PRISONS AND PROBATION OMBUDSMAN
for England and Wales

Independent Investigations

Learning from PPO Investigations

Risk factors in self-inflicted deaths in prisons

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Contents

Foreword

This thematic report focuses on learning about risk factors for suicide from my independent investigations into self-inflicted deaths in prisons. The report uses information from 361 such deaths investigated by my office between 2007 and 2013.

If the Prison Service is to prevent suicide and self-harm in prison, identifying and assessing risk as accurately as possible is crucial. Prison Service Instructions go to considerable lengths to set out the factors staff ought to bear in mind when making such judgements. Unfortunately, assessment of risk is not an exact science and the risk prisoners pose to themselves is influenced by a great many things, so it is not possible to predict exactly how an individual will react to different situations or events. Nevertheless, some things are known to increase risk, for example a history of self-harm, certain types of offence, lack of experience of prison, the first days in custody, being on remand or receiving upsetting news. Giving proper consideration to such risks is key.

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

Given the sharp and deeply troubling increase in self-inflicted deaths in custody in recent months, this study, and a simultaneously published one on suicide and self-harm procedures in prison, offers timely and important lessons from my investigations. Learning these lessons about better identification of risk and about taking appropriate consequential action may help stem the apparently rising tide of despair in prison and reinvigorate the way the Prison Service supports prisoners in crisis.

I would like to thank my colleague, Helen Stacey, for preparing this report. It is part of a series reflecting my commitment to publish regular reports and bulletins setting out the lessons from my investigations which, if learned, could help ensure custody is safer, fairer and more effective.

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Executive Summary

This report looks at data collected relating to 361 self-inflicted deaths in prisons investigated by the Prisons and Probation Ombudsman (PPO) between 2007 and 2013. It examines the characteristics of those who died, the events in the 72 hours leading to their deaths, and the prisons' approaches to assessing and managing risk.

Prison Service Instructions provide a detailed guide to suicide and self-harm prevention through assessment, monitoring, staff and peer support. First night and induction procedures are intended to provide extra support for prisoners who are newly arrived in custody. The instructions also specify a non-exhaustive list of factors and triggers that indicate prisoners are at heightened risk. This includes having a history of self-harm, mental health issues, substance misuse problems, certain offence types, receiving a life sentence and being in the early days of custody. Identifying individuals at heightened risk can be particularly difficult in a prison environment, since being in custody itself increases risk.

In the sample, most of those who died were white, single men and remand prisoners were over-represented. A quarter of the sample were in the first month of their custody and a third were in prison for the first time. A quarter had committed their main offence against a family member or partner.

The report looks in detail at the following groups of prisoners:

- those with a history of mental health issues;
- those with a history of self-harm or who had attempted suicide in custody;
- those who misused drugs or alcohol;
- new arrivals to custody;
- life and indeterminate sentenced prisoners;
- those held on remand or who were convicted but unsentenced;
- those whose offence, or alleged offence, was against a family member or someone else they were close to.

The groups differed in terms of their risk factors, but ultimately the findings about the assessment and management of their risk were broadly similar. Knowledge of which factors indicate risk is key, and too often too much weight was placed on judging how the prisoner 'presented' rather than on indications of risk, even when there had been very recent acts of self-harm or suicidal ideation (having suicidal thoughts). The other main findings were that:

- risk changes over time and in response to context and events;
- contact with health services was common in the final 72 hours and represents a key opportunity for suicide prevention;
- prisoners often withhold their distress from staff and fellow prisoners, and processes must be in place to respond effectively when family, friends or other contacts in the community raise concerns;
- reception screening needs to take fully into account concerns raised by police, escort services or the courts;

Prison Service Instructions should list being held on remand as a risk factor and the risk factors for suicide and self-harm should be presented clearly and concisely.

1. Suicide and self-harm in prison

Risk factors for suicide and self-harm are the characteristics and circumstances associated with an individual which indicate a greater potential or likelihood of suicidal behaviour. A person's risk is not a fixed thing. New factors may become relevant or changes in circumstance may alter their significance. Risk factors include both characteristics possessed by an individual, such as a history of depression, and more changeable events or circumstances such as bereavement or isolation. Sometimes these two aspects of risk are referred to as 'fixed' and 'dynamic' risk factors respectively. Not all dynamic factors change frequently and some can remain stable for long periods of time.

Identifying individuals at heightened risk can be particularly difficult in a prison environment, since being in custody is itself considered a risk factor. The World Health Organisation identifies people in prison as an 'at risk population' for suicide[1]. The Ministry of Justice 'Safety in Custody' bulletin reports 57 self-inflicted deaths in prisons in 2011 which is 66 deaths per 100 000 population. Over the same period the ONS gives the suicide rate for the whole of the United Kingdom as 12 deaths per 100 000 population[2]. In addition, several characteristics known to be correlated with higher suicide rates in the general population are also found in higher proportions in the prison population. This includes people with drug or alcohol problems and with mental health problems.

Clearly some risk factors will pre-date arrival in prison but others, such as social isolation or feelings of shame and guilt, may be a direct consequence of the person's incarceration. New arrivals to custody, prisoners sentenced to life imprisonment, and offenders recalled to prison for breach of licence are recognised by the Prison Service Instructions as groups at higher risk of self-inflicted death. The World Health Organisation also highlights pre-trial detainees (known as remand prisoners in the UK) as being at particular risk within the prison population[3].

The overwhelming majority of self-inflicted deaths in prison are by hanging. Hanging and self-strangulation account for 73% of the 661 apparently self-inflicted deaths in prison between 2004 to October 2013[4]. In a restrictive prison environment alternative means are mostly unavailable or, like prescription medication, subject to strict controls[5]. Hanging, strangulation or suffocation is also the most common method of suicide by men in the community, this accounted for 56% of male suicides in England in 2011[6].

2. Prison Service approaches to managing risk

2.1 Screening and risk assessment

The Prison Service procedures and practices to identify, manage and support prisoners who are at risk of suicide or self-harm are set out in Prison Service Instruction (PSI) 64/2011. Prisoners at risk of suicide or self-harm are identified using a list of risk factors and triggers outlined in the PSI[7]. The guidance sets out risk factors separately for self-harm and for suicide. This recognises one of the most difficult facts about trying to assess risk: while those with a history of self-harm are at greater risk of suicide and suicide attempts, overall the profile of those who kill themselves is different from those who harm themselves non-fatally. For example, adult men over 21 make up most self-inflicted deaths in custody yet it is young adults and women who are more likely to self-harm.

The PSI divides risk factors into several different categories: demographic characteristics, historical factors, feelings and attitudes, and the immediate 'context' faced by the individual. This encourages staff making an assessment to think about not only how the person presents in terms of their mood and behaviour, but also about their personal characteristics and history. The risk factors highlighted for suicide and self-harm by PSI 64/2011 are set out in Table 1. The instructions separate out risks for suicide and for self-harm, recognising that these differ, however staff screen for both together and the same process is used to manage both types of risk. In some cases it is unclear why the factors are treated differently for self-harm and suicide. For example, lack of social support is listed as a psychological factor for suicide and a demographic factor for self-harm, and loneliness is listed separately for self-harm but not for suicide. Given the number of risk factors that should be considered and the duplication of factors between the lists for suicide and self-harm, a single list could provide a clearer and more effective prompt for staff – especially in the often busy environment of a prison reception where staff need to check for multiple factors across a range information sources. It is also the case that some acts of self-harm result in death, even when this was not intended.

The guidance also identifies 'triggers' which may increase the risk of harm. A trigger is an event that has or may have an adverse impact on the individual's level of risk. By their nature triggers tend to be highly specific to the individual, and some are more easily identified than others, but the guidance gives some common potential triggers including change in sentencing status. Other possible triggers are court appearances, new criminal charges, key anniversaries, bereavement, relationship breakdown, segregation, immigration issues, transfers to different prisons and licence recall. The lists of risk factors and triggers are not designed to be exhaustive, and the distinction between them is not entirely clear. Refusal of parole, a significant event, is listed as a risk factor rather than a trigger. Together the list of risk factors and triggers given by PSI 64/2011 provides information about some of the key and most common things to consider, and supports staff who must use their judgement to come to a considered assessment of how serious and how immediate a risk is posed.

Table 1: PSI 64/2011 list of risk factors

Risk factor	Suicide	Self-harm
Demographic factors		
Lack of social support		X
Low socioeconomic status	X	
Unmarried, separated, widowed or recently divorced	X	X
Young age		X
Background history		
Childhood adversity / maltreatment (e.g. sexual abuse)	X	X
Deliberate self-harm (especially with high suicide intent)	X	
Family history of mental illness	X	X
Family history of suicide	X	
History of violence		X
Spouse / partner with terminal illness	X	
Clinical history		
Mental health in reach	X	
Mental illness diagnosis	X	X
Personality disorder diagnosis	X	X
Physical illness (especially chronic illness, pain, functional impairments)	X	X
Recent contact with psychiatric services	X	X
Recent discharge from psychiatric services	X	X
Psychological and psychosocial factors		
Anger		X
Shame		X
Desperation		X
Disconnection		X
Hopelessness	X	X
Impulsiveness	X	
Lack of social support	X	
Loneliness		X
Low self-esteem	X	
Powerlessness		X
Relationship instability	X	
Sadness		X
Significant life event	X	
Worthlessness		X
Current 'context'		
Availability of means	X	
Early days in custody and following transfer	X	
Hostile rejection of help		X
Irrational behaviour		X
Lethality of means	X	
Life sentence	X	
Longer sentence than expected		X
Offence (violence especially against family, arson)	X	
Parole refusal or other knock-back	X	X
Recent suicide of someone similar to themselves		X
Recklessness		X
Relationship problems		X
Substance misuse		X
Suicidal ideation	X	
Suicide plans	X	
Violence or intimidation (either experienced or fear of it)		X

Prison staff should actively identify risks based on checks of relevant documents (such as the Person Escort Record, Suicide and Self-harm Warning Forms, pre-sentence reports, NOMIS, and clinical records), information from the prisoner or raised by their friends and family members, and any concerns of staff who interact with them.

However, many of our investigations have found that relevant information was not considered. For example, prisoners are 'screened' on reception to make an initial assessment of whether they pose a risk to themselves, but in some cases prison officers appeared to believe that the responsibility for assessing risk of suicide and self harm in reception lay with healthcare staff. Healthcare staff are required by the Early Days in Custody PSI (74/2011) to conduct a detailed medical examination on a prisoner's first night in custody. Along with assessing physical and mental health, this must consider whether there are any safer custody concerns. However, it does not specify how this clinical view should be considered with the information and documentary evidence available to the officers in reception. As a result, information was often not shared between healthcare and prison staff, or vice versa. No one person in reception was responsible for collating and considering all the known risks holistically. Neither the Safer Custody PSI (64/2011) nor the Early Days in Custody PSI (74/2011) are explicit about where this overall responsibility rests.

The Safer Custody PSI recognises that risk is not static and that it is not sufficient to rely solely on reception screening. Not only can new information come to light over time, but the prisoner's circumstances can change. Dynamic risk factors and, in particular, specific triggers, can have an immediate impact on the likelihood that prisoners might harm or kill themselves. Even when the reception screen indicates prisoners are at low risk, vigilance is always needed.

When prisoners are identified as having self-harmed or attempted suicide, or they are believed to be at risk of suicide or self-harm, staff are required to manage the prisoner through ACCT procedures. Assessment, Care in Custody and Teamwork (ACCT) is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. As part of the process, a caremap (plan of care, support and intervention) is put in place. There should be regular multi-disciplinary review meetings involving the prisoner. The ACCT process is one of the most common topics of the Ombudsman's recommendations following a self-inflicted death. Learning specifically about ACCT procedures is discussed in a separate report[8].

2.2 Peer supporters

Listeners are adult prisoners who are trained by the Samaritans and volunteer as peer supporters. Prisons are not required to have a Listener scheme, but many do or else run other peer support schemes. Listener schemes are run according to Samaritan guidelines, although some additional requirements are set out in PSI 64/2011. The prison has to ensure prisoners have timely access to Listeners and they must also be able to call the Samaritans, in private and at no cost to themselves. The prison must also ensure that prisoners acting as Listeners are appropriately trained, supported and able confidentially to contact the Samaritans themselves. Taking on the role of Listener must not put them at greater risk themselves.

Another common peer support system is the Insiders scheme. This is designed to provide specific support to new prisoners, a group considered to be at increased risk of suicide and self-harm. Insiders are not intended as a replacement for Listener support, instead they provide information about prison life and basic reassurance during the early days of custody.

Peer supporters can be very effective in helping prisoners to voice and address anxieties. The ability to speak to a trained volunteer confidentially and, often equally importantly, speak to someone who has an insight into their situation and the particular stresses of custody is a valuable resource, but as it is a confidential service peer supporters cannot directly support prison staff in suicide prevention.

2.3 First night

Prisoners are often at their most distressed on arrival at prison. Some will not have been anticipating a custodial sentence, others face the uncertainty of entering prison on remand, some may be withdrawing from drugs or alcohol, and many will be struggling with the sudden separation from their family. For those who find themselves in custody for the first time it can be especially intimidating as few will know what to expect. This is explicitly acknowledged in the PSI dealing with early days in custody which states:

"All prisoners must be held lawfully, and their well being must be the primary concern of staff throughout the reception and first night process. The guiding principle in management of reception and first night is the duty of care to prisoners." – PSI 74/2011

Alongside the use of Listeners and Insiders to ease the transition into prison life, local prisons which receive prisoners directly from the courts usually have first night centres or processes and often have specific induction wings for new arrivals. On their first night, new arrivals should be given the opportunity to make a phone call, take a shower, and have a hot meal. They must also receive appropriate toiletries and a 'reception pack' of basic items such as tea (and tobacco if they smoke). If a prison does not have dedicated first night accommodation, or none is available, new prisoners are required to be allocated a location that meets 'at least the minimum national standard for certified accommodation and which is suitable for new prisoners'[9].

In addition to these immediate adjustment needs, there are also many potential worries for new prisoners about the life they have left behind. PSI 74/2011 lists some of the urgent needs prisoners may arrive with:

- accommodation (for example where dependents are locked out or where homes have been left unsecured);
- health related issues (for example where either prisoners or dependents need access to specialist medication that is not in their possession);
- issues relating to the safety or well being of children or family members;
- other issues relating to the prevention of harm to others.

After their first night, prisoners should receive an induction to prison. For new prisoners this will usually cover a range of information both about the prison system and routines in the prison they are in. The outcome should be that 'prisoners know and understand their entitlements and responsibilities, and how to access support and facilities available to them'.[10] There is often specific accommodation for the induction process, as a stepping stone between first night accommodation and the general population.

The operation of first night and induction wings varies between prisons. Differences reflect the different roles of prisons, the specific needs or vulnerabilities of the particular populations they receive, the number and frequency of new arrivals and the availability of resources and accommodation. However constituted, the intention of first night and induction processes is to provide space and additional support to help new prisoners adjust and begin to absorb the information needed to navigate prison life.

2.4 Substance misuse

Prisoners arriving with alcohol or drug misuse problems are particularly vulnerable, as there is a significant relationship between drug or alcohol withdrawal and suicide. Therefore instead of the process described above, these prisoners should be identified on reception and diverted to drug stabilisation accommodation. This accommodation has specially trained staff and healthcare workers. There are requirements for specific levels of observation, depending on which substance the prisoner is dependent[11]. When it is considered safe, these prisoners are transferred to take part in the induction process and, where appropriate, referred for further substance misuse treatment.

3. PPO investigations into self-inflicted deaths

Since 2004, when the Ombudsman took over responsibility for investigating deaths in prison, to October 2013, he has investigated, or is currently investigating, over 600 self-inflicted deaths of prisoners. PPO investigators have access to the deceased prisoner's medical records, prison records (including security information reports) and can request any information they may need for the purpose of investigation. They are able to interview any member of prison staff including healthcare staff and prisoners if they consider it will aid the investigation. In addition to the investigation report, investigators complete a detailed data collection form for each investigation. These forms allow some standardisation of the information collected during the investigations to enable cases to be compared, but not all information is available or recorded in all cases. The forms are split into 19 sections and cover most aspects of prison life.

The data in this report are based on the forms of 361 completed investigations into self-inflicted deaths in prison[12]. Generally, the demographic information collected does not distinguish the characteristics of the deceased from those of the general prison population. However, the numbers of remand prisoners are a clear exception to this; they make up a far greater proportion of self-inflicted deaths than would be expected given their numbers in the general population. Surprisingly, remand prisoners are not listed as a group at particular risk by PSI 64/2011.

Where possible the demographic information of the sample is provided alongside information about the prison population as a whole, using population data from April 2013. The size and composition of the prison population changes over time, so population figures such as these merely give a snapshot. As such it is illustrative but not a direct comparison to the PPO data, which covers a number of years.

3.1 Key characteristics

- 96% were male. For comparison, in April 2013, 95% of the 84,176 people in custody were male[13];
- Although a higher proportion of women than men in prison self-harm, they are not more likely to die a self-inflicted death. 4% of the sample were female and 5% of the prison population in April 2013 were female;
- 81% were white, higher than the 73% of the prison population;
- 17% were of asian, black, mixed, chinese or other ethnicity, lower than the 25% of the prison population. Figure 1 shows further breakdown by ethnic group[14];
- 17% were foreign nationals compared to around 13% of the population[15];
- 51% were single, including those who were divorced or widowed[16];
- Remand prisoners, including convicted prisoners awaiting sentencing, made up 46% of the deaths (Figure 2) but are only 13% of the total prison population;
- 18% had received a life or other indeterminate sentence. This is similar to the current proportion of prisoners serving this type of sentence (16%);
- The average length of time served on the current sentence was 16 months, although the average for life or other indeterminate sentenced prisoners is significantly higher (57 months);
- 25% died within a month of entering custody, 10% died in their first 3 days;
- 36% were in prison for the first time;
- 26% committed their main offence against somebody they were intimate with or a member of their family.

Figure 1: Ethnic make-up of the PPO sample (n=361)

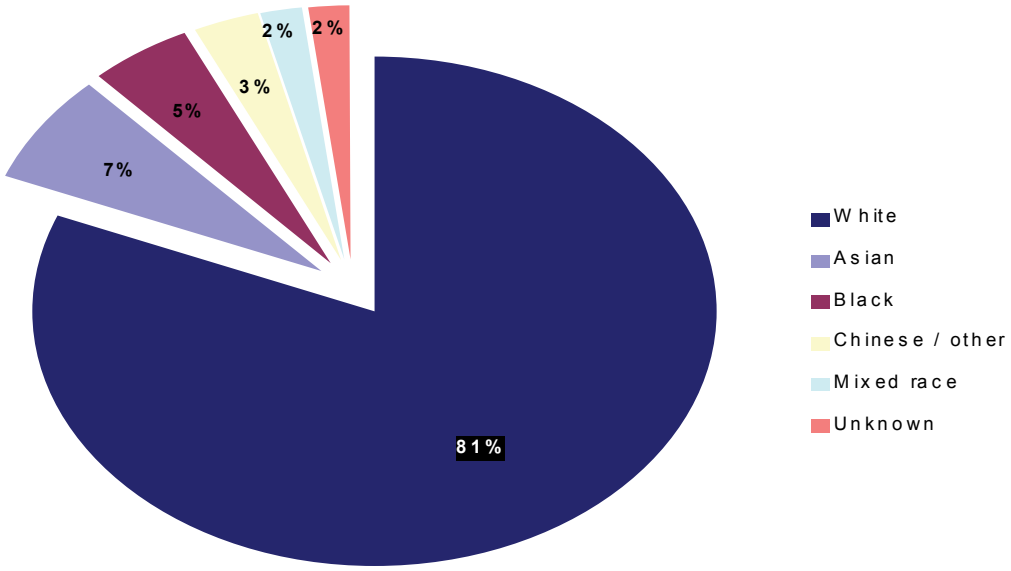
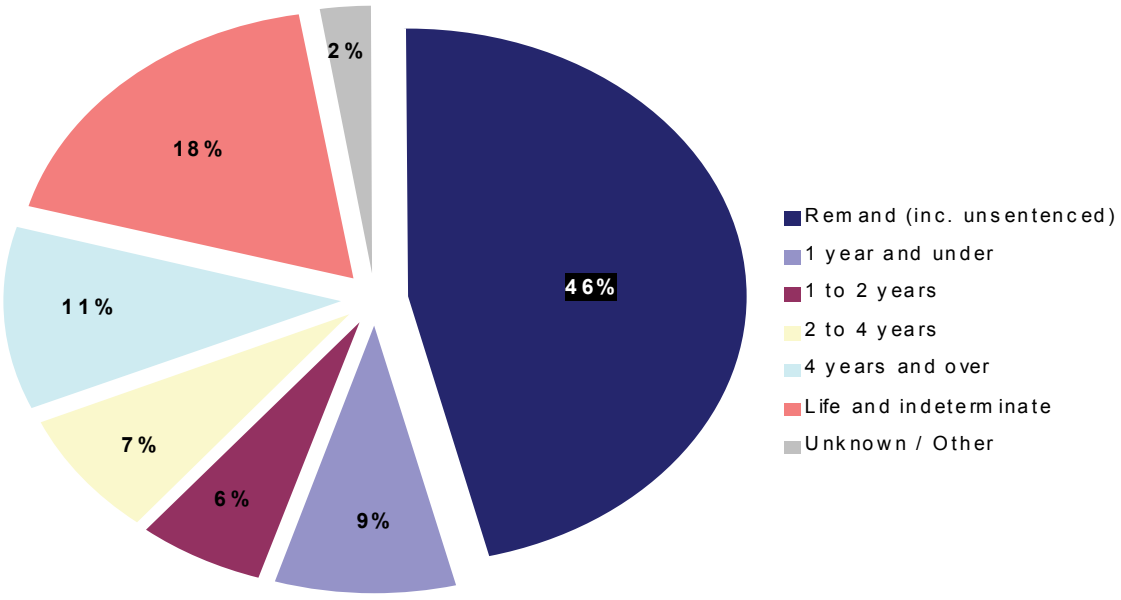


Figure 2: Sentence length in the PPO sample (n=361)



4. Antecedents of death

Investigators record whether various 'antecedents of death', occurred in the period immediately before the death. This information was recorded in 98% of the sample[17]. They deal with a range of issues including sentencing, segregation and discipline, visits and contact with staff, healthcare and mental healthcare, substance misuse and treatment, self-harm, loss of employment and changes to cell or cellmate. The investigator records any events they are aware of, whether or not it was felt to be a significant factor in the death.

The recorded antecedents demonstrate just how wide a range of events can take place immediately before a prisoner's death. Table 2 shows the antecedents recorded most often. Certain themes are clear: interaction with healthcare, events related to ACCT processes, contact with staff other than uniformed officers, change in location or cellmate and issues related to substance misuse. Some antecedents, such as substance misuse, may have played a causal role in the death. Others, such as who the prisoner interacted with, may provide a focus for future suicide prevention.

Half the sample (50%) had been monitored on ACCT processes at some point during their time in prison. However just a quarter (24%) were being monitored on ACCT processes at the time of their death, and slightly fewer (18%) had these processes begun or reviewed in their final three days. This indicates how few of the prisoners were recognised to be at particular risk, and in part, that many prisoners were able to disguise their feelings from staff. This is why it is important that, when considering risk, both the known characteristics and history of the individual are taken into account along with the prisoner's presentation to staff and the impact of recent events.

Table 2: Antecedents of deaths – events within 72 hours of death

Antecedents of death	Within 72 hours (n=351)
Appointment with GP or healthcare staff	32%
ACCT open or reviewed	18%
Moved to a new cell or changed cellmate	17%
Seen by member of staff other than officers or healthcare staff	13%
Self harmed, or expressed suicidal feelings to staff	11%
Court appearance	11%
Substance misuse/withdrawal (including starting or ceasing detox)	8%
Anti-social behaviour	8%
Increase in supervision	6%
Observations reduced	5%
Moved to segregation	5%
Non-compliance with medication	5%
Change in healthcare treatment (e.g. drug dosage)	5%

Officers working on the residential wings often have the most frequent contact with prisoners. This gives them a particular opportunity to be aware of prisoners who may be becoming more withdrawn or when changes in behaviour may indicate a prisoner at risk. However, the antecedents to death indicate another potentially effective staff group for suicide prevention. One of the most striking findings is that 32% of the prisoners had seen a member of staff from healthcare in the 72 hours before they died. In total, 69% had had an appointment with the doctor or healthcare staff in the last three months of their life. Moreover, one in eight (13%) had had contact with staff other than officers or healthcare staff, such as chaplaincy and education staff. While a health appointment is not in itself an indicator of suicide risk, interaction with a different group of staff offers the opportunity to get a different perspective on potential risk and, where necessary, an opportunity to intervene. Accordingly, it is crucial that all staff working in prisons are aware of suicide risk factors, have access to the information necessary to identify an individual's risk factors, understand their responsibilities for safer custody, and are confident about initiating and using the ACCT process when they have concerns.

Prisoner relationships and interaction with healthcare and other staff groups can differ significantly from those with staff working on the wings. They offer a different perspective to prison officers who might be seen to have a focus on order and security. Other staff groups can represent a more 'neutral' source for prisoners. For some prisoners knowing they can speak in confidence with staff, particularly healthcare and chaplaincy staff, will be important in helping them be more open about how they are coping and their risk for self-harm or suicide.

Case study A

Mr A was a life sentenced prisoner expecting to be released on parole. When the parole hearing was unexpectedly postponed he suffered such a severe panic attack that he was moved from his open prison to the healthcare unit of a nearby closed prison which was better equipped. He spoke about suicide to a nurse who was concerned enough about his risk of suicide or self-harm to move him to a safer cell. Despite the concern, the nurse decided not to open an ACCT.

Mr A later moved from the healthcare unit to a standard prison wing. An ACCT would have been a clear record that healthcare staff had indentified Mr A as a suicide risk. Despite the fact he had been returned to closed conditions due his health rather than any discipline or security grounds, there was no clear plan to return him to open conditions. Several months later, Mr A again experienced chest pains and was re-admitted to the healthcare unit. The next morning he was found hanging in his cell.

Prison Service Instructions recognise the role different groups of staff can have in suicide prevention stating 'the identification and management of prisoners at risk of suicide and/or self harm is everyone's responsibility'[18]. It is important that all prison staff understand and use the suicide prevention processes. Mr A had told the healthcare team about his thoughts of suicide, but it is not clear that they had considered the significance of the delayed parole hearing and a return to closed conditions for a life sentenced prisoner and what impact this had had on his risk of suicide. Mr A had been moved to a safer cell which limits access to ligature points and so restricts the means for suicide. However, it does not support someone through a crisis or help address the underlying causes of their distress.

Other common antecedent events highlight certain groups already identified in Prison Service Instructions as representing a higher than average risk: prisoners with substance misuse issues, and those returning from court. There were 8% known to have demonstrated anti-social behaviour in the 72 hours before their death and 7% of prisoners had an adjudication hearing resulting from poor behaviour within the month preceding their death. As the Ombudsman found in the investigations of the recent child deaths in custody, emotional distress can manifest in different ways, including anti-social or other rule-breaking behaviour[19] and too often this is not recognised.

5. Particular vulnerabilities

PSI 64/2011 lists a significant number of factors known to impact on the risk of suicide. In this section we look at three characteristics that are prevalent in the deaths in our sample, and indeed in the prison population as a whole, which increase risk[20]. These are: a history of mental health issues (76% of the sample), a history of self-harm or suicide attempts (38%) and substance misuse or withdrawal (19%). While these are discussed separately it is important to bear in mind the extent to which these three groups overlap. Of those with a history of mental health problems, the largest group, nearly half (47%) had also self-harmed in custody and 37% had substance use problems.

The section then looks at four groups of prisoners at particular risk in prison: new arrivals, remand[21], life or indeterminate sentenced prisoners, and those with an offence against a family member or someone else they were close to. The new arrivals sub-section looks at the 10% of prisoners who died within three days of entering custody. Remand prisoners accounted for 46% of the sample yet they make up only around 13% of the prison population. Indeterminate sentenced prisoners comprised 18% of the sample and, in many ways, represent a different challenge for assessing risk. A long way from their first night and first reception, the average time these prisoners had served was nearly five years. For a quarter of the sample (26%) their offence was against a family member or someone they were close to. 65% of this group were being held on remand.

5.1 Prisoners with mental health difficulties

People with mental health problems, whether in prison or in the community, are recognised as at particular risk of suicide. Research shows that people diagnosed with schizophrenia are up to twelve times more likely to kill themselves than others[22]. Three quarters (76%) of the prisoners in our sample were identified as having mental health issues and it is these prisoners who were most likely to have had contact with a healthcare professional in the last days before their death. A third (34%) had seen a healthcare professional within their final 72 hours, compared to just 6% of the prisoners who were not identified as having mental health problems. Two fifths (40%) of prisoners with a history of mental health problems committed their offence against a family member or someone close to them, this was true of 30% of others. A similar proportion were in prison for the first time (37%) and the average time they had served was 17 months.

Case study B

Mr B had been receiving mental health care for a number of years before he was charged with arson and sent to prison on remand. At court a self-harm warning form was completed and Mr B was monitored as a risk of suicide because he had threatened to set fire to himself. His records from the police also showed he had previously tried to hang himself. When he arrived at prison, the PER contained details about Mr B's risk of self-harm. The nurse conducting the first healthcare screen noted that he had arrived with a self-harm warning form. The nurse did not place him on suicide prevention procedures but referred him to the mental health in-reach team. The prison officer who completed the Cell Sharing Risk Assessment noted that Mr B had been suicidal earlier that day but he also did not open an ACCT.

Mr B was admitted as an inpatient to the healthcare unit straight from prison reception for further observations and assessment of his unusual behaviour by the mental health team. A psychiatrist saw him and prescribed antipsychotic medication but over the following weeks his behaviour continued to be erratic and he was monitored by the mental health team. A month after he had arrived Mr B transferred to the remand wing of the prison, although the investigation found no record of his discharge from the healthcare unit.

Mr B was convicted – but not sentenced – via a video link from the prison to the court. This did not trigger a review or assessment, despite the fact that this was a change in status and his offence carried a maximum sentence of life imprisonment. However, a few days later a member of the mental health in-reach team saw him. This was his first contact with the mental health team since he had left the healthcare unit a month earlier. Mr B saw a doctor the day before he was due to be sentenced, and said that he had thoughts racing through his head. The doctor referred him for psychiatric assessment. On the day of the hearing Mr B's sentencing was adjourned for a week. Two days later, and before he could be seen by the psychiatrist, he was found hanging in his cell.

Prison Service Instructions recognise mental illness as a factor which increases the risk of suicide, but a history of mental health problems is not unusual in the prison population. It would therefore be wholly unreasonable to expect an ACCT to be opened in every case. However, mental health problems do present a particular risk and the presence of other risk factors and any change in circumstances or behaviour should be of particular concern and fully considered in any assessment. In Mr B's case he had a long history of contact with the mental health services (although the prison did not obtain his community GP records). His bizarre behaviour caused concern when he received into the prison. There were a number of other risk factors, including being on remand and facing a charge of arson. There were warnings from the courts and the police about his risk of suicide which were not acted on. Had an ACCT been opened in reception this might not have changed the eventual outcome but it would have provided a more systematic assessment and monitoring of Mr B's risk. In light of his risk factors, it is especially unfortunate that his mental health assessment took over a month after leaving the healthcare unit and that he was not reviewed after his conviction when sentencing was adjourned.

5.2 Prisoners with a history of self-harm or previous suicide attempts in custody

Over a third (38%) of the prisoners were known to have either self-harmed or previously attempted suicide while in prison; 13% had attempted suicide in the prison in which they later died. On average, the prisoners with a history of self-harm or suicide attempts were 34 years old, slightly younger than other prisoners in the sample (an average age of 36). This group were more likely than the rest of the sample to have been fostered or in care as children (11% compared to 5%), or to have suffered physical or sexual abuse in the past (15% compared to 4%). They were slightly more likely to have committed their offence against a family member (42% compared to 35%). It appears their particular vulnerability was recognised, but the extent of this may not have been fully appreciated. In the last few days before their deaths most (68%) were thought to be at some risk of suicide and 40% were on ACCT when they died, but for the most part the risk was felt to be low – only 7% were assessed as high risk of suicide.

Table 3: Antecedents of deaths by self-harm history – events within 72 hours of death

	Past self-harm or suicide attempt in custody (n=134)	**No known history** (n=217)
Appointment with GP or healthcare staff	37%	29%
ACCT open or reviewed	30%	11%
Self harmed, or expressed suicidal feelings to staff	20%	6%
Seen by 'other' member of staff	17%	11%
Moved to a new cell or changed cellmate	13%	20%
Anti-social behaviour	12%	5%
Increased supervision	9%	4%
Non-compliance with medication	7%	3%
Observations reduced	7%	5%
Moved to segregation	6%	5%
Family etc contact prison concerned	6%	3%
Admitted to healthcare unit	5%	4%
ACCT closed	5%	2%

Information about the antecedents to death suggest that prisoners who had self-harmed or attempted suicide previously were more likely to have come to staff attention as at increased risk to themselves immediately before their death. Nearly a third (30%) had had an ACCT document opened or reviewed in their last 72 hours and a fifth (20%) had either self-harmed or expressed suicidal thoughts to staff, compared to 6% of others respectively. Incidents of anti-social behaviour were more common in this group (12%) than prisoners who had not self-harmed in the past.

In general, the self-harm behaviour differed from that which caused the deaths. Just under half (45%) were known to have self-harmed by cutting or scratching in the last three months, which caused just 3% of deaths. Nearly three quarters of deaths were from hanging and 2% by suffocation but only 9% had self-harmed by self-strangulation in the previous three months, although 28% had made ligatures. A tenth (10%) had self-harmed through food refusal, but this was the cause of death in only 1% of cases. Self-harm by strangulation or suffocation is likely to be harder to detect than cutting wounds, so this behaviour may be under-recorded. However, it would make sense that individuals may alter or escalate their behaviour according to whether the intention is to harm or to cause death: self-strangulation, hanging, and suffocation are particularly risky as they can be fatal in a matter of minutes.

Case study C

Mr C was a foreign national prisoner. He remained in custody beyond the end of his sentence under immigration powers while arrangements were made to deport him. He was transferred to a different prison but it was not properly communicated that he had harmed himself three months earlier and that, soon afterwards, he had set a fire in his cell and tried to hang himself. The investigator was unable to obtain the ACCT documents relating to these incidents and it did not appear that they were transferred to the new prison.

The documents which were provided on transfer lacked sufficient detailed information about Mr C's risks. The Person Escort Record (PER) (which accompanies all prisoners when they move) mentioned that an ACCT had been closed but gave no details of the incidents or the known risk factors and triggers. Mr C had been under the care of the mental health in-reach team at his previous establishment who had identified that he had ongoing problems with a number of issues: unresolved grief, an infatuation with a particular officer, feelings of loneliness, and concerns about deportation. When Mr C transferred to the new prison he lost the support he had previously been given for these problems and he was not referred to the mental health team at the receiving prison. In particular, his immigration status was a cause of significant distress for him, yet few members of staff working with him at the new prison were aware of this.

A few weeks after he moved to the other prison, Mr C made a small cut to his neck and as a result monitoring under ACCT was begun. There is no evidence that staff checked previous entries in his prison or medical clinical records. Had they done so they would have found information about his previous self-harm and fire setting. The next morning Mr C was discovered hanging and later died in hospital.

Safety in Custody[23] statistics show that in 2012/13 6,772 individuals harmed themselves in prison. Relatively few go on to kill themselves, but compared to others their risk of suicide is increased[24] and in some cases acts intended only to harm can be inadvertently fatal. Awareness to a history of self-harm could help guide staff managing the present risk, or could show a pattern of increasingly risky self-harm behaviour. The staff who began the ACCT monitoring for Mr C did so without knowing about his history and risk factors, despite the information to evidence this being available in his records.

5.3 Prisoners who misused substances

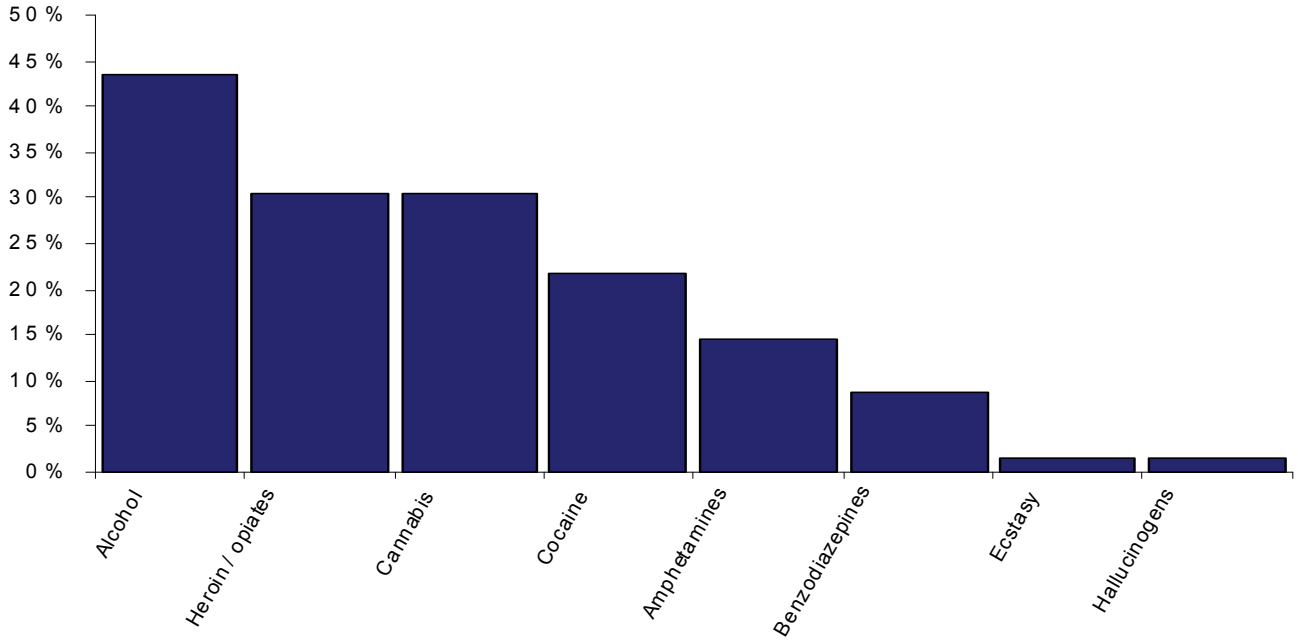
Use of drugs or alcohol can be a risk factor for suicidal behaviour. On reception into the prison, 19% of the prisoners were dependent drug or alcohol users and a further 17% were frequent users[25]. The largest proportions of prisoners were dependent on heroin or other opiates (48% of dependent users), or alcohol (41%). Frequent use of heroin or alcohol was most often reported, and many reported using cannabis, cocaine or amphetamines frequently (Figure 3). Some of the prisoners were known to have used either drugs or alcohol in the establishment (17% of dependent users and 18% of regular users). The process of detoxification is also recognised as increasing

risk for suicide or self-harm. In all, 33% of dependent users and 16% of regular users were referred to a detoxification unit for either drugs or alcohol.

Prisoners who misused substances and killed themselves were slightly less likely to have some of the other key risk factors, which may have led to an appearance of reduced vulnerability. Just over a fifth (22%) of the substance users were in prison for the first time, whereas 45% of prisoners who were neither dependent nor regular substance users were serving their first sentence. However, the average time served on their current sentence was similar (15 months against 17 months). Fewer had committed their offence against a family member (29% compared to 42% of others).

Twenty percent of substance users had either used a substance or were in withdrawal in the 72 hours before their death. Possibly as a result of this, a higher proportion had seen a healthcare professional in the days before their death; 37% compared to 27% of other prisoners, although the prisoners who had been regular or dependent substance users were slightly less likely to have seen other staff (8% compared to 15% of other prisoners). More (21%) had moved cell or had a different cell mate, than among the other prisoners (14%).

Figure 3: Regular users of drugs and alcohol[26]



Case study D
Mr D was a dependent heroin user and just days after being released on licence he was arrested by the police and recalled to prison. At the police station, Mr D was moved to a shared cell after self-harming by banging his head against the cell wall. He had also spoken of intending to kill himself, of a recent bereavement, and of his fear he would be in danger when he returned to the prison. The police completed a suicide and self-harm warning form with this information.

The form accompanied Mr D to the prison but his reception screen did not record any history of self-harm and there was nothing noted in the section which asks about any recent self-harm. Instead, it was recorded that Mr D had no thoughts of self-harm or suicide. Of the triggers and risk factors in PSI 64/2011 Mr D was a drug addict, had recently self-harmed, had recently been bereaved, had recently arrived in custody, and had been recalled to prison for breach of licence. He had also told police that he intended to kill himself. The nurse conducting the reception health screen was aware of the suicide warning form from the police, but knew Mr D from his previous time at the prison and did not consider him to be at risk. No ACCT was opened and none of his risk factors including those identified in police custody were noted. The next day, a nurse from the Drug, Alcohol Recovery Team saw him and said that he had appeared very upset. Mr D talked about being bereaved and worried about being estranged from his children. He said he had no thoughts of harming himself. Again an ACCT was not opened.

Before he had been released from his original sentence he had been receiving daily methadone medication which he continued to receive in the community and when he was in police custody. When he returned to the prison, urine tests showed the presence of drugs other than methadone. Methadone can interact badly with other drugs and can increase the risk of overdose. Because of this the prison doctor decided to delay prescribing Mr D methadone. Without methadone Mr D became increasingly distressed and agitated and a few days later he cut his face and was placed on ACCT monitoring. The ACCT document recorded that Mr D had self-harmed because he had not been prescribed methadone. Mr D was moved from his shared cell to a single cell in the healthcare unit and placed on hourly observations. Apart from the record of these observations no other part of the ACCT document was completed.

After cutting his face Mr D told staff that without methadone he would take his own life. Just hours later he was found hanging in his cell in the healthcare centre. The Ombudsman concluded that during the reception screening and his subsequent interactions with staff too much emphasis had been placed on staff's knowledge of Mr D from his previous time in custody and there was too much reliance on him saying he did not intend to kill himself. Insufficient consideration had been given to Mr D's known risks, some of which had been clearly identified by the police.

5.4 New arrivals

A tenth of the prisoners (10%) died in the first three days after arriving in prison either to start their sentence, or on remand. The early days of custody are recognised in PSI 64/2011 as a risk factor. The new arrivals who killed themselves were slightly less likely to be serving their first sentence, 29% compared to 37% of prisoners further into their time in custody. It appears that the risk for new arrivals is particularly acute for those with substance misuse problems. More than two thirds (69%) were habitual or dependent substance users before entering prison - like Mr D - compared to only one third (33%) of other prisoners. In addition, 69% of the prisoners who killed themselves in the first three days were being held on remand. The heightened risk for these prisoners is discussed further in the next section.

Some prisoners can feel shocked and scared when they first arrive at a prison, even if they have been in prison before. They may not have had the opportunity to ensure that affairs such as their housing, employment, and relationship or childcare issues are settled and prepared for the time they will spend in custody. People entering prison are suddenly taken out of comforting settings or routines, feelings of guilt or shame can be running high and those facing long sentences may feel little hope for the future. This is recognised as an especially risky time and first night procedures are set up to try to alleviate some of these feelings, ensure monitoring and generally reduce risk where possible. Prisoners are also new to staff, and the information they arrive with can be patchy, so it is vital the initial reception screening is undertaken as thoroughly as possible. It must take into account any available information about the individual's circumstances, history and possible risk factors.

Case study E
When Mr E arrived in prison he told reception staff that this was not his first time in custody, that he suffered from a mental illness, and that he drank alcohol to excess. His PER recorded that he had self-harmed during previous periods in custody. Although this indicated he had a number of risk factors, he denied any thoughts of harming himself and was not made subject to suicide and self-harm monitoring. Mr E began an alcohol detoxification programme but was located on a standard wing rather than the prison's detoxification unit or in the healthcare centre as would normally be the case.

He was found hanging in his cell the morning after his arrival in prison. The Ombudsman was concerned that staff seemed to have relied too much on subjective assessments of Mr E's demeanour and behaviour, a man they were not familiar with, against the documented risk factors.

5.5 Remand prisoners

Remand prisoners, who are mostly unconvicted but also include prisoners who have been convicted but not yet sentenced, are disproportionately represented in the sample. Although many were also in the early days of custody, it is surprising remand is not specifically highlighted in the 'current context' section of the list of risk factors of PSI 64/2011. Aside from the uncertainty that their situation represents, high proportions of the remand prisoners had other key risk factors. Half the remand prisoners (58%) were in prison for the first time. More were alleged to have committed their main offence against somebody they knew intimately or a family member (36% compared to 17% of the other prisoners). Remand prisoners were also more likely than sentenced prisoners to have substance misuse problems (41% to 32%) and a similar proportion had a history of mental health problems (77% and 74%). Despite this, 80% of the remand prisoners who killed themselves were thought, in the last few days before their deaths, to pose no or a low risk of suicide[27].

Remand prisoners are more likely to have to attend court which can be a particular cause of worry or anxiety; 16% of the unsentenced prisoners had had a court appearance in their last three days, compared to 5% of the other prisoners. Many will arrive at prison from court, like Mr F, new to prison and with documents from a range of different agencies. While the judgement of staff based on how the prisoner presents, their apparent mood and state of mind, is important, prisoners will often try to hide distress, particularly in a strange setting and with people they do not know. Assessments based on immediate behaviour must be balanced against the available information about known and evidenced risk factors, particularly when there are concerns from others including family, the courts and the police.

Case study F
Mr F was only in prison a very short time. His risk factors appear to have been significant: he faced charges of sexual offences against his family, it was his first time in custody, he had a history of depression, and was recorded as having made a recent attempt at suicide. The police had assessed him as at risk of self-harm or suicide. Although they recorded this risk, the escort staff who took him to court did not consider he was a risk; when they asked about his history of self-harm Mr F denied any knowledge and the escort officers said he seemed surprised to have been asked.

In court it emerged that Mr F had been arrested on a motorway bridge and the warrant to hold him on remand described this as a suicide attempt. On reception at the prison, the information on the warrant was not picked up by the staff. They told the investigator that they expected that kind of information to appear on the PER. Although the escort officers had not included it on the PER, the police had done so but not in detail. Mr F denied any thoughts of self-harm and the staff conducting the screen considered that he appeared fine, although shocked and upset at being in prison. The reception screen noted it was his first time in prison and that he was dyslexic. He was not identified as posing a risk to himself.

A nurse who conducted an interview about his health described him as weepy and upset but also noted that he said he had no thoughts of harming himself. Mr F was located in a shared cell on the induction wing. The man he shared a cell with said that Mr F was clearly upset when he arrived and continued be upset throughout the night. The next morning his mother rang the prison to say she was concerned about her son's state of mind and what he might do. An officer spoke to Mr F and described him as 'upbeat', although he became teary-eyed when he spoke about the charges he was facing and his upcoming court appearance. The officer opened an ACCT, with observations every 30 minutes. Less than an hour later he was found hanging in his cell.

It is clear that Mr F was not open about his feelings but even in the very short time he was in custody there were a number of occasions on which he appeared upset to staff. The Ombudsman concluded that too much emphasis had been placed on his presentation rather than the other salient and recorded factors when his risk of suicide and self-harm was assessed.

5.6 Life and indeterminate sentences

Just under a fifth (18%) of the prisoners were serving an indeterminate sentence, either a life sentence or an Imprisonment for Public-Protection (IPP) sentence. In both cases, prisoners have a minimum amount of time they must serve in prison (the tariff), after which they become eligible for release if they can demonstrate to the Parole Board that their risk of reoffending is much reduced. This is an uncertain situation and for some could lead to hopelessness, which is associated with increased risk of suicide. These prisoners tended to be slightly older; the average age was 37 compared to 34 in the other prisoners. They were more likely to have had a history of self-harm or previous suicide attempts in prison. This applied to 59% of indeterminate sentenced prisoners, compared to 33% of others. However, this could be partly a result of more time spent in custody; fewer were first time prisoners (although this was still 59%) and they had served an average of 57 months (nearly five years). Other prisoners had served an average of just 7 months. The life sentence and IPP prisoners were predominantly in single cells (85%). In contrast, 34% of the other prisoners were in a double cell or dormitory.

Case study G

Mr G was serving an IPP sentence for offences against children. As a result he was subject to public protection measures that placed restrictions on him contacting children, including his own. He had however been allowed sporadic contact with his youngest son, although the correct procedures had not been followed. He told friends and staff that contact with his son was very important to him. At various times in his sentence Mr G reported feeling depressed and had been prescribed medication.

Part way into his sentence, he transferred to a new prison in order to undertake an offending behaviour programme. The programme encouraged Mr G to think about the offences he had committed and he told staff that he felt guilty and remorseful about what he had done. Other investigations of prison suicides have found that such programmes can be distressing for prisoners. Mr G told staff he had struggled with suicidal thoughts in the past, and it seems he had made earlier attempts on his life, but he also took great pains to tell staff that he would not act on the thoughts and the staff were reassured by this.

The prison also noticed that the required public protection procedures had not been followed and told Mr G that he would not be able to have further contact with his son until the appropriate risk assessments could be carried out. Mr G was clearly upset by this but staff involved believed he understood the reasons for the decision. The officers working on his wing were not aware that he had received this upsetting news and Mr G does not appear to have shared the level of his distress with either staff or other prisoners.

Mr G had a history of depression, had previous suicidal thoughts, was reported to have made earlier attempts at taking his own life, and he was serving an indeterminate sentence. In this context, the loss of contact was something those staff needed to be aware of. A few nights after receiving the news, Mr G hung himself in his cell where he was found by an officer the next morning.

Given the longer time spent in custody, these prisoners build up substantial records which can provide vital information about risk factors. They will usually have had time to build up relationships with staff and to settle in to prison life. In these circumstances assessing risk will often be about judging how emerging events and context may exacerbate existing static risk factors. Mr G had been in prison several years and his main risk factors were, on the whole, stable: a history of depression and a history of suicidal thoughts (at least since entering custody). He was, for the most part, able to hide his feelings from staff and fellow prisoners, yet recently there had been two significant events: he had completed a course which had caused feelings of guilt and remorse, and he had been informed that he could no longer contact his child.

5.7 Prisoners who committed their offence against family members or someone else close to them

Over a quarter (26%) of the prisoners in the sample had committed, or were alleged to have committed, their main offence against a family member or someone else close to them. Of these, 33% had been convicted or were facing charges of homicide and 52% were in prison for the first time. The majority (66%) were remand prisoners. There was also significant overlap with other risk factors: 80% had mental health concerns, 40% had a history of self-harm or previous suicide attempts in custody, 27% were habitual or dependent substance users, and 12% had arrived in prison in the previous 3 days.

PSI 64/2011 says 'Offence particularly those charged with violence against another person, especially against family members or partners' is a risk factor for suicide. It is important that staff recognise the seriousness of such charges and appropriately assess the risks associated with them.

Case study H
Mr H was remanded into custody on suspicion of murdering his partner. The escort services, despite his assertions that he did not intend to harm himself, opened a suicide and self-harm warning form and made the decision to observe him constantly. The PER document that accompanied him to court and then to prison said in the box next to 'suicide/self-harm risk': "stated he wanted to kill himself" (although it is unclear when he made this statement). It also noted he had been arrested on suspicion of murder.

During reception into prison both an officer and a nurse recorded (on different documents) that Mr H said he had no thoughts of self harm. A doctor, having seen that the nurse recorded no concerns about self-harm, signed the self-harm and suicide warning form from the court and noted that suicide and self-harm procedures were not begun at the prison.

Mr H was taken to court for an initial hearing. The PER which accompanied him contained conflicting information – the suicide and self-harm section said there was no information, but the section on mental health reported he was on ACCT monitoring (which was not the case) and highlighted the self-warning form from his previous appearance at court. After the initial hearing he transferred to a different prison. Neither the prison officers nor the healthcare staff on reception identified him as at risk of self-harm or suicide and the ACCT monitoring process was not begun. He attended a further court appearance. He was seen by chaplaincy staff on his return who recorded no concerns about him. Just under two weeks later he was discovered dead in his cell.

Mr H died in 2011, before the PSI came into effect, but the existing guidance[28] also made explicit mention of the risk saying: 'Reception/first night staff must be made aware of the suicide and self-harm risks associated with prisoners who are charged with offences related to violence against a family member and/or homicide.' His risk factors were significant: he was charged with murdering his partner, it was his first time in custody and it was recorded he had recently said he wanted to commit suicide. Although the court and escort services treated him as at risk of suicide and self-harm and recorded this information, he spent time in two prisons and neither took action on his risk.

6. Lessons to be learned

Prison Service Instructions clearly recognise that there are certain characteristics which increase the likelihood of an individual being a risk to themselves. The deaths investigated by the Ombudsman confirm this. Only seven groups of risk factors have been examined – history of mental illness, history of self-harm in custody, substance misuse, new arrivals to custody, remand prisoners, indeterminate sentenced prisoners, offence against family members – but one or more of these factors occurred in 94% of the 361 self-inflicted deaths discussed in this report. The main finding of this report is not that there is a lack of clarity around the factors which increase risk, but that too often when risk is assessed this evidence is not fully considered. Instead, too great an emphasis is often placed on staff perceptions of the prisoner's state of mind. To compound this, there is often no record that the known risk factors have been considered and then discounted. There are, therefore, key lessons which can be learned from these deaths.

- There should be clear local procedures which require prison and healthcare staff in reception to actively identify risk factors together based on checks of relevant documents such as the Person Escort Record, pre-sentence reports, NOMIS, and clinical records. Reception screening needs to take fully into account concerns from others about an individual's risk to themselves, such as the police, escorts, the courts and families.
- Evidence of risk should be fully considered and balanced against how the prisoner presents themselves. Reception staff should record what factors they have considered and the reasons for decisions.
- An individual's level of risk is not fixed. Distressing and stressful events can have a sudden and critical impact. Where such information is known, staff working closely with the prisoner should be made aware.
- A third of the prisoners had seen healthcare staff in the 72 hours before their death. This represents a key opportunity to intervene. Healthcare staff need to be confident about initiating and using ACCT monitoring and be clear when to share concerns about prisoners more widely. Similarly, prison staff need to ensure, particularly in reception, that healthcare staff are given all relevant information about risk and that this is discussed with them.
- Many prisoners will attempt to withhold the extent of their distress from staff and other prisoners. In this context it is important to act promptly on any concerns family and friends convey to the prison.
- NOMS should amend PSI 64/2011 to set out a clear, standardised list of risk factors for suicide and self-harm which includes being held on remand as a risk factor for suicide.

End notes

[1] Preventing suicide in jails and prisons. Department of Mental Health and Substance Abuse, World Health Organisation
[2] The number of deaths for the 12 months ending December 2011 is reported in the Ministry of Justice 'Safety in Custody Statistics Quarterly' available at (https://www.gov.uk/government/publications/safety-in-custody). The prison population figures, also published by the Ministry of Justice, are available at https://www.gov.uk/government/publications/prison-population-2011. The ONS report, 'Suicide in the UK 2011', is available at http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2011/stb-suicide-bulletin.html
[3] Preventing suicide in jails and prisons. Department of Mental Health and Substance Abuse, World Health Organisation
[4] Based on the PPO classification of cause of death. Some investigations are on-going and initial classifications may change.
[5] The Comprehensive Textbook of Suicidology. Berman, Silverman, & Bangor.
[6] Statistical update on suicide. Department of Health. September 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/137639/Statistical-update-on-suicide.pdf
[7] PSI 64/2011, Chapter 3
[8] Learning from PPO Investigations: Self-inflicted deaths on ACCT
[9] PSI 74/2011
[10] PSI 74/2011
[11] PSI 45/2010
[12] The data have been collected in this way since 2007. The data were extracted for this report in November 2013.
[13] Offender management statistics quarterly: January - March 2013. Ministry of Justice, https://www.gov.uk/government/publications/offender-management-statistics-quarterly-jan-mar-2013
[14] In both the sample and the prison population 2% were of unknown ethnicity.
[15] Foreign national population at the end of March 2013. Offender management statistics quarterly: October-December 2012. https://www.gov.uk/government/publications/offender-management-statistics-quarterly--2
[16] This is excludes 53 cases where the information is not known
[17] 351 cases
[18] PSI 64/2011
[19] Learning Lessons Bulletin Fatal Incidents 3: Child deaths. Prisons and Probation Ombudsman. March 2013 http://www.ppo.gov.uk/docs/LLB_FII_03_Child_deaths.pdf
[20] The analysis is this section is of the 351 cases which included information about antecedents to death.
[21] Remand includes both unconvicted detainees and prisoners who are convicted but unsentenced
[22] Reassessing the Long-term Risk of Suicide after a First Episode of Psychosis. Archives of General Psychiatry. December 2010. http://phys.org/news/2010-12-people-severe-mental-illness-commit.html
[23] Safety in Custody Statistics England and Wales update to March 2013. Ministry of Justice. (https://www.gov.uk/government/publications/safety-in-custody)
[24] Preventing suicide in jails and prisons. Department of Mental Health and Substance Abuse, World Health Organisation
[25] At least once a week
[26] Percentage is of regular users (excludes any regular substance misuse by dependent users). Some prisoners were regularly using more than one substance so this sums to >100%.
[27] Excluding 52 cases where this information is not known.
[28] Prison Service Order 2700: Suicide and Self-harm

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