Guide to Safety in Custody Statistics

Ministry of Justice

Statistics bulletin

Contents

Introduction .... - 3 -
Overview of Safety in Custody Statistics .... - 5 -
Background to the Safety in Custody Statistics Bulletin .... - 5 -
Timeframe and Publishing Frequency of Data .... - 5 -
Revisions .... - 5 -
Explanatory Notes .... - 8 -
Data Sources and Data Quality .... - 11 -
Deaths .... - 11 -
Self-harm .... - 11 -
Assaults .... - 12 -
Overview of data accuracy .... - 13 -
Process for producing statistics .... - 15 -
Quality assurance .... - 15 -
System for classifying deaths .... - 17 -
Overview .... - 17 -
Exclusions .... - 17 -
Comparison with other systems .... - 18 -
Data developments .... - 20 -
Potential underreporting of incidents .... - 20 -
Changes to the way deaths are classified and reported .... - 20 -
Changes to the incident reporting system .... - 21 -
Self-harm and Assaults in the young people's estate .... - 25 -
Glossary .... - 26 -
Timeline .... - 30 -
Directory of Related Internet Websites and on line references .... - 34 -
Contact points .... - 36 -

Introduction

Safety in custody statistics cover deaths, self-harm and assaults in prison custody (including Young Offenders Institutes and HMPPS operated Immigration Removal Centres) 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. HMPPS (previously known as 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:

https://www.gov.uk/government/collections/safety-in-custody-statistics and earlier editions at:

http://webarchive.nationalarchives.gov.uk/20130315183909/http://www.justice.gov.uk/statistics/prisons-and-probation/safety-in-custody/safety-in-custody-earlier-editions

Related publications

The Safety in Custody statistics bulletin is published alongside three 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 Bulletin: This provides proven re-offending figures for offenders who were released from custody, received a non-custodial conviction at court, received a caution or received a reprimand or warning.

Safety in the children and young people secure estate Statistics Quarterly Bulletin: This provides statistics covering assaults, self-harm and deaths across all sectors in the Children and Young People Secure Estate in England and Wales.

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, MoJ announced its intention to produce a dedicated statistical bulletin that would contain a much wider range of information than would be practical to include in the HMPPS (formerly 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 do not show notable seasonal patterns 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. Data on deaths in prison custody is available three months ahead of assaults and self-harm, therefore, the deaths year ending December (and therefore annual release) is published in the year ending September publication.

Revisions

In accordance with Principle 2 of the Code of Practice for 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:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182363/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 (HMPPS Deaths in Custody Database), assaults from 2002 and self-harm from 2004 (HMPPS 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):

https://www.gov.uk/government/collections/safety-in-custody-statistics

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).

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

..	Figures suppressed due to 1 or 2 incidents
0	Nil or less than half the final digit shown

-	Not applicable
(p)	Provisional data
(r)	Revised data

Explanatory Notes

Safety in custody statistics cover deaths, self-harm and assaults in prison custody in England and Wales. Supplementary tables, providing more in depth statistics on deaths, self-harm and assaults on a calendar year basis, are also available alongside this bulletin and can be found at https://www.gov.uk/government/collections/safety-in-custody-statistics.

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

When considering particular statistics, readers should note the following:

- Risk of death, self-harm or assaults is distributed unevenly around the prison estate. Differences in age, gender, time in custody and random variation, among many other factors, explain to an extent much of the differences between prisons and particular risk groups.
- In prisons, as in the general population, self-harm is often covert and assaults may go unreported. In prison custody, however, such incidents are more likely to be detected and counted. Recording of self-harm and assault incidents in prison custody has improved over the years but it remains the case that they cannot be counted with absolute accuracy, and represent reported incidents.

Although this publication concerns statistics, the incidents described in this report are, by their nature, tragic and distressing to the prisoners, their families and staff.

From time to time, events in prison custody and developments within and outside HMPPS have changed the way safety in prisons is viewed and managed. Some have resulted in changes to the way offenders are managed, others have affected the way statistics are collected and reported. The accompanying guide includes a timeline summarising some of the key events and developments that have affected safety in prison custody and supporting statistics. These help with interpretation of longer term trends.

Deaths

A death in prison custody is defined as *'any death of a person in prison custody arising from an incident in or, on rare occasions, immediately prior to prison custody'.* All deaths in prison custody are subject to a police investigation and a coroner's inquest. Once the inquest has been concluded, the Prisons and Probation Ombudsman's office publish a detailed 'Fatal Incident Report'[1] on the death. Until this time, for administrative and statistical purposes,

[1] Prisons and Probation Ombudsman: Fatal Incident Reports http://www.ppo.gov.uk/document/fii-report/

HMPPS classifies deaths by *apparent* cause of death. As there are a number of deaths yet to be classified, it is likely that some will be reclassified when sufficient information becomes available. For this reason all figures for the last two years are provisional.

Natural cause deaths include any death of a person as a result of a naturally occurring disease process.

Self-inflicted deaths are any death of a person who has apparently taken his or her own life irrespective of intent. This not only includes suicides but also accidental deaths as a result of the person's own actions. This classification is used because it is not always known whether a person intended to commit suicide.

Homicides include any death of a person at the hands of another. This includes murder and manslaughter cases. As with self-inflicted deaths, the classification system does not make any judgement about intent with regards to homicide.

'Other' deaths include any death of a person whose death cannot easily be classified as natural causes, self-inflicted or homicide. The category includes accidents and cases where the cause of death is unknown even after all of the investigations have been concluded.

During the period of the COVID pandemic, figures for the number of deaths included COVID deaths in prison custody. The number of COVID deaths were reported within the commentary, showing (1) the total number of prisoners that died within 28 days of having a positive covid-19 test or where there was a clinical assessment that COVID-19 was a contributory factor in their deaths regardless of the cause of death, and (2) any death within 28 days of a positive Covid-19 test (or where it is confirmed post-mortem), regardless of the cause of death. As with all deaths in prison custody, each case will be investigated by the Prisons and Probation Ombudsman and subject to an inquest to determine the official cause of death and where necessary this data will be updated.

Self-harm

Self-harm in prison custody is defined as "*any act where a prisoner deliberately harms themselves, irrespective of the method, intent or severity of any injury.*" Neither this measure, nor the outcome of self-harm incidents give an indication of attempted suicide. Although incidents of self-harm may include attempts at suicide, it is difficult to determine intent with sufficient accuracy to be recorded as such. While some incidents may result in serious outcomes, such as hospitalisation, the purpose or intent of an act may be unclear.

Those who self-harm often do so covertly. In the general population, such self-harm will often go undetected. In prisons, such incidents are more likely to be detected and counted although there will still be incidents that are not detected.

Assaults

Assaults refer to unwanted physical contact between two or more individuals, excluding lawful Use of Force by staff (but including where staff are assaulted during use of force) or anything of a purely verbal or threatening nature.

Assaults in prison custody cover a wide range of violent incidents including fights between prisoners. HMPPS does not use the Home Office counting rule definitions of Actual Bodily Harm (ABH), Grievous Bodily Harm (GBH), affray etc.

Serious assaults are those which involve 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; incurs any 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, temporary or permanent blindness.

Users and uses of these statistics

The cost of deaths, self-harm and assaults in prison custody, in both human and financial terms is high. This report adds to the body of learning in this area and supports work to prevent such tragedies in future. The contents support a wide range of operational and strategic decisions including:

- Management of risk;
- Deployment of staff (identification of high risk periods and locations etc.);
- Design of prison cells (identification and reduction of ligature points); and
- Assessment of changes in sentencing and other policies affecting prisoners.

The statistics included in this publication are used extensively and meet a broad spectrum of user needs as shown below.

User	Summary of main statistical needs
MOJ Ministers	Use the statistics to monitor the safety and wellbeing of the prison population; assess policy impacts (e.g. changes to managing vulnerable prisoners)
MPs and House of Lords	Statistics are frequently used to answer parliamentary questions
Monitoring and Accountability	E.g. Justice Select Committee use Safety in Custody as a primary data source for monitoring and public accountability.
Policy teams	Statistics are used to inform policy development, to monitor impact of changes over time and to model future changes and their impact on the system
Agencies responsible for offender management	Current and historical robust administrative data are used to support performance management information at national and local levels to complement their understanding of the current picture and trends over time
Academia, students and businesses	Used as a source of statistics for research purposes and to support lectures, presentations and conferences
Journalists	Used as a compendium of robust data on safety in custody so that an accurate and coherent story can be told on the safety of the prison environment.
Voluntary sector	Data are used to monitor trends of the safety and wellbeing of prisoners, to reuse the data in their own briefing and research papers and to inform policy work and responses to consultations.
General public	Data are used to respond to ad-hoc requests and requests made under the Freedom of Information Act. Recent requests include number of deaths, self-harm and assaults in prisons.

MoJ regularly receives requests for statistics for more recent date periods than those covered in published statistics. In accordance with the Code of Practice for Statistics, MoJ and HMPPS are unable to release figures for periods in advance of those published in Official Statistics publications.

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:

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

Deaths

Data sources: Deaths in prison custody statistics are compiled from the HMPPS 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
- HMPPS strategic IT systems including;
    i. HMPPS Incident Reporting System (IRS),
    ii. NOMIS (which replaced the Local Inmate Database System(LIDS)),
    iii. Accommodation and Occupancy (A&O) database and
    iv. 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 HMPPS 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 of birth limit the accuracy to which individuals can be counted. As with incidents, numbers of individuals are satisfactory for determining trends. In order to identify the number of individual self-harmers requires prisoner involvement to be recorded alongside the incidents. Since 2006 there have been substantial improvements to the coverage of prisoner involvements recorded with each incident of self-harm. In 2006 around 6% of prisoner involvements remained missing from incident records. This has improved to 4% during 2015. Although this means some under-reporting of the number of individual self-harmers, it is important to note that, given how prolific many self-harmers are, the actual impact to the under-reporting of figures for self-harming individuals is likely to be substantially lower than these figures suggest. However, this cannot be quantified. Work is continuing to improve coverage of prisoner involvements.

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 HMPPS 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	In a small percentage of cases, less than 1%, incidents may include reports of assault that subsequent

Accuracy Measure	Deaths	Self-harm	Assaults
		general concerns etc. and not actual self-harm in prison custody.	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. In a small percentage of cases, less than 1%, some incidents of prisoner on prisoner assaults and assaults on staff maybe misclassified as serious as it is not always known whether it was the prisoner or staff that suffered the serious injury.
Non-response	None known although deaths occurring in hospitals/hospices are sometimes slow to be reported	All self-harm incidents are required to be reported but 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.	All assault incidents including fights are required to be 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 of 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.

In advance of the publication date the draft publication and supporting tables are checked for internal consistency and that figures reconcile with what has been previously published, or are marked as revisions where appropriate. There is also focus on the commentary and interpretation of trends.

Although Safety in Custody statistics have a long history, the bulletin is still evolving. As a result, processes continue to be 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 HMPPS 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 HMPPS 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 as 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 in 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 HMPPS 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 HMPPS 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 HMPPS 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 HMPPS 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 HMPPS 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 http://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 in prison custody and approved premises and they report on these independently from HMPPS. In the PPO's annual report the following categories for death were used:

- Natural causes
- Self-inflicted
- Homicide
- Other non-natural
- Awaiting classification

PPO statistics on deaths relate to investigations started into deaths within their scope. As this is broader than HMPPS deaths in prison custody, their figures will tend to be slightly higher and cannot be directly compared. Prior to each Safety in Custody bulletin, HMPPS officials and PPO staff meet and discuss the classification of each death in detail, aligning wherever possible.

Independent Police Complaints Commission (IPCC)
IPCC's responsibility includes investigating and reporting on a range of deaths[2]:

- 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 2011 report they used the following categories:

- Natural causes (exc. cardiac arrest)
- Natural causes and alcohol/ drugs
- Cardiac arrest
- Cardiac arrest and alcohol/ drugs
- Cardiac arrest and internal organ failure
- Stab wounds
- Restraint related
- Asphyxiation and drug overdose
- Awaited

These categories are not directly comparable with those used in HMPPS.

[2] IPCC http://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.

Potential underreporting of incidents

When an incident occurs in prison, it is immediately recorded in the paper-based wing observation book. As soon as practicable afterwards, it is transferred to the electronic Incident Reporting System (IRS), which allows collating and analysing incident information centrally. The IRS is used to produce internal reports and official statistics (including those published in the Safety in Custody Bulletin).

If an administrative error occurs, it is possible for an incident recorded in the wing observation book not to appear in the IRS. Regular IRS data quality audits are therefore performed at each prison to ensure compliance with data recording procedures. HMPPS continuously monitors incident reporting standards. The July 2018 issue of the Safety in Custody Bulletin contains an annex summarising recent analysis of incident reporting across the prison estate in the 2016/17 and 2017/18 performance years.

Changes to the way deaths are classified and reported

Deaths in prison custody have been reported in a broadly similar way since 1877.

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. Electronic records of the number of deaths are not held prior to 1978, and the database of deaths begins from 2000.

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. It is unclear how such deaths will eventually be classified. 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.

In July 2015 refinements were implemented to the Incident Reporting System. Although these do not relate directly to Safety in Custody, these may impact on the overall level of reporting of assaults and self-harm incidents from July 2015 onwards.

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 not included from the publication because they are significantly under-reported compared with current standards.

From April 2017, self-harm incidents are monitored as performance metrics and reported in the new performance tables. The addition of self-harm incidents as a performance metric and the release of additional guidance to support prisons in recording the data may lead to increased reporting. The reported statistics and underlying data will be analysed to monitor the impact of the changes in reporting practices.

From April 2020, a change was implemented instructing establishments to stop reporting incidents where material has been fashioned into a noose but was no suggestion that it has been placed around the neck or attached to a ligature point, or had any weight or tension applied to it. This incident type does not fit the definition, because there is no evidence of harm or injury resulting from it. There are also practical challenges in determining the intended use of torn bedding or clothing seen in the possession of prisoners, and these are known to have been causing inconsistency in reporting. For these reasons in April 2020, establishments were instructed to stop reporting as self-harm incidents occasions where a noose was suspected and/or seen; but with no suggestion that it has been placed around the neck or attached to a ligature point, or had any weight or tension applied to it.

Incidents where a noose has been seen around the neck or attached to a ligature point, or there is evidence that it has had weight or tension applied to it, and those where there was another method of self-harm are still reported and included within the statistics.

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 late 2002 onwards. Figures prior to 2003 are accordingly omitted from the publication.

In April 2017, refinements were made to the recording of Assaults under the Incident Reporting System. Overall reporting of assaults was not expected to be impacted, although there is likely to be some impact on the reporting of specific assault information.

Assaults on staff:

Previous system: Users could describe the type of assault as i) prisoner on prisoner, ii) prisoner on officer, iii) prisoner on other, or iv) other.

An assault was counted when a prisoner-on-officer assault was indicated or any assault type selected and one or more of the following conditions had been met:

- member of staff was injured
- member of staff was detained in outside hospital
- member of staff was on sick leave following the incident
- member of staff was off duty following the incident.

New system: The prisoner-on-officer category no longer exists. It has been replaced by prisoner on staff and the type of staff is selectable in the follow-on question. Within the detailed, annually published statistics, if the victim is recorded as a prison officer, then the incident is counted as a prisoner-on-officer assault and any other type of staff is counted as a prisoner-on-other incident.

A second question asks for all assault types whether any staff member has been assaulted.

Expected impact: We expect data quality to improve. Assaults on staff other than officers would not have been be counted if they were not injured, on sick leave, off duty or detained in hospital as a result. Conversely it was possible that staff would be counted where they were not assaulted for example if they fell over running to the scene.

Spitting:

Previous system: Spitting was listed with the other weapon types

New system: Spitting is now removed from the list of weapons. Users answer questions about whether spitting was used, where the saliva hit the victim and whether the assailant is known to have an infectious disease that can be transmitted in saliva. If users indicate that spitting was used then it is counted as a weapon regardless of whether it hit anyone.

Expected impact: This will have some impact as users will be more conscious of the category and therefore potentially use it more.

Treatment for concussion or internal injuries:

Previous system: A single question was asked about whether medical treatment for concussion or internal injuries was required.

New system: The question remains the same but users must indicate that injuries were received during the incident before they can answer the question.

Expected impact: Minimal.

Injuries requiring attendance at hospital as inpatient:

Previous system: There was one question that asked whether injuries required attendance at hospital as an inpatient

New system: This has been replaced by a series of questions:

1. The user needs to indicate that injuries were received during the incident.
2. They need to state if the injuries resulted in attendance at a hospital.
3. They need to state the type of admission, with 'inpatient' one of the selectable options.

Expected impact: Some impact as users need to answer two previous questions before selecting 'inpatient'. This should improve accuracy as it allows the type of attendance at hospital to be correctly recorded. Table 2 shows the number of assaults that required hospital attendance. There were 10% of assaults that required attendance at the hospital

with the majority being admitted to A & E. Only 4% of those admitted to hospital were admitted as an inpatient.

Table 2: Assaults requiring hospital attendance, April to December 2017

	Number of incidents
Assaults	22,792
Requiring hospital attendance	*2,349*
A & E	*2,258*
Inpatient (over 24hr)	*60*
Inpatient (overnight only)	*31*

Self-harm and assaults in the young people's estate

Summary Tables 3a and 4a show the number of self-harm and assaults occurring in the young people's estate. It includes all incidents in establishments designated to hold entirely young people (15-17 years old) and any incidents in other establishments involving young people.

In 2018, the population in Cookham Wood, Wetherby and Werrington consisted entirely of young people, although prisoners turning 18 may remain there for a short period. Feltham and Parc also have designated places for young people, but they also hold people of other age groups in separate parts of the establishment. Incidents at these two establishments are only included in Tables 3a and 4a if they involved young people. As a result, the figures in these tables may be slightly lower than the total number of incidents in the young people's estate because they exclude cases when a detainee turned 18 or if the detainee's age could not be ascertained because their identity was not recorded against the incident.

As from April 2020, the youth estate figures were published within the Safety in the children and young people secure estate quarterly statistical bulletin. This publication captures quarterly statistics on assault and self-harm incidents, and deaths for children and young people in the secure estate.

https://www.gov.uk/government/collections/youth-justice-statistics

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 HMPPS 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[3]. 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[4] 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.

Annualised Quarterly Rate: the annualised quarterly rate is an estimation of the annual rate, estimated from the latest quarter's data, adjusted for the number of days in that quarter.

Assailant: This refers to assault incidents in which there is a clear aggressor (assailant) and victim. Such incidents arise from offences of GBH and ABH. 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 including fights between prisoners. HMPPS does not use the Home Office counting rule definitions of Actual Bodily Harm (ABH), Grievous Bodily Harm (GBH), affray etc. and figures cannot be compared directly.

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.

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

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

[4] Public Order Act 1986 http://www.legislation.gov.uk/ukpga/1986/64)

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: This refers to assault incidents in which there is no clear aggressor or victim. Such cases arise from offences of affray. 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[5]. 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 HMPPS system for classifying deaths.

Her Majesty's Prison and Probation Service (HMPPS): The agency responsible for prisons and probation. Up to 1 April 2017, this agency was known as the National Offender Management Service (NOMS).

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 HMPPS.

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 HMPPS system for classifying deaths.

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

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

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 HMPPS 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 HMPPS system for classifying deaths. It includes a wider range of deaths than just suicides.

Standardised Mortality 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. However, it does not take into account other unmeasured factors which may be important in understanding the difference between the prison and general populations, such as vulnerability, socio-economic status, etc.

Standardised Mortality Ratio for suicide: The Standardised Mortality Ratio for suicide compares the rate of self-inflicted deaths in prison custody with the rate of suicide in the general population, adjusting for age and gender. This ratio gives an indication how much greater the likelihood is of this kind of death in prison custody, compared to the wider population, on a more comparable basis. HMPPS does not attribute intent behind self-inflicted deaths, and as such custody figures may include unintended deaths at one's own hand in addition to suicides. These cannot be isolated from suicides. However, the ONS definition of suicide, as used for general population figures, includes "injury/poisoning of undetermined intent" and "sequelae of intentional self-harm/event of undetermined intent". As such, the definitions are closely aligned.

Suicide: Any death of a person who has voluntarily taken their own life - a verdict determined at inquest. As inquests will not have occurred at the time HMPPS publishes deaths statistics, HMPPS makes no attempt to attribute intent (which is the responsibility of the coroner/inquest). HMPPS does not produce official statistics on suicides but does monitor inquest verdicts to ensure that classifications of deaths are consistent.

Victim: This refers to assault incidents in which there is a clear aggressor (assailant) and victim. Such incidents arise from offences of GBH and ABH. The system does not record details of non-prisoner victims, for example staff and visitors.

Timeline

Key events: From time to time, events in prison custody and developments within and outside HMPPS 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. This timeline summarises some of the key events and developments since 2000 that may 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

- April: New national self-inflicted deaths Key Performance Indicator (KPI) introduced
- 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
- April: New Serious assaults KPI and prisoner KPT (Key Performance Target) introduced

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
- New prisoner information system (NOMIS) starts to be rolled out to all prisons

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
- April: All prisons are using the NOMIS System
- May: Review of unclassified deaths between 2010 and 2011 (Mc Feeley)
- October: Operation Yewtree launched – police investigation into sexual abuse allegations

2013

- April: Fair and Sustainable effective in all prisons
- May: 'Transforming rehabilitation: a strategy for reform' published
- October: Benchmarking phase 1 rolled out
- November: Revised Incentive and Earned Privileges scheme comes into effect affecting all prisoners aged 18 and over.
- 11 prisons closed

2014

- June: Probation Trusts cease to exist, and National Probation Service and Community Rehabilitation Companies established deliver services in the community.
- Offender Rehabilitation Act 2014

2015

- Violence Reduction Project to address increasing violence in prisons
- Criminal Justice and Courts Act 2015
- July: Enhanced Incident Reporting System changes implemented

2016

- May: Psychoactive Substances Act 2016
- September: Mandatory Drug Testing for novel psychoactive substances (NPS) introduced

2017

- April: Update to Assaults reporting in the Incident Reporting System

2020

- April: Update to Self-harm methodology to exclude incidents of noose-making where the noose was not put around the prisoners neck

Changes affecting prisons level figures: Table 3 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:

http://www.justiceinspectorates.gov.uk/hmiprisons/inspections

Table 3: 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
Edmunds Hill	July	2001	Highpoint (North and South) separated into Edmunds Hill and Highpoint
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
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

Establishment		Year	Type of change
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	September	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
Isle of Wight	April	2009	Albany, Camp Hill and Parkhurst merged. Only reporting as Isle of Wight from 2013.
Isis		2010	Opened
Northumberland		2011	Acklington and Castington merged
Ashwell	March	2011	Closed
Morton Hall	June	2011	Changed from female prison to Immigration Removal Centre holding male only
Latchmere House	September	2011	Closed
Lancaster Castle		2011	Closed
Highpoint	April	2011	Edmunds Hill merged with Highpoint
Thameside	March	2012	Opened
Oakwood	April	2012	Opened
Brixton	July	2012	Changed from Cat B to Cat C prison
Wellingborough	December	2012	Closed
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
Ashfield	June	2013	Changed from YOI to Cat C prison
Downview	October	2013	Closed pending change from female to male prison
Verne	October	2013	Changed from Cat C prison to Immigration Removal Centre
Blundeston	December	2013	Closed

Establishment		Year	Type of change
Dorchester	December	2013	Closed
Reading	December	2013	Closed
Northallerton	December	2013	Closed
Warren Hill	January	2014	Changed from YOI to male adult prison
Humber	April	2014	Everthorpe and Wolds merged
Blantyre House	March	2015	Temporarily closed
Haslar	April	2015	Decommissioned places for detainees. Temporarily closed pending re-role
Dover	October	2015	Decommissioned places for detainees. Temporarily closed pending re-role
Downview	May	2016	Reopened as a female prison
Holloway	June	2016	Closed
Kennet	December	2016	Closed
Berwyn	February	2017	Opened
Holme House	May	2017	Changed from local to Cat C prison
Glen Parva	June	2017	Closed
The Verne	December	2017	Decommissioned places for detainees. Temporarily closed pending re-role
The Verne	August	2018	Reopened as a Male Cat C prison
Birmingham	July	2019	Changed from private to public

Directory of Related Internet Websites and on line references

HM Inspectorate of Prisons

- Prison and YOI inspections (http://www.justiceinspectorates.gov.uk/hmiprisons/inspections)

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

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

Independent Police Complaints Commission (IPCC)

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

Ministry of Justice/HMPPS

- Coroners statistics (https://www.gov.uk/government/collections/coroners-and-burials-statistics)
- Prison Service Orders (http://www.justice.gov.uk/offenders/psos)
- Prison Service Instructions (http://www.justice.gov.uk/offenders/psis)

Office for National Statistics

- Death registrations, England and Wales (http://www.ons.gov.uk/ons/rel/vsob1/death-reg-sum-tables/index.html)
- Suicides in the United Kingdom (http://www.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/index.html)

Prison Probation Ombudsman (PPO)

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

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

- Prison mortality statistics (http://www3.unil.ch/wpmu/space/space-i/)

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

- ICD 10 (http://apps.who.int/classifications/icd10/browse/2016/en)

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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:

http://www.scotland.gov.uk/Topics/Statistics/Browse/Crime-Justice

http://www.dojni.gov.uk/index/statistics-research/stats-research-publications.htm

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

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