuals who find it difficult to cope, they collect excessive numbers of people with mental disorder, they collect individuals who have weak social supports, they collect individuals who, by any objective test, do not have rosy prospects. This collection of individuals is humiliated and stigmatized by the process of arrest, police inquiry and court appearance. Prisoners suffer the ultimate ignominy of banishment to an uncongenial institution, which is often overcrowded, where friends cannot be chosen, and physical conditions are spartan. Above all, they are by the process of imprisonment, separated from everything familiar, including all their social supports and loved ones, however unsatisfactory. This is what is supposed to happen, this is what the punishment of imprisonment is all about. This collection of life events is sufficient in any individual to make him or her depressed. The depressive feelings may include hopelessness, despair, morbid thoughts, and a wish to die. Sometimes this will inevitably lead to suicidal activity and some deaths."

3.12 This is a particularly poignant description of the impact of imprisonment on the vulnerable which stresses that prison itself is a high impact event and prisoners themselves a particularly vulnerable group.

3.13 Despite the fact that the above group and those who are clearly mentally ill give many clues to staff about their vulnerability, it will still not be possible to prevent every suicide. Moreover some prisoners may be robust personalities with little history of previous self injury or psychiatric contact, some may have served several years and many carry out their suicide well into the night when they can be confident that they will not be discovered. In these circumstances it may be impossible for staff to take any preventative action at all and it is important therefore to recognize that not all suicides can be prevented.

The Duty of Care

3.14 When people are committed to custody, they are removed from their normal environment. This separation also takes away their normal support network and ways of coping. It is therefore implicit

16 Gunn, J. (1994). Suicide in Scottish Prisons - a brief review. Unpublished report.

that the Prison Service's duty of care should include adequate means to sustain prisoners in difficulty and enable them to cope as far as possible with the burden of custody. It is therefore fully appropriate for the Prison Service to adopt an approach which seeks to assess risk and prevent suicide. This can never be wholly successful however and therefore it is essential to acknowledge the fear of failure and the distress that accompanies failure despite all best efforts. It is to be hoped that the ideas developed in this review will reinforce the courage of prison staff that an active approach can reduce the occurrence of suicide in prisons.

The difference between accountability and blame

3.15 None of this is eased by the discouraging weight of the "blame culture" which has pervaded large parts of the Prison Service, and one ambition of this review is to encourage a more positive stance about what can and cannot realistically be done to prevent self-inflicted deaths, and promote staff confidence in their own judgements. Where staff carry out their duties responsibly and carefully, working on the knowledge available to them, they should have nothing to fear and should be visibly supported. For managers, concentrating energy in this way, is more likely to bring about improvements. **It is the responsibility of the Prisons Board and managers at all levels to ensure that effective systems to prevent suicide operate in every establishment and that all concerned know and are accountable for the part that they are required to play.** The corollary to this is of course that inquiries must distinguish between cases in which errors were made in good faith and those in which there was a clear failure in duty of care. **In such cases it is incumbent on the Prison Service to take firm action and not to disguise their failure from those with a legitimate interest.**

Stimulating the will to live

3.16 What has been striking is the depth of the distress, that brings so many prisoners down to the point where they want to hurt themselves or to die. This distress is something far greater than the general level of unhappiness that any ordinary person might be expected to feel on being put into custody. It is the grinding sense of hopelessness that sets in because an individual sees no relief from his/her feelings of despair.

3.17 The approach which is proposed in this review is designed actively to address this level of distress, and stimulate the will to live in prisoners as a means of discouraging suicide, without becoming over-focused on the act of suicide itself and the understandable fear of it which grips staff, especially after one has already occurred. This is not to detract from the importance of the Suicide Prevention Strategy itself, but to give it a more positive focus, which stresses the value of developing regimes which give prisoners positive interests and restore some motivation to continue to live, while at the same time raising the confidence and motivation of staff who work with them.

The impact that staff and prisoners can have in preventing self-inflicted death

3.18 Whilst the number of deaths is a major concern, there are many suicide attempts, and episodes of despair, from which prisoners recover because of preventative or prompt and supportive action by alert staff and prisoners. Too little is known of this largely unpublicized good work of which we have heard many examples during the course of this review. *The day by day care from prisoners and staff in turning around the many distressed and disaffected people is very commendable.*

WHEN A PRISONER DIES

Summary

- the full impact on relatives of a death in custody must be more fully understood
- effective contingency plans are required for the way in which family and friends are to be informed of a death in custody and how they are to be supported. An identified member of staff should work with the family
- Prison Service investigations into deaths in custody should look into how families are supported and assisted
- there should be a clear Prison Service policy about the information which should be given to families after an investigation
- guidance for relatives involved in the Coroners courts should be available
- coroners should be kept up to date on Prison Service policies
- the good work of staff in dealing successfully with cases of determined suicide attempts is recognized
- the Prison Service strategy of care for staff is endorsed
- contingency plans should support prisoners directly affected by a suicide
- the shock to the establishment of a death in custody must not deflect the Governor and staff from providing support for relatives.

Family and Friends

4.1 For many families, a death in custody may seem like a second bereavement because they have already lost their family member to prison. And then comes the news of the death, replacing one set of concerns with a whole new set of feelings which are far worse. An important consideration in these circumstances is that the risk of a family member committing suicide is increased by the original suicide, which is a powerful argument for approaching families with sensitivity. People bereaved by suicide are shocked, isolated and often angry at the rejection they feel from the family member who has died. They need to work through a turmoil of emotions and may see the way prisons sometimes behave as yet another rejection.

4.2 After a death in custody there are several critical series of events which each bring their own difficulties and which are identified below. Alongside each, we quote remarks made by families, not because every case was handled badly by the Prison Service, but to illustrate the lasting hurt which is left to linger on if any of these steps is not carried out thoughtfully. They are presented not for dramatic effect but because it is important to acknowledge the feelings of those people who have encountered the tragedy of suicide and its aftermath. We consulted with relatives directly and these quotations represent a fair reflection of the responses we received from families. Alongside these expressions of anger and frustration from bereaved relatives about their treatment by prison staff, it is important to record that inspectors have seen several letters of thanks from families for the help they received.

4.3 Each of the stages has the potential to influence the later ones right through to the outcome of the inquest, and to affect the degree of confidence that exists between the bereaved family and the Prison Service.

Telling the news

"I was told my son was now free …. I kept thinking he had escaped".

"We went on holiday, camping, on the Saturday. We did not know my son had been taken into custody on the Friday. He hanged himself on the Sunday afternoon. On the Monday two policemen eventually found us and told us … we had to pack up and wait for friends to come and get us ….".

"The police came to our home on a day when we were away visiting relatives (N.B. several hundred miles away). They informed our younger son who was at home, to ring the prison. When he did, he was told that his brother was dead. He tracked us down and told us over the phone. The Governor seemed very nice at the start but we soon realized we were wrong".

"Two policemen came to our house and told me to phone the prison. I spoke to the Deputy Governor who informed me "I am sorry to tell you, your son is dead". With this, the phone was put down."

"My brother was found at about 7 p.m. and died in the hospital at about 10.20 p.m. I live only 20 minutes away and could have got there before he died. His wife was told 12 hours after he was found. They said they knew she had children and did not want to upset her".

Support and sharing the news

"I was left without the name of anyone to contact. You want to share it with someone who has had the same experience. The chances of finding someone like that in the local community are slim".

"My son had a solicitor who was very fond of him so she was a help and put us in touch with Inquest. Without Inquest we would have had no idea of what to do".

"Eventually I heard about Inquest through my solicitor".

"My brother was 34 and left behind seven children. I am the only one who can speak about it. My sister in law has had a complete nervous breakdown. The only good thing is that I saw Inquest on the TV the day before the inquest".

The impact of the speed of the media

"By the time we got home my son's 75 year old grandmother had heard it on the news – she hadn't even known he was in custody".

"Our other son heard the news on his car radio somewhere between 6 p.m. and 9 p.m.".

"My mother heard it (my brother's death) on the radio".

Handing over the property

"It would have been nice to have been told to bring along a suitcase. I was handed what was left of my son in three bin bags".

"Our son's belongings were thrown into three containers which we were told to burn as the prison did not want them back".

"I was given bin bags with my son's belongings shoved in them. As these were handed over, I heard one officer say "another one bites the dust". After that there was no contact at all with the prison".

Seeing the cell

"We wanted to see and be in the place where our son spent his last moments but we were told we couldn't".

Funeral arrangements

"There was a total blank on the funeral arrangements. We rang DSS, Probation etc but no one wanted to know. By chance we rang NACRO and were told about Inquest".

Follow-up

For the families we met, the handling of the news indelibly coloured the interval through to the Inquest. A brother said:

"I desperately need the Prison Service to just say they made a mistake and they are sorry. Then the burden of guilt that weighs so heavily on me would be lifted and I could attempt to get on with my life".

The inquest

"At the inquest we were treated very badly as if no one cared. All the officers sat at the back of the room, egging each other on. If an officer had wanted to tell the truth it would have been extremely difficult in front of others and the Governor. We found it unbearable that there were people smiling during the inquest".

A mother:
"At the inquest there were about 13 or 14 witnesses on the prison's side and one prisoner on the family's side. I didn't know who could speak or that I could ask for witnesses".

A second mother:
"At the inquest all the officers and governors sat there laughing. When the suicide verdict was given, the Governor looked overjoyed and raised a fist in the air and said "yes"."

Treatment given to families

" We were treated like scum – we are not criminals".

"At the prison we were treated like dirt, even sworn at when we reached the gate as though we were also criminals".

The feelings of responsibility and guilt summed up by a parent, even when their children are adult:

"I have to live the rest of my life with the guilt of knowing I could not save my son".

A personal account

4.4 The pain caused to relatives of a self-inflicted death in prison and for whom this is a personal loss, is long lasting. We have reproduced below a summary of an account sent to us by a young woman about the suicide of her best friend 12 years previously. She agreed to be quoted from her long and careful letter: it must have taken a lot of courage to revisit such a sad period in her life. It is presented here to personalize the experience of loss and to contrast the personal impact of a suicide with the impact on the institution which is significant at the time but relatively short lived.

"I am now 33. Jim (name changed) was three years older than me. He was my best friend, we were inseparable for the last three years of his life. He used heroin – under my bullying he sometimes managed to stay free of it for long periods. He was ashamed but could not stay off it. I didn't see him for a couple of weeks but one morning on my way to work he called to me from the other side of the road. I was concerned about being late for work so I said I couldn't stop ….. that was the last time I saw him. On the Friday of that week I heard he had been remanded on drug charges. On the Monday another friend rang to tell me Jim was "lost" …. she could not trace him in prison or via the courts. On the Wednesday night, on return from work, I received a letter from him. As I finished it a friend rang and I was telling her about the letter and gave her a message from it. She said "Haven't you heard?". I said "Heard what?". She said "Jim is dead …. he hung himself ."

Have you ever been given news like that? How did it hit you? I couldn't understand what she was telling me. I remember feeling desperate, feeling empty handed, as if nothing was solid anymore. I remember sliding down the sofa to the floor, needing to feel something firm under me. Soon after, my sister came home and told me there had been a call for me in the morning after I had left for work. She had answered it. A man had asked for me. He identified himself as a member of the police and the call was in regard to Jim who had put me as his next of kin and he had been found hanging in his cell. He refused to divulge anymore information because my sister was not

family. He didn't ask her who she was, whether she knew Jim herself, if there was anyone with her, if she was alright , nothing. She still remembers his attitude as "callous, brutal, uncaring, thoughtless".

His friends all congregated at our flat. I can't remember very much about that time. It was shock and disbelief interspersed with a desperate unhappiness. We all cried a lot and talked about Jim a lot.

Two of us made an appointment to see someone at the prison. We had to queue with all the other visitors who were waiting to see their loved ones. We were going to talk to someone about the suicide of our loved one. We were shown to an office, which had been a cell. It was gloomy and scary. The member of staff read through Jim's file quickly. He was unprepared. We asked questions about Jim. He finally admitted he had not actually seen Jim at any time. All he could tell us was what was written in the file. He was entirely, utterly uninvolved. This was merely one of the many things he had to do in his busy working day.

We ganged up on him and shouted and sobbed. When we started asking questions again, he was glad to be able to answer from the file – some of it made sense, some of it didn't. I told myself to remember as much of it as I could. It was all I had left of Jim.

He took us along corridors, up some stairs to a small windowless room to wait for Jim's worldly goods. He gave us them in a large, brown paper envelope – unsealed. We took his things and we left. We went to the pub – we were shaking.

For many of us, it was our first funeral. None of us was over 24. We told stories and toasted Jim.

At the inquest his dad was holding himself together. There was a sense that if he let go of his control, even for an instant, he would split into shards and fly into pieces. I was trembling under my skin as if I had a fever. The facts came out. They seemed damming to us. The jury was out for 15 minutes. The foreman asked to make some remarks. The coroner said "No, just the verdict". The verdict was misadventure, as the coroner had directed. Again the coroner talked over the foreman who almost shouted that although, they were convinced that Jim had died by his own hand, the suicide should and could have been prevented. The situation was almost farcical. The coroner called for the next case.

Jim's dad and I went to the nearest pub. He gave me something of Jim's – these bits and pieces – the few photos and bits of jewellery – are all we have of our lovely, shy, funny friend. I miss him badly, still and often. Writing this has been hard, I have felt again the grief and the rage, the stupid horrible waste of his life. Too often I am made aware of the grief of another family.

I hope that this story will contribute to the difference of others. Thank you for the time and patience taken to read this".

4.5 This extract illustrates many of the significant events already referred to, but it serves to remind us of the depth of the experience that remains with friends and family forever.

The effect of a suicide on other prisoners

4.6 When a self-inflicted death occurs other prisoners are likely to be affected. This may be because they witnessed the suicide or its immediate aftermath, have been a friend or associate. They may suffer acute post-incident trauma and can be affected by what the death means to them individually by confronting them with their own pain and the possibility of escaping in this way. Suicides do sometimes occur in clusters, the first possibly acting as a model of escape from pain for other prisoners. Staff should not under-estimate the possible impact of a suicide on other prisoners.

Post incident care for prisoners

4.7 Contingency plans should be prepared to provide support for prisoners directly affected by a suicide. As much information as possible should be passed quickly to prisoners. Consideration should be given to allowing relatives to meet prisoners who were friends of the deceased. Memorial services have been found to be an important way for prisoners to present their own feelings of respect.

Staff and their families

4.8 At the same time as families and friends are being confronted by news of the death of a loved one, prison staff are also having to come to terms with a prisoner's death. The effect on prison staff in these circumstances is rarely if ever mentioned in public. However, they are frequently traumatized and filled with confusing thoughts and emotions. There is the shock of finding the body and attempting resuscitation, of dealing with the aftermath of feelings from other prisoners, worrying whether they are in any way responsible and whether the Prison Service will hold them to blame. We heard of examples where such events have had serious effects on the families of staff. Not infrequently, prison staff are falsely characterized as unfeeling and uncaring. However, *much praise is due to the many staff who have acted valiantly and selflessly in persevering to save those attempting suicide. No one should under estimate how hard and unpleasant this has been for many of them. An officer said:*

"It wasn't until after you realize exactly what you have seen and done. You sort of go on automatic pilot. Contrary to the public perception of prison officers, we are human – with human feelings. The bottom line is that regardless of what he has done, he is in prison as punishment and it is not for us to add to this punishment".

Another officer said:
"We are told how to deal with a dead body but not how to deal with our feelings and our emotions – they are not trained up or hardened. We have to walk away from a dead body. Regardless of what or who he was, it is still a very hard thing to do. We are still ill-prepared for coming across a hanging or slashed up body. I don't know how you get training for that, to harden – but if you harden them (your feelings) towards that, then you remove them even further from the situation and we would then be losing our compassion".

Post incident care for staff

4.9 Post-trauma support may be difficult for some staff to accept. They may not be able to talk about the psychological and emotional turmoil they are in; the prison environment may not support this. **A healthy prison environment should provide a culture in which staff are able to work through their personal turmoil.** The relevance of Chapter Seven is of great importance in this. We commend the Prison Service policy that every establishment should have a post-incident care team to respond to the needs of individual staff who have been involved in serious incidents. During this review we have received very little information about the effectiveness of teams in practice. **It is important to stress the need for ongoing support for staff in these circumstances up to and beyond the inquest with specialized counselling where necessary. Samaritans are there for them to talk to in confidence which could be of help to them and to their families.**

MAKE SURE FAMILIES ARE TREATED WITH RESPECT AND GIVEN COMFORT

Giving the news to relatives

4.10 In the event of a suicide, there is a strong tendency for a prison to behave as if the death was its loss and for the main preoccupation to be resolving the degree of blame, collective or individual. This is totally wrong and the effect on the family when this happens is devastating. Notwithstanding the importance of properly supporting staff and ensuring that practical issues are dealt with, it is the family and friends who are the bereaved and who are in need of professional care and attention from prison staff.

4.11 For the prison to concentrate on its own needs at such a time may partly be explained by cultural taboos about facing the impact of death and the natural instinct of an institution to close in upon itself when under threat and to adopt a defensive and introspective stance. No doubt in many cases it is also because of a genuine wish not to intrude into private grief. However, any signs of evasiveness are interpreted by the family as grounds for suspicion, and the institution itself is not helped to resolve its own trauma by a closed and secretive approach.

4.12 Institutions must not lose sight of their primary responsibility to the prisoner's family. The manner in which the news of a suicide is delivered to relatives is so profoundly important that it is likely to determine everything thereafter. **It would be good practice therefore to nominate a member of staff to act as a continuing personal link between the family and the establishment.**

The need for support for establishments

4.13 In our view the demands upon the governing Governor are not fully appreciated within Prison Service Order 2710. He or she has to support staff whilst attending to the grief of relatives and dealing with his/her own feelings. The new instruction, welcome as it is, is therefore only a start. **It needs to be supplemented by arrangements to deliver support to governing Governors so that they can in turn support their staff and engage meaningfully with the family of the deceased.** There appears to be no formal recognition that establishments should receive special support after a death or that the governing Governor may have a particular need for support. In the report of the review of suicide precautions at HMDC and HMYOI Glenochil, led by Dr Derek Chiswick in 1985, paragraph 10.3 reads:

" We do think that if a suicide occurs, there is a requirement for added sensitivity and support from central administration".

4.14 Although we are aware that SASU currently delivers informal support **we recommend that a skilled and knowledgeable liaison person from Headquarters is always allocated to an establishment to work alongside the governing Governor in the crucial period following a suicide.**

4.15 Other crucial aspects to be addressed within instructions to governors following a death are:

4.16 The speed in getting the news to the family as they may wish to see the body as soon as possible, especially prior to the post mortem. They need to know where the body has been taken and may have a long journey to make. This issue is addressed in a new order issued by the Prison Service.

4.17 The importance of the Governor offering to attend the funeral, and that

this offer is made in such a way that the presumption is that the Governor would like to be present, subject to any clear preference against this.

4.18 The importance of staff understanding that families may be angry with them. Feelings of anger are natural at this time and staff should be helped to understand this and not to take the anger personally.

4.19 The need for training for staff in helping the bereaved. This is a specialized area and should not be left to chance. Training should be prepared in conjunction with an external organization such as CRUSE or the Samaritans and should take staff through the detail of how to refer to the deceased, how follow-up contact should be managed and include awareness of the feelings that accompany a self-inflicted death in families, prisoners and themselves. Staff should also be trained to be in a position where they can offer good practical advice to relatives about how they can make contact with bereavement counsellors.

Examples of good practice in helping bereaved relatives

4.20 Prison Service Order 2710 encourages establishments to offer information to relatives about external organizations which might be able to offer help and advice. However, there is as yet no evidence that either Inquest or Prison Watch are being used in this way. Establishments more often perceive them as being against the prison. Not all families will need or want the support of organizations such as Inquest but most who have made contact with this organization have been very appreciative of their specialized support.

4.21 Another example of thoughtfulness was related directly to us by a couple who were deeply touched to receive from the Governor of a prison in which their son had been held, a video which featured their son. This one gesture gave these parents a piece of their son's life which they had not known about and was received as a precious gift. It is of course a matter of fine judgement as to whether an offer like this would be welcome. Good practice would be to consider offering something to the family as a reminder of their loved one's recent life.

4.22 Being able to speak to staff who had recent contact with the deceased, especially the last person to have contact has also been experienced as helpful. We quote the emptiness felt by the mother who said:
"I could not find anybody who had spoken to my son in the three days he was in the Health Care Centre".

Contacts should be encouraged between the staff most recently involved with the deceased and his/her family.

4.23 Dialogue with families may reveal important information to assist in piecing together what happened. One couple told us:
"Our son had rung the night before and we had stayed up all night worrying about him and what we should do – fearful that we might make it worse for him if we rang the prison. He was already on medication and we thought they might put him in a straightjacket".

Investigations

4.24 When someone dies in prison custody, several investigations are set in hand and proceed in parallel, the Prison Service internal investigation, the coroner's inquest and possibly a police investigation. It is the first two of these which are most significant for this review. It has also been recently established that all prison deaths are referred to the National Confidential Inquiry (which is an ongoing exercise by the University of Manchester on contract to the Department of Health to look into self-inflicted deaths in England and Wales, with particular reference to those where the deceased has used psychiatric services prior to his/her death).

The Prison Service Investigation

4.25 Prison Service Instruction 36/1998 establishes a revised method of

investigation from 1 April 1998. It is designed to achieve a better quality inquiry but unfortunately includes only the barest reference to the feelings arising from a death and to the needs of families. It is obviously early days for the new procedures but, it is vital that new-style investigations emphasize:

- that the purpose is to get at the truth of the events leading up to the death
- a clear chronology of key events to be sure that decisions taken at the time are assessed in the light of information known at that time
- a rigorous test as to whether the systems recognize the whole person at the centre of them
- how greater openness will come about.

4.26 The areas to be covered specify "how its aftermath was handled" but there is no further definition as to how the investigator will reach a conclusion. There is no mention of informing relatives that an investigation is underway or what it will cover, far less how they might be involved. Only the most cautious of references appears in paragraphs A2.3 as follows:

"Care must be taken in considering how evidence from relatives/close friends of the deceased might be taken. In some instances it may be preferable for this to be channelled through the Governor; in other cases it may be possible for the investigating team to take comments directly. Where this happens great care must be taken in recording the exchange, whether by phone or face to face, and the coroner's office must be consulted beforehand where possible".

4.27 There is of course a difficult balance to be struck between openness and caution, given the very real possibility of litigation, but the most important people should not be excluded from the outset. Families are entirely dependent on the prison authorities for information at this stage. Feeling distanced from events, with a range of practical problems looming – how to get to the prison, paying for the trip and the funeral etc – may leave relatives in such turmoil that they will not know what to think or feel or where to direct their feelings. It is easy to see how barriers, real or perceived, can arise in such circumstances. It is the responsibility of the Prison Service at this critical point to ensure that they act honestly, sensitively and with proper regard for the family's situation.

4.28 The Prison Service Order should be reconsidered to give greater recognition of the place of families in this process; firstly, to take account of the help they could offer and secondly to acknowledge their legitimate interest in the process.

4.29 We examined several reports of the new-style investigations. None made any mention of the funeral or if a Governor's representative attended, or offered to attend; and merely recorded the facts of who notified the family and a brief comment about the likelihood of any difficulty, e.g. litigation. The question arises as to who ought to be responsible for a quality judgement of how the Governor handled the follow-up. **The Prison Service Order should be amended to require the investigator to examine the handling of events after a death, including all affected parties, and in particular the relatives, in order to assess whether Prison Service Order 2710 has been fulfilled.**

4.30 The Deputy Director General should personally satisfy himself that the Area Manager has considered the implications of each investigation and introduced changes where appropriate.

4.31 Consideration should also be given to how an assessment of each case by the National Confidential Inquiry should help the Prison Service.

4.32 It may not be possible for the Prison Service to reveal to the relatives the complete investigation report, due to the possibility of disciplinary action or the revealing of security information. However, all parties should have confidence in the

integrity of the investigation process and its recommendations. Therefore **independent monitoring of investigations should take place and the results published. We recommend to the Secretary of State that the remits of either the Ombudsman or Her Majesty's Chief Inspector of Prisons are recommended to take account of this.**

The coroner's role in the inquest process

4.33 Coroners are independent judicial officers whose powers and duties are defined by law and by regulations and who are assisted by officers who make enquiries on their behalf. The inquest is an inquiry to establish the identity of the deceased and how, when and where he or she died. If a death occurs in prison custody, the inquest must be held in front of a jury, and it is the jury who makes the final decision, i.e. return the verdict. The inquest is based on an inquisitorial process. Most people's perception of a coroner's court will be based on their understanding of procedures in the criminal courts. They perceive proceedings as a trial rather than an investigation. Most relatives have little idea of how they can be involved.

4.34 The inquest is usually formally opened soon after the death, but the full hearing can take many months to be heard and we have been made aware of one case in which an inquest had not been held more than two years after the tragedy. Delays are due to many factors but are regrettable because they tend to fuel suspicions that information is being withheld. In the interval, families prepare for the hearing, and are greatly assisted if the coroner and the prison work in close co-operation with each other.

4.35 To assist families understand this process, the Home Office provides coroners and other agencies with a leaflet "The work of the Coroner" for distribution as they see fit. In the absence of any specific responsibility for their issue however, not all families of deceased prisoners receive them. Coroners told us that the expectations of families could be raised inappropriately by false information and that it was therefore important that official information was provided at an early stage.

4.36 The coroner's officer may play a valuable role in the interval between the inquest being opened and the hearing being completed. Families should know what they are entitled to request of the coroner, e.g. for certain witnesses to attend. To do this they need to have access to the prison information to enable them to know who are the likely witnesses and to judge the relevance of what they might know. Given that many families cannot afford legal representation they should receive clear guidance on their rights and responsibilities. At the present time the procedure is shrouded with mystery and the coroner may be perceived as representing the same legal authority which sent their family member to prison and failed to protect him or her whilst there. **The Prison Service and the Coroner's Unit in the Home Office should examine the present information available for families in these circumstances and should consider whether better guidance, perhaps jointly prepared and issued, might help to clarify the distinction between the respective responsibilities of coroners and governors.**

4.37 One mother related how supportive the coroner's officer was by simply keeping in touch regularly to tell her what was happening, and by doing so in a sensitive manner. By initiating the contact he made her feel she was not forgotten and recognized her need to know, rather than leave her to chase for information. **The provision of timely and clear information about the inquest to the relatives is critical. It is important for regular and sensitive contact to be maintained with them until the inquest. Coroners officers are best placed to perform this function.**

4.38 For coroners to carry this out successfully they need to have sufficient understanding of what the family can expect from the prison, both in the period immediately after the death and in the

follow-up stages. **Their training should therefore include issues peculiar to deaths in prison and in prison procedures for follow-up. This might be achieved by their participation in Prison Service training, firstly, to explain their own role and, secondly, to gain sufficient understanding of the Prison Service policy and practice in this area.**

4.39 Families have been critical of the court room atmosphere during the hearing and of the adversarial tone that can develop, partly because there is no legal aid available for them. They feel disadvantaged when they see the weight of the other "side" represented by the number of official witnesses and their legal representatives and the bulk of papers on display. By virtue of their experience, prison staff appear to know how to behave in such circumstances, and so are less intimidated by the event.

4.40 Staff attending as witnesses need to be aware how their demeanour affects bereaved relatives and be sensitive to their vulnerabilities. The training manual contains a module (also reiterated in the Prison Service Instruction) for preparing staff to conduct themselves appropriately in these circumstances. **Managers need to ensure that all staff appearing as witnesses are suitably prepared in line with the existing instructions.**

4.41 Coroners expressed the view that an early admission of any misjudgements on the part of the prison would defuse many of the difficulties that are evidenced in the court room but the defensive culture of prisons prevented this. **The Prison Service should carefully evaluate what it can do in this respect to clear the way for the inquest to carry out its proper functions.**

4.42 Many coroners do not have prisons within their jurisdiction and of those who do some have had fewer prison deaths to deal with than others. Coroners will therefore have different levels of awareness of what goes on in prison and the kind of pressures, which exist for prisoners and for staff. Jurors will have even less understanding of such matters, and will presumably rely on the evidence which the coroner draws out. At the very least, **coroners should be kept up to date with the Prison Service policies and procedures on suicide prevention.**

4.43 Every crown court now has a witness service run by the charity Victim Support and active consideration is being given to extending it into every magistrates' and youth court. Our view is that coroners courts by the very nature and purpose are bound to be dealing with very distressed witnesses, who are handling bereavement in unusual circumstances, even if imprisonment is not amongst them. The stresses peculiar to this judicial process will almost certainly put witnesses into very unfamiliar territories. **Consideration should therefore be given to offering a similar form of support for bereaved families in coroners' courts.**

THE EFFECTIVENESS OF CURRENT PRACTICE

Summary

- the Prison Service strategy 'Caring for the suicidal in custody' was basically well conceived but failed to give sufficient attention to the particular needs of women, young prisoners and those in local prisons.
- the implementation of the strategy failed because there was inadequate commitment and detailed attention from senior managers
- the effectiveness of Suicide Awareness Teams was variable
- communication among staff about prisoners who were suicidal was generally poor
- there was too much emphasis on filling in form F2052SH rather than ensuring the proper care of the suicidal
- training of staff should not just be about equipping them to assess risk of suicidal behaviour but enabling them to see that there are forms of support they can offer
- managers at all levels have failed to recognize the scale of the cultural shift that was needed to equip prison staff to care for suicidal prisoners to the extent that was expected
- support plans were often inadequate and in only half the cases were conferences held
- the work of SASU has been impressive
- although a vital part of suicide prevention is for officers to respond promptly to cell call bells, during inspections we have found long delays before staff have responded
- if the current strategy is properly implemented it remains appropriate for adult training prisons.

Background to suicide prevention in the Prison Service

5.1 In 1987 revised suicide prevention procedures came into effect in the Prison Service but the high suicide rate continued. The then Home Secretary decided in February 1990 that a further review was needed. He therefore asked my predecessor Sir Stephen Tumim "to review the effectiveness of the current policy and procedures for the prevention of suicide and self-harm in Prison Service establishments in England and Wales, with particular reference to the risks posed by mentally disturbed prisoners; and to make recommendations." His report was published in December 1990[17] and contained one hundred and twenty three recommendations which drew attention to the importance of the overall quality of life for prisoners and the effect it had on their sense of dignity.

The development of the Prison Service Suicide Awareness Strategy

5.2 In August 1992 the Prison Service published an information paper entitled "The Way Forward", as part of its work to develop a revised strategy towards the prevention of suicide. It incorporated a

[17] HMCIP (1990). Suicide and self-harm in Prison Service establishments in England and Wales. London: HMSO.

search of the literature, an analysis of suicides in prison both in this country and abroad, and commissioned independent research by Dr Alison Liebling at the Institute of Criminology in Cambridge into the behaviour and characteristics of male prisoners who attempt suicide or harm themselves. This produced lists of risk behaviours which should alert staff to suicide vulnerability, and of triggers which may hasten the onset of suicidal feelings. This gave rise to the present strategy as set out in a comprehensive folder, "Guide to Policy and Procedures – Caring for the Suicidal in Custody", issued under Instruction to Governors 1/94. It was implemented from April 1994 onwards through a 'cascaded' programme of training conducted by staff from each establishment who themselves had attended central training in the delivery of the modules.

5.3 Pivotal to helping establishments implement their suicide prevention strategies has been the role of SASU. Their sensitivity to the issues surrounding the occurance of suicides has been to the credit of the Prison Service.

Main policy features of the suicide prevention strategy

5.4 The main features of the 1994 strategy were:

- greater responsibility for all prison staff in caring for the suicidal
- a move away from reliance on health care staff
- a new form for managing those considered as being at risk (F2052SH)
- involvement of The Samaritans
- the development of Listener schemes.

5.5 There follows an assessment of the way in which the strategy has been implemented. This is based on an analysis conducted at our request by Boards of Visitors, from our own field work and from information collected within inspections. Copies of a questionnaire were sent to the Chairperson of every Board of Visitors asking for details of how the strategy was being implemented in Part A, for an analysis of 10 F2052SH forms in Part B and for details about the regime and quality of life for prisoners in Part C. The full questionnaire and analysis of the replies are contained in Appendix 5A to C. Where differences emerge between the answers for local and training prisons these are reported separately. (Appendix 5A II and 5B II.)

Policies for the prevention of suicide and self-harm

5.6 Virtually all BOVs indicated that their establishment had a policy and a Suicide Awareness Team (SAT) and this applied equally to local and training prisons. Policies were displayed mainly in residential areas, health care centres and in reception and made known to staff through training and notices. SATs met mostly quarterly, with the rest meeting monthly. Only 5 per cent of SATs met less than quarterly. This did not seem inappropriate. It might be expected, for example that a team would meet less frequently in an open prison than in a local prison.

5.7 From our review however there has been an evident inconsistency in the effectiveness of different Suicide Awareness Teams. Some have been energetic and imaginative and have played a large part in influencing the performance of their establishments. Others have been weak and ineffectual. **Suicide Awareness Teams should always review 2052SHs since the last meeting. The onus should be on senior line managers to make clear that they are only interested in outcomes as far as the work of Suicide Awareness Teams are concerned.** *Several establishments, both local prisons and others, have included a representative of the appropriate escorting contractor as a member of the team. This seems a very good practice for all establishments to adopt.*

5.8 Another example of good practice which we commend is that in operation at HMP Liverpool, *Probation Officer carries out non medical-interviews of all prisoners following incidents of self-mutilation. Comments from these prisoners and issues which arise form part of a quarterly report which is distributed to members of the Suicide Awareness Committee.*

5.9 The aims of the interviews and the subsequent reports are to generate discussion about common triggers for self-mutilation which might be prevented. The model recognizes that regime factors are equally important in triggering self-harm as features of the individual personality.

5.10 He writes of the benefits 'Most were eager and relieved to talk. In a good number of cases I was left asking, "Did the prisoner really need to do this in order to get attention?" Responses required to relieve some of the immediate anxieties were often as simple as a phone call to family or an acknowledgement that someone/the regime listened and understood what they were saying' (Merseyside Probation Service, HMP Liverpool 1/3/98 – 31/5/98)

5.11 Questions included:

Was there anything that could be identified that may have helped the prisoner prior to the incident? How many harmed themselves before when in custody? How readily available is this information at reception? How important is an active regime? It was found at Liverpool that around 75-80% of those who self harmed were unemployed.

5.12 This process of good practice was expected to identify patterns to the behaviour that indicated where the Suicide Awareness Team might intervene; for example there was a recognition that prisoners in court cells awaiting escort to prison should be handed a clear statement of what to expect when they arrived in the reception area of the prison. Also recognized was the importance of staff/prisoner relationships and the culture that pervaded the prison.

THE NEED FOR DIFFERENT STRATEGIES FOR DIFFERENT GROUPS OF PRISONERS

5.13 Although policies were in place across the Prison Service, there was little differentiation within them between the needs of different types of prisoner.

Young People

5.14 The need for different strategies was emphasized by one governor of an establishment holding juveniles who said that for his population the need was not so much suicide prevention as strategies for self-harm linked to distress and unhappiness.

5.15 Young people in prison are more vulnerable and impulsive than most adults. Young people in general and young prisoners in particular (and those on remand even more so) are impulsive, uncertain and changeable. A study by Thornton (1990)[18] reported that one in eight had a history of self-injury. Young offenders often have limited understanding of the consequences of their actions and little sense of future. Classically, they are at a formative stage and highly susceptible to influence. They need adults whom they can trust and talk to. Arguably, professionals who work with adolescents at risk have an extended duty of care; for example, the role of the personal officer as significant adult, role model and a help to a young person in distress. For the children and young people in custody they are in "loco parentis", at least in spirit if not in law. Any death by suicide is devastating, the untimely death of a child or young person seems particularly tragic. The impact of a young death on family and on staff is likely to be profound. Most young attempters seem to be highly ambivalent: sure of wanting to be dead now, but not sure about later.

[18] Thornton, D. (1990). Depression, self-injury and attempted suicide amongst the YOI population. In N.L. Fludger & I.P. Simmons (Eds.), Proceedings from Psychologists' Conference 1989. DPS Report Series 1, No 34 (pp 47-55). London: Directorate of Psychological Services.

5.16 There is an extra ethical dimension to work with this age group. Comparatively few teenagers commit suicide in prison, but attempted suicide and self-mutilation are particularly prevalent in the 15-25 years age range. While completed suicide figures are steady or reducing, figures for attempts and self-mutilation are rising in the general population for this age group. For many young people self-mutilation is seen as a coping mechanism and/or as a way of expressing distress.

5.17 These issues are brought out in detail in HMCIP's thematic review 'Young Prisoners' (October 1997). Staff need good training and on-going support and supervision so that they can:

- understand suicidal behaviour in the context of adolescent risk taking, the early onset of mental health problems, the experience of loss and poor coping
- understand and manage the impact of work with disturbed and disturbing young people
- be someone to talk to and someone who can seek specialist help when needed.

There should be focused policies for self-harm behaviour in establishments holding young people.

Female prisoners

5.18 This review acknowledges gender differences and is critical of staff training which fails to address the needs of women prisoners (see also HMCIP's thematic review 'Women in Prison' March 1997). Particular concerns in relation to suicide include:

- reliance on prescribed medicines in prisons militates against the creation of a healthy environment
- much has been written about both the social construction and the prevalence of depression in women in the general population, especially those with young children. The depression is no less real for it being in custody. The research by Liebling (1992) indicated that women are more affected by separation from their families than by aspects of prison regimes. The conflict between incarceration and continuing to maintain responsibility for family and household, inevitably impacts on mental health. Constructive ways to help women deal with depression are included in the Trust for the Study of Adolescence training programme
- exceptionally high levels of abuse have been documented. Abuse and broken relationships are probably the two most critical factors in relation to women's self-destructive behaviour. An increased understanding of the impact of abuse, a knowledge of how to help and the limits of work in a prison setting, active support for and maintenance of self-help groups and information about sources of specialist help are all essential for staff. The information sheet for staff on helping sexually abused women provides a good starting point. It was produced by the Psychology Department at Holloway and is included in the TSA training pack on "Understanding and Working with Young Women in Custody"
- distressed women will often mutilate themselves. Staff need to know this and understand both the self-loathing which often stems from the experience of abuse and the powerlessness which can lead to the use of self-mutilation as a way of coping with and expressing distress. Bodily harm is a key issue in women and mental health. Deliberate self-mutilation and eating disorders are specific examples. Staff need to be prepared for this and encouraged to help women find other more acceptable ways to seek help and express distress.

There should be focused policies for self-harming behaviour in establishments holding women.

Gay prisoners

5.19 Young people who are gay can be seen as particularly vulnerable to the risk of suicide or self-harm. This is not because of their sexual orientation as such, but due to their isolation, fear of being misunderstood or abused, and lack of people to trust and talk to. **Again we stress the importance of increasing understanding and tolerance of diversity.**

Communication

5.20 Staff spoken to during the field work stressed the importance of effective systems of communication about at risk prisoners within establishments, between establishments and between establishments and external organizations. This is especially important in local prisons in view of the high turnover of prisoners and number of new receptions who have no previous prison experience.

5.21 Information from families can be vital at this stage, not only for the sake of the knowledge itself but also for the message conveyed to families about their worth. Trying to get past a switch-board operator when you do not know who to ask for or where your family member is located must be very difficult especially when worried. To get a response from someone who welcomes the contact must seem like a God-send to an anxious person. **Staff should know that they are expected to receive such information, assess it and act upon it. It is necessary therefore for every establishment to have nominated staff to receive calls from people who are anxious about individual prisoners and this should cover a 24 hour period. Information should be properly recorded so that it can be assessed and followed through.**

A mother:
"I had telephoned the prison to warn them of his depressed and potentially suicidal state. Professionals that had had contact with him, rang to do the same. These warnings were unheeded. It seemed that no one cared. I feel his death was not prevented due to lack of communication in the prison".

A mother:
"He had been identified as a risk on a previous stay in the same establishment one month earlier. When he went in again his previous screening was not looked at. They said they did not have time to consult previous records. He went onto a wing other than the normal one for new receptions and staff seemed to have no information about him".

A father:
"I have been told there is no record of the form (a POL 1) that should have gone with him to inform the prison of a suicide attempt at a police station when he was first arrested. Warnings of my son's condition were in place, written and verbal. These and guidelines should have triggered some action or care plan to be drawn up".

5.22 Overall, the performance of the Prison Service in communicating essential information about prisoners within institutions themselves, between establishments and between establishments and external agencies, including families, was significantly weak. Examples of good practice were far outweighed by other examples of sloppiness and lack of care. It is important to record how frequently we found juveniles in custody with little or no information from agencies that had dealt with them in the past. We also frequently found that health care records were not available for assessment purposes. **Systems for prompt retrieval of histories from previous periods of custody, whether in the same establishment or from elsewhere, and from external agencies need to be in place so that full screening can be done.** *The practice at Doncaster where night nursing staff obtained previous records and read through them, seemed to us to be an extremely constructive use of the night hours. The computer system installed at Chelmsford prison by Essex Health Authority to allow rapid access to health information was a further example of good practice.*

Training

5.23 Part of the new suicide strategy was to introduce awareness training for all prison staff. BOVs indicated that the levels

of training completed were very variable. An analysis of questionnaires from 593 prison staff about their training in suicide prevention carried out during full inspections revealed that 68 per cent had had no training. We observed some 'Training for Trainers' and initial prison officer training and the majority of the time was spent on understanding how to use the F2052SH forms. Although this is important we believe that there should be more of an emphasis on skills than an awareness about risk factors and rather than how to fill in forms.

5.24 Staff are not confident to approach those they may believe are at risk if they do not know how to do so, and are frequently reluctant to discuss suicide with someone they suspect to be suicidal for fear that they might trigger the very action they are seeking to prevent. This has been addressed in Professor Gunn's report on suicide prevention policies at Doncaster prison. He states:

*"… **This point relates to a fairly universal myth in the general community, which is that asking about suicidal ideas puts suicidal ideas into a person's head and is likely to increase their risk of suicide. There is no evidence for this whatsoever; indeed the contrary is strongly supported by data and clinical experience. Of course if an individual without suicidal ideas is constantly badgered by someone constantly asking about suicidal ideas they may become irritable and use a few choice words, but they would not by that simple process become suicidal.***
Staff should be trained, encouraged and supported to face this difficult subject".[19]

5.25 The Prison Service should therefore define the objectives of the training and the desired outcomes in terms of staff performance on suicide prevention and review the delivery of staff training to achieve them. Line managers should also ensure that the training objectives are achieved.

Prisoner Support Schemes

5.26 In recent years the Prison Service has started to recognize the value of prisoners supporting other prisoners. We support the development of informal and formal structures which make use of the ability of prisoners in this way. This is particularly important for women and young prisoners.

5.27 Listener schemes were introduced in the new suicide prevention strategy as a means of enabling suitable prisoners to help other prisoners, recognizing that they are frequently well placed to understand the feelings involved and accepting that some prisoners may be more likely to share their feelings with a fellow prisoner. The schemes operated according to the principles of the Samaritans. Listeners are selected, trained and supported accordingly and within this scheme a Listener can always disclose information to either the Samaritans or another Listener in order to obtain suitable support and guidance. Further disclosure is not made without the prisoner's agreement. Our survey indicated that payment to Listeners in cash or in kind was made in only 10 per cent of establishments.

5.28 Boards of Visitors reported that most establishments had listener schemes and that these usually featured as part of the local suicide prevention policy. However, training establishments were more likely to have schemes (86 per cent) than local establishments (77 per cent) and prisoners had 24 hour access to listeners more frequently in training prisons (79 per cent) than in local prisons (69 per cent), which is disappointing given the importance of suicide prevention in local prisons. However the practice of noting on LIDS against the prisoner's name when an F2052SH is opened occurred in 95 per cent of local prisons as opposed to 61 per cent of training establishments.

5.29 Listener schemes were mostly supported by the Samaritans in all of the areas of selection, training and support, though there were other schemes involving

[19] Gunn, J. (1998). Suicide Prevention Policies at Doncaster Prison – a personal review.

prisoners helping other prisoners developed at a few establishments, which were neither supported by The Samaritans nor run on their principles, notably at Doncaster with its Buddy Scheme, and at Wayland. The key difference in these schemes was that a form of privacy was the foundation rather than total confidentiality. Certain matters could thereby be shared with staff without the prisoner's consent, and this was well publicized to all prisoners who used the scheme.

5.30 It was a strong conclusion from this review that prisoner support to other prisoners was highly valued by those vulnerable to suicide. The positive effects on the self-esteem and confidence of those prisoners acting as Listeners should also not be underestimated. *The progress facilitated by SASU within the Prison Service in recognizing the support that prisoners are able to offer each other and developing formal schemes to enable this to happen is hugely commendable.*

The Samaritans

5.31 There has been a very significant involvement of The Samaritans with the Prison Service in the last decade. We wholeheartedly commend the work and dedication of an organization, which depends entirely on volunteers. BOV questionnaires indicated that Samaritans visited regularly in 93 per cent of establishments, in most either weekly (56 per cent) or fortnightly (22 per cent) and mostly to attend meetings (85 per cent) or support listeners (73 per cent). There was however a dedicated phone line to the Samaritans in only 40 per cent of establishments. We believe that there should be a clear directive as to whether these should be provided or not and **we recommend that the Prison Service reviews the value of this arrangement and issues such a directive to prison governors.** **Similarly with the provision of crisis, care or befriending suites.** These were in place in 32 per cent of local and 40 per cent of training prisons, but we were unable to discover the extent of their use. **If they have value then they should be available more widely.**

5.32 To encourage their continuing involvement Governors need to ensure that they contribute towards the Samaritans work in whatever measure they can, commensurate with the amount of work that their local Branch is able to perform. Volunteers tend not to be good at asking for money from those they serve nor would it be their style to easily withdraw their services for the want of payment. However some branches do not receive anything from establishments. Governors should take the lead in this and arrange a basis for payment of expenses to support their prison work. **The Prison Service should ensure that Governors implement the existing instruction.**

Personal Officer schemes

5.33 Implicit in the involvement of prison staff with suicidal prisoners is a degree of continuity of staff attendance and deployment which, in practice, was frequently missing, especially in local prisons (see Chapter Six). The sentiments of the local prison governor who was quoted in the Tumim Report, are still relevant today:

"My own view is that the ethos of an establishment, how inmates are treated, will determine the amount of suicide and self-injury. While I understand the need for form-filling and insurance policy type activity, it is not a substitute for investing in time spent with staff. Firstly, letting them know that it is part of the culture to demonstrate concern for inmates, and secondly, showing them ways of letting it show".

5.34 Each prisoner should be allocated a personal officer who is the key worker in helping him/her deal with problems and is proactive in custody or sentence planning and in reviewing progress.

5.35 In the survey which Boards of Visitors carried out for this review, they told us that although 87 per cent of establishments had schemes in name they varied in effectiveness. BOVs estimated that Personal Officers were known to prisoners more often in training prisons (mostly or all known in 81 per cent of

cases) than local prisons (mostly or all known in 67 per cent of cases). In training establishments the prisoner population is relatively settled and staff continuity relatively good. From inspections we have found that many personal officer schemes, particularly those in local prisons, were hardly worthy of the description. The performance of the Prison Service in ensuring that prison staff, but particularly officers, engaged constructively with prisoners was, at best, patchy. Managers at all levels have failed to recognize the scale of the cultural shift that is needed to equip prison staff to assess and care for suicidal prisoners to the extent that is required.

The contribution of prison staff

5.36 We fully endorse the development of the role of all prison staff in suicide prevention. Officers, instructors, teachers and other specialists are after all in regular contact with prisoners as part of their day to day work and should therefore be well placed to observe changes in mood or patterns and hold responsibility for making the strategy work. We entirely agree with Joseph Rowan an expert on suicide prevention, whose work has mostly been concentrated in New York State and Florida, and who was heavily involved in the work to develop the present strategy. He has said:

"The discipline officer is the backbone of suicide prevention".

The "At Risk" Form – F2052SH

5.37 This form is opened when any member of staff considers a prisoner to be at risk. It was designed in considerable detail to manage the measures to be taken to support an individual at a time of a suicidal crisis to the point where risk was reduced and the form could be closed. The form is only intended however as a framework and following the stages of the form should not be the end in itself. Writing on the form is not what sees someone through a crisis. If the contents become cliched and repetitive, the piece of paper becomes meaningless, and worse, staff quite wrongly feel they have done their job. This is not to argue against the role of the form, but to emphasize that it is not the most important feature of the strategy and it should not be relied on as the sole mechanism for intervention. The most important outcome of any process is that the prisoner concerned receives the help he/she needs to get through the crisis.

5.38 The BOV analysis indicated that F2052SH forms were opened in local prisons more often by health care staff (38 per cent) than officers (27 per cent), whereas for training prisons this was reversed with officers more likely (40 per cent) than health care staff (24 per cent) to open a form. This was also reflected in the location the prisoner was moved to. This was the Health Care Centre in 46 per cent of cases in local prisons in contrast with 19 per cent of cases in training prisons. The 'at risk' prisoner was more likely to be managed on normal location in training prisons (54 per cent) than in local prisons (33 per cent).

5.39 A case conference was more likely to be held in training prisons (62 per cent) than local prisons (53 per cent) and was more likely to be held for men than for women in both prisons. In local prisons case conferences were held for men in 60 per cent of cases and for women in 41 per cent. In training prisons the proportions were 67 per cent for men and 61 per cent for women. The prisoner was far more likely to be present at the case conference if he was male. Sixty per cent of men were present in local prisons as opposed to 11 per cent of women, and 49 per cent of men were present in training prisons as opposed to 37 per cent of women.

F2052SH Liaison Officers

5.40 The Prison Service policy required F2052SH liaison officers to be appointed. This very valuable role combined staff support, monitoring and training on the spot in a very active way. Using staff in this valuable role was not fully exploited by managers in the Service. Some establishments had appointed more liaison officers than others and it was clear to us that the number should match the size of the establishment.

5.41 Some of the strengths and weaknesses of the F2052SH forms have led us to recommend the following:

- **jargon should be avoided**
- **a member of the Suicide Awareness Team should read and sign the forms weekly and discuss with the staff who made the entries**
- **the view of the prisoner about why he/she is feeling suicidal should be recorded**
- **there should be a daily briefing of staff about those prisoners on open forms**
- **a photo should be attached to each open form**
- **meaningful entries can best be made by staff who feel comfortable to sit in a cell and talk to the prisoner**
- **Suicide Awareness Teams should analyze F2052SH forms regularly to help to understand the relationship between staff concerns, self-harm behaviour and suicidal actions**
- **managers should challenge inadequate entries on F2052SH forms.**

5.42 Managers at all levels, including Area Managers and above, should therefore sample F2052SHs regularly for quality to ensure they support a whole prison approach and to check the outcome for individual prisoners.

Support plans

5.43 The appendix gives full details of the BOV analysis of support plans. These were drawn up in both local and training prisons at about the same rate (64 per cent) but suffered from several deficiencies. Support plans were often inadequate, poorly written and without support observations. There was an initial conference in only between one half and two thirds of cases which gave evidence that the system was not working. If the strategy is to meet the needs of individual prisoners, then the opening of the form should be only a start and the case conference and support plan are essential. The only conclusion to come to was that **managers at all levels had not been ensuring that case conferences took place in every case.**

Closing the form and aftercare

5.44 It is the responsibility of the manager of the unit in which the prisoner is living to decide during a conference whether the form can be closed. We found that staff had great anxiety about deciding whether a form should be closed because of genuine concern as to whether the suicidal tendencies had abated. Unless case conferences are held it is very difficult to make sound judgements because staff do not become practised in making these assessments. The relatively low level of prisoner participation in case conferences, particularly for women, reflected a hesitation on the part of many staff to talk to prisoners directly about their suicidal thoughts. This left staff poorly equipped to reach a conclusion. Officers stated to us their concern about being blamed later if things went wrong. **If managers ensured that the policy was followed properly these anxieties would be removed.**

The impact of regimes

5.45 The last part of the BOV questionnaire asked about features of the regime which affected the well-being of prisoners. These were analyzed for local and training prisons separately and the following emerged:

- the routine was disrupted more often in local prisons (38 per cent) than in training prisons (11 per cent)
- the environment was estimated as free from bullying in 27 per cent of local prisons but 50 per cent of training prisons
- induction was thought to equip prisoners to seek assistance with problems in 56 per cent of local prisons and 80 per cent of training prisons
- prisoners were judged to have sufficient time out of cell to build relationships which could be sustained in 51 per cent of local prisons but 88 per cent of training prisons
- relationships were judged to be of a quality where prisoners could

approach staff to discuss their problems in 69 per cent of local prisons and 81 per cent of training prisons

- prisoners were judged as believing they could receive individual care and attention in 48 per cent of local prisons and 70 per cent of training prisons.
- each prisoner was judged as being able to take part in daily purposeful activity in 55 per cent of local and 81 per cent of training prisons
- opportunities for self expression were judged as available to prisoners in 39 per cent of local prisons and 78 per cent of training prisons
- decisions were judged to be perceived as fair and adequately explained in 36 per cent of local prisons and 59 per cent of training prisons.

5.46 Clearly the regimes available in local prisons were more likely to cause frustration, irritation and aggression and less likely to offer support than the regimes in training prisons.

Observation of suicidal prisoners

5.47 For many years the Prison Service operated fixed intervals to observe prisoners at risk of suicide. The Tumim Review on Suicide published in 1990 strongly pointed to the dangers of this practice and recommended that the period between observations should be made according to the perceived needs of the individual prisoners concerned. This was endorsed in the Prison Service suicide strategy.

5.48 However, it was clear from the review that, more often than not, establishments had persisted with traditional fixed interval checks. **Managers should ensure that the Prison Service policy on observing prisoners at risk of suicide according to their individual need is fully implemented.**

Isolation

5.49 The suicide awareness strategy is based upon a prison community approach, which encourages supportive relationships in the belief that a suicidal prisoner can be helped to cope, subject to his/her willingness to receive the help on offer. The environment in which the prisoner is placed should be as normal as possible. Shared accommodation is the preferred approach, especially for those newly received, although the particular needs and wishes of an individual should be taken into account. The emphasis for care of in-patients is on the use of ward or shared accommodation, unless there are clear reasons to the contrary.

5.50 In a survey of the use of seclusion in four in-patient units inspected in 1997/1998 36 patients were secluded. An episode of seclusion lasted on average 50 hours. An analysis at a large local prison found that there had been 195 episodes of seclusion in 1998 each lasting on average seven hours. Virtually all episodes of seclusion in health care centres were because of risk of self-mutilation. They all resulted from there being too few staff to provide a more humane and effective response.

5.51 None of the Governors who wrote to us on the subject were keen on the use of seclusion rooms. A number advocated the judicious use of isolation but others suggested that to end the use of seclusion rooms altogether would force senior managers to look for more humane ways of managing the suicidal. Some Listeners said that the degrading impact of being put in a strip cell was compounded by the associated procedures of having normal clothing removed. We fully endorse the opinion of Professor John Gunn in his recent report on suicide prevention policies at Doncaster prison:

"Seclusion is a nursing technique on the one hand and a punishment strategy on the other. It is a useful nursing technique in the management of highly disturbed, usually psychotic, and violent patients who are a danger to others. It is never used in a hospital setting for suicidal patients because it is a

depressing experience that can increase suicidal ideas … In short, seclusion is anti-therapeutic".

5.52 Some prisoners sought to be put in unfurnished rooms but many commented on how it made them feel worse. We believe that there is still too much reliance on isolation in some form. **There should be much more rigorous management checking of the procedures and reasons for employing this measure both in segregation units and health care centres. The first principle should always be that no one who is identified as actively suicidal should be left on their own.**

Emergency

5.53 Speed of access is vital in reviving someone who may be found after an attempted suicide, or who may have been injured or taken ill. Staff must never assume that death has occurred. This is especially important in cases where a ligature has been used, most commonly by hanging but also in a sitting or lying position. This was vividly described by a senior officer who spoke on a radio programme from Liverpool prison. After being called to a cell by a prisoner who had returned to find his cell-mate hanging he said:

"It was probably the worst thing I have ever seen in my life - to see this eighteen stone man hanging, his neck very thin, eyes bulging, tongue hanging out and for all intents and purposes we thought he was dead. Fortunately my colleague had a penknife on him and we elevated the body, cut the ligature from the window because it is impossible to undo the knot with the weight of the body, got him to the floor, cut the ligature from his neck, slapped him on the back and he breathed in ….."

5.54 A person may begin a suicide attempt and may have a change of mind and manage to summon assistance by pressing the cell call button or rely on the routine which may bring him to staff attention. A cellmate may be alerted by the prisoner or may be disturbed and find the prisoner after an attempt or staff may come upon a situation by normal observation. **Therefore every cell must have a system by which prisoners can call prison officers to the cell for assistance and it is a fundamental part of a prison officer's duty to respond promptly;** the above example illustrates the importance in preventing suicide.

5.55 During inspections we physically check the response of staff to cell call bells. On sufficient occasions to cause us great concern, we have found long delays before staff have responded and on some occasions there has been no response at all. We have also found cell call bells which have not been in working order which indicated that proper checks had not been made. There is little doubt that in some of these cases they had been deliberately muted. Staff told us that prisoner misuse of cell call bells led to an undermining of the need for an urgent response. Prisoners frequently told us that the only way to get immediate action was to kick their doors.

5.56 Clearly the proper functioning and response to cell call bells is crucial to any effective strategy to prevent suicide. **Managers must make it a continuous priority to ensure that the cell call systems are in working order and receive a prompt response day and night.**

5.57 The Prison Service has issued a recent instruction reinforcing the correct procedures for responding to suicidal behaviour. We endorse these contingency arrangements and find that staff, including night staff, are becoming more aware of their responsibilities in this area. However, some information we received indicated that staff were occasionally uncertain about entering a cell without sufficient support from colleagues. **Managers must ensure that staff respond appropriately to situations to meet the priority of preserving life.**

5.58 We consider that the Prison Service policy towards the prevention of suicide is fundamentally sound when applied in its entirety to training and dispersal prisons. The modern history of the Prison Service reveals that systems are only as effective as the competence and

commitment of the managers and staff who operate them. The Prison Service has demonstrated its competence and commitment successfully in several areas of its work and must now make it a higher priority to ensure that its suicide prevention strategy is equally rigorously implemented. **The creation of a suitable Key Performance Indicator for suicide prevention should be introduced into all establishments.**

LOCAL PRISONS

Summary

- local prisons and remand centres have a significantly higher rate of self-inflicted deaths than training establishments
- the rapid turnover of the population, the known vulnerability of prisoners to harm themselves soon after entering custody and conflicting operational demands mark out these prisons as requiring special attention
- the current suicide prevention strategy is not appropriate for local prisons
- similar problems to those found in English local prisons were experienced in New York City Corrections Department for which a specific strategy was drawn up. This has been shown to be effective in reducing suicides and has been considered as a way forward for local prisons in England and Wales
- a whole-hearted determination on the part of Ministers, senior managers and all Prison Service staff to reduce self-inflicted deaths can be effective in reducing suicides in local prisons
- a set of principles for a new strategy to meet the needs of local prisons and remand centres is presented
- practical suggestions for implementing the strategy are given.

"It appears:
That persons under remand or awaiting trial are more liable to commit suicide than those who have received sentence.
That prisoners in prison for the first time are more liable than others to commit suicide.
That persons who are guilty of violence to others are specially prone to commit violence on themselves.
That the motives for suicide are generally fear, depression, passion, unsoundness of mind, after effects of drink, and remorse."
From Prison Service Standing Orders 1933.

The incidence of self-inflicted death in local prisons

6.1 In December 1995 the Prison Service[20] concluded an operational review of the 60 self-inflicted deaths which took place between 1 January 1994 and 31 March 1995 for which inquests had been completed. This review demonstrated that the majority of the deaths (62%) had occurred in local prisons/remand centres. A high proportion of the prisoners (45%) were on remand or awaiting sentence and a third were in the first month of their sentence when they committed suicide.

6.2 A significant proportion of self-inflicted deaths occur in local prisons by comparison to any other type of establishment in England and Wales. Although 1997 figures showed a reduction in the percentage of suicides in local prisons (56%) on the 1996 figures (64%), the percentage in 1998 increased to 73%, see Table 1.

[20] SASU (December 1995) Review of self-inflicted deaths. Internal Prison Service report.

Table 1. The incidence of self-inflicted deaths 1996-1998 by type of establishment*

Type of establishment	1996		1997		1998	
	No	%	No	%	No	%
Local prisons	41	64	38	56	60	73
YOI/RC	7	11	11	16	8	10
Category B	5	8	10	15	6	7
Category C	4	6	4	6	3	4
Female	2	3	2	3	3	4
Dispersal	3	5	1	1	2	2
Court	1	1.5	2	3	-	-
Category D	1	1.5	-	-	-	-
Total	64		68		82	

* figures from Suicide Awareness Support Unit, Prison Service HQ

6.3 An analysis of incidents of self-mutilation by prisoners has also shown that a higher proportion of these incidents occurred in local prisons than in any other type of establishment. In 1997, of a total of 1,591 incidents of deliberate self-harm, 58% were carried out by prisoners in local prisons.

6.4 The extent to which self-inflicted deaths are more likely to occur in local prisons has also been established for previous years, fluctuating between 64% and 86% over a six year period.

6.5 When looking at the prevalence of self-inflicted deaths within a local prison environment, it is important to note that these have been occurring both in the sentenced and unsentenced populations, although the proportion of self-inflicted deaths in the unsentenced population is significantly greater than the proportion in the sentenced population.

6.6 Given that the percentage of suicides in local prisons and remand centres remains so consistently high, this is clearly where scope lies for making a real impact.

Pressures on local prisons

6.7 Local prisons and remand centres are the cornerstones on which the whole Prison Service in this country is built. It is these establishments which first receive people from court remanded for trial and then, after findings of guilt, hold prisoners until sentence and allocation. The impact of custody, coming to terms with the length of sentence of imprisonment, estrangement from friends and relatives and the isolation

Table 2: Self-inflicted deaths from 1985 to 1990 in prisons in England and Wales

	1985		1986		1987		1988		1989		1990	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Local Prisons:	25	86%	16	76%	33	76%	22	64%	33	70%	35	78%
All others:	2**	14%	5	24%	14	24%	15	36%	15	30%	15	22%
Total	27		21		47***		37		48		50	

* figures from Suicide Awareness Support Unit, Prison Service HQ

** 2 self-inflicted deaths were not included in the official statistics

***The figure in official statistics is 46 although there are 47 recorded in the book. This does not include the final entry for 1987, where the prisoner was classified as out of custody at the time of death.

Table 3. Self-inflicted deaths in local prisons 1996-1998 by custody status*

Custody Status	Self-inflicted deaths 1996		Self-inflicted deaths 1997		Self-inflicted deaths 1996	
	No	%	No	%	No	%
Sentenced	11	27	12	32	14	23
Remand	26	63	19	50	36	60
Convicted/unsentenced	4	10	7	18	10	17
Total	41		38		60	

* figures from Suicide Awareness Support Unit, Prison Service HQ

of being placed in a penal establishment all have a profound effect on those who are received into local prisons.

6.8 As the number of people imprisoned by the courts in this country has risen dramatically in recent years, there has been a deliberate policy on the part of the Prisons Board to overcrowd local prisons, in order to protect regimes in training establishments. In order to understand this policy, it is necessary to appreciate the real pressures which have been brought to bear on all prisons, but particularly local prisons, through prison population increases. The Prison Service is charged with holding all those sent to it by the courts, and has to make use of every available bed space, within every part of the prison estate, to avoid the expensive use of police cells. When running close to, or above, its certified normal accommodation capacity, the Service never has all the prisons it needs in which to accommodate every different type of prisoner in every part of the country. On average local prisons run at approximately 126% of normal capacity, but even they are constantly having to move prisoners to other establishments, on over crowding drafts, so that they have sufficient spaces to enable them to receive the next wave of prisoners sent by the courts.

6.9 During inspections we regularly encounter severely impoverished regimes for prisoners in local prisons. These are invariably over crowded, lack sufficient constructive activities for prisoners and adequate medical facilities. Despite this they are required to make budgetary savings year on year as part of the Prison Service strategy to meet the government's required savings.

6.10 Local prisons appear, currently, to be under three dominant imperatives:

1. to have sufficient spaces each day to avoid locking prisoners in police cells
2. to avoid escapes and loss of control
3. to reduce costs.

6.11 Local prisons and remand centres are organized in such a way as to ensure that these imperatives are satisfied, often at the expense of the needs of individual prisoners. Thus, for example, in HMP Nottingham, we were informed that in the six months prior to our inspection, over 400 prisoners had been transferred on overcrowding drafts, carried out at short notice with prisoners receiving only a few hours notice. They were despatched to all parts of the country. HMYOI and Remand Centre Feltham has continued to move each young person into one unit 36 hours before his court appearance. This is to make the logistical processes of discharging young prisoners to court on time easier to facilitate but pays no heed to the consequences on the well- being of the young prisoners concerned.

6.12 Obviously, there is no denying the importance of effective systems to preserve security and control, and provide a proper service to the courts, nor is there any denying the Prison Service's insufficiently well publicized success in

both areas. However, we now ask whether there is room for a further imperative: to target resources and introduce new systems for the management of suicide risk in local prisons.

6.13 Undoubtedly this would represent a very significant challenge but one to which we are confident that the Prison Service could rise. Only five years ago there was an acceptance within the Prison Service in England and Wales that a considerable number of escapes from prisons was inevitable. Yet, following the high profile incidents at Whitemoor and Parkhurst, a political commitment was made to stop them, affirmed by very significant financial resources to improve physical security, and an unmistakable message of accountability which defined the roles of managers and staff at all levels. What has ensued has been nothing short of a complete culture change with regard to security, such that escapes, even from low security establishments, are now rare. These improvements have been brought about directly through a combination of direction from the top, service wide commitment and dedicated resources. Success in improving security has demonstrated the capability of Prison Service staff. We are convinced that the Prison Service could as effectively improve its performance in reducing suicides in local prisons and remand centres if there was similarly consistent direction from politicians and senior management and a willingness to introduce the organizational changes that may be required.

New York City Department of Correction

6.14 In 1985 the New York City Department of Correction faced a rising suicide rate under similar pressures of maintaining security and reducing costs. Their total population of 17,524 in 1998 was similar in size to the remand population in England and Wales, with most being on remand and a small number serving sentences of no more than one year and one day (Prisoners serving longer sentences are sent to New York State rather than to city institutions). With the introduction of radical new systems and procedures the numbers of suicides have fallen by 64 per cent and been maintained at this level, with an average of 4 suicides per year over the last fourteen years.

6.15 From our observations it appears that the key features of the model are:

- *The creation of minimum standards for mental health*
  Driven by the Board of Correction, the main watchdog of prison conditions, the ever present fear of law suits has ensured that politicians and officials of the Correction Services have taken the implementation of mental health minimum standards very seriously. The American use of the term "mental health" embraces a much wider notion of an individual's emotional and social well-being than in the United Kingdom, where it is commonly used to refer to psychiatric state. This does not however imply that the New York City Department of Correction operates a medical model of suicide prevention. Many of those responsible for the care of those at risk have been recruited from backgrounds in social work and psychology.

- *The contracting out of health care to New York Health Services*
  A significant organizational difference is that the City of New York Charter holds the Department of Health responsible for the health, including mental health, of its prisoners, which is exercised through the Health and Hospitals Corporation which contracts out the services for most prisons. The Department of Health liaises with the Department of Correction to create satisfactory arrangements for the monitoring and management of the contract and to ensure the quality of the delivered health care. The Health and Hospitals Corporation run several wards in general hospitals to care for acutely suicidal prisoners. Prisoners are seen as patients in the care of psychiatrists and trained nurses, while security and control of

prisoners in these wards is administered by Corrections staff.

- *A commitment to reduce suicide and self-harm and a strong sense of accountability at all levels*
  It is noticeable that the commitment to reduce suicide and self-harm stretches right the way through the organization, from politicians, through the Commissioners who run the Service, through the wardens who run the institutions, and to every level of management and staff in each of the facilities we visited. From our visit we were left with the impression that avoiding suicide was seen as being as much the business of all Correctional staff as maintaining good security and control.

- *Staff training in mental health*
  One measure of the commitment of the New York Department of Correction towards suicide prevention is the training it gives to staff in being recognizing the symptoms of prisoners at risk. As part of basic training, every single New York Correction Service officer undergoes 40 hours learning about mental health issues for prisoners, including the identification of possible symptoms.

6.16 Obviously caution must be exercised when translating lessons from one culture to another. However, the model operated by the New York City Department of Correction affirms the practicality of the overall direction we are minded to take in this review, in seeking to develop the Prison Service's suicide prevention strategy as it applied to local prisons and remand centres.

A new strategy for preventing suicide in local prisons

6.17 In our view the current Prison Service strategy for suicide prevention, even if operated effectively, is not suitable for local prisons primarily because it is not geared to cope with the sheer numbers of potentially suicidal prisoners held in these establishments. Any new system for preventing suicide in local prisons must satisfy the following principles:

- there must be a total commitment to reducing suicide in local prisons from Ministers and the Prisons Board
- suicide prevention should be a top priority for all levels of management
- there should be much better training for all local prison staff in recognizing and responding to vulnerable prisoners
- there should be more effective initial risk assessment in reception
- all new receptions should be held for 48 hours under close observation in a dedicated induction area
- specialist trained staff should interview and support at risk prisoners
- all at risk prisoners should have a care plan
- there should be more use of prisoners to assist staff to prevent suicide
- there should be co-operation between specialist trained staff and health care staff.
- Each of these principles is further developed below:

There must be total commitment to reducing suicide in local prisons from Ministers and the Prisons Board

6.18 No suicide prevention strategy in local prisons and remand centres will be effective unless Governors, managers and staff in establishments are convinced that the Prisons Strategy Board and Area Managers are totally committed to it, and that everyone is accountable for the part they play.

Suicide prevention should be a top priority for all levels of management

6.19 In our view the following steps should be taken:

- **there should be an auditable standard for the suicide prevention**

strategy in local prisons which is adopted by all local prisons

- **this standard must cover the exchange of information between outside agencies and the prison, management systems, procedures and training**
- **the Governor should have in place, and take personal responsibility for the suicide prevention strategy for the whole establishment**
- **the operation of the strategy should be monitored**
- **Area Managers on visiting establishments should carry out personal checks to monitor the strategy**
- **one member of the senior management team should be held accountable for implementing and overseeing the suicide prevention strategy**
- **all managers should be accountable for the operation of the strategy in their specific areas**

There should be much better training for all local prison staff in recognizing and responding to vulnerable prisoners

6.20 Any successful strategy to reduce suicide in local prisons and remand centres must include much greater investment in awareness and skill training for front line staff, to increase their understanding of the factors influencing the mental well-being of prisoners. Such training should ensure that the whole issue of self-harm and suicide is placed within the context of a healthy establishment (see Chapter Seven) and the problems prisoners face on entry into custody.

6.21 In our view the following steps should be taken:

- **there should be a national training package for local prison staff, covering how to acquire, assess and interpret background information, victimization, recognizing at risk behaviour, action to be taken when a prisoner is believed to be at risk, checks to be carried out during specific periods of the establishment's routines, and managerial checks to be carried out at regular intervals**
- **the manager responsible for the suicide prevention strategy should ensure that all staff receive the national training**
- **every member of staff should carry a pocket sized booklet explaining symptoms of suicidal behaviour and what action to take**
- **there should be additional training for specialist staff acting as suicide support workers**
- **health-care staff should receive specific training in how to integrate their work with that of suicide support workers.**

There should be more effective initial risk assessment

6.22 On entry into the local prison from court, a more careful and detailed initial assessment should be undertaken. In reply to our questionnaires only 23% of medical officers who responded declared themselves to be totally satisfied with the thoroughness of the suicide screening process on initial reception. A secondary analysis of the ONS survey of psychiatric morbidity among prisoners in England and Wales carried out in 1997 by the Department of Health says:

"The correlates of suicidal behaviour allow for a more rigorous routine empirical assessment of risk than is often carried out, and there is a strong argument that all prison staff should be aware of these correlates, and trained to carry out risk assessments".

6.23 The Prison Service therefore can and now should introduce more thorough initial screening for suicide prevention. Any indication of a new reception being at risk should result in a referral to a suicide support worker. The following steps should be taken:

- **on entry into an establishment, it should be the responsibility of**

reception staff using an improved initial reception screening procedure to identify any prisoner who is at risk of suicide. (Useful guidance on serious risk factors can be found in Professor John Gunn's recently written report on suicide prevention at Doncaster prison)

- **all necessary information should be received from the court to assist staff in identifying those who are at risk**
- **court staff, probation staff, social workers for young offenders, police and escorting staff should be expected to ensure that 'at risk information' for a prisoner is conveyed to the establishment**
- **on arrival, reception staff should, on being informed of 'at risk information' inform his or her supervisor of this concern and ensure the prisoner is screened by a suicide support worker**
- **no prisoner so identified, should be left alone**

All new receptions should be held for 48 hours under close observation in a dedicated induction area

6.24 A full induction programme should be provided for all those entering prison for the first time. This should monitor behaviour as well as provide essential support and information. The induction programme should last for a minimum period of 48 hours during which time prisoners should be under close supervision from staff and trained prisoners in a dedicated induction area. **Cells in which new receptions and those identified as being at risk of suicide are held, should be free from ligature points.** We are encouraged by the ongoing efforts being made in the Prison Service to develop safer cellular accommodation for prisoners.

6.25 In our view:

- **an induction unit should include shared accommodation**
- **on the first night prisoners should be seen individually by a member of staff and given essential information**
- **on arrival in the induction unit, every prisoner should be given essential toiletries, reading material and a radio**
- **the induction programmes should provide prisoners with full information about how they will be treated and how to obtain help**
- **induction staff should observe and assess prisoners for signs of suicide risk.**
- **trained prisoners should also have a role (see later).**

Suicide support workers should interview and support at risk prisoners

6.26 Suicide Support workers should be recruited to undertake the assessment and care of those at risk. They should have specialized training and be suitably qualified. In our view:

- **suicide support workers should be trained to assess, interview and provide support programmes for those at risk of self-harm and suicide**
- **suicide support workers should be available 24 hours a day, and during periods of unlock there should be one on duty within the establishment**
- **it should be the responsibility of suicide support workers to:**
  - **record relevant information on the individual concerned**
  - **draw up support programmes**
  - **supervise support programmes**
  - **monitor those in their care**
  - **review those in their care to decide whether they can be returned to normal location or removed from programmes**
  - **be involved in the management of the suicide prevention strategy**
  - **be involved in the training of staff**
  - **work alongside health care staff**
- **in monitoring progress, suicide support workers should be alert to and challenge misuse of the support programmes**
- **the suicide support worker should refer to the health care service anyone in need of psychiatric oversight.**

All at risk prisoners should have a care plan

6.27 In our view:

- **suicide support workers should draw up care plans for every prisoner at risk which should be documented**
- **each prisoner in a support programme should be seen daily by a suicide support worker**
- **suicide support workers should work with other members of staff to provide the necessary assistance for each prisoner at risk**
- **suicide support workers should have clearly defined authority to provide support within all areas of the prisoner's life, including, for example, the provision of extra visits, phone calls and referral to other agencies.**
- **there should be recognition that on normal location the influence of other prisoners is likely to be significant in precipitating suicidal behaviour because of bullying or threats of intimidation. This will need to be taken account of when considering the appropriate location of prisoners at risk.**

There should be more use of prisoners to assist staff in preventing suicide

6.28 One of the most impressive features of the American model is the use of paid prisoners to give minute by minute observation and support to other prisoners assessed as being at risk of suicide or self-harm. Observation aides, or companions, as they are called in the federal system, are trained and expected to be proactive (for example to hold a conversation with each prisoner for whom they are responsible within defined time boundaries, such as for 10 minutes).

6.29 In our view:

- **suitable prisoners should be recruited as Inmate Observation Aides in local prisons**
- **Inmate Observation Aides should be suitably trained and be accountable to an identified manager**
- **they should be responsible for mixing with and talking to prisoners who may be at risk**
- **whenever Inmate Observation Aide believe someone to be at risk they should report this to a member of staff**
- **nothing relevant to the care of prisoners at risk should be withheld from staff**
- **they should work a three shift system and provide continuous 24 hour observation of those at risk.**

6.30 Having a group of prisoners who are paid to observe other prisoners and are accountable to staff for their work, provides a very different form of service than from the present Listener schemes. Many establishments in the United Kingdom have developed excellent Listener schemes in which prisoners are trained by the Samaritans to operate within the limits of total confidentiality. Unless they have the consent of the prisoner who has chosen to come to them voluntarily to share his/her feelings they are not allowed to disclose information to other people. We continue to commend Listener schemes, particularly in training prisons and in long term units in local prisons, however we believe that they can usefully be supplemented in local prisons by inmate observation aides.

There should be co-operation between suicide support workers and health care staff

6.31 The implementation of this strategy will have implications for health care services in local prisons and remand centres if our proposal to appoint suicide support workers is accepted because it provides new and important additional resources to work alongside health care staff.

6.32 We therefore recommend to the Home Secretary that the Prison Service develops and implements a standard which includes a new strategy for preventing suicide in local prisons and remand centres which has the essential features listed in this chapter. We are convinced that without a suitable initiative based on the above principles, the number of prisoners who succeed in taking their own lives in local prisons and remand centres will remain at or above the current level.

HEALTHY PRISONS

Summary

- the total experience of imprisonment affects suicidal behaviour
- in every prison there must be an appropriate balance between security, control and justice
- 'a healthy prison' is one in which prisoners and staff can remain healthy
- the key constituents of a healthy prison are:
  - a safe environment
  - treating people with respect
  - a full, constructive and purposeful regime
  - resettlement training to prevent reoffending
- the essential elements of 'a healthy prison' will form the foundation of future inspections.

The importance of the quality of life in preventing suicide

"In its widest sense it (suicide prevention policy) must be about creating a climate in which suicidal thoughts and feelings are less likely to take root. Inmates will normally be less prone to suicidal behaviour in the establishment where regimes are full, varied and relevant; where staff morale is high and relationships with inmates positive; where good basic living conditions are provided; where every effort is made to encourage contacts with family and the community". (Prison Reform Trust 1996).

7.1 Most of this review has been concerned with the need for better understanding of and support for prisoners who are at risk of suicide by virtue of their personalities and early life experiences, and for better and more humane treatment of bereaved relatives. This chapter stresses the importance of the total prison environment in amplifying or mitigating suicidal feelings in those who are at risk. Alan Beith MP writing in the August 1998 edition of the Prison Officers' Association magazine 'Gatelodge' says:

"Unless these good intentions (i.e. the keenness of the prison minister to reduce the number of suicides in prison) are integrated with policies that improve conditions and empower staff to help, they remain futile".

7.2 A considerable amount of literature now exists on the subject of prison suicides in the United Kingdom, some of which is based on academic research (e.g. Liebling, 1992). The overwhelming conclusion from this research is that suicidal behaviour is not just a function of individuals' vulnerability and circumstances but is also influenced by the quality of prison regimes and the response of staff. This is strongly supported by those we have consulted during this review

[20] SASU (December 1995) Review of self-inflicted deaths. Internal Prison Service report.

and from our own regular inspection of Prison Service establishments. How a prisoner is treated whilst in custody clearly affects his or her sense of well being.

"Evidence heard at Inquests far too often seeks to explain the deaths in terms of the individual's ability to cope or their supposed personality problems, rather than looking at the psychological distress caused by regimes, conditions, isolation and lack of access to education, training and support" . (Inquest, 1996)[21]

Coping with imprisonment

7.3 Being sent to prison is rarely, if ever, a neutral experience for prisoners. Either they gain from or are made worse by the experience. There is a danger that prison staff who become used to the prison environment fail to understand the impact it has on prisoners who are entering it for the first time and that they lose sight of the fact that prisoners are individuals with human needs.

7.4 It is hard to imagine living in an environment where you have little control or influence, where you are forced to mix with and feel yourself to be at the mercy of other prisoners, where you are forced to rely entirely on the integrity of staff, where you feel there is no privacy, where the apparently trivial feels overwhelming, where you are deprived of normal family contacts and where scope for choosing what you do at any time is severely restricted or denied altogether. The effects of custody can be very destructive.

7.5 Research suggests that there are a number of features and characteristics of those who engage in suicidal behaviour. These include poor upbringing, the inability to make good inter-personal relationships, social and economic disadvantage, alcohol and drug addiction, poor educational attainment and employment history, low self-esteem, frequently brought about by the experience of having been abused, weak problem solving ability and low motivational drive. Just as it is difficult for such people to sustain themselves in the outside community, it is also difficult for them to survive in the prison environment. Signs of weakness can be met with verbal and physical abuse, theft, taxing, sexual violence and psychological torment from other prisoners.

7.6 The mental well-being of these prisoners is seriously jeopardized by the prison experience. Many openly demonstrate to staff their inability to cope; they can be self-destructive or confrontational and aggressive. Those who are familiar with institutional life learn to disguise their weaknesses beneath the "macho" culture which prevails in closed male prisons (although it is not as pronounced in contracted out establishments). Unless there is a clear policy which stresses the importance to prison staff of retaining a prisoner-centred approach, the culture allows institutional blindness to prevail and for prisoners in need either to be not seen or not responded to. The solution is not a medical one unless the prisoner is clinically depressed so there is no avoiding the obligation on all staff to provide a supportive environment.

7.7 In most areas of prison life the prisoners at risk are worse off than others. They are less likely to be engaged in activities such as PE; they are less likely to have a job; they are more likely to have relationship difficulties with other prisoners and staff; they are unlikely to receive consistent helpful support from outside and they are unable to occupy themselves constructively when left alone in their cell.

7.8 However, prisons can and should provide positive experiences for prisoners in which they are offered opportunities to change and thereby avoid re-offending on release, through fair treatment, education, work on offending behaviour, work training and resettlement. There is a connection between the objectives of reducing suicidal behaviour and preventing re-offending in

[21] Coles, D. and Shaw, H. (1996). Deaths in Prisons: breaking the wall of silence. Prison Report No 37.

that both rely on the provision of a healthy prison environment. Prisons, however over-crowded must provide sufficient attention to individual prisoners to help them adjust to custody and to make personal progress.

7.9 The influence of the officer is paramount here, particularly in local prisons where there are many first time prisoners. How prison officers do their job can prevent a prisoner feeling panic stricken and isolated and help him or her to settle into an establishment. Engaging constructively with prisoners is the core job of prison officers. They will only do this well when there is leadership of the prison culture. This requires continuity in office for senior prison managers, particularly for Governors. By focusing on the needs of prisoners and understanding the connection between the objectives of reducing suicidal behaviour and reducing reoffending, they will be contributing to the essence of a healthy prison. This vision requires staff to model 'healthy' positive behaviour to prisoners.

TESTS OF A HEALTHY PRISON

7.10 Our society recognizes that where the state deprives citizens of their freedom by holding them in prison, whether awaiting trial or after sentence, it has a clear duty to provide an environment which will sustain them. Lord Woolf in his report following the Strangeways riot in 1991 pointed out the importance of maintaining a proper balance between these:

"For present purposes, "security" refers to the obligation of the Prison Service to prevent prisoners escaping. "Control" deals with the obligation of the Prison Service to prevent prisoners being disruptive. "Justice" refers to the obligation of the Prison Service to treat prisoners with humanity and fairness and to prepare them for their return to the community in a way which makes it less likely that they will reoffend
There are two basic rules if these requirements are to be met. They are:
i) sufficient attention has to be paid to each of the requirements;
ii) they must be kept in balance." [22]
(para 9.20)

7.11 The Government White Paper 'Custody, Care and Justice' 1991 endorsed the position of Lord Woolf as follows:

"The Government accepts the central propositions in the Report that security and control must be kept in balance with justice and humanity and that each must be set at the right level". (Para 13)

7.12 Building on the lead given by Lord Woolf we give below a description of significant elements in control and justice which we consider are required if the state is to be seen to be fulfilling this duty. For ease of reference we refer to this as the concept of the healthy prison. This is not a new term: indeed a very successful international conference was held in Liverpool in March 1996 from which are drawn some of the points made here. We believe the phrase "healthy prison" is useful in helping to demonstrate positive aspects of custody but the term in no way implies that prisons, even those that are very well run, are 'healthy' in the full sense of the word. What is important is for prisoners and staff to be enabled to live and work in prisons in a way that promotes their well-being.

[22] Prison Disturbances (April 1990). Report of an Inquiry by the Rt Hon Lord Justice Woolf, CM 1456.

Below are the four main principles which should be used as tests of the health of establishments:

- the weakest prisoners feel safe
- all prisoners are treated with respect as individuals
- all prisoners are busily occupied, are expected to improve themselves and given the opportunity to do so
- all prisoners can strengthen links with their families and prepare for release.

Test 1 - the weakest prisoners feel safe

7.13 By their nature prisons are unsafe places in which to live. Very often bullying and stealing are rife. Many offenders who come into prison have survived outside by bullying and stealing and continue this sort of behaviour during their period of imprisonment. Prisoners should not escape these realities by living indefinitely in isolation; nor can staff keep prisoners away from each other yet still enable them to take part in purposeful activity or live useful lives.

7.14 The confidence that staff have in their own ability to maintain control is very important. The routines of the establishment have to be sensible and programmed to make the environment as safe as possible and give prisoners a strong sense of security and stability. Routines and activities should start and finish on time. Necessary rules need to be made widely known, be fairly administered by staff and not undermined by unnecessary staff practices. The importance of the personal example of staff cannot be over emphasized.

7.15 Measures against bullying must pervade every aspect of life in a prison. An effective anti-bullying strategy cannot just be an adjunct to a prison regime – it has to be led by the Governor and senior managers and implemented by staff at all times. Its effectiveness relies on staff being able to understand what is happening between prisoners, take appropriate action against bullying and being in control of arrangements for cell sharing and making their decisions after careful consideration. Good supervision from staff, for example in monitoring showering arrangements and meal collection, can reduce opportunities for bullying. Staff have to be aware that victims will not readily report their experience. A safe prison environment is one in which prisoners who feel threatened can let it be known and where the behaviour of the bullies and the bullied can be challenged by staff.

7.16 A safe prison must at least:

- **create a safe and predictable environment**
- **regularly monitor the well-being of prisoners to establish that they are safe**
- **have an effective anti-bullying strategy**
- **have an incentives scheme that encourages responsible behaviour and does not just reward conformity**
- **have rules which are necessary, that are explained to prisoners and are fairly administered**
- **keep good records of individual prisoners.**

Test 2 - Prisoners are treated with respect as individuals

7.17 Behind much of the anti-social behaviour demonstrated by people who find it difficult to cope in prison is a serious lack of self-esteem. Feeling good about ourselves is closely bound up with the respect which others show us. In committing offences prisoners have often shown little respect towards others, but the negative behaviour demonstrated through crime can never be used as the reason for not giving prisoners the respect that is due to them as human beings. Aside from any moral reasons, if respect is denied to prisoners their own behaviour and prejudices against authority are confirmed.

7.18 Prisoners will not learn to respect others unless this is demonstrated to them: one of the key responsibilities of prison

staff therefore is to present a model of how people should relate to each other. When officers have treated prisoners with kindness we have been told by prisoners how much this has meant to them and how effective it has been in taking matters forward. Compassion should not be mistaken for condoning the prisoner's offence nor excusing behaviour but as a means of showing understanding which needs to be sustained even in the face of rejection and hostility. Respect shown by staff towards prisoners should be the model for the way in which prisoners are expected to treat each other.

7.19 The ways in which a prison can demonstrate respect for prisoners are many and various. It can ensure that a person has a decent cell in which there is sufficient space and opportunity for privacy. Routines can ensure that there is the chance of a daily shower and that clothing and bedding are clean. Arrangements for cooking and serving food should be hygienic and it should be possible to eat meals in the company of others. The standard of cleanliness should be high. There should be opportunities to exercise choice and to take responsibility for these choices. There should also be opportunities for positive forms of self-expression.

7.20 Health care and health promotion are key activities in helping prisoners to develop self-respect and take responsibility for themselves. The importance of the health care check and assessment on reception has been referred to in other parts of this review: it is particularly important in identifying mental disorder at the earliest point. The promotion of healthy drug-free lifestyles can make a big impression on the quality of life of prisoners and reduce future offending where this is associated with problems of addiction.

7.21 From the evidence we have received, the attitude that staff demonstrate towards them as individuals is the most important aspect of life for the vast majority of prisoners. These attitudes can be assessed from the first greeting that an officer gives to a prisoner on reception. First night arrangements, which pay particular attention to their immediate needs is also a clear indication to prisoners of staff attitudes. This is especially important for those coming in on a Friday or over the weekend. Induction is the opportunity for staff to introduce newcomers to their systems and rules and assess how an establishment's resources might be used to meet the needs of individual prisoners. Many of the most helpful measures are simple actions on the part of staff which serve to reassure and build a sense of self-worth.

7.22 The evidence received during this review and confirmed from inspections is that the vast majority of establishments are unsuccessful in treating prisoners with respect. One Governor wrote to us as follows:

"Regrettably, we have a history in the public sector Prison Service of dealing with prisoners differently (from the private sector). Our systems and relationships with them usually stress their inferiority and exclusion. This is a policy which cannot be defended in terms of mental health or in terms of helping to support those at risk of suicide and self-harm."

7.23 All of the prisons which are contracted out and a few prisons in the public service have adopted the practice of addressing prisoners by the title of "Mr" or by the use of a first name and staff in female establishments mostly address women prisoners by their first name. Inspections have revealed that where establishments have taken these approaches, prisoners have responded well although some male prisoners who had years of experience of being treated differently in other prisons were uncomfortable and at first suspicious. It is noticeable that where this practice is used properly, prisoners feel an element of self-worth and identity which enables staff to find an easier way of working with them. **The Prison Service should work towards the adoption of this practice in all of its establishments.**

7.24 Many prisoners on entering prison for the first time are confused, inarticulate,

shocked, withdrawing or too ill to understand what is happening. It is unreasonable to expect people who are experiencing the impact of imprisonment to speak about the distress they are feeling. For many it is a matter of pride that they should not disclose their problems to prison staff. It is therefore essential that prison staff are able to create the opportunities for prisoners to talk to them. It is insufficient for staff just to "be available". More often than not, staff have to provide many opportunities for prisoners to speak to them before they will be confident to do so and staff have to demonstrate that they have genuine interest, concern and can be trusted. This can only be provided in a stable environment in which prisoners are treated consistently, fairly and with respect.

7.25 It is a matter of deep regret that there are now too few establishments with key worker or personal officer schemes which are worthy of the name. This is not the fault of individual staff. Too frequently, shift arrangements ignore the need for continuity and militate against opportunities for staff to build relationships with prisoners. On the other hand, working arrangements should not be used as an excuse for staff to avoid this basic and vital aspect of their work. Skilled officers can and do anticipate when support is needed before a prisoner indicates but this is not general practice.

7.26 In an establishment which demonstrates respect:

- **Governors and senior managers monitor if prisoners are treated with respect through talking to them**
- **prisoners understand how to access services, maintain family links and receive attention when in need**
- **prisoners are approached by staff who check on their well-being and offer support**
- **prisoners are spoken to by staff with courtesy and treated with fairness and openness**
- **prisoners have access to a health care service equivalent to the National Health Service**
- **prisoners receive individual attention through a recognized key worker scheme supported with training and ongoing supervision.**
- **prisoners have rights of access to appeal against decisions**

Test 3 - Prisoners are fully and purposefully occupied and are expected to improve themselves

7.27 There is nothing worse for the mental well-being of those who find it difficult to cope with life in prison than being idle. A healthy prison provides a range, variety and choice of activity in which prisoners can be involved. The aim must be to motivate prisoners towards improving themselves. It is not sufficient to provide opportunities for education, employment, exercise and physical education, access to library and other activities. It is just as important to ensure that staff have the skill to encourage prisoners to take up these opportunities. Again, the importance of an induction and assessment programme which shows prisoners what can be achieved, cannot be over emphasized. Healthy establishments provide prisoners with opportunities to gain qualifications and also the help and support they need to take advantage of them. Prisons are full of people who have achieved little in their lives and who have had little experience of praise and encouragement. The opportunity to do something of which they can be proud can have an important influence on their mental well being, their views of other people and on their attitude to future offending.

7.28 A prison providing purposeful activity will at least:

- **ensure that all prisoners are purposefully occupied in constructive activity as part of each working day**
- **provide a range of meaningful activities allowing for some choice where possible**
- **encourage prisoners to understand, join in and complete programmes**
- **allow prisoners to improve their basic literacy and numeracy skills**
- **recognize the need to allow prisoners to achieve qualifications**

- **provide oppotunities for self expression**
- **continue to analyze the range and type of activity available against individual needs**

Test 4 - Prisoners can strengthen links with their families and prepare themselves for release

7.29 All prisoners need supportive relationships, whenever possible from family and friends outside. This makes the priority that prisons give to the development of links with family and friends vital. A healthy prison is one which provides detailed information for families about visiting arrangements and treats visitors to prisoners with respect. The quality of a prison's performance is best judged not from a written policy, but from the way that a prison and its staff enable prisoners to meet their visitors. Regrettably, many prisoners lack the support of family and friends and have poor interpersonal skills. The use of suitable volunteers as prison visitors to meet this need can be another feature of a healthy establishment.

7.30 With the Home Secretary's declared priority for all Criminal Justice agencies to prevent reoffending there is an unequivocal responsibility on Prison Service establishments to assess what needs to happen to every sentenced prisoner to help prevent further crime and where possible to address these needs during the period of time in custody. Towards the end of a sentence a prisoner may well require practical help in obtaining accommodation and employment. A healthy establishment is one which provides this guidance and support and sees its duty as extending beyond the prison gates. It is the very opposite of creating an easy life for prisoners: rather, it is helping prisoners face up to and overcome problems and prepare for a useful life on release which will help to prevent further victims.

7.31 To assist resettlement, prisons will at least:

- **challenge offending behaviour for sentenced prisoners and provide programmes to help prevent reoffending on release**
- **provide resettlement programmes to prepare all prisoners for release**
- **ensure that all staff and the culture of the establishment support offending behaviour work**
- **ensure that other statutory, voluntary or community agencies, social services and health services are involved where necessary to provide care after release**
- **take measures to increase the employability of offenders**
- **ensure all prisoners are released to suitable accommodation.**

THE IMPORTANCE FOR STAFF OF WORKING IN HEALTHY PRISONS

7.32 We have seen that the values of an establishment as expressed in its regime are crucial to the well-being of prisoners: they are just as crucial to the well-being of staff. People who work in successful organizations are, to a greater or lesser extent, sustained by them. As total institutions, prisons develop strong cultures, which can sustain staff if they are well led *A healthy prison will have a very strong positive culture fully embracing the declared aims of the Prison Service and to which all staff subscribe.*

7.33 But prison cultures can become dysfunctional when establishments develop values which are not those of the Prison Service. This can happen quickly or build up over several decades. Indeed inspections reveal many examples of staff

attitudes and performance which are the very opposite of the Prison Service's Statement of Vision and Values. Dysfunctional prison cultures tend to prioritize the needs of staff over the need to control and care properly for prisoners. **It should be a priority of the Prisons Strategy Board to identify inappropriate cultures and create healthy alternatives**.

7.34 Tragically, there have been significant numbers of prison staff suicides in recent years. As with any other suicides, the causes are never known for sure but it seems to us that in a Service where the primary purpose is to care for prisoners, the principles should extend, as far as is reasonable within the employer/employee relationship, to the staff who may find the stresses of delivering the care in a prison environment too great.

7.35 A healthy prison for staff is one in which:

- **staff feel safe**
- **they are treated with respect as individuals**
- **they are informed and consulted within their sphere of work**
- **they have high expectations made of them**
- **they are well led**
- **they respect their own health.**

7.36 The concept of a healthy prison environment is not an invention of this review, having been taken up by the World Health Organization[23] and other groups. Mental health is a positive sense of well-being, from which springs the emotional and spiritual resilience which is important for personal fulfilment and which enables us to survive pain, disappointment and sadness. It requires an underlying belief in our own and others' dignity and worth. While it may be difficult to contemplate the existence of positive mental health among prisoners, prison should provide an opportunity for prisoners to be helped towards a sense of the opportunities available to them for personal development, without harming themselves or others.

7.37 There are already establishments in England and Wales which are building regimes with this in the forefront of their thinking. In our view there is no doubt that the concept of a healthy prison has a particular significance for preventing suicidal behaviour among prisoners.

7.38 The essential elements of a prison described in this chapter will be the cornerstone of future prisons inspections. Over the next two years we will aim to gain a greater understanding of how these principles cohere, and whether we wish to recommend that this model is adopted as a basis upon which whole prisons may be accredited.

[23] World Health Organisation (Regional Office for Europe) Consensus Statement on Mental Health Promotion in Prison The Hague, November 1998.

RECOMMENDATIONS

To the Secretary of State

8.1 Ministers and the Director General of the Prison Service should declare a commitment to reduce suicides in prisons in England and Wales. A suitable key performance indicator for suicide prevention should be introduced.

8.2 Ministers and the Director General of the Prison Service should endorse the principles of "a healthy prison" given in this report which should be used to take forward the treatment of prisoners and the management of staff in every Prison Service establishment.

8.3 Coroners' officers should be advised that relatives of prisoners would benefit from early information about the process of an inquest and that regular and sensitive contact with them would be helpful.

8.4 This review should be brought to the attention of coroners.

8.5 Consideration should be given to offering support similar to a witness service in coroners' courts for relatives of prisoners who wish to benefit from it.

To the Director General

8.6 Independent monitoring of investigations should take place and the results published. We recommend to the Secretary of State that the remits of either the Ombudsman or Her Majesty's Inspector of Prisons are re-examined to take account of this.

8.7 It should be a priority to use the principles of a healthy prison in order to identify establishments in which the treatment of prisoners is undermined by inappropriate cultures; alternative healthy cultures should be promoted.

8.8 The Prisons Strategy Board should endorse the full implementation of the current strategy for suicide prevention as applied to training prisons.

8.9 The Prisons Strategy Board should develop a new strategy for suicide prevention in local prisons, based on principles described in this review.

8.10 The full impact of a death in custody must be understood by the Prison Service and effective contingency plans provided in all establishments.

8.11 The Prisons Strategy Board should introduce suicide prevention strategies for female prisoners and young prisoners which are based on the different needs of these groups.

8.12 Line managers should be accountable for the detailed implementation of appropriate suicide prevention strategies in all establishments and effective contingency plans in the event of a death in custody.

8.13 Detailed recommendations emphasized in bold type in Chapters 3, 4, 5, 6 and 7 of this report should be implemented.

'No man is an island entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friends or of thine own were; Any man's death diminishes me because I am involved with mankind; And therefore never send to know for whom the bell tolls; It tolls for thee.'

John Donne (1573-1631) Sermons on Divergent Occasions

APPENDIX 1

Self-inflicted deaths in prison custody 1996 and 1997

Detailed information was collected on the self-inflicted deaths in custody from the investigation reports held by the Suicide Awareness Support Unit. Of the total of 132 self-inflicted deaths that occurred in 1996 and 1997, full records were available in 128 of these cases at the time of data collection, relating to 63 suicides in 1996 (out of a total of 64) and 65 suicides in 1997 (out of a total of 68).

Further data was forthcoming from the Prison Service after these analyses had been completed which included information on the four missing cases mentioned above together with data on self-inflicted deaths in 1988 which had then become available. Tables in the main text of the review have been altered to reflect these additions. This appendix provides analysis of self-inflicted deaths in 1996 and 1997 only. Where information was not available for some of the cases, the tables in this appendix reflect this as missing data where relevant.

A breakdown of information is provided in the following areas:

Personal information

1.1. Gender
1.2. Ethnicity
1.3. Age
1.4. Marital status
1.5. Previous history of self-harm in custody
1.6. Previous history of self-harm in custody and outside custody
1.7. Contact with psychiatric services
1.8. History of substance abuse

Custodial details

2.1 Type of establishment
2.2 Custody status
2.3 Time spent at establishment where self-inflicted death occurred
2.4 Time elapsed from sentencing
2.5 Length of sentence
2.6 Type of offence

Details concerning the suicide

3.1 Month in which self-inflicted death occurred
3.2 Day of death
3.3 Time at which prisoner discovered
3.4 Location of incident
3.5 Means by which self-inflicted death occurred
3.6 Type of ligature used
3.7 Type of fixture used
3.8 Time elapsed between last contact with the prisoner and time of discovery
3.9 F2052SH forms
3.10 Suicide notes
3.11 Other indicators

Personal information

1.1 Gender

	1996 No.	1997 No.
Male	62	65
Female	2	3
Total	64	68

1.2 Ethnicity

	1996 No	1997 No
White	58	63
Black	3	4
Asian	1	-
Other	-	1
Missing	2	
Total	64	68

1.3 Age Group

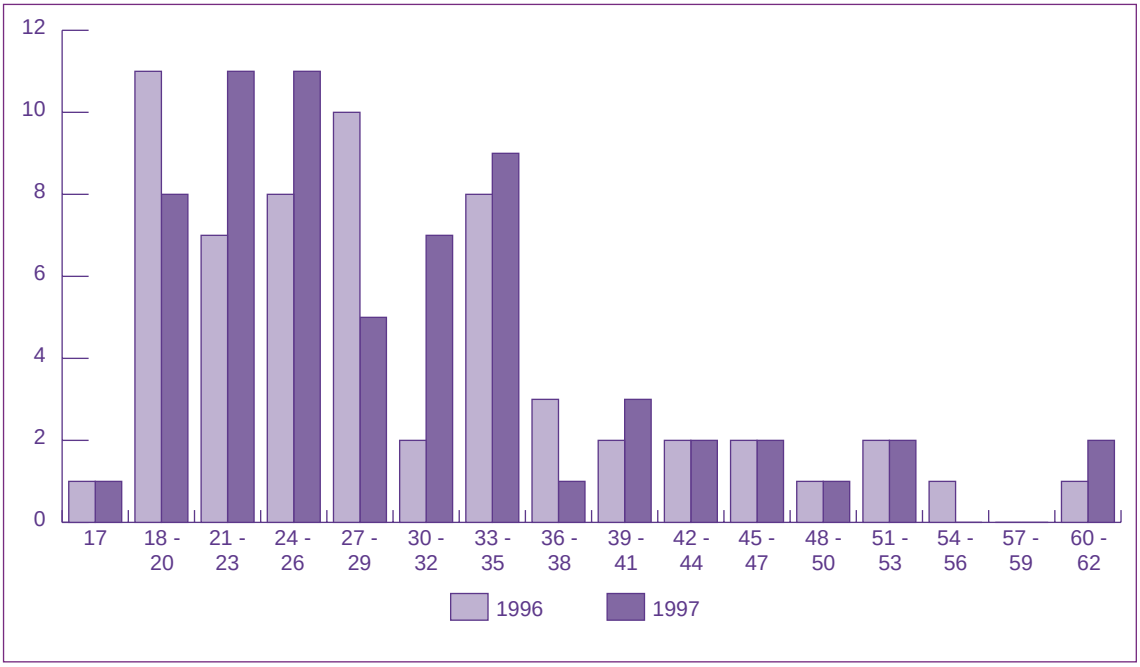
	1996 No	1997 No
17	1	1
18-20	11	8
21-23	7	11
24-26	8	11
27-29	10	5
30-32	2	7
33-35	8	9
36-38	3	1
39-41	2	3
42-44	2	2
45-47	2	2
48-50	1	1
51-53	2	2
54-56	1	-
57-59	-	-
60-62	1	2
Missing data	3	3
Totals	64	68

- In 1996 juveniles accounted for 2%, young prisoners 17% and adults 81% of the total of self-inflicted deaths by prisoners in custody. The corresponding percentages in 1997 were 2% for juveniles, 12% for young prisoners and 86% for adults.

- The ages of those who committed suicide in custody ranged between 17 and 62 years in 1996 and between 17 and 61 years of age in 1997.

- 59% of those in 1996 and 55% of those in 1997 who committed suicide in custody were less than 30 years of age.

Figure 1.3: Number of self-inflicted deaths by Age Group



1.4 Marital Status

	1996		1997	
	No	%	No	%
Single	33	52	42	62
Married	6	9	9	13
Cohabiting	7	11	4	6
Divorced	6	9	4	6
Separated	2	3	2	3
Missing data	10	16	7	10
Total	64		68	

- 52% of those who committed suicide in custody in 1996 and 62% in 1997 were single
- 20% in 1996 and 19% in 1997were listed as either married or cohabiting
- a minority of 12% in 1996 and 9% in 1997 were either divorced or separated

1.5 History of self-harm in custody

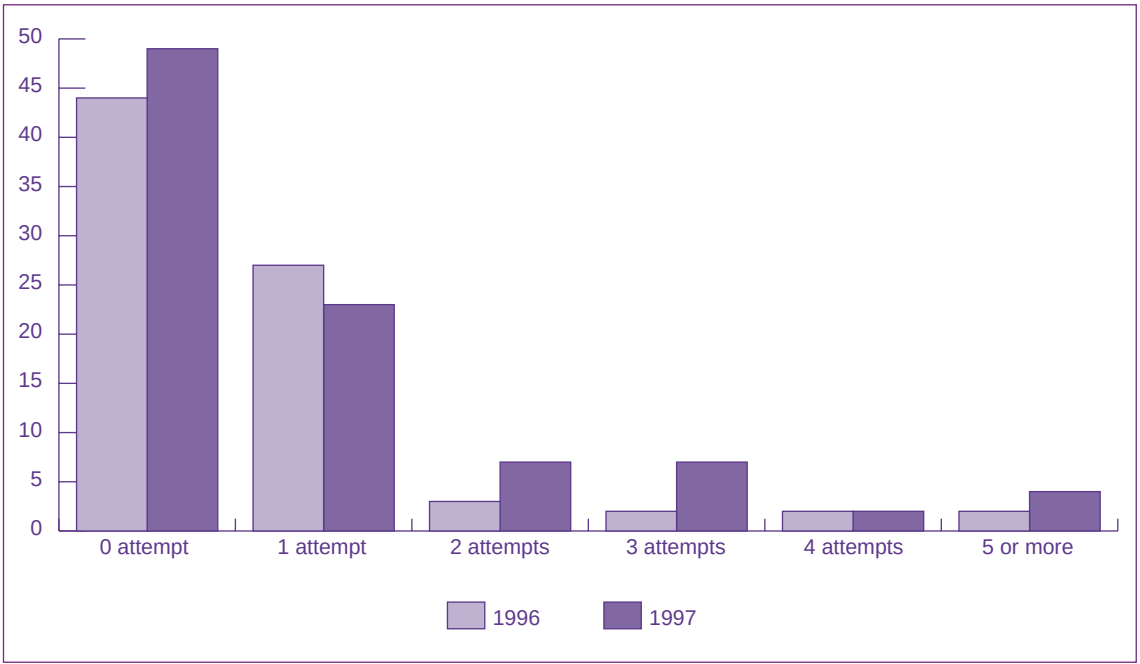
- Information concerning the occurrence

	1996		1997	
	No	%	No	%
No previous attempts	28	43%	32	47%
1 attempt	17	26%	15	22%
2 attempts	2	3%	5	7%
3 attempts	1	2%	5	7%
4 attempts	1	2%	1	2%
5 or more	1	2%	2	3%
Missing data	14	22%	8	12%
Totals	64		68	

of any previous suicide attempts in custody was missing in 14 of the 64 records for 1996 and in 8 of the 68 suicides in 1997 for which detailed records were available.

- 43% of those who committed suicide in 1996 and 47% in 1997 had no record of any previous suicide attempts while in custody
- 26% in 1996 and 22% in 1997 had made one previous suicide attempt while in custody
- 9% in 1996 and 19% in 1997 had made two or more suicide attempts while in custody (ranging in 1996 between 2 and 10 attempts and 2 and 14 in 1997)

Figure 1.5: Previous Suicide Attempts in Custody (%)



1.6 Whether previous history of self-harm in prison/outside prison

- Of the 22 people in 1996 and 28 people in 1997 who had previously self-harmed in prison (Table from 1.5 on the previous page):
  - 54% (12 people) in 1996 also had self-harmed in the community
  - 46% (13 people) in 1997 also had self-harmed in the community
- Of the 28 people in 1996 and 32 people in 1997 who had no prior history of self-harm in prison:

	1996		1997	
	No	%	No	%
Previously self-harmed both in custody and outside	12	19%	13	19%
Previously self-harmed in custody but not outside	10	16%	15	22%
No previous self-harm in custody or out of prison	24	37%	24	35%
Previously self-harmed outside prison but not while in custody	4	6%	8	12%
Missing data	14	22%	8	12%
Totals	64		68	

– 14% (4 people) in 1996 had self-harmed in the community prior to prison
– 25% (8 people) in 1997 had self-harmed in the community prior to prison

1.7 Contact with psychiatric services

- 41% of those who committed suicide in prison in 1996 and 32% in 1997 had had some contact with psychiatric services. This may have been in the form of inpatient/outpatient treatment or may have occurred during custody.

- Of the 41% of people in 1996:

  – 31% (8) people had had contact with psychiatric services whilst in prison

- Of the 32% of people in 1997:

  – 43% (9 people) had had contact with psychiatric services whilst in prison

1.8 Previous history of substance misuse

- 77% of the self-inflicted deaths by prisoners in custody in 1996 and 69% of those in 1997 had a history of having been either single or multiple drug misusers.

- These figures comprised the following breakdown:

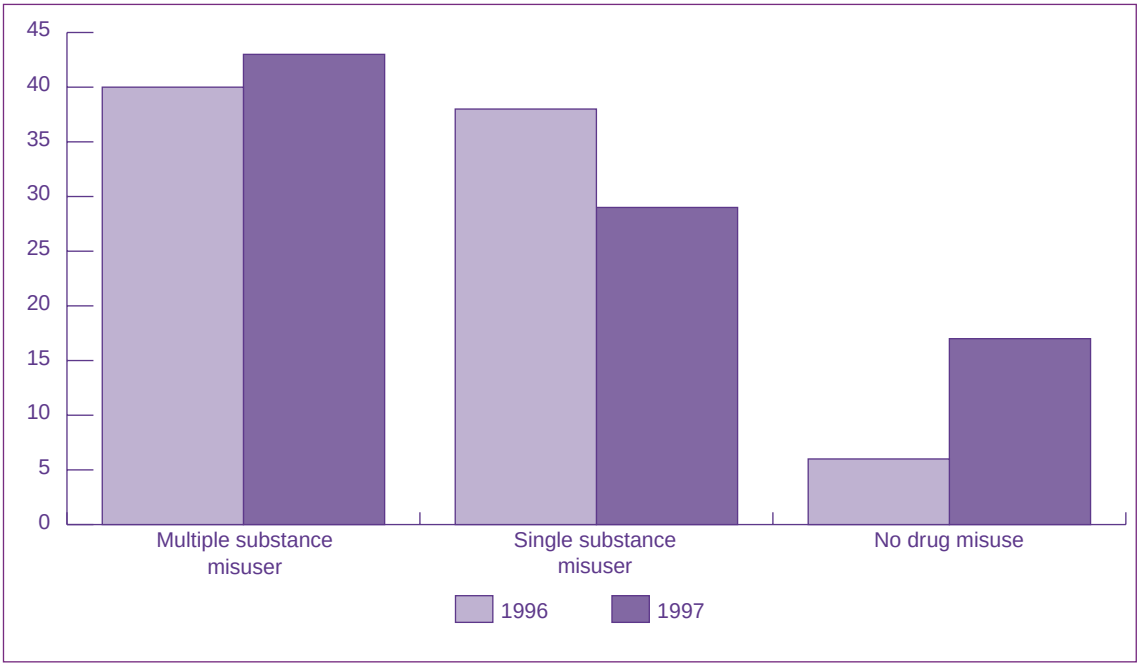
  – 38% in 1996 and 28 in 1997 were listed as single drug misusers
  – 39% in 1996 and 41% in 1997 were multiple drug misusers.

	1996		1997	
	No	%	No	%
Multiple drug misuser	25	39	28	41
Single drug misuser	24	38	19	28
No drug misuse	4	6	11	16
Not known	11	17	10	15
Totals	64		68	

	1996	1997
	No*	No*
Opiates	23	26
Cannabis	17	23
Alcohol	18	19
Amphetamines	10	14
Barbiturates	9	4
Crack/cocaine	9	8
Hallucinogens	5	8
Solvents	-	2
Total*	92	104

* are not mutually exclusive

Figure 1.8: Previous history of substance misuse (%)



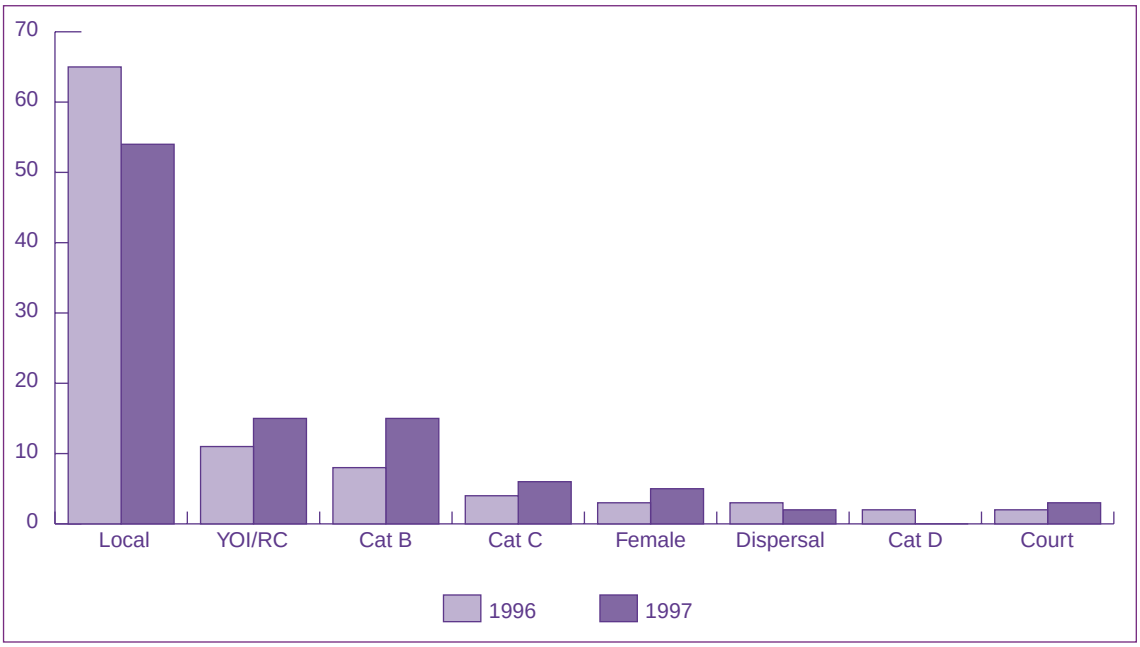
Custodial Details

2.1 Type of establishment

	1996		1997	
	No	%	No	%
Local prisons	41	64	38	56
YOI/RC	7	11	11	16
Category B	5	8	10	15
Category C	4	6	4	6
Female	2	3	2	3
Dispersal	3	5	1	1
Category D	1	1.5	-	
Court	1	1.5	2	3
Totals	64		68	

- 64% of self-inflicted deaths in 1996 and 56% in 1997 occurred in local prisons

Figure 2.1: Type of establishment (%)

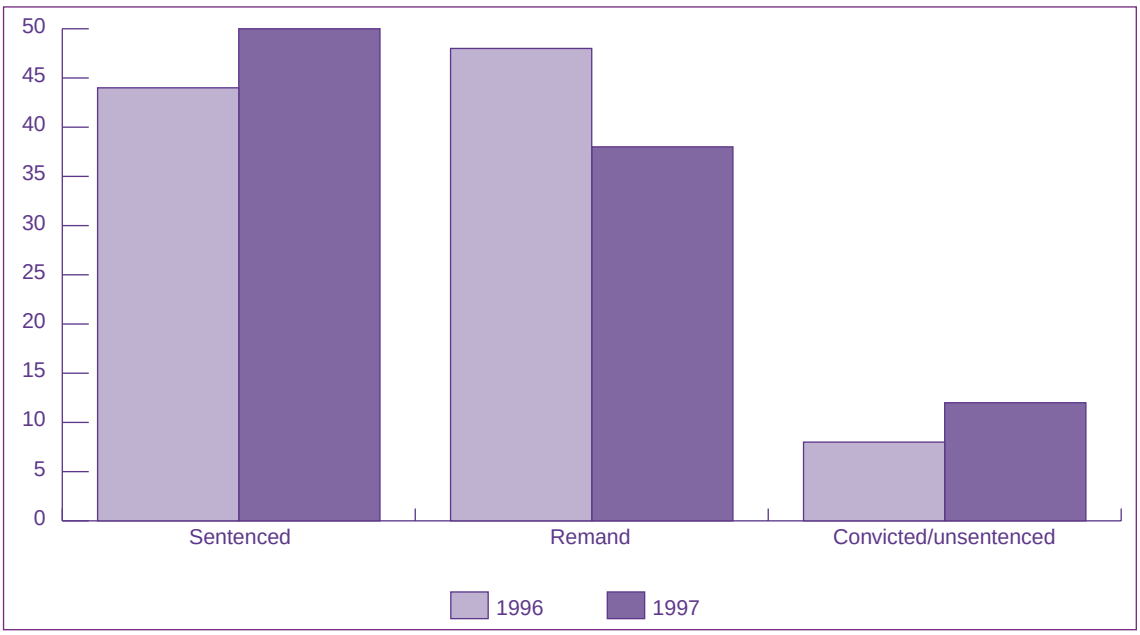


2.2 Custody status

	1996		1997	
	No.	%	No.	%
Remand	28	44	34	50
Sentenced	31	48	26	38
Convicted/unsentenced	5	8	8	12
Totals	64		68	

- In 1996 the proportion of self-inflicted deaths by unsentenced prisoners was greater (56%) than those who were sentenced (44%) but in 1997 the proportions were similar
- For 29% of the prisoners in 1996 who committed suicide and 28% in 1997, it was their first time in prison

Figure 2.2: Custody Status (%)



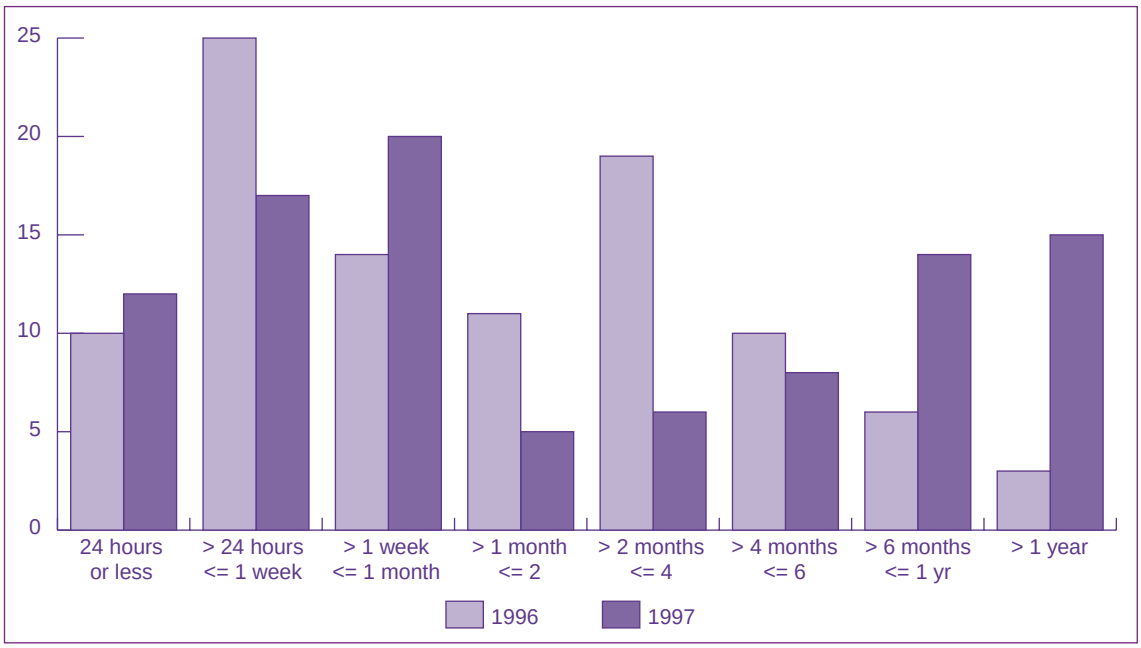
2.3 Length of time in establishment prior to self-inflicted death*

	1996		1997	
	No	%	No	%
24 hours or less	6	9	8	12
> 24 hours < = 1 week	16	25	11	16
> 1 week < = 1 month	9	14	13	19
> 1 month < = 2 months	7	11	3	4
> 2 months < = 4 months	12	19	4	6
> 4 months < = 6 months	6	9	5	7
> 6 months < = 1 year	4	6	9	13
> 1 year	2	3	10	15
Missing data	2	3	5	7
Totals	64		68	

* Slightly different cut-off points were used in this table by comparison to those used in Table 11, Chapter 1 which accounts for the differences in the percentages

- Just under half of the self-inflicted deaths in custody in 1996 and 1997 occurred within one month of being in the prison (48% in 1996 and 47% in 1997). Of these:
  - 9% in 1996 and 12% in 1997 occurred within 24 hours
  - 25% in 1996 and 16% in 1997 occurred between 2 and 7 days
- In 1996 there was a higher proportion of self-inflicted deaths by prisoners who had been in the prison for periods of more than 1 month but less than 6 months (39%) by comparison to 1997 (17%)
- The proportion of prisoners who committed suicide having been in the establishment for periods of more than 6 months in 1997 (28%) was higher than in 1996 (9%)

Figure 2.3: Length of time in establishment (%)*



(*time periods not equivalent in length)

2.4 Length of time elapsed from sentencing to self-inflicted death

- Of the 28 people in 1996 and 34 in 1997 who were sentenced, information concerning the length of time that had elapsed between sentencing to the time they committed suicide was missing in 4 cases in 1996 and 8 in 1997.

	1996	1997
– 1 week or less:	4%	20%
– > 1 week < =1 month:	11%	15%
– > 1 month < = 6 months:	43%	15%
– > 6 months < =1 year:	7%	12%
– > 1 year	21%	32%
Missing data	14%	6%

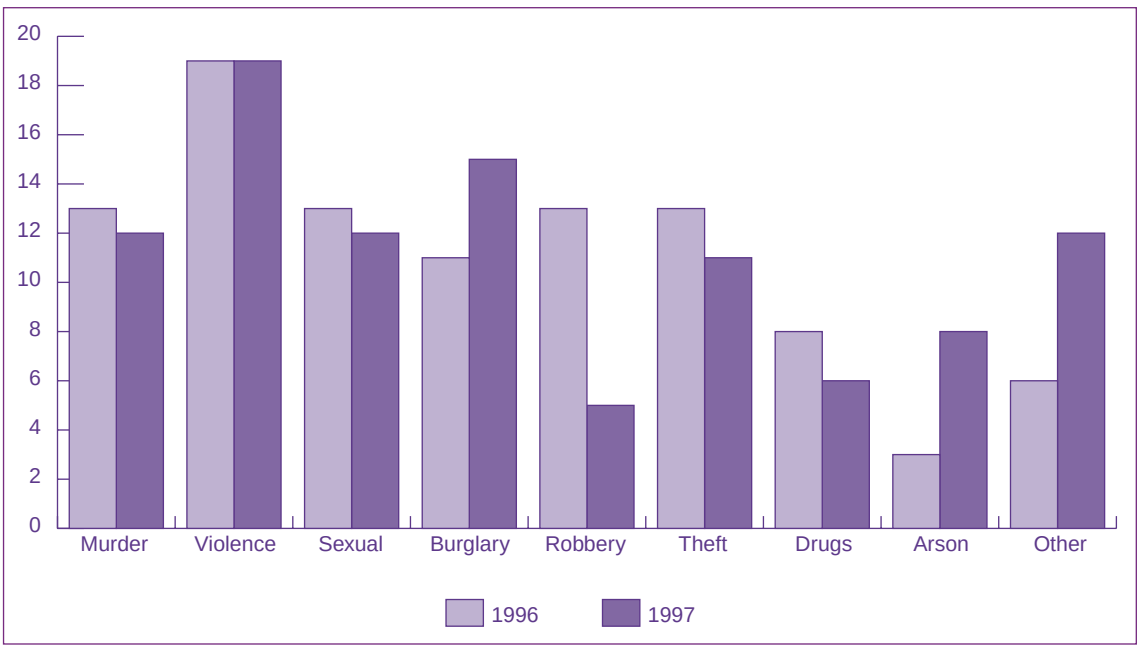
2.5 Sentence length

- The range of sentence length was between 3 months and life in 1996 and 13 days and life in 1997.

- Information was missing in 7% of the 28 cases in 1996 and 6% of the 34 cases in 1997. For the remainder, sentence length was as follows:

	1996	1997
– 4 years or less	46%	51%
– more than 4 years	22%	23%
– Life	25%	20%
Missing data	7%	6%

Figure 2.6: Type of offence (%)



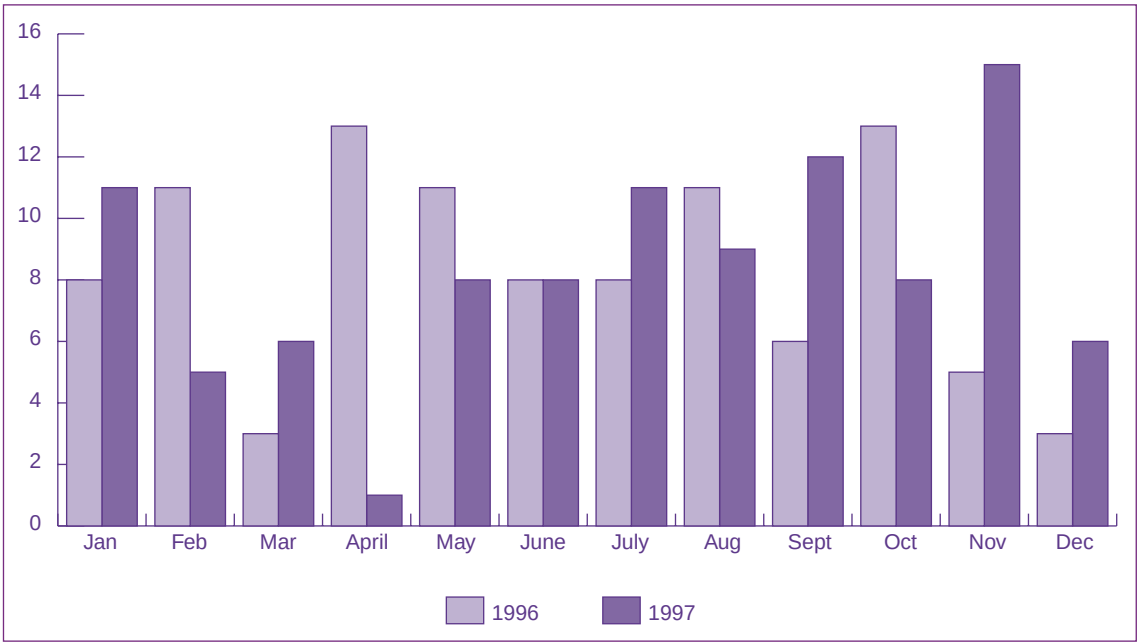
Details concerning self-inflicted deaths: 1996 and 1997

3.1 Month of the year in which self-inflicted death occurred

	1996		1997	
	No	%	No	%
January	5	8	7	10
February	7	11	3	4
March	2	3	4	6
April	8	12	1	2
May	7	11	5	7
June	5	8	5	7
July	5	8	7	10
August	7	11	6	9
September	4	6	8	12
October	8	12	5	7
November	3	5	10	15
December	2	3	4	6
Missing data	1	2	3	4
Totals	64		68	

- In 1997 more suicides occurred in November 1997 (10) than in any other month and the month in which the least number of suicides occurred was April (1)

Figure 3.1: Month in which self-inflicted death occured (%)

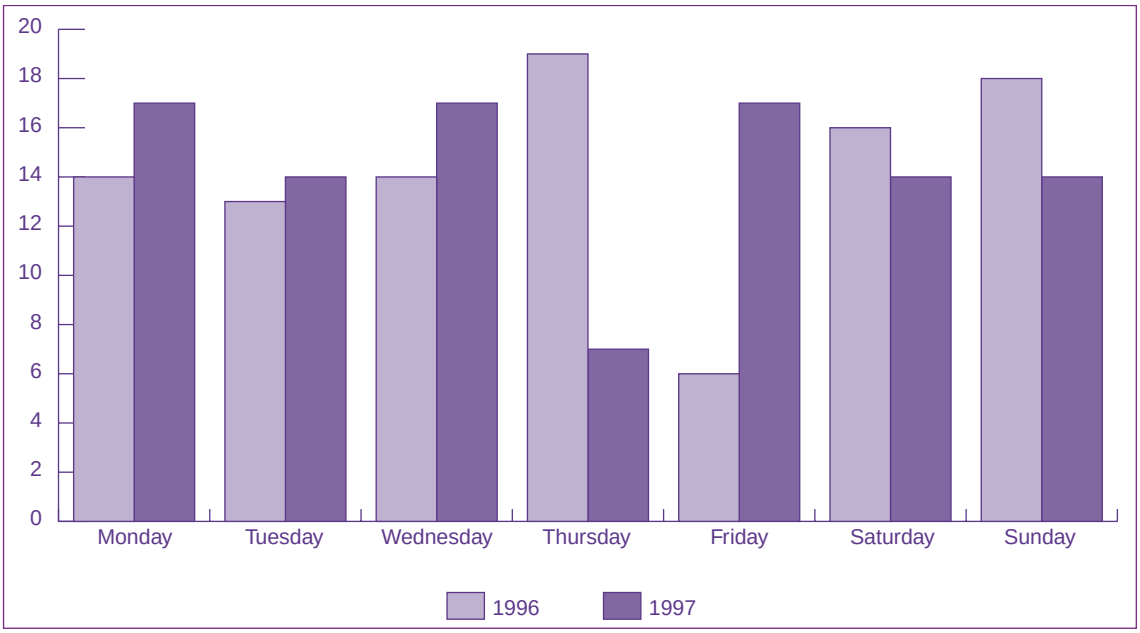


3.2 Day of the week in which self-inflicted death occurred

	1996		1997	
	No	%	No	%
Monday	9	14	11	16
Tuesday	8	12	9	13
Wednesday	9	14	11	16
Thursday	12	19	5	7
Friday	4	6	11	16
Saturday	10	16	9	13
Sunday	11	17	9	13
Missing data	1	2	3	4
Total	64		68	

- No particular pattern was evident from the analysis of which day of the week the self-inflicted death occurred or between weekdays and weekends.

Figure 3.2: Day of the week in which self-inflicted death occured(%)



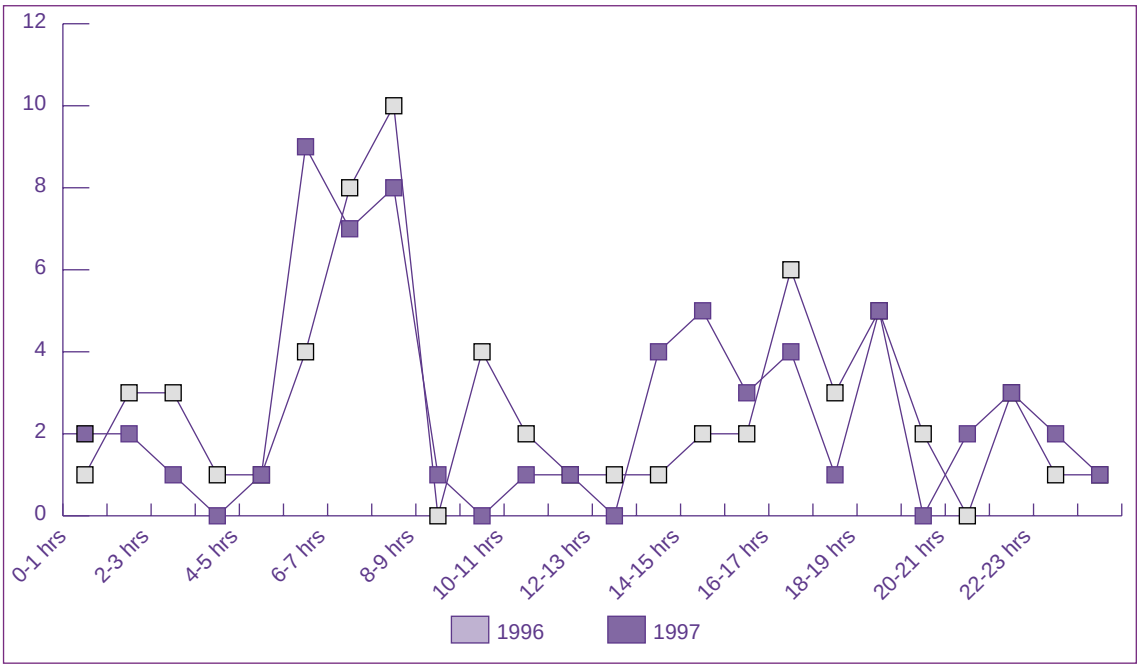
3.3 Time at which the self-inflicted death was discovered

	1996	1997
0 – 1 am	2	1
1 – 2 am	2	3
2 – 3 am	1	3
3 – 4 am	0	1
4 – 5 am	1	1
5 – 6 am	9	4
6 – 7 am	7	8
7 – 8 am	8	10
8 – 9 am	1	0
9 – 10 am	0	4
10 – 11 am	1	2
11 – 12 am	1	1
12 – 13 am	0	1
13 – 14 am	4	1
14 – 15 am	5	2
15 – 16 am	3	2
16 – 17 am	4	6
17 – 18 am	1	3
18 – 19 am	5	5
19 – 20 am	0	2
20 – 21 am	2	0
21 – 22 am	3	3
22 – 23 am	2	1
23 – 0 am	1	1
Missing data	1	3
Total	64	68

- A higher proportion of suicide incidents were discovered between 5am and 8am (38% in 1996 and 34% in 1997) than during any other 3 hour period

- The hours between 4pm and 7pm was another particular time when over a fifth of suicides were discovered in 1997 and 16% in 1996

Figure 3.3: Time at which self-inflicted death was discovered



3.4 Location where self-inflicted death occurred

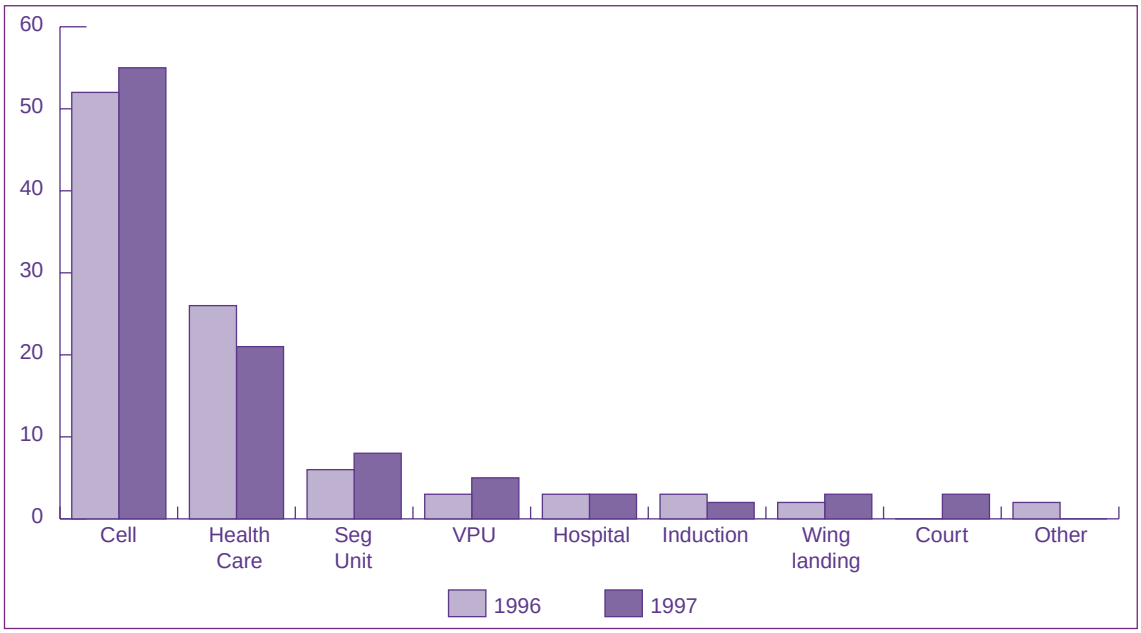
	1996		1997	
	No	%	No	%
Cell	33	52	36	53
Health Care Centre	14	22	14	21
Segregation Unit	4	6	5	7
Vulnerable prisoner unit	2	3	3	4
Induction	2	3	2	3
Hospital	2	3	2	3
Court	1	2	1	2
Wing landing	-		2	3
Other	1	2	-	
Missing data	3	5	3	4
Total	64		68	

- Over half of all self-inflicted deaths in custody took place in the prisoner's cell - 52% in 1996 and 53% in 1997

- The Health Care Centre was the location where the next highest proportion of self-inflicted deaths in custody were located - 22% in 1996 and 21% in 1997

- Most of the self-inflicted deaths were by prisoners located in single cells (59% in 1996 and 66% in 1997). However, over a quarter occurred in double cells (28% in 1996 and 27% in 1997). A very small proportion of the remainder occurred either in a ward or dormitory location.

Figure 3.4: Location where self-inflicted death occurred (%)



3.5 Means by which self-inflicted death occurred

	1996 No	1997 No
Hanging	59	59
Self-strangulation	1	-
Self-cutting	1	3
Asphyxiation by swallowing paper/bag over head	1	1
Overdose	-	1
Jumping from landing	-	1
Food refusal	1	-
Missing data	1	3
Total	64	68

3.6 Type of Ligature used

	1996 No	1997 No
Bedding	30	28
Clothing	18	20
String (not from clothing)	2	1
Bandage	1	-
Plastic	1	-
Towel	-	1
Swing	1	-
Missing data	11	18
Total	64	68

3.7 Type of fixture used

	1996 No	1997 No
Window	30	40
Bed	6	8
Wall unit	2	3
Beam/pipe	3	3
Door	5	1
Light	4	1
Brackets/screws	4	1
Sink/toilet	1	1
Air vent	1	-
Missing data	8	10
Total	64	68

3.8 Length of time between last contact with the prisoner and time of discovery

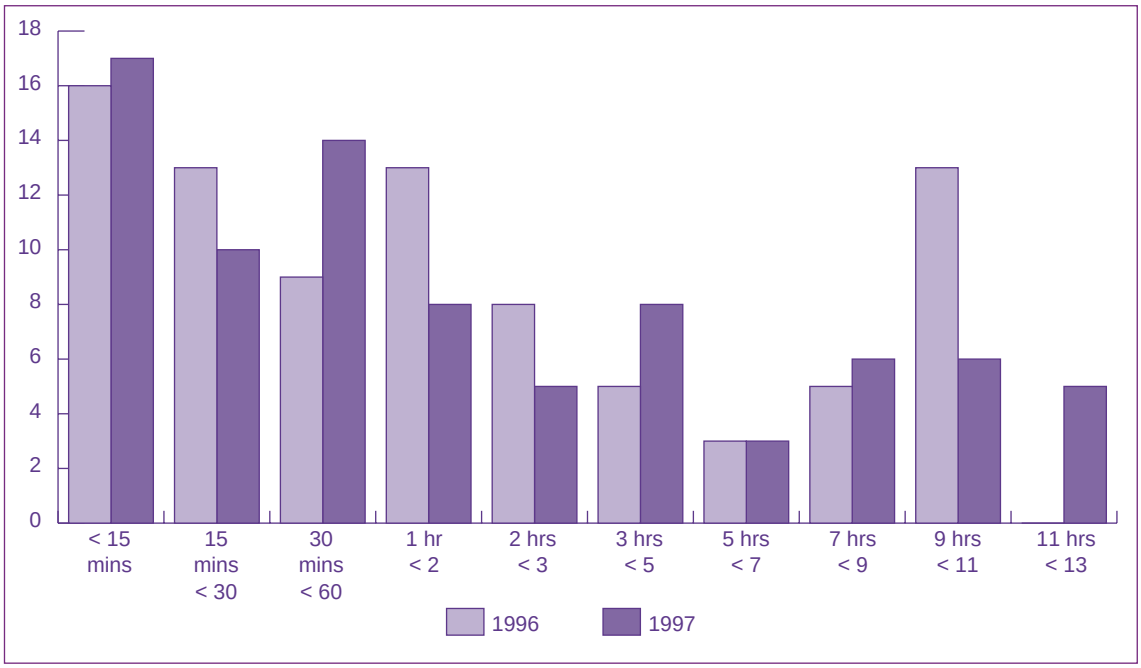
	1996		1997	
	No	%	No	%
Less than 15 minutes	10	16	11	16
15 minutes less than 30	8	12	7	10
30 minutes less than 60	6	9	9	13
1 hour less than 2	8	12	5	8
2 hours less than 3	5	8	3	4
3 hours less than 5	3	5	5	8
5 hours less than 7	2	3	2	3
7 hours less than 9	3	5	4	6
9 hours less than 11	8	12	4	6
11 hours less than 13	-		3	4
Missing data	11	17	15	22
Total	64		68	

- Of the 37% of prisoners in 1996 and 39% in 1997 who were found less than an hour following previous contact having been made with them: 16% in 1996 and a similar proportion in 1997 had had prior contact less than 15 minutes previously.

- A further 12% in 1996 and 10% in 1997 had had prior contact between 15 and 30 minutes previously and for the remainder (9% in 1996 and 13% in 1997) previous contact had been established between 30 minutes and 1 hour

- The range of time which had elapsed between previous contact being made and being found for the remainder of prisoners was between 1 hour and 13 hours (45% in 1996 and 39% in 1997)

Figure 3.8: Time lapsed between last contact (%)



(*time periods not equivalent length)

3.9 F2052SH Forms

- F2052SH forms had been opened in 19% of suicide cases in 1996 and 22% in 1997

- 34% of those who committed suicide in 1996 and 35% in 1997 had had a previous history of open F2052SH forms

3.10 Suicide notes

- Suicide notes were left by 25 prisoners in 1996 and 22 prisoners in 1997 who committed suicide, the contents of which included:

  – farewells and apologies to family members
  – admission of feelings of guilt/remorse related to the offence
  – protestations of innocence
  – instructions about what should be done after death
  – drug withdrawal
  – fear of vulnerability
  – anger and hopelessness at the situation and about the future
  – previous abuse
  – finding prison unbearable
  – breakdown of friendships in prison
  – criticism of treatment by staff and prison conditions
  – lack of telephone contact due to inability to purchase a phone card
  – bullying
  – spending 23 hours locked up in cell with only 1 hour out for meals/association

3.11 Other indicators

- Just under a quarter of those who committed suicide in 1996 and in 1997 had a disciplinary history

APPENDIX 2

Recorded incidents of attempted suicide/deliberate self-harm in custody 1996 and 1997

Information on recorded incidents of attempted suicide/deliberate self-harm by prisoners in custody in 1996 and 1997 was provided by the Suicide Awareness Support Unit at Prison Service Headquarters.

The dataset provided was compiled on the basis of the number of recorded incidents rather than the number of people to whom the incidents referred. The analyses done on the basis of recorded incidents is included in section 1.

The dataset was then re-analysed to establish the number of individuals for whom the recorded incidents of attempted suicide/deliberate self-harm in 1996 and 1997 were made. The analyses done on the basis of individuals is included in section 2.

1. Analyses of recorded incidents of attempted suicide/deliberate self-harm

1.1 By year
1.2 By month and by year
1.3 Age group
1.4 Gender
1.5 Ethnicity
1.6 Type of establishment
1.7 Custody status
1.8 Length of sentence
1.9 Type of offence
1.10 Method
1.11 Location

2. Analyses based on the number of people for whom incidents of attempted suicide/deliberate self-harm were recorded in 1996 and 1997

2.1 Number of people for whom incidents were recorded in 1996 and 1997
2.2 Number of people and whether single or repeat incidents in the 24 month period 1996/97
2.3 Analysis by gender and whether single or repeat attempts in the 24 month period 1996/97
2.4 Analysis by age for the 24 month period 1996/97
2.5 Analysis by age and whether single or repeat attempts were made for the 24 month period
2.6 Analysis by year of those who made single attempts or two or more attempts
2.7 Analysis by year of those who made repeat attempts

1.1 Recorded incidents of attempted suicide/deliberate self-harm by year

- 1996 907
- 1997 1,591

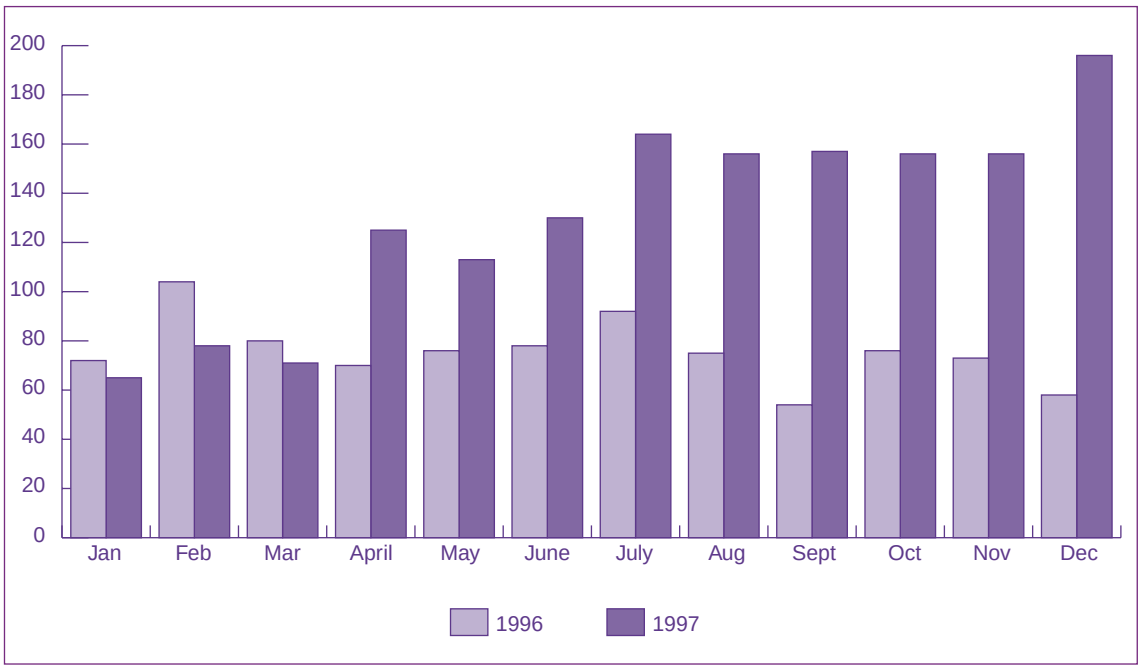
Total: 2,498

1.2 Recorded incidents of attempted suicide/deliberate self-harm by month and by year

- A change in reporting procedures, introduced in April 1997, resulted in all incidents of self-harm being recorded from that point and included in the reported incidents of attempted suicide/deliberate self-harm from each establishment.

Month of recorded incident	1996	1997
January	72	65
February	104	78
March	80	71
April	70	125
May	76	113
June	78	130
July	92	164
August	75	156
September	54	157
October	76	156
November	73	156
December	58	196
Total recorded incidents	907	1,591

Figure 1.2: Recorded incidents of attempted suicide/deliberate self-harm by month

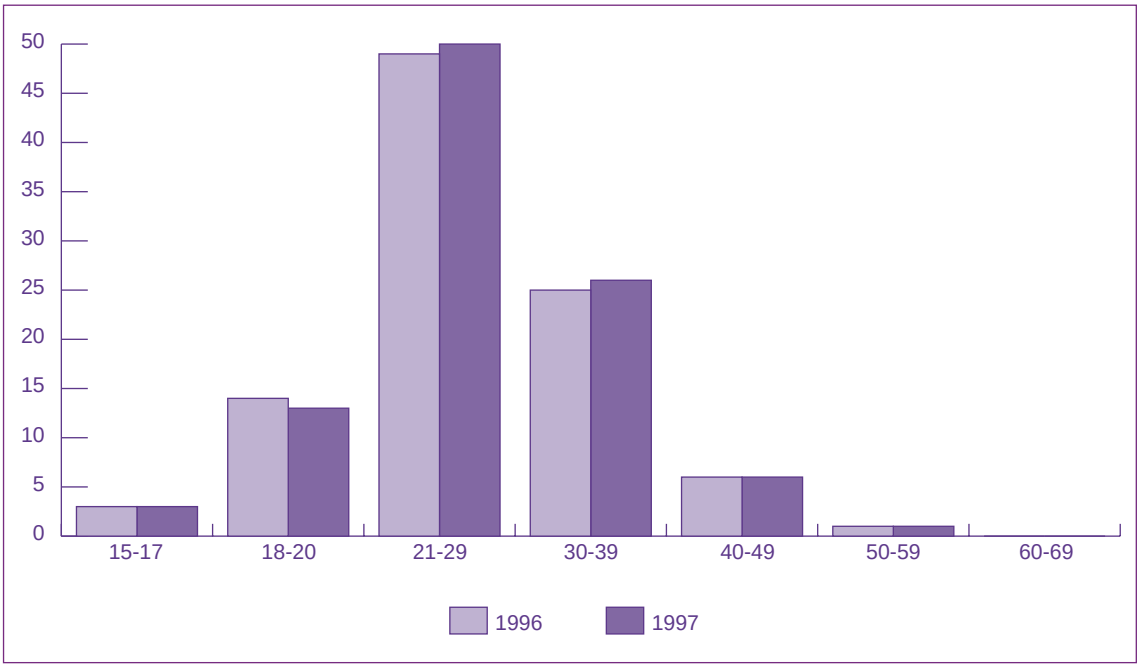


1.3 Recorded incidents of attempted suicide/deliberate self-harm by age group

Age group	1996		1997	
	No	%	No	%
15 – 17 years	31	3	51	3
18 – 20 years	126	14	205	13
21 – 29 years	443	49	805	50
30 – 39 years	225	25	407	26
40 – 49 years	55	6	91	6
50 – 59 years	8	1	19	1
60 – 69 years	2	-	-	-
Missing data	17	2	13	1
Total recorded incidents	907		1591	

- half of the recorded incidents of attempted suicide/deliberate self-harm occurred in the 21-29 age group
- a quarter of the recorded incidents of attempted suicide/deliberate self-harm occurred in the 30-39 age group
- juveniles and young offenders accounted for 17% in 1996 and 16% in 1997 of the total of recorded incidents of attempted suicide/deliberate self-harm

Figure 1.3: Recorded incidents of attempted suicide/deliberate self-harm by age group* (%)



(*all age groups not equivalent in length)

1.4 Recorded incidents of attempted suicide/deliberate self-harm by gender

Gender	1996		1997	
	No	%	No	%
Male	827	91.2	1430	89.9
Female	63	6.9	152	9.6
Missing information	17	1.9	9	0.6
Total recorded incidents	907		1591	

1.5 Recorded incidents of attempted suicide/deliberate self-harm by ethnicity

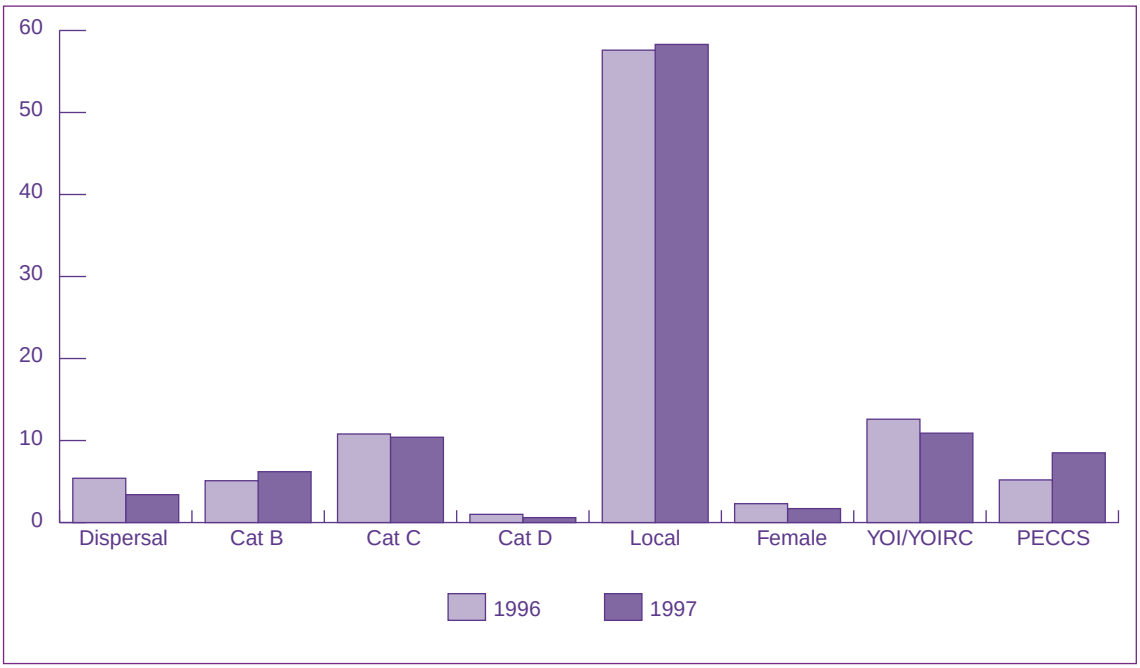
Ethnicity	1996		1997	
	No	%	No	%
White	742	81.8	1348	84.7
Asian Bangladeshi	3	0.3	3	0.2
Indian	2	0.2	11	0.8
Pakistani	5	0.6	18	1.1
Other	3	0.3	8	0.5
Black African	11	1.2	19	1.2
Caribbean	32	3.5	40	2.5
Other	16	1.8	20	1.3
Other	36	4.0	39	2.4
Missing information	57	6.3	85	5.3
Total recorded incidents	907		1591	

1.6 Recorded incidents of attempted suicide/deliberate self-harm by type of establishment

Type of establishment	1996		1997	
	No	%	No	%
Dispersal	49	5.4	54	3.4
Category B	46	5.1	98	6.2
Category C	98	10.8	166	10.4
Category D	9	1.0	10	0.6
Local	522	57.6	927	58.3
Female	21	2.3	27	1.7
YOI/YOIRC	115	12.6	174	10.9
PECCS (court escort)	47	5.2	135	8.5
Total recorded incidents	907		1591	

- Over half of all recorded incidents of attempted suicide/deliberate self-harm in 1996 and 1997 occurred in local prison establishments
- Of the 58% of recorded incidents in local establishments in 1997, 57% were by people aged between 21-29 years and 29% by those aged between 30-39
- Young offender institutes and young offender remand centres accounted for 13% in 1996 and 11% of all recorded incidents of attempted suicide/ deliberate self-harm

Figure 1.6: Recorded incidents of attempted suicide/deliberate self-harm by type of establishment (%)

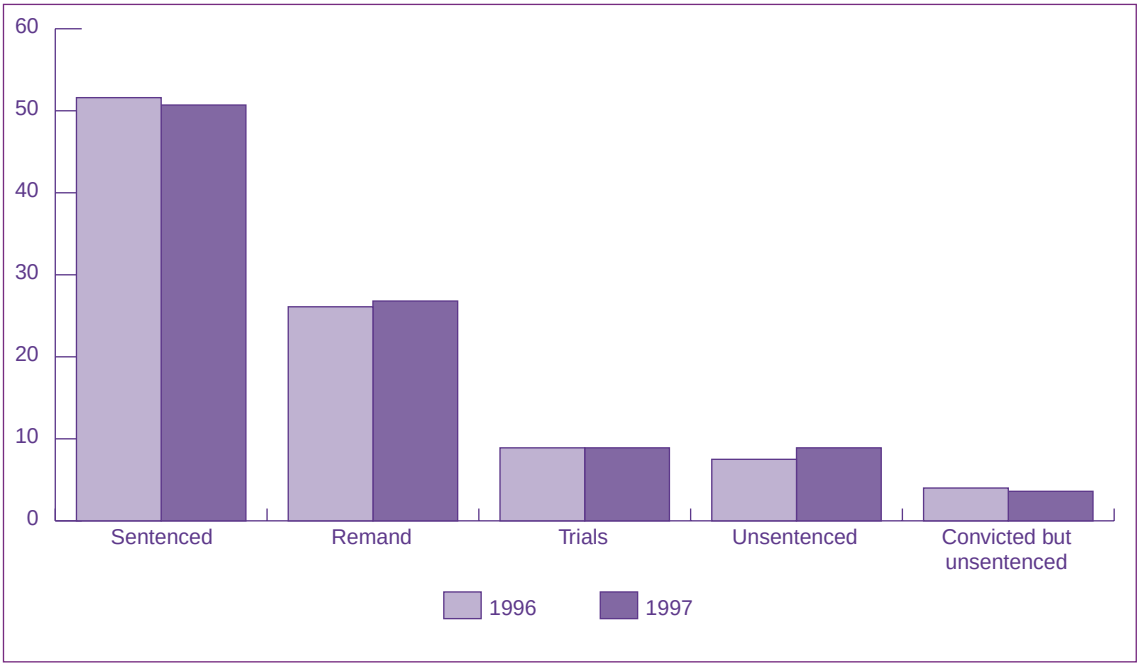


1.7 Recorded incidents of attempted suicide/deliberate self-harm by custody status

Custody Status	1996		1997	
	No	%	No	%
Sentenced	468	51.6	807	50.7
Remand	237	26.1	426	26.8
Trials	81	8.9	142	8.9
Unsentenced	68	7.5	141	8.9
Convicted but unsentenced	36	4.0	58	3.6
Missing data	17	1.9	17	1.1
Total recorded incidents	907		1591	

- Just over half of the recorded incidents of attempted suicide/deliberate self-harm were by sentenced prisoners in 1996 and 1997
- Unsentenced prisoners accounted for 48% of the recorded incidents of attempted suicide/deliberate self-harm in 1996 and 49% in 1997

Figure 1.7: Recorded incidents of attempted suicide/deliberate self-harm by custody status (%)

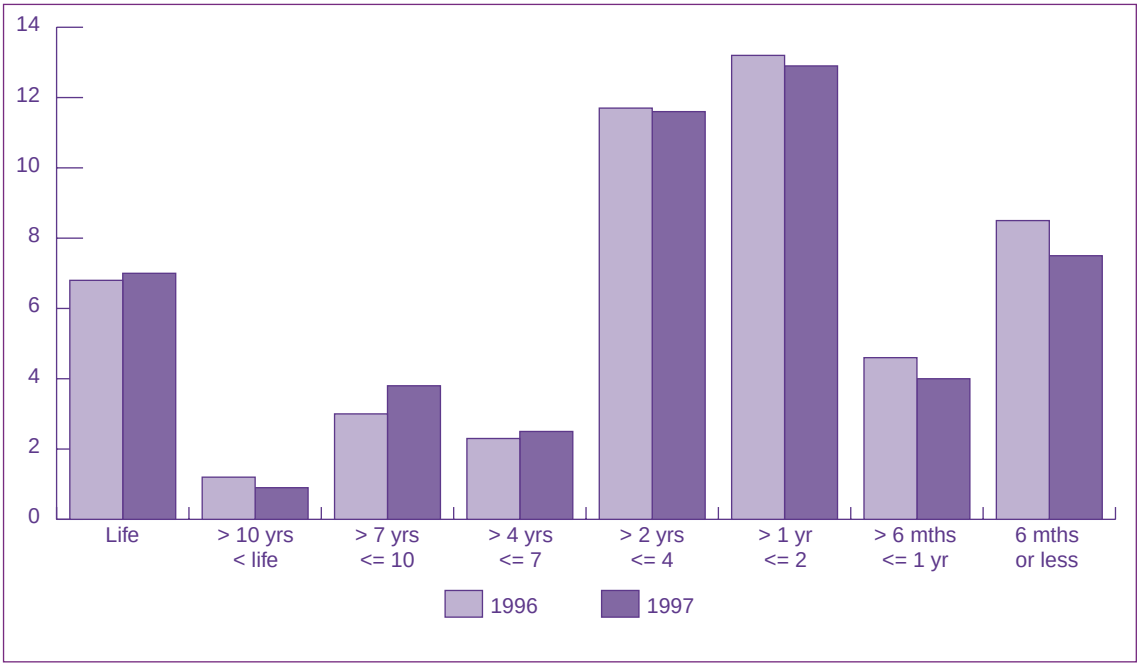


1.8 Recorded incidents of attempted suicide/deliberate self-harm by length of Sentence

Length of sentence	1996		1997	
	No	%	No	%
Life	62	6.8	112	7.0
> 10 years < life	11	1.2	14	0.9
> 7 years < = 10 years	27	3.0	60	3.8
> 4 years < = 7 years	21	2.3	40	2.5
> 2 years < = 4 years	106	11.7	185	11.6
> 1 year < = 2 years	120	13.2	206	12.9
> 6 months < = 1 year	42	4.6	63	4.0
6 months or below	76	8.5	120	7.5
Not applicable/not known	442	48.7	791	49.8
Total recorded incidents	907		1591	

- A quarter of recorded incidents of attempted suicide/deliberate self-harm of those who were sentenced related to prisoners serving between 1 and 4 years
- Prisoners serving periods of a year or less accounted for approximately 12% of recorded incidents in 1996 and 1997
- Recorded incidents of attempted suicide/self-harm amongst life sentence prisoners comprised 7% of the total in both years

Figure 1.8: Recorded incidents of attempted suicide/deliberate self-harm by length of sentence (%)

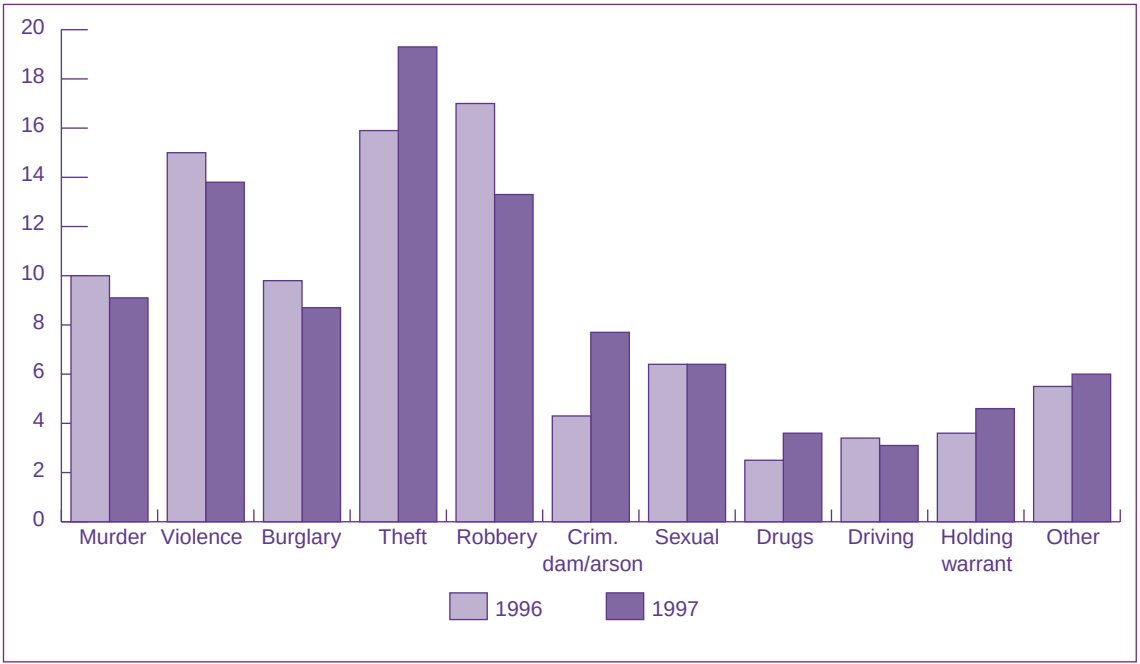


1.9 Recorded incidents of attempted suicide/deliberate self-harm by type of offence

Type of offence	1996		1997	
	No	%	No	%
Murder	91	10.0	144	9.1
Violence against the person	136	15.0	220	13.8
Robbery	89	9.8	139	8.7
Burglary	144	15.9	307	19.3
Theft	154	17.0	212	13.3
Criminal damage/arson	39	4.3	123	7.7
Sexual offences	58	6.4	102	6.4
Drugs	23	2.5	57	3.6
Driving offences	31	3.4	49	3.1
Holding warrant	33	3.6	73	4.6
Other offences	50	5.5	95	6.0
Missing data	59	6.6	70	4.4
Total recorded incidents	907		1591	

- 43% in 1996 and 41% in 1997 of recorded incidents of attempted suicide/deliberate self-harm were carried out by prisoners charged with an acquisitive offence such as robbery, burglary or theft
- 25% in 1996 and 23% in 1997of recorded incidents related to prisoners charged with offences of violence, including murder

Figure 1.9: Recorded incidents of attempted suicide/deliberate self-harm by type of offence (%)



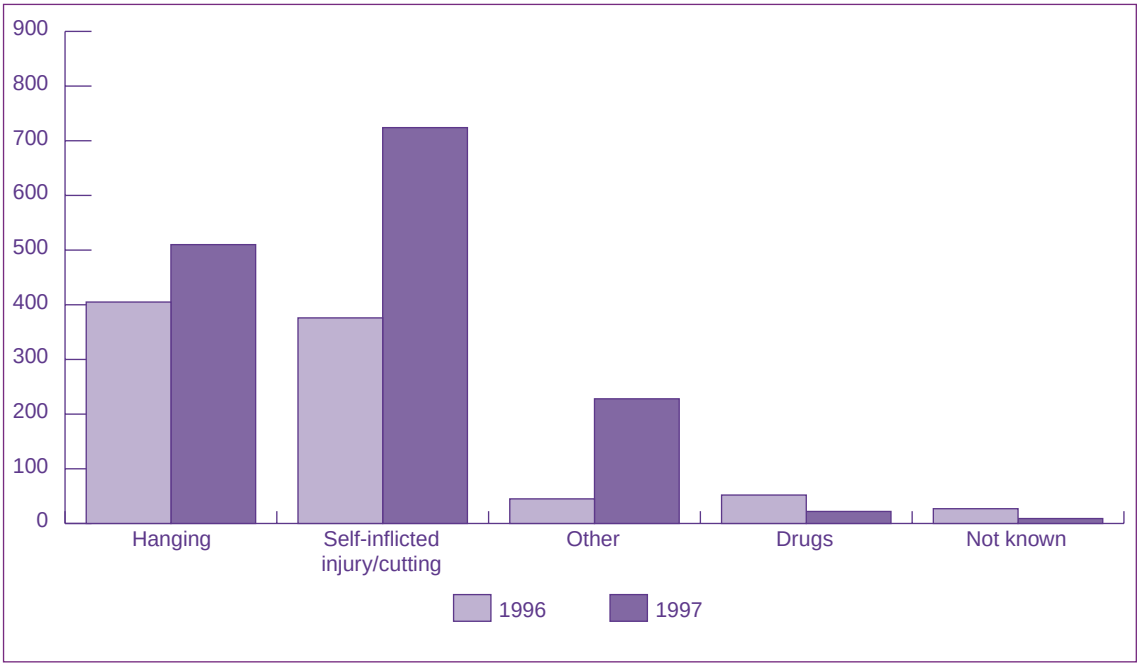
1.10 Recorded incidents of attempted suicide/deliberate self-harm by type of method used

Method	1996		1997	
	No	%	No	%
Hanging	405	45	510	32
Self-inflicted injury	376	41	90	6
Cutting/self-mutilation*	-	-	724	45
Drugs	52	6	22	1
Suffocation	-	-	8	1
Drowning	2	-	-	-
Other	45	5	228	14
Not known	27	3	9	1
Total recorded incidents	907		1591	

* incidents of self-mutilation/cutting were not recorded separately in 1996 but serious incidents were reported as self-inflicted injury. Following changes in recording and reporting procedures in April 1997 all incidents of self- mutilation/cutting were included from that point in reported recorded incidents of deliberate self-harm

- Attempted suicide by means of hanging was the most frequently used method, accounting for 45% of the total of 907 recorded incidents in 1996
- In 1997, recorded incidents of attempted suicide by means of hanging increased to 510 from 405 in 1996, a year on year increase of 26%
- Recorded incidents of attempted suicide by means of self-inflicted injury in 1996 accounted for 41% of the total of 907 by comparison to 51% in 1997 (combining 90 incidents of self-inflicted injury and 724 of self-mutilation/cutting)

Figure 1.10: Recorded incidents of attempted suicide/deliberate self-harm by method used (%)

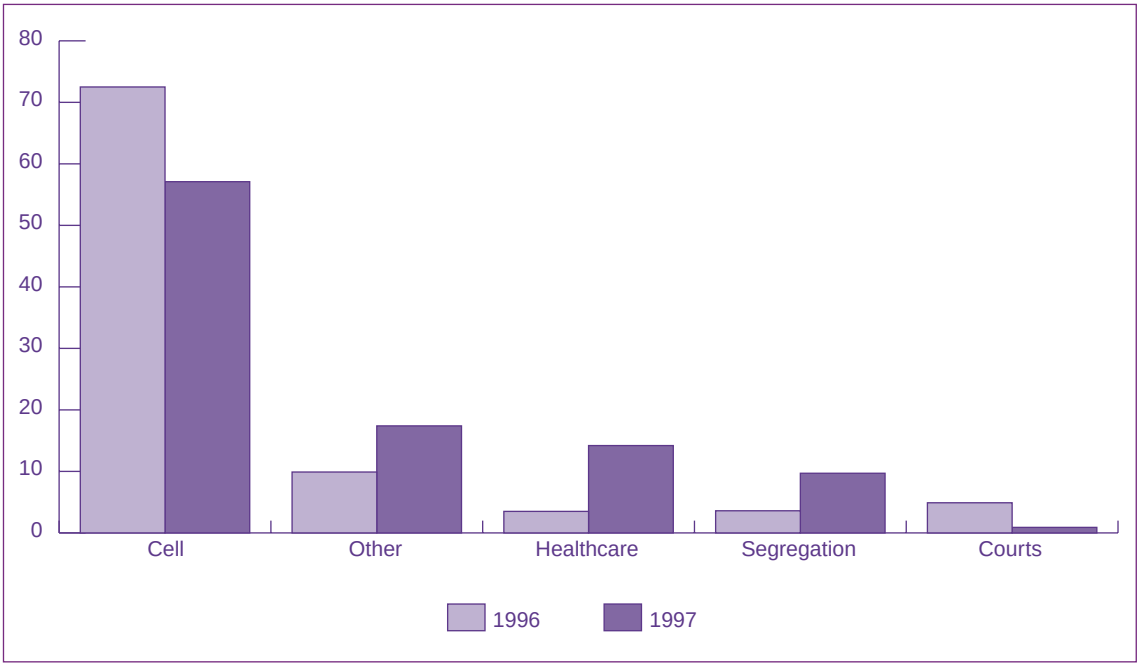


1.11 Recorded incidents of attempted suicide/deliberate self-harm by location

Location	1996		1997	
	No	%	No	%
Cell (single, shared, dormitory)	658	72.5	908	57.1
Other (chapel,/educ/association)	90	9.9	277	17.4
Health Care Centre	32	3.5	226	14.2
Segregation Unit	33	3.6	154	9.7
Crown/Magistrates courts	44	4.9	14	0.9
Not known	50	5.6	12	0.7
Total recorded incidents	907		1591	

- Prisoners' cells (either single, shared or dormitory) were the most likely location for incidents of attempted suicide/deliberate self-harm to occur
- The percentage of incidents of attempted suicide/deliberate self-harm recorded as being in prisoners' cells reduced from 73% in 1996 to 57% in 1997
- Other locations (such as on association, in the chapel, at education or on the wing) accounted for 10% of recorded incidents in 1996 and 17% in 1997
- The percentage of incidents of attempted suicide/deliberate self-harm recorded as occurring in health care centres increased from 4% in 1996 to 14% in 1997 and in the segregation unit from 4% in 1996 to 10% in 1997
- The percentage of incidents recorded by court escort services decreased from 5% in 1996 to approximately 1% in 1997

Figure 1.11: Recorded incidents of attempted suicide/deliberate self-harm by location (%)



Section 2

2.1 The number of people for whom incidents of attempted suicide/deliberate self-harm were recorded in 1996 and 1997

- The total of 2,498 referred to the number of incidents of attempted suicide that were reported for the years 1996 and 1997 rather than the number of individuals who made those attempts. The total of 2,498 incidents therefore included those people who made single attempts and also those who made multiple attempts.
- Further analysis of the dataset was undertaken to identify the number of individuals for whom the total of 2,498 recorded incidents of attempted suicide/deliberate self-harm referred over the two years 1996 and 1997.

2.2 Analysis of the number of people recorded as having attempted suicide/deliberate self-harm one or more times in the 24 month period 1996-1997

Number of recorded attempts	Number of people	% of people
One attempt only	1,686	85
2 attempts	194	10
3 attempts	60	3
4 attempts	19	1
5 attempts	14	1
6 attempts	3	-
7 attempts	4	-
8 attempts	1	-
9 attempts	1	-
10 attempts	1	-
11 attempts	1	-
19 attempts	1	-
People who made one attempt	1,686	85%
People who made two or more	299	15%
Total recorded incidents	1,985	

- A total of 1,985 people accounted for the total of 2,498 recorded incidents of attempted suicide/deliberate self-harm recorded over the period 1996/1997 of whom:
  - 85% were recorded as having made one attempt
  - 15% were recorded as having made between 2 and 19 attempts

2.3 Analysis by gender of the people recorded as having made single or repeat suicide attempts in the 24 month period 1996/1997

Gender	Single %	Repeats %
Male	93	88
Female	7	12

2.4 Analysis by age of the people recorded as having made single or repeat suicide attempts in the 24 month period 1996/1997

Age group	No of people	%
15 – 17 years	73	4
18 – 20 years	277	14
21 – 29 years	960	48
30 – 39 years	506	25
40 – 49 years	114	6
50 – 59 years	23	1
60 – 69 years	2	-
Missing data	30	2
	1,985	

- 48% of those who had incidents of attempted suicide/deliberate self-harm recorded in 1996 and 1997 were aged between 21- 29 years
- a further 25% were aged between 30 - 39 years
- 18% were juveniles or young offenders

2.5 Analysis by age and by number of recorded attempts in 1996 and 1997 combined

	15 –17 years	18 – 20 years	21 – 29 years	30 – 39 years	40 – 49 years	50 – 59 years	60 – 69 years	Total
1 attempt	67 *92%*	236 *85%*	798 *83%*	439 *87%*	93 *82%*	21 *91%*	2	1,656*
2 attempts	5 *7%*	29 *10%*	102 *11%*	42 *8%*	16 *14%*	-	-	194
3 attempts	-	11 *4%*	32 *3%*	14 *3%*	1 *1%*	2 *9%*	-	60
4 attempts	1 *1%*	1 *1%*	14 *1.5%*	2 -	1 *1%*	-	-	19
5 or more	-	-	14 *1.5%*	9 *2%*	3 *2%*	-		26
Totals	73	277	960	506	114	23	2	1,955*
Row %	*4%*	*14%*	*48%*	*25%*	*6%*	*1%*	-	

*excludes 30 (2%) people whose ages were not known

- Overall, those aged between 21 - 29 years accounted for both a higher proportion of recorded incidents of attempted suicide/self-harm and a more extensive pattern of repeat attempts by comparison with other age groups (7 of the 14 people with 5 or more attempts made between 7 and 19 attempts in the 24 month period)

2.6 Analysis by year of the number of people for whom incidents of attempted suicide/deliberate self-harm were recorded

- The following analyses were carried out to identify the proportion of people recorded as making one or more suicide attempts within 1996 or 1997.
- Where individuals made one suicide attempt in 1996 and a repeat attempt in 1997 (41 people in total, 2% of the total of 1,985 people), they have been counted once in 1996 and again in 1997 in order to conduct a year by year analysis.

No of people	1996		1997		Total number of people
No of people who made one attempt only	648	84%	1,038	82%	1,686
No of people who made two or more attempts	119	16%	221	18%	340*
Total number of people	767		1,259		2,026*

*includes 41 people who were counted once in 1996 and once in 1997

2.7 Analysis by year of the number of people who were recorded as having made two or more attempts of suicide/deliberate self-harm (excludes single attempts only)

Number of people & number of attempts	1996		1997		Total
No of people who made one attempt in this year (plus one or more repeats in the other year)	24 *	20%	25 **	11%	49
No of people who made two attempts in this year only	69	57%	125	57%	194
No of people who made 3 attempts	14	12%	42	19%	56
No of people who made 4 attempts	8	7%	11	5%	19
No of people who made 5 attempts	2	2%	10	4%	12
No of people who made 6 attempts	1	1%	5	2%	6
No of people who made 7 attempts	-		1	1%	1
No of people who made 8 attempts	-		-		-
No of people who made 9 attempts	-		2	1%	2
No of people who made 10 attempts	1	1%	-		1
Total number of people	119		221		340

* 24 of 41 people counted in both years: remaining 17 made 2 or more attempts in 1996 and 1997

** 25 of 41 people counted in both years: remaining 16 made 2 or more attempts in 1996 and 1997

APPENDIX 5A(I)

Analysis of Part A - about the establishment - from the Boards of Visitors Questionnaire

A questionnaire was sent to all Boards of Visitors as part of the thematic review of suicide and self harm. We are very grateful to all those who took so much time and care in fully completing these questionnaires.

An example of the questionnaire can be found as Appendix 6.

Part A - about the establishment - 113 questionnaires returned

POLICY

1. Within the establishment in which you work is there a policy for the prevention of suicide and self-harm?

Yes	96%
No	2%
No answer	2%

2. How are staff made aware of the policy?

Booklet	38%
Notices	73%
Governor's Order	61%
Training	88%

Other :
Briefings/meetings
Publicity
Suicide Awareness Committee minutes
Policy statements issued to staff
Policy document held on each wing

3. Is the policy on suicide and self-harm displayed in residential areas?

Yes	75%
No	21%
No answer	4%

4. Is the policy on display in any other areas?

Reception	55%
Education	31%
Workshops	19%
Chapel	30%
Health Care	63%

Other: Activities
Entrance areas
Farms
Works
Segregation Unit
Library
Staff areas/information boards
Governor's office
Visits room

5 a. Is there a Suicide Awareness Team?

Yes	99%
No answer	1%

5 b. How often has it met in the last 12 months?

2 - 3 times	5%
4 times	42%
5 - 9 times	25%
10 - 12 times	21%
28 - 52 times	3%
No answer	4%

6. If YES who regularly attends the team meetings?

Health Care	94%
Chaplain	94%

Governors	92%
Samaritans	91%
BOV	83%
Probation	79%
Officers	76%
Senior Officer	72%
Listeners	65%
Principal Officers	61%
Instructors	21%

Other: Psychology
Gym staff
Escort staff
Social Services
External Probation
Voluntary Group workers
Salvation Army
Drugs Counsellor

TRAINING

7. How many staff have had any suicide awareness training in the last year?

Officers	61%
Senior Officers	53%
Principal Officers	39%
Instructors	35%
Governors	29%
OSG	38%
BoV	25%
Night Patrol	21%
None	5%
No answer	20%

Other: Admin
Health Care
Chaplain
Probation
Gym staff
Education
Psychology
Catering
Works

8. Which of the following types of training packages are used and how long is each type of course?

F2052SH Awareness 72%
Duration: 30 mins-8 hours

Local Suicide Awareness course 65%
Duration 0-12 hours

Training Manual 60%
Duration: 30 mins-48 hours

Training for Trainers 42%
Duration: 1-235 hours

Other: Induction for Prisoners
Duration: 15 mins

Managers course
Duration: 3 hours

Video
Duration: 30 mins

Refresher course
Duration: 30 mins-1 hour

No answer 5%

9. Who is responsible for the delivery of local training in suicide and self-harm?

Suicide Awareness Trainer	80%
Training Manager	50%
Discipline Staff	23%
Medical Staff	21%
Education Staff	1%

Other: Outside college/specialist
Chair of Suicide AwarenessTeam
Chaplain
Governor
Probation
Psychology

LISTENERS

10. Is there a Listener Scheme in the establishment?

Yes	81%
No	17%
No answer	2%

(nb. the following 'no answers' will contain those that had no listener scheme)

11. Is the Listener Scheme supported by the Samaritans?

Yes	79%
No	4%
No answer	17%

12. What involvement do the Samaritans have with the listeners?

Select:	Yes	61%
	No	12%
	No answer	27%
Train:	Yes	73%
	No	3%
	No answer	24%
Support:	Yes	77%
	No	2%
	No answer	21%

13. If there is a Listener Scheme that is not supported by the Samaritans please specify who is responsible for the Listeners?

Suicide Awareness Team
Ex Samaritan
Discipline Officer
Psychologist
Sister in Health Care Centre

14. How are prisoners made aware of the existence of the Listeners?

Notices	80%
Staff	77%
Word of mouth	75%
Prisoners	67%
Induction	66%
Listeners wear special badges/clothing	57%
Leaflets	50%
No answer	19%

Other: BOV
Cell door plates
Photos of listeners on wings
Listener magazine
HCC application forms
Personal letter to every prisoner
Samaritans

15. How are prisoners able to gain access to a Listener?

Approach Listener	79%
Approach staff	74%
Make application	42%
No answer	19%

Other: Other prisoners approach staff
Approach Samaritans
Box in library
Staff observation
Prison visitors

16. Is there a Duty Rota for Listeners?

Yes	41%
No	38%
No answer	21%

17. Has a local policy been drawn up that relates to the Listener Scheme?

Yes	61%
No	18%
No answer	21%

18. Are Listeners allowed to visit prisoners on other residential units than their own?

Yes	70%
No	9%
No answer	21%

19. Do prisoners have 24 hour access to Listeners if requested?

Yes	60%
No	19%
No answer	21%

20. Are Listeners given any type of funding, either by payment or canteen vouchers?

Yes	10%
No	69%
No answer	21%

21. How many contacts have been made with Listeners in the last three months?

0-50	17%
51-100	6%
101-200	7%
201-500	4%
501-930	3%
No answer	63%

SAMARITANS

22. Do the Samaritans visit the establishment regularly?

Yes	93%
No	4%
No answer	3%

23. How often do they attend?

Weekly	56%
Fortnightly	22%
Monthly	7%
Quarterly	4%
No answer	3%
Other:	Ad hoc and when called out
	More than once a week
	For training and meetings

24. What is the purpose of their visits?

Attend Meetings	85%
Hold surgery	31%
Individual Counselling	40%
Visit residential units	44%
Work with Listeners	73%
No answer	7%
Other:	Attend induction
	Liaise with listener co-ordinator
	Support staff/ staff induction

25. Is there a dedicated phone line to the Samaritans for prisoners to use?

Yes	40%
No	55%
No answer	5%

26. Is there a liaison officer for the Samaritans within the establishment?

Yes	89%
No	5%
No answer	6%

F2052SH

27. How many F2052SHs are open within the establishment today?

No answer	4%
None	24%
1-5	32%
6-10	19%
11-20	9%
21-30	10%
31-34	3%

28. How many forms have been opened in the last three months?

No answer	5%
None	4%
1-10	29%
11-30	26%
31-60	18%
61-591	18%

29. How many F2052SH files have been closed in the last three months?

No answer	6%
None	6%
1-10	36%
11-30	26%
31-60	16%
61-321	12%

30. How many prisoners did these closed forms relate to?

No answer	16%
1-5	19%
6-10	11%
11-30	24%
31-60	16%
61-115	12%

31. When F2052SHs have been closed where are they stored?

Main File (F2050)	90%
Wing File	6%
Medical Record	4%

32. Is there a central register of F2052SH forms?

Yes	97%
No	2%
No answer	1%

33. Is it accurate?

Yes	88%
No	6%
No answer	6%

34. If YES to question 32, where is the central file held?

LIDS	38%
Health Care Centre	36%
Discipline Office	10%
Control/Communications Centre	35%
No answer	4%

Other:
- Admin
- Chair of Suicide Awareness Team
- Suicide awareness Co-ordinator
- Externals Office
- Gate
- Operations
- Orderly officers
- PO's office
- Probation
- Psychology
- Security office
- Regulators office

35. Is an open form entered against the individual name on LIDS?

Yes	70%
No	26%
No answer	4%

If so, how is it done?

No answer	46%

Other:
- On medical remarks
- Centre CSR list
- Annexe A of procedural document
- F2052SH remarks update
- General remarks
- Against inmate details
- Top right of first page
- Update menu - further options

36. When an F2052SH has been opened on a prisoner how are:
a) wing staff made aware of its existence?

Verbal Handover	90%
Entry in Observation Book	68%
File on Display in Staff Area	79%
All of these	51%
No system	2%

Other:
- Local checklist
- Special watch list displayed in each building
- Orange card pinned to wall in centre
- Gate informs all new staff
- Handover sheet
- LIDS
- Note sent to all interested parties
- Weekly list to all departments

b) night patrols made aware?

- Handover/log/verbal
- Observation book entry
- Files displayed
- LIDS
- List on centre
- Control

No answer	12%

GENERAL INFORMATION

37. Is there a Crisis or Befriending Suite for those considered to be at risk of suicide or self-harm?

Yes	36%
No	60%
No answer	4%

38. Is the suite observed via CCTV?

Yes	5%
No	40%
No answer	55%

39. Who monitors the CCTV and how often?

No answer	94%

Other:		
	Deputy Governor	irregularly
	HCC staff	every 15 mins
	Comms room	constantly
	OSG/night patrol	regularly
	SO's	
	Security	
	'staff'	

40. Who is authorised to open the suite?

Officers	5%
SO	12%

PO	12%
Orderly Officer	15%
Duty Governor	22%
Health Care Staff	21%
Anyone	10%
No answer	62%

Other: Suite unused/ forms part of CNA
Board of Visitors
Psychologists

41. Do listeners accompany a prisoner in the suite during the day?

Always	19%
Usually	5%
1 at a time	13%
2 at a time	4%
No answer	74%

during the night?

Always	22%
Usually	4%
1 at a time	10%
2 at a time	9%
No answer	73%

42. How many prisoners can be accommodated in the suite?

One	15%
Two	15%
Three	4%
No answer	65%
Other	4/5

43. How many times has the suite been used in the last three months?

0	6%
1-5	13%
6-10	4%
11-20	4%
20-35	2%
No answer	71%

44. On average how long was the suite open for?

up to 10 hours	13%
>10 - 24 hours	9%
>24 hours- 2 days	4%
No answer	71%

Other: Not used overnight 3%
Not used 2%

45. How are incidents of self-harm reported?

Incident Report	72%
F213	87%
To Health Care	87%
Accident Book	35%

Other: Lids
Regime Monitoring Form
Central register
Verbally /telephone
Comms
Main file
F2052SH
H & S Accident book
IMR

46. How many incidents of self-harm have been recorded in the last three months?

0	5%
1-10	6%
11-30	3%
31-12	56%
No answer	20%

47. Which of the following items, if any, are held on the residential units?

Sealed	First Aid Kits	93%
	Body Fluid Spill Kit	85%
	Ligature Cutters	94%
	No answer	4%

48. Is there a Personal Officer Scheme?

Yes	87%
No	12%
No answer	2%

49. To what extent do prisoners know who their personal officer is?

Not at all	1%
Some	19%
Most	33%
All	35%
No answer	13%

50. To what extent do personal officers attend review boards, such as sentence plan reviews, for their prisoners?

Occasionally	30%
Sometimes	14%
Invariably	30%
No answer	26%

51. Are all residential officers also personal officers or is there a dedicated group to fulfil this role?

All personal officers	72%
Dedicated Group	12%
No answer	16%

52. Is there an Anti-Bullying Strategy?

Yes	96%
No	3%
No answer	1%

53. How are staff made aware of the Anti-Bullying Strategy?

Booklets		50%
Notices		81%
Governor's Order		59%
Training		76%
Other:	Bully Week	
	Anti Bullying Liaison Officer	
	Anti Bullying Management Committee	
	Policy Document	
	Op procedures	

54. How are prisoners made aware of the Anti-Bullying Strategy?

Booklets		43%
Notices		91%
Governor's Order		26%
Training		25%
No answer		4%
Other:	Sign contract/compact	
	Induction	
	BOV	
	Reception	
	Personal Officer	
	Video	
	Word of mouth	

55. Who is responsible for the strategy?

The Governor		29%
Deputy Governor		27%
Governor Grade		44%
Probation Officer		9%
PO		24%
SO		16%
No answer		4%
Other:	All staff	
	Everyone	
	Anti-bullying group	
	Clinical Manager	
	Counsellor	
	Nurses	
	Psychology	

56. What makes the strategy effective?

No answer 13%

Other	Officers being aware and diligent
	Booklets
	Meetings
	Assessment
	Targeting and challenging the bully
	Ensuring prisoners have the confidence to report
	Small establishment
	Links with incentive scheme
	Observation and education
	Relationships with Personal officers
	Zero tolerance
	Co-operation between units
	Consistency
	Continual review/development and policing of policy
	AB officer on each wing
	Enthusiasm from the top
	A safe environment
	Publicity
	BOV
	Multi disciplinary approach