Ministry of Justice

A Review of Self-inflicted Deaths in Prison Custody in 2016

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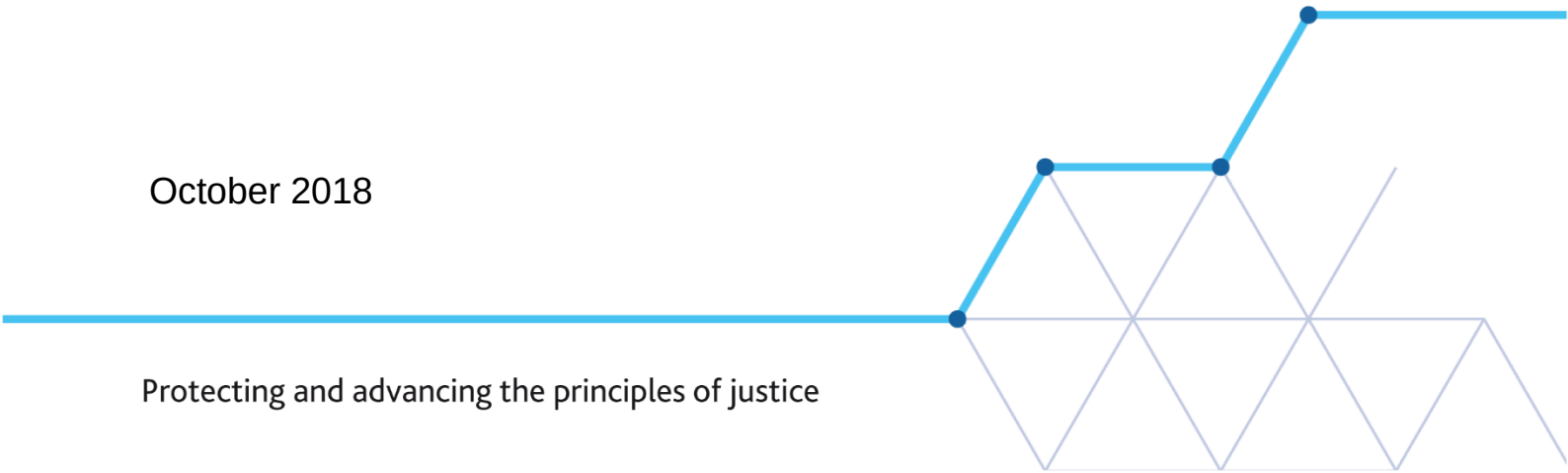

Protecting and advancing the principles of justice

A Review of Self-inflicted Deaths in Prison Custody in 2016

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Introduction

In January 2017, the then Parliamentary Under-Secretary of State for Justice, Dr Phillip Lee, committed to carry out an internal review of self-inflicted deaths[1] in prison custody in 2016, with a focus on cases where mental health had been identified as an issue. This commitment was made as part of a response to a question in Parliament from Luciana Berger MP about the death of Mr Dean Saunders at HMP&YOI Chelmsford in January 2016. It also followed increasing concern from parliamentarians and interest groups over the high numbers of self-inflicted deaths and self-harm in our prisons. Our annual safety in custody statistics in January 2017 showed that in the 12 months to December 2016, there were 122 self-inflicted deaths in our prisons, the highest number since records began.

The Ministry of Justice (MoJ) and Her Majesty's Prison and Probation Service (HMPPS) have undertaken this review together. Its scope was to review the details of these cases, particularly the way in which mental health concerns[2] were identified, assessed and managed, to see whether a pattern of common factors exists that indicates a need for policy change relating to mental health assessments in prisons.

The review considered a wide range of information sources, including:

- a review of published reports and recommendations made by independent and parliamentary scrutiny bodies on self-inflicted deaths and mental health in custody in 2016-17
- analysis of the published data on self-inflicted deaths in custody and the general population in 2016
- examination of all recommendations made by the Prisons and Probation Ombudsman (PPO)[3], following its investigations into self-inflicted deaths in 2016, to identify the most common areas for improvement
- a review of a sample of published PPO cases where there was a mental health concern

What follows are the findings, themes and lessons from this review and a summary of the steps we are taking to address them. **Chapter 1** then sets out the known risks and

[1] HMPPS classifies deaths by apparent cause of death. A self-inflicted death in custody is defined as any death of a person who has apparently taken his or her own life, irrespective of intent. More information on safety in custody statistics is available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/676151/safety-in-custody-statistics-guide.pdf.
Accessed 22 August 2018.

[2] The most prevalent mental health concerns linked to self-inflicted deaths in prison are anxiety, depression, bipolar disorder, psychosis, schizophrenia and personality disorder.

[3] Reporting to the Secretary of State for Justice, the PPO independently investigates deaths in adult and youth custody, immigration detention and Approved Premises, and makes recommendations for improvement.

triggers associated with self-inflicted deaths and gives information on prison reception screening, mental health assessments and the provision of care in prisons. This chapter also details the government's commitment in its white paper to reform the prison system and the key aims of the prison safety programme. **Chapter 2** provides an overview of the themes and lessons from independent and parliamentary scrutiny of self-inflicted deaths, while **Chapter 3** details the results of our analysis of safer custody data, the PPO's recommendations from its investigations, and our response to the issues identified. Finally, in **Chapter 4**, we set out the wider work under way to build the capability of staff and of the prison system overall to make prisons safer.

Findings, themes and lessons

Analysis of the data and PPO recommendations from 2016

- Self-inflicted deaths in 2016 rose by 36% from the previous year. This rise was the highest in the past 10 years, followed in 2017 by a 43% drop, making 2016 an exceptional year in terms of both the increase in the rate of self-inflicted deaths and their number.
- The rise did not reflect an increase in the prison population, either overall or in any high-risk group. While there was no single characteristic accounting for the increase, there were disproportionate increases for women; for black men; for people in their thirties; and for people serving the shortest and longest sentences.
- We received PPO reports about 121 of the 122 people who died that year. They contained over 400 recommendations. On average, there were three to four recommendations for improvement per case. In five cases no recommendations were made.

Our response to the findings, themes and lessons from scrutiny of self-inflicted deaths

- **Collaboration:** to ensure the best outcomes for people in prisons with mental health needs, we continue to work closely with our partners in the Department of Health and Social Care (DHSC), NHS England, Public Health England (PHE) and the Welsh Government.
    - We have developed a new national partnership agreement to strengthen the way we work together to deliver health and justice services in England. We are also working with colleagues in Welsh Government to deliver shared priorities which are based on a whole-prison approach to improve health and well-being. Finally, we are working with our partners to respond to the National Audit Office's recommendations to improve the use of data, to help us respond to mental health needs in prisons.
- **Oversight of implementation of recommendations:** we will continue to strengthen the arrangements in place for making best use of the learning derived from independent scrutiny of custody at a national, group and establishment level.
- **Prison staff capability:** we are improving staff knowledge to identify and respond appropriately to people at risk of harming themselves, particularly on arrival and during the early days and weeks in custody. Prison and healthcare staff need to understand their respective roles and work together effectively to ensure that any mental health issues identified are then referred for assessment, onward action and support. This includes specialist mental health support for people with acute needs.
    - We continue to roll out suicide and self-harm prevention training to all staff with prisoner-facing roles, as well as the new Suicide Prevention Learning Tool, developed in conjunction with the Samaritans, to help staff identify and address

risks. We have identified that some prison staff need help in understanding how to make a mental health referral and we are putting plans in place to refresh mental health training, improve access to training and issue guidance on working with health partners to promote understanding of referral routes.

  - We have also identified that, in a very small number of cases, there were delays in assessing and transferring people for hospital treatment due to a lack of understanding about the process by healthcare staff. We have already issued a learning bulletin on transferring people to and from secure hospital and asked senior leaders across HMPPS to share it with both prison and healthcare staff. This contains guidance on the care and management of people before and after a transfer and a reminder of the process to be followed. Additionally, learning from a joint NHS England and HMPPS evidence-gathering exercise has identified areas for improvement in both policy and practice. NHS England has committed to action across policy, commissioning and operations. This will include the definition of new expectations for achieving timely transfer, with greater priority being given to urgent cases.
  - NHS England has rolled out new healthcare screening templates for prison reception and full healthcare screening, in line with the current National Institute for Health and Care Excellence guidance. New service specifications for mental health in prisons have also been developed and introduced from April 2018.

- **Information sharing:** we are continuing our efforts to improve the flow of information into prisons, and the exchange of information between prison and healthcare staff. This will ensure that the identification and assessment of safety and security risks are accurate and based on the best available information, and that decisions on the most appropriate and coordinated care can be made effectively.
- **Assessment, Care in Custody and Teamwork (ACCT):** we are continuing to improve use of the case management system for people at risk of harming themselves to ensure that they are monitored, cared for appropriately, and receive the right support to help them to reach the point at which they no longer pose a risk to themselves. We have already published guidance on multi-disciplinary working, defensible decision-making and understanding suicide risk, development and implementation of suicide and self-harm awareness, and ACCT training packages.

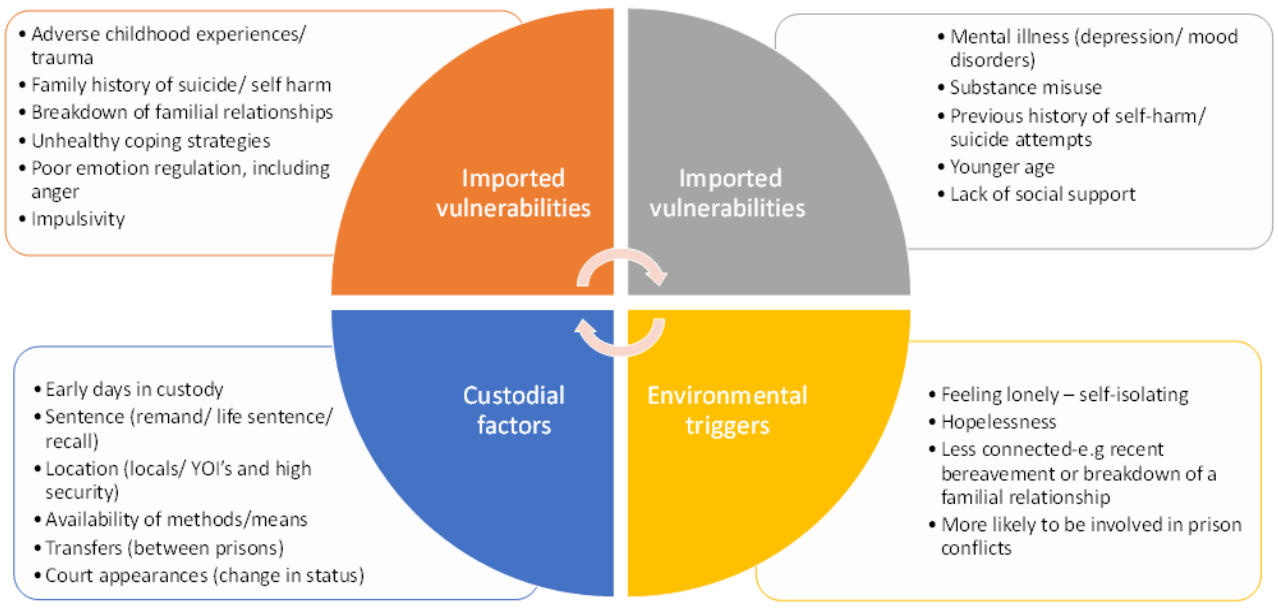
Chapter 1 Background

Known risks and triggers of self-inflicted deaths

1. Many people who are placed in custody already have complex needs that increase their vulnerability. Literature on the extent and nature of contact between vulnerable people and the Criminal Justice System (CJS) indicates that a significant number have poor mental health.[4] This is an important risk factor for suicide. We also know from literature that alcohol and drug dependencies are often a problem for people in custody and that there are heightened risks of suicide for those with a 'dual diagnosis' of mental ill-health and alcohol or substance misuse. Being in prison can aggravate these factors and increase the risk of people harming themselves.

2. There is a rich body of evidence to inform our understanding of the nature, scale and drivers of suicide and self-harm in prison. The table below separates these drivers into individual and prison-level factors.

Risk factors are broadly similar for suicide and self-harming behaviours. Whilst we know self-harm can be predictive of suicide, it is also important to separate the two behaviours. This can helps to develop our understanding of prisoners in crisis and the underlying reasons.



3. In addition to mental health and substance misuse, people may bring with them histories of self-harm or risk of suicide when they enter prison, as well as a range of other vulnerabilities such as poor coping mechanisms and troubled family backgrounds, which can increase this risk. Prison-level factors that commonly

[4] Her Majesty's Inspectorate of Constabulary (2015). *The welfare of vulnerable people in police custody.* www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/the-welfare-of-vulnerable-people-in-police-custody.pdf. Accessed 22 August 2018.

increase risk include: the experience of being in custody for the first time; the early days in custody (whether on remand, or due to a change in status such as being sentenced or recalled or transferred from another prison); being in segregation; and the closure of an ACCT plan.

Screening in prisons and mental health assessments

4. As part of the reception, first night and induction process, prison staff use an initial questionnaire to determine immediate risks. The Basic Custody Screening Tool (BCST) can also help identify risk of suicide and self-harm. Although the BCST is used primarily for sentence and resettlement planning, it can identify people who would benefit from referral to mental health services and those for whom procedures for ACCT should be followed. Healthcare professionals also carry out a full health screening for all people in prison reception and may refer them for further internal or external assessment or treatment when mental health needs have been identified.

The use of the ACCT process

5. Every day, prisons use the ACCT process to plan and provide care and support for people at risk of suicide and self-harm. Over 48,000 ACCT plans were opened in 2017. The flexibility of the process allows prisons to monitor closely those identified as at risk and to engage them fully in plans to address their immediate issues, and longer-term risks. Trained ACCT assessors interview people to identify risks, triggers and protective factors, before an individual care plan is drawn up at a multi-disciplinary case review. Thereafter, regular case reviews are chaired by a dedicated ACCT case manager to monitor and revise a person's care and support. Only when all the actions in a care plan have been completed should an ACCT be closed.

Training for prison staff

6. A suite of training packages is available to prison staff to support the ACCT process, some of which are mandatory:

    - Introduction to Suicide and Self-Harm (SaSH) training - mandatory for new officers as part of entry-level training and open to all existing staff with prisoner-facing roles (both directly and non-directly employed by HMPPS). This package includes a module on ACCT, which gives information about its purpose, the process, how to open a plan, and what to record. SaSH training also includes mental health awareness as a separate module, with a focus on the myths and stigmas around mental health and how to engage positively with people presenting different conditions.
    - ACCT Assessor - mandatory training for prison staff (Band 3 and above) who volunteer for the role, with a focus on communicating with people at risk, identifying risks, triggers and protective factors.
    - ACCT Case Manager - recently refreshed, this mandatory training for prison staff (Band 4 and above) focuses on understanding and managing risk, support planning, chairing multi-disciplinary case reviews and defensible decision making.

- An enhanced mental health training package is mandatory for prison staff undertaking both ACCT assessor and case manager roles.

Healthcare provision and the equivalence of care

7. Healthcare services are commissioned by NHS England for English prisons and are informed by a health needs assessment in each prison. Since April 2017, governors have been given a greater say in the services that have been commissioned in their prisons by working with NHS England Commissioners. In Wales, health in public sector prisons is devolved to the Welsh Government and commissioned by local health boards. Healthcare services are commissioned on the principle of "equivalence of care", which means that people in custody should have the same access, range and quality of care as the general population can expect to receive. Quality healthcare provision relies on the close co-operation and support of the prison service to ensure prison staff are available to escort people to health assessments and appointments, both within the prison and off-site.

Capacity and workforce across the prison estate in 2016

8. In the twelve months to December 2016, the average monthly useable operational capacity of the whole prison estate was 87,327[5]. In terms of the flow of people through prison custody, the number of sentenced people arriving in prison in 2016 was 3% lower than in 2015. Admissions of untried people, and of people who were convicted but unsentenced, fell by 15% and 14% respectively when compared with 2015.

9. Against a backdrop of operational pressures in the prison estate including the abuse of illegal drugs, particularly psychoactive substances, and the use and trade of mobile phones, 2016 also saw a slight reduction in the number of full time equivalent (FTE)[6] staff of 2.3% compared with 2015. As of 31 December 2016, there were 42,927 full time equivalent (FTE) staff in post - a reduction of 366 staff in post since 31 December 2015; and of these, 30,742 (71.6% of HMPPS staff) were in public sector prisons. There were 23,417 operational prison service staff, comprising 54.6% of HMPPS staff. This represented a reduction of 542 FTE (2.3%) compared to the previous year. The number of Band 3-5 prison officers[7] also fell slightly from 18,235 FTE to 17,888, a fall of 1.9% on the year.

[5] This fluctuates through new capacity coming into use, capacity returning to use following maintenance, and places being taken out of use due to damage and the need to carry out urgent or planned maintenance.

[6] This includes those in prison service operational grades, HM Prison Service and HMPPS HQ non-operational grades, and National Probation Service (NPS) grades. As a small number of staff in NPS grades work in other parts of HMPPS, not all staff in NPS are included.

[7] HMPPS operational roles with regular face to face contact with people in custody. These include prison officers (Band 3), supervising officers (Band 4) and custody managers (Band 5).

The government's prison reform programme

10. Before the 2016 data on deaths in custody was released, the government launched its white paper, 'Prison Safety and Reform'.[8] Published in November 2016, the white paper described where and how violence, self-harm and self-inflicted deaths had risen. The white paper also set out the government's commitment to make prisons safer, and to build the rehabilitative culture that people need to break the cycle of harm that they cause to themselves and others.

11. The commitments outlined in the white paper are:

    - investing £100m to recruit 2,500 new staff and embedding new staff retention measures
    - introducing a new key worker role to provide support to people in custody
    - modernising the prison estate - closing some older prisons that are not fit for purpose and creating in their place high-quality, rehabilitative establishments
    - simplifying the organisation of the adult prison estate into three functions - reception, training and resettlement - by 2021
    - developing new security measures, including a new £3m national intelligence hub to target organised crime, the introduction of body worn cameras across the estate, and fitting prisons with cutting-edge technology to block illegal mobile phones
    - introducing performance measures to help drive up standards and allow prisons to focus on offender outcomes
    - empowering governors to improve the services provided in their prisons, which will achieve better outcomes for the people in their care
    - introducing a stronger scrutiny and inspection regime, which includes a new emergency trigger for the Justice Secretary to step in if prisons are failing
    - delivery of new education and employment strategies to redefine how we rehabilitate people whilst they are in custody
    - cutting the annual £15bn cost of re-offending to society

12. Reducing self-inflicted deaths is a top priority for the prison safety programme. To create a safer living environment for people in prison and a safer working environment for staff, our approach to making prisons safer currently focuses on three areas:

    - transforming the prison workforce by increasing both the number and capability of staff in prisoner-facing roles to run rehabilitative regimes, and to support better staff / prisoner relationships

[8] Ministry of Justice (2016). *Prison Safety and Reform.* www.gov.uk/government/uploads/system/uploads/attachment_data/file/565014/cm-9350-prison-safety-and-reform-_web_.pdf. Accessed 22 August 2018.

- developing further the collection and use of management information, so that prison governors and directors are well informed about the risks to their specific prisons, and can use their resources effectively to address them
- modifying relevant national policies and practices to increase consistency in identifying and managing risk of harm across the prison estate

Diverting vulnerable people away from custody

13. In addition to making prisons safer for people where the only option is custody, we also recognise the importance of diverting vulnerable people away from the CJS, where appropriate. At the first point of contact with the CJS, liaison and diversion services (L&D) are being rolled out across England and were operating at 82% at the end of March 2018. This should increase to 90% by the end of March 2019, with full rollout by 2020/21. Wales has a separate but similar criminal justice liaison and diversion service. L&D services place clinical staff at police stations and courts to provide assessments and referrals to treatment and support. Offenders may be diverted away from the CJS altogether, away from charge, or away from custody to a community sentence with a treatment requirement. The service is intended to identify and provide early intervention for people with mental health problems, substance misuse problems and other vulnerabilities as soon as they come to the attention of the CJS.

14. We are also developing a community sentence treatment requirement protocol that will set out what is expected from all relevant agencies and improve access to mental health and substance misuse services for offenders who need them. We are going to test the protocol in several areas to make sure that it works and offers people the right support to end the cycle of reoffending. This includes a new maximum waiting time for court-ordered treatment that is in line with waiting times for the general population. It also includes a new single point of contact within each local mental health and substance misuse service.

Chapter 2 Themes and lessons from scrutiny of self-inflicted deaths in prison

15. There have been several inquiries into and reviews of self-inflicted deaths in custody, both before and after the sharp rise seen in 2016. Common among them has been a focus on the prevalence of mental illness in custody and how it is managed. The summary points to emerge from our review of this literature are as follows:

Independent scrutiny

16. The PPO published a thematic review of mental health in prisons in March 2016[9] and identified 25 lessons for the attention of HMPPS, primary and mental healthcare, and substance misuse services. Based on analysis of 557 of its own death in custody investigations between 2012 and 2014 (of which 199 were self-inflicted), the lessons followed a person's experience of custody from arrival through to referral for mental health assessment and treatment, and centred around improving the identification of mental health concerns and the provision of care. Common among the lessons was communication and information sharing, notably: prison and healthcare staff using all available information to ensure that the right decisions are made at the right time in identifying risks and making referrals for mental health assessments; and the exchange of information between relevant staff and services (and between prisons during a person's transfer) to put appropriate coordinated care in place. Specifically, in relation to care, the report also pointed to the need for staff with prisoner-facing roles to monitor closely compliance in taking medication, and for community-based psychological therapies to be made available to people in custody who might benefit from them.

17. In response to the 12 self-inflicted deaths in women's prisons in 2016, the Independent Advisory Panel (IAP) on Deaths in Custody carried out a rapid information-gathering exercise. Published in March 2017,[10] its report made a series of community and prison-based recommendations to prevent suicide and self-harm and keep women safe. This reflects the panel's wider remit to look at deaths in police, immigration and prison custody (including those who die on licence in Approved Premises) and deaths of people detained under the Mental Health Act. In addition to making improvements to mental health provision, and notably to '*develop a gender-aware and trauma informed environment in all women's prisons'*, the recommendations also focused on improving

[9] Prisons and Probation Ombudsman (2016). *Learning from PPO investigations, Prisoner mental health*. www.ppo.gov.uk/wp-content/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf. Accessed 22 August 2018.

[10] Independent Advisory Panel (2017). *Preventing the Deaths of Women in Prison - initial results of a rapid information gathering exercise by the Independent Advisory Panel on Deaths in Custody*. http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2017/04/IAP-rapid-evidence-collection-v0.2.pdf. Accessed 22 August 2018.

the transfer of information about women at risk, maximising family contact and family input where appropriate and safe to do so, and preparing women for release.

18. The rise in women's deaths in 2016 also prompted the PPO to issue a bulletin[11] that drew on a review of 19 of its investigations between 2013 and 2016. From looking at this snapshot of cases, the PPO identified lessons under the themes of identifying, monitoring and acting on risk, the role of mental health, bullying, the ACCT process, and emergency response. Most of the findings echoed broadly those made by the IAP, particularly those relating to mental health and drugs misuse service provision and the importance of the exchange of information about risk and care planning. The PPO also identified weaknesses in joint working between front-line mental health and prison staff - partly the result of incorrect perceptions on both sides around roles and responsibilities in supporting women at risk of harming themselves.

19. In January 2017, the MoJ commissioned Stephen Shaw, a former Prisons and Probation Ombudsman, to provide independent professional advice on the prevention of self-inflicted deaths and self-harm at HMP Woodhill, where there had been seven self-inflicted deaths during 2016. This followed a judicial review application from members of the families of two of the people who died. Their claim was subsequently rejected by the High Court in a judgment of 23 May 2017 (Scarfe & Ors, R (on the application of) v HMP Woodhill & Anor [2017] EWHC 1194 (Admin)).

20. The report[12], submitted in May 2017, concluded that '*no one visiting Woodhill at the present time could be in any doubt as to the absolute focus upon the prevention of self-harm and suicide'*, and that the emphasis upon prisoner safety was one that the author had "*not encountered in nearly four decades of visiting, writing about and* overseeing *prisons"*. It described the actions taken by the governor and (then) deputy director of custody for the high-security estate as representing '*a robust and focused approach to the tragedies at Woodhill*', and concluded that Woodhill is not a *'bad, sick or failing*' prison. The report made no specific recommendations for Woodhill. It did, however, end with two over-riding lessons that apply nationally as well as to the prison, about the ACCT process and staffing pressures.

21. In June 2017, the National Audit Office (NAO) published a report following its review of mental health in prisons.[13] While the report recognised our current work to reduce self-inflicted deaths and self-harm in prisons, the NAO made six recommendations

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[11] Prisons and Probation Ombudsman (2017). *Learning lessons bulletin, Fatal incidents investigations, Issue 13. Self-inflicted deaths among female prisoners.* www.ppo.gov.uk/wp-content/uploads/2017/03/PPO-Learning-Lessons-Bulletin_Self-inflicted-deaths-among-female-prisoners_WEB.pdf. Accessed 22 August 2018.

[12] Shaw Stephen (2017). *INDEPENDENT PROFESSIONAL ADVICE ON THE PREVENTION OF SELF-INFLICTED DEATHS AND SELF-HARM AT HMP WOODHILL.* http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2018/02/Advice-on-self-inflicted-deaths-and-self-harm-at-HMP-Woodhill-Stephen-Shaw.pdf. Accessed 22 August 2018.

[13] National Audit Office (2017). *Mental Health in Prisons, Report by the Comptroller and Auditor General.* www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf. Accessed 22 August 2018.

urging for further joint working between MoJ, HMPPS, DHSC and NHS England to ensure better outcomes for people in prison with mental health needs. This included one specific, joint recommendation to address the rise in incidents of suicide and self-harm in prisons, as a matter of urgency.

Parliamentary scrutiny

22. Mental health and deaths in custody continue to be the focus of parliamentary scrutiny. In May 2016 the Justice Select Committee published a report of its inquiry into prison safety[14] following concerns over increases in violence, self-harm and suicide in prisons. With specific reference to self-inflicted deaths and the early days in custody, the Committee cited evidence from both Her Majesty's Chief Inspector of Prisons and the PPO that assessments during induction were variable in quality and that prison staff were not always capable of identifying and acting upon information about the factors known to increase the risk of suicide. The Committee called upon MoJ and the then National Offender Management Service to produce an action plan for improving prison safety to address the wider factors underlying violence, self-harm and self-inflicted deaths. The government formally responded to the Committee's recommendations on 12 September 2016.[15]

23. The Joint Committee on Human Rights published an interim report on its inquiry into Mental Health and Deaths in Prisons on 2 May 2017.[16] Among the main findings, the Committee highlighted the variation in the availability of mental health services across the prison estate; the need for more prison staff training to identify mental health issues and support the people in their care; and the importance of continuity of care for people in custody and on release. The Committee made several recommendations to the government about the legislative levers it should consider to improve mental health and reduce deaths in custody.

24. The government officially responded to the interim report in January 2018.[17] This outlined the progress being made by MoJ and HMPPS, often in partnership with DHSC, NHS England and Public Health England, to address recommendations without the need for legislative change.

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[14] House of Commons Justice Committee (2016). *Prison Safety, Sixth Report of Session 2015-16*. https://publications.parliament.uk/pa/cm201516/cmselect/cmjust/625/62506.htm#_idTextAnchor020. Accessed 22 August 2018.

[15] House of Commons Justice Committee (2016). *Prison Safety: Government Response to the Committee's Sixth Report of a Session 2015-16. First Special Report of Session 2016-17.* https://publications.parliament.uk/pa/cm201617/cmselect/cmjust/647/647.pdf. Accessed 22 August 2018.

[16] House of Lords House of Commons Joint Committee on Human Rights (2017). *Mental Health and Deaths in Prison: Interim Report*. Seventh Report of Session 2016-17. https://publications.parliament.uk/pa/jt201617/jtselect/jtrights/893/893.pdf. Accessed 22 August 2018.

[17] House of Lords House of Commons (2018). *Mental Health and Deaths in Prison: Interim Report: Government Response to the Committee's Seventh Report of Session 2016-17. Second Special Report of Session 2017-19.* https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/753/75302.htm. Accessed 11 September 2018.

25. Following on from this report, a Public Accounts Committee (PAC) session in October 2017 heard evidence from MoJ, HMPPS and NHS England. Following this session, PAC issued a report into mental health in prisons[18] and made several recommendations either singularly or jointly to MoJ, HMPPS, and NHS England. They focused on the recruitment and training of mental health and prison staff, tackling substance misuse, improving both health screening and the process of transferring mentally unwell people to and from secure settings, and improving knowledge and information sharing. The government formally responded to these recommendations through the Treasury Minute process, published on 1 March 2018.[19]

26. In April 2018 the Health and Social Care Committee launched an inquiry[20] into prison healthcare services, seeking written evidence on the effectiveness of these services in identifying, treating and managing the health and social care needs of people in custody. The scope of the inquiry also included prison safety and the effect of the custodial environment on the physical, mental and social wellbeing of both staff and the people in their care. MoJ and HMPPS provided written and oral contributions to the inquiry as part of wider evidence with DHSC, NHS England, and PHE.

[18] Committee of Public Accounts (2017). *8th Report - Mental health in prisons*. https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/400/400.pdf. Accessed 11 September 2018.

[19] HM Treasury (2018). *Treasury Minutes, Government response to the Committee of Public Accounts on the Fourth to the Eleventh reports from Session 2017-19*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/684805/Cm_9575_Treasury_Minutes_Web_Accessible.pdf; HM Treasury (2018). *Treasury Minutes, Government response to the Committee of Public Accounts on the Twelfth to the Nineteenth reports from Session 2017-19*. www.parliament.uk/documents/commons-committees/public-accounts/Cm-9596-Treasury-Minutes-march-2018.pdf. Accessed 11 September 2018.

[20] Further information is available at: www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/news/prison-healthcare-launch-17-19/.

Chapter 3 Analysis of the data and the PPO's recommendations from 2016's self-inflicted deaths

27. The prison population in England and Wales has been relatively stable for the last four years at about 85,000. The male and female prison populations have also remained relatively stable at around 81,000 and 4,000 respectively. In 2016, the average population over the twelve-month period was 85,348 (81,493 male and 3,854 female). This was less than 2015's average of 85,626 where the male and female populations were slightly higher (81,741 and 3,885).

28. Changes in the composition of the prison population from 2015 to 2016 do not explain the sharp increase in self-inflicted deaths. Rather, it is likely to be due to a complex combination of individual, custodial and environmental factors. This view was shared by the then Prisons and Probation Ombudsman who said in his Annual Report for 2015-16:

    "It is deeply depressing that suicides in custody have again risen sharply but it is not easy to explain this rising toll of despair. Each death is the tragic culmination of an individual crisis for which there can be a myriad of triggers."

29. It is also evidenced in a recent study published in The Lancet,[21] which points to the international problem of prison suicide. The research found that, while we can be more confident in identifying individual-level characteristics associated with prison suicide (psychiatric illness, substance misuse, and repetitive self-harm are known risk factors), less is known about prison and health service-level factors. Evidence of an association between overcrowding and prison suicide is inconsistent and evidence of other prison factors that may increase the risk of prison suicide such as low staff engagement, negative staff-prisoner relationships and high prison population turnover is limited. Prison suicides are, therefore, likely to be the result of a complex interaction of factors, and not merely due to the prison environment.

30. A systematic review of risk factors and risk scales, published in the British Journal of Psychiatry in 2016,[22] urges some caution in our ability to predict suicide. Focused solely on longitudinal studies of people with a history of self-harm, this research found that some factors associated with suicide (in clinical populations of people with at least one incident of self-harm or poor mental health) are so prevalent that they are of little help in predicting later risk of suicide or in differentiating, with sufficient accuracy, those at highest risk. The review therefore argued for an approach where each

[21] Fazel, et al. (2017) *Suicide in prisons: an international study of prevalence and contributory factors*, The Lancet Psychiatry, Vol. 4, Issue 12, 946-952.

[22] Chan MK, Bhatti H, Meader N, Stockton S, Evans J, O'Connor RC, et al. *Predicting suicide following self-harm: systematic review of risk factors and risk scales,* British Journal of Psychiatry 2016; 209: 277–83.

person was individually risk-assessed to help identify personal factors that might increase the likelihood of a suicide attempt in the future.

In November 2015, a man with a history of bipolar affective disorder and attempted suicide was remanded in custody. Staff started ACCT procedures soon after he arrived but he refused to participate or take his medication. Staff then placed the man on complex case monitoring under the ACCT process to support his needs better, and following two assessments of his mental health in December 2015 and May 2016, he was transferred to hospital where he remained for seven weeks.

When the man returned to prison, he was monitored and supported again through the ACCT process. The prison healthcare team, which included mental health staff, continued to be involved in his care.

Tragically, the man took his own life in August 2016. Following an investigation, the PPO concluded that staff identified appropriately his risk of suicide and self-harm, delivered a good standard of care and support under the ACCT process, and provided him with excellent healthcare. Moreover, as the man gave little indication that he was at imminent risk of suicide, staff could not have reasonably predicted or prevented his actions.

The PPO made no recommendations.

31. The summary points to emerge from our analysis of 2016's data on self-inflicted deaths in custody are as follows.

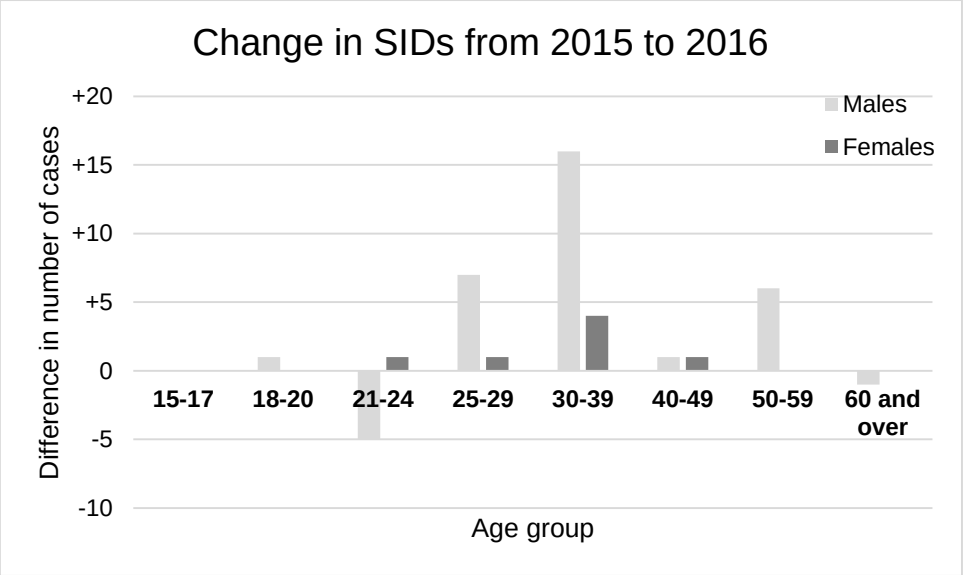
Women

32. The proportion of women in all deaths in custody doubled between 2015 and 2016 (from 3% to 6%). Women make up around 4.5% of the total prison population overall, but the rate of self-inflicted deaths per 1,000 people in custody was higher for females (3.11) than for males (1.35). While not unprecedented (the same occurred in 2015), this does present a stark contrast to suicides in the general population, which are over 3 times more frequent among men than women.

Age

33. The number of self-inflicted deaths in the 30 to 39 age group increased by 63% between 2015 and 2016, and accounted for almost two thirds of the 36% increase overall. The prison population decreased between 2015 and 2016 in all age groups under 30. There was a 1% increase in the 30 to 39 years age group. Within this group, the number of women in prison remained the same and only slightly increased for men, and proportionately more men and women took their own lives. Self-inflicted deaths also increased among 50 to 59-year-olds but decreased among people younger than 25. For women, the number of self-inflicted deaths increased in all categories between 21 and 49 years of age.

34. The table below shows the difference in the number of self-inflicted cases between 2015 and 2016, broken down by age group.



35. Nearly 80% of all self-inflicted deaths were men between the ages of 25 and 60. This was disproportionately higher than the number of men in this age group in the overall prison population (72%). While the number of women who died in custody in 2016 was far less than the number of men (and the figures less reliable as a result), women in all age groups between 18 and 60 were more likely than men to take their own lives.

Time in custody

36. We know that people experiencing the early days in custody and those who transfer between prisons, are high risk groups. Of the 122 self-inflicted deaths in 2016, 10% occurred in the first week, and 21% within the first month. People in prison for more than one year accounted for one third of the total number of self-inflicted deaths in custody. Moving between prisons also remained a risk: 6% of deaths occurred within the first month after a move to another establishment.

Ethnicity

37. In 2016, white people accounted for 85% of self-inflicted deaths and 74% of the prison population. This group was, however, disproportionately represented in self-inflicted deaths when compared with the prison population. Between 2015 and 2016, the white prison population decreased by 1% but self-inflicted deaths increased by 33%.

38. Black men, on the other hand, accounted for 6% of self-inflicted deaths and 12% of the prison population. This still represents an increase in risk: the black prison population rose by 0.2% in 2016, but the number of self-inflicted deaths in this group doubled.

39. Of the 12 women who took their own lives in 2016, 10 were white. White women make up less than 4% of the prison population but they accounted for more than 8% of the self-inflicted deaths. This group also showed the largest percentage increase (150%), followed by black men (133%), although absolute numbers were relatively low in both cases (10 and 7, respectively).

Nationality

40. EEA nationals were overrepresented in the number of self-inflicted deaths. While estimated to make up around 5% of the prison population, EEA nationals accounted for 8% of the 122 deaths in 2016. Other foreign nationals also accounted for 8% of the deaths but are estimated to make up around 7% of the prison population.

41. Our previous analysis of data over the last five years showed that foreign national offenders from Lithuania and Poland (both with higher rates of suicide in the community than the UK) were particularly at risk of taking their own lives. British nationals were underrepresented in the figures.

Status

42. People serving long-term sentences (4+ years, life and IPP) accounted for 41% of all self-inflicted deaths in 2016. While they make up half of the prison population, so that their incidence of self-inflicted death was proportionately lower, there was a dramatic increase among this group from 2015 to 2016 (21 cases or 72%). This accounted for two thirds of the rise in the number of deaths overall.

43. Those serving short sentences (up to six months in prison) accounted for 11% of all self-inflicted deaths. While their number decreased by 1% in 2016 to 4% of the overall population, self-inflicted deaths among people serving six months or less rose by six (86%), and accounted for 17% of the overall increase that year.

44. Among people on remand, there was a slight decrease in the number of self-inflicted deaths. In 2016, 33 people who took their own lives were on remand, a decrease of 3 cases (8%) from 2015. Over the same period, the overall number of people on remand in prison fell by around 14%.

Prisons

45. The 122 self-inflicted deaths in 2016 occurred in 63 different prisons. In terms of the spread across the prison estate, this was slightly more concentrated than in 2015 where 90 deaths affected 55 prisons. We know that ‘cluster deaths’ (where one prison experiences three or more self-inflicted deaths within a 12-month period) can have a very strong effect on both prison staff and the people in custody. In 2016, seventeen prisons experienced three or more deaths[23] and three (HMP Chelmsford, HMP Exeter

[23] A total of nine male and female prisons experienced three self-inflicted deaths; six male prisons experienced four, and in the two other prisons, also male, one experienced five self-inflicted deaths and one experienced seven.

and HMP Woodhill) experienced 'cluster deaths' for the second year running. A total of ten prisons had experienced three or more deaths in 2015.

Analysis of PPO recommendations following investigations into self-inflicted deaths in 2016

46. We examined the recommendations made by the PPO following its investigations into self-inflicted deaths in custody in 2016 to identify predominant themes. The PPO categorises its recommendations under several headings; five of these categories together accounted for 70% of the 412 recommendations made. Annex A lists all PPO recommendations for 2016 by category.

    Our response to the most frequently made recommendations from PPO investigations is summarised here.

ACCT

47. The PPO made 97 recommendations under this category. Of these, the most common focused on increasing the capability of staff to identify, record and manage risk of self-harm and suicide according to national ACCT guidance. There were specific recommendations around induction procedures, identifying and recording risk factors (particularly during the early days and as circumstances change over the course of sentence), and on responding with specific and measurable care plans agreed by a multi-disciplinary team. The PPO also recommended that Governors put in place quality assurance processes to keep the use of ACCT under scrutiny, in accordance with the relevant Prison Service Instruction.[24]

48. Building on a review of the ACCT process in 2015, and as part of HMPPS's suicide and self-harm reduction project, we undertook further work to improve the case management process for people at risk of harm. In common with the issues previously raised by scrutiny bodies, identifying risk, a lack of confidence and capability among staff to identify it, and capacity issues in resourcing the ACCT process were all found to be areas where improvements could be made. We are addressing these issues through our safety programme and have already published guidance on multi-disciplinary working, defensible decision-making and understanding suicide risk, development and implementation of suicide and self-harm awareness, and ACCT training packages. We have also launched a communication campaign on suicide and self-harm reduction and we ran a national learning day for prison staff in March 2017.

[24] PSI 2011/64 Management of Prisoners At Risk of Harm to Self, to Others and From Others.

49. We know that people in the early days in custody are a high-risk group. As part of our safety strategy, we are improving staff capability across the whole estate by continuing the roll-out of improved SaSH training for new and existing staff. This includes a module on mental health awareness to equip staff with an understanding of common mental health concerns in prisons, how to interact positively with people presenting different conditions, and how to raise a concern. Our most recent data shows over 17,000 new and existing staff have started SaSH training and almost half of these staff have completed the training in full. Of these, over 8,000 new and existing staff have completed the introduction to mental health module.[25]

50. This strand of work also includes roll-out of the new Suicide Prevention Learning Tool, developed in conjunction with the Samaritans, to help staff identify and address risks. In 2017-18, we gave the Samaritans extra grant funding for developments to the peer support scheme through which people in custody are trained as 'Listeners' to support other people in emotional distress. The grant is also being used to fund other pilot schemes, including emotional resilience training for people in the early days of custody. More recently, we have renewed our partnership with the Samaritans and confirmed that grant funding for the Listener scheme will continue until March 2021.

51. The results of our recent mental health training needs assessment identified where we can focus our efforts on increasing and further improving prisons' mental health training. Building on this, we are putting plans in place to:

    - Refresh training in mental health awareness and enhanced mental health, and for peer support workers, and introduce a leadership training package on mental health and wellbeing. We will also evaluate externally delivered training to specialist prison staff.
    - Improve information about and access to the training packages available, and use targeted campaigns to raise awareness about mental wellbeing and mental illness.
    - Give prisons guidance on engaging with health partners to promote understanding of referral routes in prisons, and publicise further the existing guidance and the learning bulletins relating to mental health.
    - Develop support for staff around mental health and wellbeing relevant to the prison environment, including ways to maintain their own and colleagues' wellbeing.

Mental health provision

52. The PPO made 35 recommendations under this category, the most frequent of which repeated several of the lessons set out in the PPO's thematic review from March 2016. Relating to prompt and thorough screening and assessment (particularly during a person's early days in custody), these recommendations focused on the need for

[25] These figures do not capture all mental health awareness training being undertaken across public sector prisons - some prisons continue to deliver locally devised packages, often in conjunction with the local healthcare provider.

staff to draw on all available information to assist them in making timely referrals to appropriate mental health colleagues (who should then respond within 72 hours). Healthcare providers, commissioned by NHS England, were urged to provide sufficient mental health care services to the prison; and to ensure staff were trained to carry out good quality mental health assessments, knew when to escalate concerns, knew to monitor compliance with medication, and understood the process for considering when to transfer a person to community psychiatric care.

53. NHS England has produced a revised mental health service specification for prisons, effective from April 2018, which improves the service offer across the prison estate. To improve the screening process in prisons, NHS England has also rolled out new healthcare screening templates (national clinical templates) for both prison reception screening and the full healthcare screening that is required within one week of reception into prison. The screening is designed to identify mental and physical health needs. The templates have been designed to match the current National Institute for Health and Care Excellence guidance on healthcare screening, and users are being supported to ensure that they are making effective use of them.

54. Before release from prison, people in custody can now register with a GP to facilitate a quicker transfer of important information from prison to GP practice. Beginning in 2019, NHS England will introduce an upgrade to the clinical IT systems in prison healthcare units to enable the exchange of health records between prisons and community GPs. In future, when a person arrives in and is released from custody, the up-to-date clinical record can be transferred from their registered GP to the prison and vice versa, improving further the continuity of care. Roll-out of the IT upgrade is due to be completed by February 2020.

55. We are working closely with health colleagues to respond to the NAO's recommendations to improve outcomes for people who are mentally unwell. This includes working across government to improve our use of data to understand and respond to mental health needs in prisons, as well as addressing self-harm and suicide. We have also developed a new national partnership agreement that strengthens further the level of co-operation and cohesiveness between health and justice departments and agencies to deliver key priorities for health services in prisons. The National Partnership Agreement for Prison Healthcare in England has been renewed for 2018-21. This document has been agreed by MoJ, HMPPS, DHSC, Public Health England and NHS England. It sets out the basis of a shared understanding of, and commitment to, the way in which the partners will work together to deliver joint objectives to improve health and justice outcomes. Key priorities for 2018-21 include strengthening multi-agency approaches to reduce the risk of self-harm and suicide, to reduce the effect of substance misuse, and to work together to improve the mental health and wellbeing of the prison population. While the agreement covers health services in adult prisons only in England, we continue to work with colleagues in Wales to improve health in public sector prisons through agreed shared priorities and to meet the needs of people moving between English and Welsh prisons.

Substance misuse

56. The PPO made 34 recommendations under this category, half of which called on Governors to establish a drugs strategy to reduce the supply and demand of illicit substances, increase the capability of staff to recognise the signs of misuse, and provide appropriate care. Further recommendations included the provision of detox services in every prison, supported by qualified staff; routine referral to substance misuse services for people found to be using psychoactive substances and other illicit drugs; swift access to drug rehabilitation treatment; and to ensure nicotine replacement was available to people on arrival in prison who smoke tobacco.

57. We are committed to making an impact on the prevalence of drugs in prisons within 12 months and have formed a drugs task force that will focus on some of the prisons with the worst drug problems while offering support to prisons across the whole of the estate. The task force is tackling both supply and demand, and is also working to ensure that the right treatment is available to support people with drug dependencies. NHS England has developed a new service specification[26] for the commissioning of quality substance misuse services from April 2018. This will support improvement in the design and delivery of substance misuse services for people in prison, including addressing issues resulting from the rise in the use of psychoactive substances, and ensuring that there is proper integration with mental health services.

Emergency response

58. The PPO made a total of 73 recommendations under this category. Frequently made recommendations called upon Governors to ensure staff, including those in the control room, understood their responsibilities when there was a medical emergency, such as knowing at what point to call an ambulance and when to attempt resuscitation. Further recommendations were made to ensure staff knew to enter cells as swiftly as possible in a life-threatening situation, and knew the right codes to use to convey the nature of the medical emergency in an accurate and timely way.

59. We issued a learning bulletin to all staff in December 2016 that stressed the importance of an immediate response. The bulletin reminds control room staff that an ambulance should be called as soon as an emergency code is received, sets out the information they need to pass on to the ambulance service, and gives guidance on how to admit an ambulance to a prison. It also reminds all staff of the details of the code red / code blue system for telling control staff the nature of an emergency and sets out in detail when CPR should be attempted, in accordance with the European Resuscitation Council's guidelines.

[26] NHS England (2018). *Service specification: Integrated Substance Misuse Treatment Service Prisons in England*. www.england.nhs.uk/publication/service-specification-integrated-substance-misuse-treatment-service-prisons-in-england/. Accessed 12 September 2018.

General prison administration

60. The PPO made 57 recommendations under this category, which covered a broad range of areas for improvement. A frequent suggestion was for Governors to make efforts to improve staff-prisoner relationships, through increasing the capability of staff to understand the needs of the people in their care, to check on their wellbeing, and to provide appropriate support. Governors were urged to make sure their staff know to check on the wellbeing of prisoners when unlocking cells and to act when observation panels are covered or cell bells are rung. The PPO suggested Governors check whether the culture or regime in some units offered enough support to vulnerable people. Another frequently made recommendation referred to improving communication and information sharing between departments within prisons, to ensure more coordinated care for people in custody.

Mental health assessments and transfers to hospital

61. People in custody with mental illnesses requiring detention in a hospital for urgent medical treatment can be referred for transfer to a secure hospital under section 48 or 49 of the Mental Health Act 1983, following two medical recommendations. Both HMPPS instructions and NHS guidance set out this process[27] and are clear that two doctors (one of whom must be a mental health specialist) must provide reports stating that the person meets the criteria for transfer. The mental health casework team in MoJ receives the reports, considers the requests and then issues transfer warrants. When identified as suitable for transfer, the NHS England health and justice commissioning team appoints an NHS England case manager to lead on this process and locate and obtain a hospital bed. DHSC guidance recommends that all people in custody needing transfer are transferred within 14 days. This guidance is currently under review to ensure that recommended transfer timescales are based on clinically informed evidence and patient need.

62. During 2016 there were 980 such transfers across the prison estate, 503 of whom were people on remand and 477 who were sentenced. Throughout 2016, 267 patients were remitted from hospital to prison custody (this figure includes patients transferred both during and prior to 2016).

63. HMPPS and NHS England have collected new evidence and developed an improved understanding of the assessment processes for transfer, where and for whom they work well, and how delays arise, and have identified areas for improvement. NHS England has committed to action across policy, commissioning and operations. This will include the definition of new expectations for achieving timely transfer, with greater priority being given to urgent cases. An annual audit of cases awaiting transfer will be completed and the results of an autumn 2017 audit are being prepared for publication.

[27] PSI 50/2007 (Transfer of Prisoners to and from Hospital Under Sections 47 and 48 of the Mental Health Act 1983) and NHS England 'Good Practice Guide – The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act'.

64. The case of Dean Saunders, which prompted this review, saw a delay in the process of assessment and transfer to hospital. Both the PPO and the coroner commented on it.

Mr Saunders was remanded in custody on 18 December 2015. On arrival, prison staff were made aware that he was at high risk of suicide and acutely mentally unwell. He was admitted to the prison's healthcare inpatient unit immediately and staff began ACCT procedures, placing him under constant supervision.

Following a psychiatric assessment on 21 December, Mr Saunders was considered eligible for a transfer to hospital under the Mental Health Act. Healthcare staff did not, however, notify NHS England's commissioning team and so the process of identifying a suitable bed at the local hospital was not started. The psychiatrist who assessed Mr Saunders as eligible did not complete the first doctor's recommendation, wrongly believing a bed should be identified first, and this delayed the transfer.

Nine days later, on 31 December, Mr Saunders' transfer to hospital was delayed again. This time, a forensic psychiatrist completed a first recommendation and a bed was identified. There was, however, confusion over who should complete the second recommendation and while any doctor, including a GP, could have completed the second report, healthcare staff wrongly believed that it had to be done by the prison psychiatrist, who was on leave until the new year.

Mr Saunders was not transferred to hospital and, on 4 January 2016, he took his own life. Following an investigation, the PPO concluded that due to a lack of understanding about the process for transferring acutely unwell people to hospital, the system to divert Mr Saunders to an environment where he could receive appropriate care did not operate effectively.

The PPO made two recommendations to address these issues.

65. In the light of this we carefully assessed each of the other 121 cases in 2016 for evidence of any similar issues. In most of the cases there was no suggestion that hospital treatment would have been appropriate. That said, we did find nine other cases in which this was, or perhaps should have been, considered.

66. In addition to Mr Saunders' case, in two further cases there were delays in assessing and transferring mentally unwell people, also stemming from misunderstandings about the process on the part of the healthcare staff in the prisons. There was no suggestion that the delay in any of these cases was the result of inaction by the mental health casework team in MoJ. In all three of these cases the PPO made recommendations to the Governor and/or the healthcare provider to improve healthcare staff's understanding of the process for bringing these cases to the attention of the NHSE commissioning team and the MoJ mental health casework team. Each of these recommendations was accepted and acted on locally.

67. In four cases (including two women) assessments took place but transfers were not considered appropriate. In each of these cases the clinical reviewers informing the PPO report judged the assessments to be appropriate and concluded that the people in custody had received a good standard of care, equivalent to that expected in the community.

68. In two cases assessments did not take place when the clinical reviewers informing the PPO report believed that they should have done. In each case the standard of care provided was described by the clinical reviewers as inadequate. The PPO made recommendations to the Governor and/or the healthcare provider about relevant aspects of the care provided locally at the prison, such as the referral process for mental health assessments and the communication between primary care and mental health in-reach teams. These recommendations were accepted and have been acted on locally.

69. Finally, as highlighted in the case study on page 12, another person was transferred to hospital for a short period and died shortly after being remitted to prison custody. In this case the clinical reviewer described the care provided as excellent, and the PPO found that the prison could not have anticipated the death and made no recommendations.

70. Based on the learning from many of the above cases, in March 2017, a learning bulletin “Prisoners Transferring to and from Secure Hospitals” was published. Senior leaders across HMPPS were asked to ensure that it was shared with custody, healthcare, wing and segregation unit staff. The bulletin contains key learning points, guidance on the care and management of people in custody before and after transfer, and a reminder of the processes to be followed. It continues to be available to staff on the safety page of the HMPPS intranet.

71. The majority of mental illness or disorder among men and women at risk of suicide in prison is not at the level of severity that would indicate referral for hospital treatment. As mentioned in Chapter 3, NHS England, with HMPPS input, has completed a full review of prison service specifications for both mental health and substance misuse, and revised specifications recognise the common co-presence of needs in both areas. NHS England’s performance framework for prison healthcare services has been reviewed with the introduction of seven new indicators for mental health and learning disability, and the framework will, for the first time, measure delivery of first and second reception health screens.

Chapter 4 Our wider programme of work to make prisons safer

72. There has been a welcome fall in the number of self-inflicted deaths in prison custody in 2018. Our most recent safety in custody statistics, published in July 2018, show that in the 12 months to June 2018 deaths classified as self-inflicted fell by 22% (from 99 to 77). This is a rate of 0.9 per 1000 people in prison. We also saw a significant decrease in the number of women who took their own lives - down from 6 in the previous 12 months to 3. The early days in custody do, however, remain a high-risk time: of the 70 self-inflicted deaths in 2017, 14% occurred within the first week and 27% within the first month - a slight increase on the previous year.

73. While we welcome this reduction in self-inflicted deaths, and we are continuing our efforts to prevent further self-inflicted deaths, we recognise that more needs to be done to build the capability of staff and of the prison system overall. The actions we have set out in this review form part of our wider prison safety and offender reform programme which includes a range of other work streams to make prisons safer to live and work in.

74. To improve prisoner and staff relationships we are rolling out the key worker role as part of the new Offender Management in Custody arrangements. This is being enabled by the recruitment of an additional 3,500 prison staff, exceeding our target of 2,500, and will train all residential prison officers to deliver key worker sessions to a caseload of about six prisoners each. The focus of the key worker role is to mitigate the negative effects of imprisonment. Key workers will coach and encourage prisoners to feel settled and safe, providing an opportunity to be calm and engaged in their rehabilitation, and supported positively through their sentence. So far 54 prisons are delivering keyworker sessions.

75. Additionally, we have bolstered the resource available at group level to support staff in prisons to improve safety. Alongside this the HMPPS Operational Systems and Assurance Group is delivering a series of safety audits across establishments. So far over 65 have been completed. To respond to concerns about safety, the national MOJ and HMPPS Safety Team is providing intensive support to help prisons with their areas for improvement. This arrangement is also supporting prisons identified through the new urgent notification system recently agreed with Her Majesty's Chief Inspector of Prisons where, if he sees something serious as part of an inspection, he can bring it immediately to the Secretary of State's attention and ask him to act. This agreement has already been used to raise significant safety-related issues at HMP's Nottingham, Exeter, Birmingham and Bedford.

76. HMPPS Psychological Services are developing and piloting support for some of the more vulnerable people, including those with traumatic brain injuries, and people who intentionally isolate themselves from the prison regime.

77. As set out in the white paper, a female offender strategy has been developed, with a dedicated focus on improving the outcomes for women in the community and in custody. Published in June[28], the strategy sets out the government's commitment to a new programme of work for female offenders, driven by a vision to see fewer women coming into the criminal justice system through early intervention and tailored support to help address often complex needs; fewer women in custody, especially on short-term sentences, a greater proportion of women managed in the community successfully; and better conditions for those in custody. The strategy also reflects the approach being undertaken by our safety programme to keep women safe and supported whilst in custody. A dedicated prison group safety lead has already been appointed to identify and share effective practice that is bespoke to women - supporting governors to address challenges to safety in their prisons. We also continue to work to meet the recommendations made by the IAP and the PPO and have made good progress in addressing all those falling within HMPPS's remit. We have improved provision across women's prisons to help women to maintain healthy relationships and positive contact with their children: family engagement workers are now available in all women's prisons, and staff in the female estate have undertaken 'trauma walk-through exercises'. Peer support workers are available for women to speak to in reception and during induction, and time spent in reception areas has been minimised. We have also collaborated with NHS England to improve continuity of access to medication when women are transferred. Recommendations requiring collaboration with other services are being progressed through our partnership working arrangements with NHS England, PHE, IAP, PPO, and representatives from both the academic and voluntary sectors.

78. We are taking steps to mitigate the risk of overcrowding through our estates transformation programme and our work to reduce the size of the prison population where possible, for example by increasing the efficiency and effectiveness of the use of home detention curfew. We are also focusing on improving the built environment to ensure both living and working conditions are safe, decent and properly maintained.

[28] Ministry of Justice (2018). *Female Offender Strategy.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719819/female-offender-strategy.pdf. Accessed 12 September 2018.

Further interest and ongoing work

79. Over the coming year, the introduction of structured professional support for governing Governors will give an opportunity to review the pressures associated with working with a range of complex and challenging issues. This includes deaths in custody, particularly where there has been a cluster of deaths in one prison. This support is designed to help a Governor to understand how best to manage both mental and emotional resilience. It will be delivered by a psychologist, a psychotherapist or a trauma specialist who has experience of working with senior managers and leaders in emergency services.

80. Added to this, there are plans to develop a staff support working group whose remit will be to consolidate the support services available to staff from a range of providers, including occupational health, psychology, care teams and chaplaincy. In bringing together the support services currently available to staff, the group will devise new ways of supporting staff who have experienced traumatic incidents within prisons, especially those where there have been a cluster of deaths.

81. The government has commissioned the Ministerial Council on Deaths in Custody to play a leading role in considering the most complex of Dame Elish Angiolini's recommendations in her report into deaths in police custody[29]. These include healthcare in police custody, inquests, legal aid and support for families. The Ministerial Council is due to report on progress to the Prime Minister in late 2018.

82. The government has also commissioned an independent review of the Mental Health Act 1983, as announced at the Conservative Party conference in October last year. The Mental Health Act is the legislative framework for detaining and treating people with a mental disorder, and applies to both civil patients and those involve in criminal proceedings. The review is considering both the legislation and its practical implementation. It seeks to make evidence-based recommendations for improving the management of those with acute mental health needs, both within and outside of the CJS. An interim report, outlining the review's key lines of enquiry, was published on 1 May 2018.[30] This confirmed an intention to explore '*how to streamline and speed up the process of transfer to and from hospital for prisoners and immigration detainees*'. A final report with detailed recommendations is expected at the end of 2018.

[29] Angiolini, Rt.Hon Dame Elish (2017). *Report of the Independent Review of Deaths and Serious Incidents in Police Custody*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655401/Report_of_Angiolini_Review_ISBN_Accessible.pdf. Accessed 12 September 2017.

[30] Department of Health and Social Care (2017). *The independent review of the Mental Health Act: interim report.* Available at: www.gov.uk/government/publications/independent-review-of-the-mental-health-act-interim-report. Accessed 12 September 2018.

83. The University of Manchester is conducting an independent examination of all self-inflicted deaths in prisons in England and Wales. Funded by DHSC, this two-year study entitled *Managing the risk of self-inflicted death to support a psychologically safe and rehabilitative criminal justice pathway* comprises a detailed audit of all self-inflicted deaths over a two-year period. Its aim is to explore, in detail, the circumstances of self-inflicted deaths by specific groups; how identifying vulnerable people can be improved; and how risks can be anticipated and acted upon more effectively. The two-part study will also focus on deaths in custody in the wider criminal justice system and will report with recommendations to improve identification, assessment and management of suicide risk. It is due to report in early 2019.

84. These studies present us with an opportunity to learn further lessons, and to use them to inform our work in reducing self-inflicted deaths and improving prison safety.

Annex A PPO recommendations: self-inflicted deaths in custody 2016

This summary of PPO recommendations was taken from a database holding the details of people who had taken their own lives in prison in 2016 and for whom HMPPS had received PPO reports. In five cases the PPO made no recommendations. Across the remaining reports, there was an average of three to four recommendations per case.

The PPO categorised its recommendations from 2016's investigations using the following groupings:

Grouping	Number of recommendations	Percentage
ACCT	97	23%
Adjudications	1	0%
Anti-social behaviour / bullying	23	6%
Complex prisoners	1	0%
Contact with family / informing next of kin	12	3%
Dual diagnosis	3	1%
Emergency response	73	18%
Equalities	5	1%
Follow up care and notification for prisoners	2	0%
Follow up care for staff	7	2%
Foreign national prisoners	1	0%
General prison administration	57	13%
Health provision	22	5%
Incentives and earned privileges	7	2%
Induction	4	1%
Mental health provision	35	8%
National recommendation	2	0%
Pre-arrival	2	0%
Reception	8	2%
Restraints and bed watch	1	0%
Attend to previous PPO recommendations	1	0%
Send all documents through to PPO	1	0%
Segregation	13	3%
Substance misuse	34	8%
Total	**412**	**100%**

Alternative format versions of this report are available on request from safercustodypolicyandlearning@noms.gsi.gov.uk