Ministry of Justice

Guide to Safety in Custody Statistics

Ministry of Justice
Statistics bulletin

Contents

Introduction

Safety in custody statistics cover deaths, self-harm and assaults in prison custody in England and Wales. This document provides more detail on those statistics and is intended to be used as a guide to concepts, definitions and interpretation of trends.

The key areas covered are:

- An overview of safety in custody statistics detailing the frequency and timings of the bulletin and the revisions policy.
- Details of the data sources and any associated data quality issues.
- The system for classifying deaths in custody.
- A glossary of the main terms used within the publication.
- A time line of developments affecting safety in custody
- A list of relevant internet sites and on-line references.

Although this publication concerns statistics, the incidents described in this guide are, by their nature, tragic and distressing to the prisoners, their families and staff. NOMS remains committed to reducing the number of self-inflicted deaths, caring for prisoners at risk of self-harm, reducing violence in prison custody and learning from such incidents.

The latest safety in custody statistics bulletin can be found at: www.gov.uk/government/publications/safety-in-custody and earlier editions at: www.gov.uk/government/publications/safety-in-custody-earlier-editions

Related publications

The Safety in Custody statistics bulletin is published alongside two inter-related bulletins:

Offender Management Statistics Quarterly Bulletin: This provides key statistics relating to offenders who are in prison or under Probation Service supervision. It covers flows into these services (receptions into prison or probation starts) and flows out (discharges from prison or probation terminations) as well as the caseload of both services at specific points in time.

Proven Re-offending Statistics Quarterly: This provides proven re-offending figures for offenders who were released from custody, received a non-custodial conviction at court, received a caution, reprimand, warning or tested positive for opiates or cocaine.

Taken together, these publications present users with a more coherent overview of offender management, re-offending among both adults and young people and the safety of offenders whilst in prison custody.

Overview of Safety in Custody Statistics

This section describes the background to the bulletin, the timing and frequency of the publication and the revisions policy relating to the statistics published.

Background to the Safety in Custody Statistics Bulletin

Safety in custody statistics, in particular those relating to deaths in custody, have been a feature of annual reports for prisons in England and Wales since 1877. In the late 1980s, the introduction of an incident reporting system started to increase the range of safety in custody information available in particular that relating to self-harm and assaults. Improvements to centrally held data now mean that there are consistent data sets for deaths (from 1978), self-harm (from 2004) and assaults (from 2002) from which to determine trends.

Although a wide range on safety in custody management information was available from around 2000, relatively little was published. Increased numbers of Parliamentary Questions and Freedom of Information requests demonstrated a need to publish more information. In response to this, NOMS and MoJ decided to produce a dedicated statistical bulletin that would contain a much wider range of information than would be practical to include in the NOMS annual report. The first annual Safety in Custody bulletin was published on 11 February 2010.

Feedback on the initial publication indicated a need for more frequent information than an annual bulletin would allow. The first quarterly bulletin covering the period up to March 2012 was published on the 24 July 2012.

Timeframe and Publishing Frequency of Data

The statistics in this publication are for a rolling twelve month reference period. Deaths, self-harm and assaults are not strongly seasonal but this time period has been chosen over shorter timeframes to reduce the volatility caused by random variation.

Each quarter, the latest reference period will be published so statistics will be for the year ending March, June, September or December. The first three datasets will be provisional and the year ending December statistics will be the final release of the calendar year data. As part of the final release, additional annexes will be published containing more detailed breakdowns of safety in custody statistics.

Revisions

In accordance with Principle 2 of the Code of Practice for Office Statistics, the Ministry of Justice is required to publish transparent guidance on its policy for revisions. A copy of this statement can be found at:
www.justice.gov.uk/downloads/statistics/mojstats/statistics-revisions-policy.pdf

The three reasons specified for statistics needing to be revised are changes in sources of administrative systems or methodology changes, receipt of subsequent information,

and errors in statistical systems and processes. Each of these points, and its specific relevance to the safety in custody statistics publication, are addressed below:

1. Changes in source of administrative systems/methodology changes
Data relating to deaths from 1978 (NOMS Deaths in Custody Database), assaults from 2002 and self-harm from 2004 (NOMS Incident Reporting System) are considered broadly consistent over those years.

Some additional fields were added to the deaths data set including ethnicity (1989), nationality (1989) and religion (2000). Statistics relating to deaths were originally compiled from registers of prison deaths. In the late 1990s a central database for deaths in custody was set up and this now contains all deaths in prison custody since 1978 (See the latest statistical bulletin which can be found here: www.gov.uk/government/publications/safety-in-custody

In the late 1980s, HM Prison Service introduced a new Incident Reporting System (IRS). In 2009 incident reporting of incidents began to be switched to the new National Offender Management Information System (NOMIS) NOMIS.

Where there have been revisions to data accountable to changes in methodology or administrative systems these will be clearly stated. Any statistics affected within the publication will be appropriately footnoted.

2. Receipt of subsequent information
Deaths:
Figures for deaths during previous years may change due to late notifications and changes in classification following an inquest, which may not be concluded for several years after the death. The changes tend to be small and do not affect reported trends.

Self-harm and assaults:
Figures for self-harm and assaults will be reviewed on a quarterly basis but, unless it is deemed to make significant changes to the statistics released, revisions will only be made as part of the final release containing the calendar year statistics. However, should the review show that the late data has a major impact on the statistics then revisions will be released as part of the subsequent publication.

3. Errors in statistical systems and processes
Occasionally errors can occur in statistical processes; procedures are constantly reviewed to minimise this risk. Should a significant error be found, the publication on the website will be updated and an errata slip published documenting the revision.

Symbols Used

..	not available
0	Nil or less than half the final digit shown
-	not applicable
(p)	Provisional data
(r)	Revised data

Data Sources and Data Quality

This section outlines the data sources used to compile the safety in custody statistics presented in the bulletin with discussion on data quality. The two main sources the statistics are compiled from are:

- NOMS Deaths in custody database (for deaths) and
- NOMS incident reporting system (for self-harm and assaults)

Deaths

Data sources: Deaths in prison custody statistics are compiled from the NOMS Deaths in Prison Custody Database which contains summary details of each death in prison custody since 1978. The database draws on data from a number of sources:

- Historical archives (Death registers)
- Prisons
- Prisoner records
- NOMS strategic IT systems including;
    - NOMS Incident Reporting System (IRS),
    - NOMIS (which replaced the Local Inmate Database System(LIDS)),
    - Accommodation and Occupancy (A&O) database and
    - Inmate Information System (IIS)
- Prison and Probation Ombudsman (PPO) fatal incident investigations
- Coroners

Initial data is based on reports from prisons where deaths occurred and is appended with further details from strategic IT systems. Once available, PPO fatal incident investigations and Coroner's inquest findings are used to cross check data held on the database and confirm classifications.

Data quality: Data relating to deaths in prison custody are closely scrutinised and are considered to be of high quality. However, it is in the nature of deaths, that numbers may change over time as new information emerges in particular following inquests which often take place some years after a death. Overall numbers of deaths in prison custody should be absolute. However, a single reclassification of a death following inquest will affect numerous tables in this publication. Figures dependent on classification of deaths should therefore be treated as provisional.

Self-harm

Data sources: Detailed information on each self-harm incident in prison custody comes from the NOMS Incident Reporting System. Monthly extracts and subsequent updates are taken from the live incident reporting system and compiled into a central database. Self-harm statistics are compiled from that database.

Data Quality: In prisons, as in the community, it is not possible to count self-harm incidents with absolute accuracy. In prison custody, however, such incidents are more

likely to be detected and counted. Self-harm data are relatively consistent from 2004 onwards and are considered satisfactory for determining trends.

In addition to incidents, self-harm statistics include numbers of individuals self-harming. A number of methods are available for counting individuals but changes to the prison numbering system, and variations in names and dates or birth limit the accuracy to which individuals can be counted. As with incidents, numbers of individuals are satisfactory for determining trends.

The self-harm data presented in this report are drawn from administrative IT systems. Although care is taken when processing and analysing the returns, the detail collected is subject to the inaccuracies inherent in any large scale recording system. The data presented in this report are considered satisfactory for analysing levels and determining trends but there will be non-response and processing errors in the underlying data.

- Self-harm non-response errors arise because self-harm behaviour amongst prisoners may go undetected. In addition, it is sometimes difficult to determine when one incident ends and the next begins particularly with repetitive self-harm.
- Processing errors may arise when incident reports are first written up or when they are subsequently recorded on the incident reporting system.

Assaults

Sources of data: As with self-harm, detailed information on each assault incident in prison custody comes from the NOMS Incident Reporting System. Monthly extracts and subsequent updates are taken from the live incident reporting system and compiled into a central database. Assault statistics are compiled from that database.

Data Quality: In prisons, as in the community, it is not possible to count assault incidents with absolute accuracy. In prison custody, however, such incidents are more likely to be detected and counted. Assaults data are relatively consistent from 2002 onwards and is considered satisfactory for determining trends. However, numbers are not absolute.

It is in the nature of assault incidents that at least two people must be involved. As the numbers involved increase so too does the complexity and risk of error. Assigning the correct role (assailant, victim, fighter etc.) to individuals involved in an incident is a potential source of error. All incidents are investigated and the majority of roles should be correctly assigned. On occasions, however, lack of witnesses or refusal of victims to co-operate will limit the accuracy of what can be recorded.

The incident reporting system only contains details of prisoners. It does not contain details of any staff or visitors involved in an incident. As a result, the relative completeness of data for particular incidents will vary. Data for different types of assaults (prisoner on prisoner, prisoner on staff etc) is considered satisfactory for determining trends but the amount of analysis and conclusions that can be drawn for particular types of assault will vary.

The assaults data presented in this report are drawn from administrative IT systems. Although care is taken when processing and analysing the returns, the detail collected is subject to the inaccuracies inherent in any large scale recording system. The data

presented in this report are considered satisfactory for analysing levels and determining trends but there will be non-response and processing errors in the underlying data.

- Assaults non-response errors arise because the victim of an assault may not inform staff and therefore the incident will go un-reported. In addition, there can be a range of factors that influence the threshold at which an event is reported as an assault incident.
- Processing errors may arise when incident reports are first written up or when they are subsequently recorded on the incident reporting system.

Overview of data accuracy

Quality of data may be measured using the six dimensions of data quality: Relevance, Accuracy, Timeliness and Punctuality, Accessibility and Clarity, Coherence and Comparability. A full review of quality is beyond the scope of this guide but the table below provides a basic assessment of accuracy for the main data streams in this report: deaths, self-harm and assaults.

Table 1: Comparison of data accuracy for main Safety in Custody data streams

Accuracy Measure	Deaths	Self-harm	Assaults
Sampling frame	Census	Census but with response bias	Census but with response bias
Coverage error	Effectively zero. All public and contracted prison establishments and escort contractors are required to report deaths in prison custody.	Effectively zero. All public and contracted prison establishments and escort contractors are required to report incidents of self-harm.	Effectively zero. All public and contracted prison establishments and escort contractors are required to report assault incidents.
Duplicates	None known	In less than 1% of cases, the same incident may be reported more than once. Repetitive self-harm sometimes results in double counting if it is unclear when one incident ends and the next begins.	In a very small percentage of cases, less than 1%, the same incident may be reported more than once
Ineligible	Effectively zero	In a small percentage of cases, less than 1%, incidents may refer to self-harm prior to custody, or general concerns etc. and not actual self-harm in prison custody.	In a small percentage of cases, less than 1%, incidents may include reports of assault that subsequent investigations indicate never happened. Injuries arising before prison-custody might also be reported.
Mis-classified	Once provisionally classified, it is estimated that some 2% of deaths will be reclassified as new information emerges	In a small percentage of cases, less than 1%, the incorrect prisoner details are recorded against an incident. A change to the reporting system was introduced in early 2012 to help reduce this problem	In a small percentage of cases, less than 1%, the incorrect prisoner details are recorded against an incident. Changes to the reporting system was introduced in early 2012 to help reduce this problem
Non-response	None known although deaths occurring in	All self-harm incidents are required to be reported but	All assault incidents including fights are required to be

Accuracy Measure	Deaths	Self-harm	Assaults
	hospitals/hospices are sometimes slow to be reported	not all are. Historically, serious incidents were more likely to be reported than less serious ones. The ratio of serious to total incidents is used to indicate possible changes in levels of reporting. This and prisoner injuries indicate that the non-response error is likely to be under ten per cent although there remains an element of uncertainty that cannot be entirely removed.	reported but not all are. Historically, serious incidents and assaults on staff were more likely to be reported than less serious ones. The ratios of 'serious to total' and 'staff assaults to total' incidents are used to indicate possible changes in levels of reporting. These and prisoner injuries indicate that the non-response error is likely to be under ten per cent although there remains an element of uncertainty that cannot be entirely removed..
Keying error	Data is entered manually and mistakes do occur e.g. date or birth, spelling of name, custody status etc. Given the level of scrutiny deaths are subject to, such mistakes are usually identified and corrected	In a small percentage of cases, less than 1%, dates, prisoner numbers or responses to questions may have been entered incorrectly. Systems are in place to reduce such errors but they cannot be completely eliminated.	In a small percentage of cases, less than 1%, dates, prisoner numbers or responses to questions may have been entered incorrectly. Systems are in place to reduce such errors but they cannot be completely eliminated.

Process for producing statistics

Approximately one month before the publication date of the Safety In Custody Statistics bulletin, copies of the deaths, self-harm and assaults data sets are set aside for analysis. A range of preset queries are run to produce statistics for each data set and the results stored in workbooks. These are similar to the published workbooks but contain extended tables used to quality assure the data.

Safety in custody statistics can change over time. If the latest analysis shows a change from previously published figures, the reasons are investigated and a decision is made on whether and how to revise the figures.

Approximately two weeks before the publication date, the draft publication and supporting tables are typically sent to two identified individuals not directly involved in the publication. One checks that the report is internally consistent and figures reconcile with what has been previously published. The other focuses on the commentary and interpretation of trends.

Although safety in custody statistics have a long history, the bulletin is relatively young and still evolving. As a result processes, are still being refined.

Quality assurance

Safety in Custody statistics are produced in accordance with Ministry of Justice custom and practice who monitor overall compliance with UK Statistics Authority requirements. In addition to independent cross checks for internal consistency and with what has been previously published, the main data streams include the following quality assurance features:

Deaths
Deaths in prison custody are subject to continuous monitoring throughout the year. The NOMS deaths in custody casework section act as an independent check on data stored on the deaths in custody database. In effect, overall numbers and classifications of deaths are assured by a dual counting method.

Management information is produced frequently throughout the year typically after each self-inflicted death. In addition, aggregate numbers are uploaded monthly onto the NOMS Performance Hub. Any discrepancies are soon spotted and dealt with.

Following each death, a questionnaire is sent to the establishment. This provides additional information on the death and acts a cross check against basic details that have been entered on the database. Data is checked intermittently as new information emerges. The final check typically occurs some years after a death when the inquest has been concluded. Soon after, the Prison Probation Ombudsman will publish the 'Fatal Incident Report' for the death and this is cross checked against information held on the database.

Self-harm and assaults
Monthly extracts of data are taken from the incident reporting system. These are combined into a separate database for each incident type to facilitate analysis. The processes for doing this have been automated and rigorously tested.

A range of checks are carried out on the data:

- Numbers of incidents by month for key variables including gender and prison
- Stray codes in response to specific questions
- Consistency of dates e.g. incident date comes is on or after date prisoner came into custody etc.

Although numerous checks are carried out on incident data, it remains the case that self-harm and assault incidents cannot be measured with absolute accuracy. Data quality has changed over time and Quality Assurance (QA) procedures plays an important part in understanding what the trends implied by the data actually mean.

System for classifying deaths

Overview

A *'death in prison custody'* is any death of a person in prison custody arising from an incident occurring during (or, on rare occasions, immediately prior to) prison custody. This includes deaths of prisoners while Released on Temporary License (ROTL) for medical reasons but excludes deaths of any prisoners released on other types of temporary license.

Each death in prison custody is provisionally classified as one of the following:

- **Self-inflicted**
  Any death of a person who has apparently taken his or her own life irrespective of intent.
- **Natural causes**
  Any death of a person as a result of a naturally occurring disease process.
- **Homicide**
  Any death of a person at the hands of another (includes murder and manslaughter).
- **Other**
  Any death of a person whose death cannot easily be classified as natural causes, self-inflicted or homicide. These include
  (i) *Other/Non-natural*: Accidents arising from external causes, accidental overdose/ poisoning and deaths where taking a drug contributed to a death but not in fatal amounts.
  (ii) *Awaiting further information:* This category includes any death for which there is insufficient information to make a judgement about the cause. The information awaited may refer to post mortem or toxicology reports, Prison and Probation Ombudsman report or the Coroner's inquest. In a small number of cases the cause of death may never be known even after all of the necessary investigations have taken place.

All deaths in prison custody are subject to a coroner's inquest. It is the responsibility of the coroner to determine the cause of death. The NOMS system for classifying deaths provides a provisional classification for administrative and statistical purposes. The final classification is only determined at inquest.

Exclusions

Data in this publication includes deaths of prisoners while Released on Temporary License (ROTL) for medical reasons but excludes deaths of any prisoners on other types of ROTL because the incident leading to a death does not usually occur within the direct control of the state. For example; a fatal overdose or road traffic accident. In addition, ROTL deaths cannot be counted accurately because:

- They are not always reported to NOMS immediately.

- When prisoners do not return to custody, they are declared as being unlawfully at large. Unless all such prisoners can be accounted for, the numbers dying while on ROTL cannot be measured with certainty.

Although non-medical ROTL deaths are excluded from deaths in prison custody figures, the Prison and Probation Ombudsman has the discretion to investigate them. A non-medical ROTL death may be included if the investigation concluded that the incident leading to the death occurred while in prison custody. We are not aware of any such cases but they are possibility.

Comparison with other systems

The NOMS system of classifying deaths evolved specifically to help place reliable numbers of deaths in prison custody in the public domain without undue delay. This section shows how they compare with other sources in particular:

- International Classification of Diseases ICD versions 9/10
- Prison and Probation Ombudsman: *Self-inflicted, Natural causes, Substance abuse, Homicide, Accidental*
- Police: *Inquest verdicts (for example, Suicide, Open verdict, Non-dependent drug abuse, Natural causes, Sudden deaths, Inquest pending , Inquest not held)*

As similar variations occur with other prison systems, it is important , to consider whether or not definitions used are comparable. For example, a number of other organisations use a *"drug-related death"* category. Although NOMS monitors drug related deaths, it does not use this category in published statistics because they are difficult to measure accurately. In addition, the category can blur the boundary with self-inflicted deaths.

The main international system for death classification is part of the International Classification of Diseases (ICD) currently on version 10. The NOMS classifications can be matched to these. Researchers wishing to compare deaths in prison custody for England and Wales with those from other sources should be aware of the following:

ICD9 comparison
- The apparent self-inflicted deaths category is a close match to E950-959, E980-E989 excluding E988.8
- Apparent homicide is a close match to: E960-E969, E979, E999.
- Apparent other/non-natural is a close match for E800-E869, E880-E929 and, if any occurred, legal intervention (E970-E978) and operations of war (E990-E998). This category also includes some otherwise difficult to classify deaths.

ICD 10 comparison (see apps.who.int/classifications/icd10/browse/2010/en)
- The apparent self-inflicted deaths category is a close match and ICD10: Intentional Self-harm(X60-X84) and ICD10: Event of Undetermined Intent (Y10-Y34).
- Apparent homicide is a close match to ICD10:Assault (X85-Y09)
- Apparent other non-natural is a close match to ICD10 Accident (V01-X59.) This category also includes some otherwise difficult to classify deaths.

Prison Probation Ombudsman (PPO)
PPO's responsibilities include investigating fatal incidents of:

i. prisoners and trainees (including those in Young Offender Institutions and Secure Training Centres). This includes people temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It generally excludes people who have been permanently released from custody;

ii. residents of Approved Premises (including voluntary residents);

iii. residents of immigration reception and removal centres, short term holding centres and persons under managed escort;

iv. people in court premises or accommodation who have been sentenced to or remanded in custody.

PPO statistics on deaths relate to investigations started into deaths within their scope which is wider than the scope of the statistics presented in this publication. Additionally, as there can sometimes be a slight delay between the death and the investigation starting, and may occasionally start in a different year to the death, where statistics on deaths in prison custody are presented they are not directly comparable.

Independent Police Complaints Commission (IPCC)
IPCC's responsibility includes investigating and reporting on a range of deaths[1]

- road traffic fatalities
- fatal shootings
- deaths in or following police custody
- apparent suicides following release from custody
- other deaths following police contact including those following police contact

In their 2012/13 report they used the following categories:

- Heart disease / cardiac arrest
- Asphyxiation
- Multiple injuries
- Drug / alcohol overdose
- Gun shot wound
- Long-term illness
- Inconclusive
- Awaited

These categories are not directly comparable with those used in NOMS

[1] IPCC www.ipcc.gov.uk/en/Pages/reports_polcustody.aspx

Data developments

This section looks at changes that have affected the reporting of safety in custody statistics.

Changes to the way deaths are classified and reported

Deaths in prison custody have been reported in a broadly similar way since 1877. However, there have been changes to categories over the years and so care needs to be taken when looking at figures before 1978.

Periods in which there were executions, the last being in 1964, are not directly comparable with periods where there were none. The reason for this is that prisoners that were executed were likely to be facing long periods in prison and would most likely die in custody of natural causes at some point in the future. In addition, such prisoners would be at high risk of taking their own lives in the early stages of custody.

A potential difficulty when looking at very long time periods is where prisoners died. Approximately half of all deaths in prison custody actually occur in outside hospitals or hospices. On occasions in the past, the much lower numbers of deaths within prison walls have been used. The current standard is to report all deaths of prisoners arising from incidents in prison custody irrespective of where the actual death eventually occurs.

A further source of difficulty when interpreting figures before 1978 is whether the narrower suicide or wider self-inflicted definition was being used. There is likely to have been some variation over the years and numbers in this category may be slightly under-reported by modern standards.

From 1978, the scope of deaths included in safety in custody statistics and their classification are considered consistent and any changes have been backdated to preserve the time series.

Homicides: The main change in the classification system since 1978 occurred around 2000 with the introduction of a new homicide category. Until that point, deaths were categorised as one of three categories: 'natural causes', 'self-inflicted [suicide]' and 'other'. Any homicides were included in the 'other' category.

Numbers of homicides were relatively small and it made statistical sense to group them in this way but external interest led to the category being further divided. The remaining deaths in the category, after homicides had been taken out, were then referred to as 'other/non-natural'.

To preserve the time series, homicides and other/non-natural since 1978 were identified and reclassified.

Awaiting further information/unclassified deaths: It has always been the case that some deaths have been difficult to classify. In 2010, there was an apparent increase in such deaths. To reflect this, the bulletin published in July 2011 included a new 'unclassified' category. At the time, it was unclear how these deaths would eventually be classified. It

has now been concluded that of the deaths for which further information is still awaited after three months, the majority will end up classified as 'other/non-natural'. Most of the remaining deaths in the category will be natural causes. Only a small proportion are expected to be self-inflicted although there will remain an element of uncertainty that will not be removed until after inquest.

To address the uncertainty and preserve the time series the bulletin published in July 2012 adopted the following approach using four main categories and two sub categories:

- Self-inflicted
- Natural causes
- Homicide
- Other -*consisting of the two sub categories:*
    - Other/non-natural
    - Awaiting further information (formerly 'unclassified')

The only essential change was that two existing categories were aggregated. The statistical reason for this change is that the two sub-categories, reported on previously, are relatively volatile changing quickly over time as new information emerges. As a result, they are not, in isolation, suitable for determining trends. However, the aggregate 'other' category is relatively stable and therefore more useful for determining trends.

The types of deaths included in the aggregate 'other' category include:

- Deaths following a fall
- Adverse reaction to medical treatment
- Refusal of medical treatment
- Drug related (other than self-inflicted overdoses)

Changes to the incident reporting system

The incident reporting system was introduced in the late 1980s undergoing major revisions in 1994 and 1997 with further revisions in later years. Each change resulted in an increase in the number of incidents reported. The incident types recorded on the system each have their own history and reached 'maturity' at different times. As a result, time ranges in which data is satisfactory for determining trends depends on each type of incident.

From 2009, prisons increasingly began to use the National Offender Management Information System (NOMIS) for entering incident data. The transition to the new system did affect recording of incidents but not enough to unduly affect most underlying trends. However, certain recorded information was affected.

Prior to NOMIS, information on prisoners that changed over time, for example sentence status, was recorded at the time the incident was reported. NOMIS reports the position at the time data is extracted. This has the effect of introducing a stepped change in the data. It does not adversely affect reported trends but does imply that some categories are either over or understated relative to the position at the time of the incident.

Self-harm

Until 1997, the focus was on reporting ‘attempted suicide’. The difficulty of this approach was that the intent of the prisoner was often unknown. Some incidents were more likely to be fatal than others but the point at which a self-harm incident became an attempted suicide was unclear. For example, a prisoner found making a noose may well have had the intent of suicide but since the incident was prevented and did not result in injury it might not have been classified as a suicide attempt. In contrast, a deep cut requiring hospital treatment might have been classified as a suicide attempt even though the wound might not necessarily have been fatal.

Since 1997, the approach switched to reporting all self-harm incidents leading to an increase in reported incidents. In December 2002 a new self-harm monitoring form was introduced based on the F213 ‘Injuries to Inmate’ form. As a result, reporting of self-harm improved further throughout 2003. Self-harm figures before 2004 are now omitted from the publication because they are significantly under-reported compared with current standards.

Assaults

As with self-harm, the focus of reporting in the early years was on more serious assault incidents. Fights between prisoners were less likely to be reported. It is now required that all assaults including fights be reported. Reporting levels have improved over the years and are relatively consistent from 2002 onwards. Figures before then are omitted from the publication.

Glossary

2052SH: HM Prison Service self-harm management documentation replaced by the ACCT care planning system in 2006

ACCT: Assessment Care in Custody and Team work -This is the NOMS care plan system for those at risk of self-harm introduced in 2006

Actual Bodily Harm (ABH): This refers to offences covered by section 47 of the Offences Against the Person Act 1861[2]. This is an assault which results in some harm as such as bruises and scratches and is less serious than Grievous Bodily Harm (GBH).

Affray: This is an offence covered by section 3 of the Public Order Act 1986[3] which states *"A person is guilty of affray if he uses or threatens unlawful violence towards another and his conduct is such as would cause a person of reasonable firmness present at the scene to fear for his personal safety."* For the purposes of this section of the Act, a threat cannot be made by use of words alone. An example of affray would be a fight between two more people.

Assailant: A prisoner involved in an assault incident whose role has been recorded on the NOMS incident reporting system as an 'assailant'. The system does not record details of non-prisoner assailants for example visitors.

Assaults: Assaults in prison custody cover a wide range of violent incidents. It includes fights between prisoners or an incident of unwanted or unnecessary physical contact. The nature of the assault can include touching, spitting, pushing or striking.

Churn: A measure of how fast a population turns over. National prison population churn may be defined using (first receptions)/(average population). Prison level churn may be defined as (first receptions + transfers in)/(average population) or (first receptions + transfers in + change in status)/(average population).

C-NOMIS: See National Offender Management Information System (NOMIS)

Coroner: A Coroner is an independent judicial office-holder, appointed by and paid by the relevant local authority. A coroner must be either an experienced lawyer, doctor or both. Coroners inquire into violent and unnatural deaths, sudden deaths of unknown cause, and deaths that have occurred in prison and certain other categories specified in the Coroners Act 1988.

Death in prison custody: Any death of a person in prison custody arising from an incident occurring during (or, on rare occasions, immediately prior to) prison custody. This includes deaths of prisoners while released on temporary license (ROTL) for medical reasons but excludes deaths of any prisoners released on other types of temporary license.

[2] Offences Against the Person Act 1861 www.legislation.gov.uk/ukpga/Vict/24-25/100/contents
[3] Public Order Act 1986 www.legislation.gov.uk/ukpga/1986/64)

Death - Awaiting further information: This is a temporary category of death, formerly referred to as unclassified. It includes any death for which there is insufficient information to make a judgement about the cause of death. The information awaited may refer to post mortem or toxicology reports, Prison and Probation Ombudsman reports or the findings of Coroners' inquest. In a small number of cases, the cause of death may never be known even after all of the necessary investigations have taken place.

F213/F213SH: The F213 form records injuries to prisoners including those arising from assaults, accidents and unexplained injuries. The F213SH, introduced in 2002, is the self-harm version of that form.

Fighter: A prisoner involved in an assault incident whose role has been recorded on the NOMS incident reporting system as a 'fighter'. The system does not record details of non-prisoners who may be involved in fights for example, visitors.

Grievous Bodily Harm (GBH): refers to offences arising from sections 18 (with intent) and 20 of the Offences Against the Person Act 1861[4]. This is a more serious offence that Actual Bodily Harm (ABH).

Homicide: Any death of a person at the hands of another. This includes murder and manslaughter. This is one the four main categories used in the NOMS system for classifying deaths.

Incident reporting System (IRS): A system first introduced in the late 1980s to record a range of incidents in prisons including escapes, absconds, fire, drugs, damage to property, assaults etc

Inquest: A fact-finding inquiry to establish who has died, how, when and where the death occurred.

Latency: The elapsed time, usually measured in days, until an event such as a death, self-harm or assault incident occurs.

Ligature: In the context of self-harm statistics, a ligature refers to an item used to effect self-strangulation or hanging.

Local Inmate Database System (LIDS): the electronic prisoner record system dating from the late 1980s and since superseded by NOMIS

Ministry of Justice (MoJ): The Ministry with responsibility for NOMS

Natural cause death: Any death of a person as a result of a naturally occurring disease process. This is one the four main categories used in the NOMS system for classifying deaths.

National Offender Management Information System (NOMIS). This is the NOMS prisoner record system which replaced LIDS. From April 2012, all prisons in England

[4] Offences Against the Person Act 1861 www.legislation.gov.uk/ukpga/Vict/24-25/100/contents

and Wales use NOMIS. C-NOMIS refers to a combined prison and probation system. P-NOMIS refers to the prisons element of NOMIS which is now fully operational. The probation element of NOMIS has not been implemented.

National Offender Management Service (NOMS): The agency responsible for prisons and probation

Other death: Any death of a person whose death cannot easily be classified as natural causes, self-inflicted or homicide. This is one the four main categories used in the NOMS system for classifying deaths. The 'other' category includes two sub categories 'other/non-natural deaths' and deaths 'awaiting further information'

Other/non-natural death: This category includes accidents arising from external causes, accidental overdose/ poisoning and deaths where taking a drug contributed to a death but not in fatal amounts. It also includes a small proportion of deaths which even after all investigations have been concluded the cause remains unknown. The category is one of two sub categories of 'other' deaths.

P-NOMIS: See National Offender Management Information System (NOMIS)

Self-harm: Any act where a prisoner deliberately harms themselves irrespective of the method, intent or severity of any injury."

Serious Assault: An assault is classified as serious if:

- it is a sexual assault;
- it results in detention in outside hospital as an in-patient;
- it requires medical treatment for concussion or internal injuries;
- the injury is a fracture, scald or burn, stabbing, crushing, extensive or multiple bruising, black eye, broken nose, lost or broken tooth, cuts requiring suturing, bites or temporary or permanent blindness.

When an assault results in one of these types of injury, it is classified as serious even if the actual damage was superficial.

Self-inflicted death: Any death of a person who has apparently taken his or her own life irrespective of intent. This is one the four main categories used in the NOMS system for classifying deaths. It includes a wider range of deaths than just suicides.

Standardised Mortality Rate/Ratio: The standardised mortality ratio (SMR) compares the death rate in custody with the death rate in the general population, adjusting for age and gender. When the rates are equal, the ratio is one. A ratio higher than one indicates that, after adjusting for age and gender, there is a higher rate of death in custody than in the general population. Standardised Mortality Rates indicate number of deaths for a given population taking into account age and gender.

Suicide: Any death of a person who has voluntarily taken their own life -a verdict determined at inquest. NOMS does not produce official statistics on suicides but does monitor inquest verdicts to ensure that classifications of deaths are consistent.

Serious assault incident: An assault incident which involves one or more of the following:

- a sexual assault

- results in detention in outside hospital as an in-patient
- requires medical treatment for concussion or internal injuries,
- one or more of the following injuries; a fracture, scald or burn, stabbing, crushing, extensive or multiple bruising, black eye, broken nose, lost or broken tooth, cuts requiring suturing, bites or temporary or permanent blindness.

Victim: A prisoner involved in an assault incident whose role has been recorded on the NOMS incident reporting system as a 'victim'. The system does not record details of non-prisoners victims for example staff and visitors.

Timeline

Key events: From time to time, events in prison custody and developments within and outside NOMS have changed the way safety in prisons is viewed and managed. Some have resulted in changes to the way offenders are managed on a day to day basis. Others have affected the way statistics are collected and reported. The timeline in summarises some of the key events and developments since 2000 that have affected safety in prison custody and supporting statistics. The list indicates major factors affecting safety in custody and helps in the interpretation of longer term trends.

2000

- March: Zahid Mubarek murdered by racially motivated cell mate at HM Young Offenders Institution Feltham

2002

- December: New self-harm monitoring form introduced
- New Cell Sharing Risk Assessment (CSRA) form introduced

2003

- January: PSO 2700, *'Suicide and Self Harm Prevention*' launched

2004

- Joint Commission on Human Rights publishes, *'Report on Deaths in Custody'*
- April: Apparent homicide of Shahid Aziz – Leeds
- May: PSO 2750, *'Violence Reduction Strategy'* launched

2006

- New at risk prisoner care planning system, *'Assessment Care in Custody and Teamwork'* (ACCT) launched
- Home Office & Department of Health set up Forum for Preventing Deaths in Custody
- Zahid Mubarek inquiry finishes

2007

- Prison staff issued with cut down tools
- March: Baroness Jean Corston publishes, a *'Review of women with particular vulnerabilities in the Criminal Justice system'*
- October: PSO 2700 revised
- December: Lord Carter publishes, *'Proposals for the efficient and sustainable use of custody in England and Wales'*

2008

- March: '*Independent review of Forum for Preventing Deaths in Custody' (Robert Fulton)*

2009

- January: Review of NOMS Violence Reduction Strategy commenced
- March: Lord Harris appointed Chair of new Ministerial Council on Deaths in Custody

2010

- February: First Quick Time Learning Bulletin published
- July: Safety in Custody statistics bulletin published

2011

- April: PSI *'Cell Sharing Risk Assessment'* is published

2012

- January: Ministerial Council on Deaths in Custody granted a further three year term by Ministers
- February: PSI *'Safer Custody'* published replacing PSOs 2700, 2750 and 2710
- May: Review of unclassified deaths between 2010 and 2011 (Mc Feeley)

Changes affecting prisons level figures: Table 2 lists prisons which have opened, closed or had major re-roles since 1997. Understanding prison level safety in custody statistics requires knowledge of when prisons open, close and re-role. Such changes affect the distribution of incidents around the prison system and often explain variations in prison level figures over time. HM Inspectorate of Prisons inspection reports contain useful insights that help in the interpretations of figures. They can be found here: www.justice.gov.uk/publications/inspectorate-reports/hmi-prisons/prison-and-yoi

Table 2: Prisons opening and closing and major re-roles from 1997

Establishment		Year	Type of change
Parc		1997	Opened
Altcourse		1997	Opened
Foston Hall	July	1997	Changed from male to female prison
Weare		1997	Opened
Lowdham Grange		1998	Opened
Send		1998	Changed from male to female prison
Aldington		1999	CLOSED
Risley	April	1999	Changed from male and female prison to male only
Low Newton	September	1999	Changed from male and female prison to female only
Ashfield		1999	Opened (On site of former HMP Pucklechurch)
Rye Hill		2001	Opened
Dovegate		2001	Opened
Downview	September	2001	Changed from male to female prison
Morton Hall		2001	Changed from male to female prison
Haslar	April	2002	Changed from prison to Immigration Removal Centre
Dover	April	2002	Changed from prison to Immigration Removal Centre
Rochester		2002	Changed from adult male prison to YOI
Buckley Hall	April	2002	Changed from male to female prison
Buckley Hall	September	2005	Changed from female to male prison
Wolds		2003	Changed from male local to male training prison
Canterbury		2003	Changed from male local to male training prison
Bronzefield		2004	Opened
Winchester	April	2004	Changed from male and female prison to male only
Weare	March	2005	CLOSED
Peterborough		2005	Opened
Durham		2005	Changed Cat A /female Cat B local to male local
Edmunds Hill	January	2005	Changed from female to male prison
Buckley Hall		2005	Changed from female to male prison
Onley		2005	Changed from YOI to YOI + cat C training prison
Swinfen Hall		2005	Changed from YOI to YOI + cat C training prison
Brockhill	July	2006	Changed from female to male prison
Bullwood Hall	June	2006	Changed from female to male prison
Kennet		2007	Opened
Cookham Wood		2007	Changed from female and 15-17 to male prison only
Hewell Cluster		2008	Hewell, Blakenhurst and Brockhill merged
Bure		2009	Opened
Isis		2010	Opened
Northumberland		2011	Acklington and Castington merged
Thameside	March	2012	Opened
Oakwood	April	2012	Opened
Bullwood Hall	March	2013	Closed
Canterbury	March	2013	Closed
Gloucester	March	2013	Closed
Kingston	March	2013	Closed
Shepton Mallet	March	2013	Closed
Shrewsbury	March	2013	Closed

Directory of Related Internet Websites and on line references

HM Inspectorate of Prisons

- Prison and YOI inspections (www.justice.gov.uk/publications/inspectorate-reports/hmi-prisons/prison-and-yoi)

Independent Advisory Panel (IAP) on Deaths in Custody (*part of the Ministerial Council on Deaths in Custody)*

- Deaths in state custody (iapdeathsincustody.independent.gov.uk/)

Independent Police Complaints Commission (IPCC)

- Deaths in Custody Study (www.ipcc.gov.uk/en/Pages/deathscustodystudy.aspx)
- Deaths following police contact (www.ipcc.gov.uk/en/Pages/reports_polcustody.aspx)

Prison Probation Ombudsman (PPO)

- Fatal Incident reports (www.ppo.gov.uk/investigating-fatal-accidents.html)
- Annual reports (www.ppo.gov.uk/annual-reports.html)

SPACE 1 (Annual Penal Statistics for the Council of Europe)

- Prison mortality statistics (www.coe.int/t/dghl/standardsetting/prisons/space_i_en.asp)

World Health Organisation (WHO) International Classification of Diseases (ICD)

- ICD 10 (http://apps.who.int/classifications/icd10/browse/2010/en)

Ministry of Justice/NOMS

- Prison and Probation (www.gov.uk/government/organisations/ministry-of-justice/series/prisons-and-probation-statistics)
- Prison Service Orders (www.justice.gov.uk/offenders/psos)
- Prison Service Instructions (www.justice.gov.uk/offenders/psis)

Contact points

Press enquiries should be directed to the Ministry of Justice press office:

Tel: 020 3334 3536

Other enquiries about these statistics should be directed to:

Steve Ellerd-Elliott
Planning and Analysis Group
NOMS Agency
Clive House
70 Petty France
London
SW1H 9EX
Tel: 03000 476286

General enquiries about the statistical work of the Ministry of Justice can be e-mailed to: statistics.enquiries@justice.gsi.gov.uk

General information about the official statistics system of the UK is available from www.statistics.gov.uk

Ministry of Justice publishes data relating to offender management in England and Wales. Equivalent statistics for Scotland and Northern Ireland can be found at:
www.scotland.gov.uk/Topics/Statistics/Browse/Crime-Justice
www.dojni.gov.uk/index/statistics-research/stats-research-publications.htm

Alternative formats are available on request from statistics.enquiries@justice.gsi.gov.uk