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# Self-inflicted Deaths in NOMS' Custody Amongst 18–24 Year Olds

## Staff Experience, Knowledge and Views

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# Preface

This Report presents the findings of research into self-inflicted deaths (SID) in custody amongst 18–24 year olds in National Offender Management Service (NOMS) custody in England and Wales. This research was commissioned by the Harris Review into Self-Inflicted Deaths In Custody Amongst 18–24 Year Olds, and was undertaken by RAND Europe and the Prisons Research Centre, Institute of Criminology, University of Cambridge.

This research focused on staff experience, knowledge and views, which have been gathered through interviews and observations at five prisons in England and Wales. The document will be of interest to government, civil society and academic audiences interested in improving prisoner wellbeing and safety generally and SID reduction and risk management specifically.

The Report consists of seven sections that address the research questions set out by the Harris Review. Sections 1 and 2 provide an overview of the background, context and methods of the study. Sections 3–6 present the findings of the study relating to four key themes – how staff conceive of risk of SID, how SID risk is managed, staff training and institutional and individual responses to SID. The report closes with a review of promising practice and areas for improvement based on staff suggestions.

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This Report has been peer reviewed in accordance with RAND's quality assurance standards. For more information about RAND Europe or this document, please contact Alex Sutherland (asutherl@rand.org).

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# Executive Summary

Prisons are high-risk environments for self-inflicted death (SID). Prisoners import complex care needs into prison, and these imported vulnerabilities can be exacerbated by the stresses and deprivations of the prison environment, which contributes to a much higher rate of suicide among prisoners when compared with the wider population in England and Wales.

Prior research has argued that there is more SID risk in the prison system than can be accounted for by imported vulnerabilities alone.[1] This is because of high prisoner turnover among those serving short sentences[2] in combination with evidence that has shown that SID risk is greatest among prisoners during the first month of custody.[3] The amount of risk presented by an individual therefore depends not only upon what s/he imports by way of characteristics and background but also upon what stage s/he is at within sentence.

Official figures show that self-inflicted deaths (SID) in prisons have been rising, from 63 between September 2012 and September 2013, to 87 from September 2013 to September 2014. There were 12 SIDs among 18–24 year olds in 2013. This is broadly consistent with the SID rate among this age group in recent years.[4] Yet, variation over time and between prisons in SID rates, alongside what we know from the literature about the potential for prison staff to keep prisoners safe, suggest that it is possible to prevent some SIDs in prison. This study, commissioned on behalf of the Harris Review, sought to explore the views of prison staff about how more deaths in prison among 18–24 year olds could be prevented. We sought to answer the following six research questions:

1. What does being 'at risk' of SID mean to prison staff? What do prison staff see as the relevant risk factors for SID? How do prison staff identify relevant risk factors for SID?

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[1] See e.g. Liebling, A. (1995) 'Vulnerability and Prison Suicide' *British Journal of Criminology* 35(2): 173–187.

[2] In 2013, 37,527 people entered prison to serve sentences of less than or equal to six months: Ministry of Justice (2014) 'Offender Management Statistics Annual Tables 2013'. London: Ministry of Justice, Table A2.1a.

[3] Ministry of Justice (2014) 'Safety in Custody Statistics England and Wales: Update to December 2013'. London: Ministry of Justice, 11–13. See also Towl, G. (1999) 'Self-Inflicted Deaths in Prisons in England and Wales from 1988 to 1996'. *British Journal of Forensic Practice* 1(2): May. Towl found that 10 per cent of prisoners who kill themselves do so within 24 hours of arrival into custody.

[4] The number of SIDs among 18–24 year olds in 2012 was 9; in 2011, it was 16; in 2010 it was 8 and in 2009 it was 15. See Ministry of Justice (2014) 'Safety in Custody: Deaths in Prison 1978–2013'. London: Ministry of Justice, Table 1.6.

2. What arrangements are staff aware of for identifying and managing SID risk? How well do staff think the processes are working? Are there any suggestions for improvement?
3. What training have staff had in identifying and managing prisoners who are at risk of self-harm or SID? Do staff feel this is adequate?
4. Do staff understand what they should do if they have concerns about a prisoner? How prepared do staff feel about identifying, managing and caring for young adults at risk of SID?
5. Do staff know how to access support? Is staff support adequate?
6. Where staff have direct experience of SID, what happened, what lessons were learned and what changes, if any, were made to operational practice?

## Research Approach

In 11 days of fieldwork spanning four weeks, the research team conducted 47 formal interviews (each lasting on average 50 minutes), six focus groups (one with prisoner Listeners,[5] five with staff and each lasting on average 60 minutes), and intensive participant observation (which included observing 15 Assessment, Care in Custody, and Teamwork (ACCT) Reviews, two of which were complex, meaning that they required more intensive and multidisciplinary review processes) across five prisons.[6] From this we generated over 400 pages of field notes in addition to 28 interview transcripts. Data were then organised and analysed thematically using a grounded-theory approach. Prisons in which fieldwork was conducted were selected in consultation with the Review. Each selected prison accommodated at least some 18–24 year olds. Most had high rates of SID, though at least one was included that had a low SID rate so as to increase our chance of capturing good practice. One of our sites housed females and two were local prisons. We did not visit any open or high security prisons.

## Findings

Our findings are organised around four key themes: (1) conceptualising risk of SID, which broadly speaking addresses question one; (2) managing risk of SID, which addresses questions two and four; (3) staff training, which addresses question three; and (4) responding to SID, which addresses questions five and six.

### *Conceptualising Risk of Self-Inflicted Death*

**Interviews with staff indicated that SID risk is seen as complex and unpredictable**. There was some variation between interviewees in how SID risk was understood. Some staff expressed views that were in accord with the available evidence on practices that may prevent self-inflicted deaths in custody. These staff expressed a conceptualisation of risk that was more likely to lead to actions that could reduce likelihood of SID, while others expressed a view that showed a more limited understanding of the management of SID risk.

[5] Listeners are prisoners who receive training from the Samaritans to enable them to support their peers through listening. See further http://www.samaritans.org/your-community/our-work-prisons/listener-scheme.

[6] Operational Support Grade (OSG) staff did not form part of our formal interviewee pool. However we did engage OSGs for extended conversations during our participant observation activities in multiple prisons.

Based on previous empirical studies **SID risk is best understood as nuanced, dynamic, reactive and environmentally contextual**. In line with this, some staff expressed a view that SID risk was contingent on a wide variety of factors that needed to be managed simultaneously, and in turn that prison management and staff actions could play a role in preventing at least some SID. Findings from interviews, in accordance with existing theoretical models, suggest that **this attitude was empowering for staff** because it enabled them to feel that they could make a difference.

**An understanding of SID risk that broader evidence suggests is less effective is binary, static, purposive and individual-centred**. Such an understanding was described by some staff interviewed. Such attitudes toward SID tended to focus on individual prisoners' characteristics and motivations for SID and self-harm, to the exclusion of broader contextual factors relating to the prison environment. Staff expressing these kinds of view were fatalistic about SID and felt disempowered regarding their abilities to reduce incidence of SID.

**Age was not seen by staff as a directly relevant factor for understanding or identifying SID risk**. However, youth was seen as an indicator of immature coping mechanisms and of impulsivity that made risk assessment more difficult. Given the predominant view among staff that age was not an important factor in SID risk management, the findings in this Report should be seen as relating to SID risk management more generally rather than on younger prisoners specifically.

**Staff identified risk factors for SID as a result of good information flowing into and within the prison and, above all, through experience or 'jail craft'** (the knowledge, skills, expertise and judgement that prison staff acquire 'on the job'). Findings indicate room for improvement in how information relevant to risk is used, the quality of information gathered during the reception process and the extent of information sharing by healthcare.

**Prison staff universally identified staff-prisoner relationships as the key to identifying and managing risk**. There was strong agreement that staff capacity to form and sustain high-quality staff–prisoner relationships supported SID prevention. Staff reported that this had been adversely affected by Benchmarking and New Ways of Working. However, the problem was not just too few staff on wings but that the staff who were present were less effective than they could be because of inconsistent detailing, the use of agency and detached duty staff and low staff morale.

### *Managing Risk of Self-Inflicted Death*

With some notable exceptions, **SID risk was generally managed more reactively than proactively**. There was widespread underestimation of the potential for early intervention and prevention, particularly among wing staff. Prison staff described the impacts of too few staff and a lack of continuity in how staff were detailed as reducing capacity for proactive SID risk management.

**The Assessment, Care in Custody and Teamwork (ACCT)[7] process dominated** the ways in which prisons managed SID risk, although the quality of ACCT implementation varied across the sites. Staff also described the impacts of staffing levels and continuity on the quality of support that ACCT could provide to vulnerable prisoners.

**Relationships between violence and vulnerability were thought by staff to be particularly complex among younger prisoners**, especially in the context of bullying and exploitation. Violent prisoners were recognised by some interviewees as being at risk of SID, but it was more challenging to identify and assess this risk than among those who were not violent. Some staff felt that there was insufficient recognition of the close relationship between violence and SID vulnerability in national policy.

**Staff were looking for an achievable model of good practice** in managing SID risk that recognised the vulnerability of most prisoners and the constraints of the prison environment. The Prisons and Probation Ombudsman (PPO) recommendations were thought by some staff to be 'too aspirational'; clear(er) and more realistic recommendations were desired.

**Where ACCT was seen by staff to be best used, staff exercised professional discretion confidently but defensibly** to tailor the process to individual needs and position ACCT within a suite of other risk management options. Where staff fear of blame for SID was high, there was limited use of discretion by prison staff and a dependency on ACCT developed. This meant that many ACCTs were opened and few closed. In a majority of the prisons that we visited staff felt that there were more open ACCTs than they could manage, which caused staff to feel that ACCT did not provide enough support for prisoners in greatest need.

**According to the wider literature and staff views, promising practice in managing SID risk involved approaching the ACCT process as a normative (values-driven) exercise in care, which required high levels of professional judgement, rather than a form of procedural compliance**. Staff who saw ACCT in this way perceived its purpose to be not just managing immediate crisis but rather helping someone in a long-term journey towards human flourishing. At its best, multidisciplinary collaboration during the ACCT process represented a 'bio-social-medical model' in which holistic individualised care, through communication and setting common goals, were the collective objectives. Staff identified effective practice where ACCT was seen as one of a suite of other vulnerability management tools, which particularly included the use of prisoner support through Listeners and Healthcare Champions.

**Staff expressed frustration at having too little time for personalised, integrated care**. Complex contractual relationships with other service providers in prison (specifically healthcare), in some cases, caused confusion and hindered collaboration and information sharing. There was general acknowledgement across prisons and staff groups that managing the SID risks of some prisoners exceeds the limits of what ACCT and prisons can, and are resourced, to do (for example, managing complex care cases or those with severe psychiatric disorders).

[7] ACCT is a process used for prisoners at risk of suicide or self-harm, used to support prisoners by identifying ways of resolving problems and monitoring their wellbeing to prevent self-harm, and suicide through regular observation and conversation.

*Staff Training*

**There was strong consensus among interviewees about the importance of work experience to their ability to identify and manage SID risks but staff welcomed more and improved training.** Although many prison staff cited experience as more important than training for identifying and managing SID risks, some staff, particularly those with specialist roles, emphasised the (potential) importance of training in equipping them with the necessary skills to prevent deaths in custody.

**The content of current ACCT foundation training was described as too focused on procedure at the expense of mental health awareness**. As a result of this, certain staff felt underprepared or under-informed about how they should manage SID risks and respond to instances of SID. Prison staff suggested training could be improved by providing more focused mental health training as well as training involving role plays and question and answer sessions.

Beyond the content of training, **staff also felt that Safer Custody training was too infrequent**, often curtailed because of staff shortages and delivered too much by way of presentation or e-learning rather than providing opportunities for discussion and reflection upon best practice.

*Responding to Self-Inflicted Death*

**Deaths in custody can result in less effective future management of SID risk**. Many staff across all of the prisons we visited described their involvement with a death in custody as having a significant impact upon their emotions and practices. Consistent with previous studies,[8] staff described feeling unfairly blamed 'when things go wrong' and unrecognised for their successes in preventing deaths. In light of the clear importance of prison staff in suicide prevention, there are risks for the effectiveness of future practice where staff become hardened or disengaged by exposure to death. Staff described a more 'defensive' professional and institutional reorientation and an erosion of confidence following a death in custody, stemming particularly from their fear of inquests. This adversely affected the ability of staff to provide high-quality support for vulnerable prisoners.

Conversely, **SIDs could act as catalysts for reflection and changes to practice that made SID prevention more effective** and where this was reported it was interpreted by the research team as promising. Adequate support for staff in preparing for inquests was identified as important in securing positive oriented learning experiences from deaths in custody, although some staff reported that 'straightforward' lessons from inquests had not been learned.

**Many prison staff preferred to find support from colleagues rather than the Staff Care Team following a death in custody**.[9] While staff recognised that institutional support mechanisms were in

[8] See, for example, Liebling, A. and H. Krarup, (1993) 'Suicide Attempts and Self-injury in Male Prisons: a Report Commissioned by the Home Office Research and Planning Unit for the Prison Service'. London: Home Office, Chapter 6.

[9] This is consistent with the findings of a recent study (in press) on the wellbeing of prison staff, led by Gail Kinman, Director of the Research Centre for Applied Psychology at the University of Bedfordshire. See: http://www.beds.ac.uk/news/2014/november/independent-survey-of-prison-officers-reveals-staff-totally-demoralised?utm_content=bufferba0cb&utm_medium=social&utm_source=facebook.com&utm_campaign=buffer

place, some questioned whether a Care Team of peers was the right form of support or whether Care Teams were adequately trained to support staff after SID. Some staff saw deficiencies in the delivery of staff support or low staff uptake of it as potentially weakening their ability to prevent future suicides by causing disengagement and hardening attitudes towards exposure to death.

## Towards a Model of Better Practice?

In the concluding section of this Report we present seven examples of practices that were described by prison staff, and that find support in the literature, as helpful in preventing deaths in custody. Within this study, staff felt that SID risk is better managed and likelihood of SID is reduced when:

1. **Prisoners are occupied, busy, and productive.** Where 'formal' regime activities are unavailable staff use their initiative to 'create' jobs or tasks with the intention of getting prisoners out of their cell, such as additional cleaning and painting on the wing.
2. **Services are fully integrated across the prison** and good working relationships exist between departments and staff that support information and expertise sharing. There is clarity about 'who does what' and wing staff feel able and willing to access help from specialist staff.
3. **A 'package approach' is taken to prisoner support**. Staff work together collaboratively across areas to ensure prisoner care. Non-ACCT options for prisoner support exist, and are used.
4. **The benefits of prisoner peer support, through Listener and Healthcare Champion schemes, are recognised** and prison staff facilitate effective prisoner work in these roles.
5. **Careful and thoughtful staffing decisions are taken** that reflect the particular importance of having the 'right' staff, who foster compassion and care, especially for those who are vulnerable, in key areas such as Reception, Induction and Safer Custody.
6. **The use of professional discretion and an individualised approach to care during the ACCT process are seen as important and are institutionally supported.** There are systems in place to encourage staff 'ownership' of care for vulnerable prisoners. Staff are given an appropriate degree of professional autonomy to manage SID risk creatively.
7. **Mistakes act as learning opportunities through careful, constructive reflection**. Change of practice is implemented in ways that empower staff to 'make a difference'.

## Limitations

Within this Report, we identify some staff views and some practices as promising or positive, in that they may be more likely to result in effective SID management. Conversely, we identify some views and practices as less likely to result in effective SID management. These statements are based on broader, evidence-based models of prisoner wellbeing, risk management and suicide reduction. However, we recognise that many of the specific examples of practice have not been tested through systematic research, and for this reason we present them as promising rather than necessarily proven or 'best' practice. We nonetheless believe, based on this study and prior research in this area, that these suggestions represent a starting point for development of better, more effective SID risk management and response.

This research was commissioned as an exploratory study and as such the transferability of our findings to other establishments remains an open empirical question. However, we acknowledge that many of the challenges the five prisons in our study were experiencing (staff shortages, resource depletion and overcrowding, for example) are occurring nationwide. We would also argue that our findings are broadly consistent with the literature and the research teams' ongoing and extensive experience of prison life through our research activities. On this basis we would argue that it is not unreasonable to assume that the findings presented here may be relevant and resonate with the views, experiences and practices of prison staff at other establishments and beyond the 18–24 year old prisoner age group. However, we especially acknowledge the distinctive nature of self-harm and suicide among imprisoned women, and recognise a more limited evidence base regarding women within this study.[10]

[10] See, for example, Ministry of Justice (2014) 'Safety in Custody Statistics England and Wales: Deaths in Custody to September 2014'. London: Ministry of Justice. Hawton, K. et al. (2014) 'Self-Harm in Prisons in England and Wales: an Epidemiological Study of Prevalence, Risk Factors, Clustering and Subsequent Suicide' *Lancet* 383: 1147–1154.

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# Abbreviations

| | |
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| ACCT | Assessment, Care in Custody and Teamwork |
| CSRA | Cell Sharing Risk Assessment |
| FLO | Family Liaison Officer |
| IEP | Incentives and Earned Privileges |
| JSAC | Job Simulation Assessment Centre |
| NOMS | National Offender Management Service |
| OSG | Operational Support Grade |
| POA | Prison Officers' Association |
| PER | Person Escort Record |
| PNC | Police National Computer |
| PPO | Prisons and Probation Ombudsman |
| PSI / PSO | Prison Service Instruction / Prison Service Order |
| SBC | Specification, Benchmarking and Costing Programme |
| SID | Self-Inflicted Death |
| VEDS | Voluntary Early Departure Scheme |
| YO | Young Offender (aged 18–21) |
| FLM | First Line Manager |

# 1. Background and Context

## 1.1. SID Trends

The number of self-inflicted deaths in custody (SID) has decreased over the last ten years and, since 2007 when NOMS introduced initiatives designed to reduce prison suicides, the number has remained fairly stable at around 60 deaths per year. However, between September 2012 and 2013, there were 63 SIDs in custody and between September 2013 and 2014 there were 87. Although the SID rate has not yet eclipsed the most recent high point of 2004, during which there were 103 SIDs, the latest 2013–14 data represent an increase of 38 per cent when compared with 2012–13. The SID rate is now only marginally less than the rate in 2007 when NOMS' introduced its new package of suicide prevention policies and processes, which included the introduction of safer cells,[11] Assessment, Care in Custody and Teamwork (ACCT) Plans,[12] Safer Custody Teams and ligature cut-down tools (see PSI 64/2011).[13] Regarding the age group of specific interest to this study, there were 12 SIDs among 18–24 year olds in 2012–13. This is broadly consistent with the SID rate among this age group in recent years.[14] The suicide rate in prison is three times higher than in the general population.[15]

[11] Cells that are designed in ways that reduce, though do not eliminate, points from which prisoners can ligature.

[12] An ACCT Plan is used for prisoners at risk of suicide or self-harm. Prison staff document a prisoner's feelings, needs and regime engagement in ACCT Plans. The ACCT process is intended to support prisoners by identifying ways of resolving problems and monitoring their wellbeing to prevent self- harm and suicide through regular observation and conversation. A specimen ACCT Plan document in its current version (5) can be viewed online: https://www.whatdotheyknow.com/request/151816/response/380515/attach/3/ACCT%20plan.pdf

[13] Ministry of Justice (2014) 'Safety in Custody Statistics England and Wales: Deaths in Custody to September 2014'. London: Ministry of Justice, pp. 10–11.

[14] The number of SIDs among 18–24 year olds in 2011–12 was 9; in 2010–11, it was 15; in 2009–10 it was 8 and in 2009–10 it was 15. See Ministry of Justice (2014) 'Safety in Custody: Deaths in Prison 1978–2013'. London: Ministry of Justice, Table 1.6.

[15] Slade, K. and R. Edelmann, (2013) 'Can Theory Predict the Process of Suicide on Entry to Prison? Predicting Dynamic Risk Factors for Suicide Ideation in a High-Risk Prison Population' *Crisis* 35(2) 82–89.

## 1.2. Prisoners' Imported Vulnerabilities

Many prisoners have complex health and social care needs in the community that are imported into, and may be exacerbated by, the prison system and its psychological and material deprivations.[16] More than 70 per cent of the prison population has two or more mental health disorders.[17] In a 2013 Ministry of Justice study 49 per cent of women and 23 per cent of male prisoners were assessed as suffering from anxiety and depression.[18] 26 per cent of women and 16 per cent of men said they had received treatment for a mental health problem in the year before entering custody.[19] Poor mental health has been reported to be even more prevalent among young people in prison, with 95 per cent having at least one mental health problem and 80 per cent having more than one.[20] Substance abuse is high:[21] in a 2013 study 64 per cent of prisoner reported having used drugs in the four weeks before entering custody.[22] Many prisoners have low levels of educational attainment: 48 per cent are at, or below, the level expected of an 11 year old in reading, 65 per cent in numeracy and 82 per cent in writing.[23] In 2012, 47 per cent of prisoners said that they had no qualifications.[24] Prisoners also frequently come from 'problematic' backgrounds; for example 24 per cent have been in care at some point during childhood and many have experienced abuse (29 per cent) or have observed violence (41 per cent) in the home.[25]

Prisoners are therefore a vulnerable population. These vulnerabilities put many prisoners at high risk of SID: while the causes of SID are complex, research has identified mental illness, substance abuse and

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[16] See, for example, the conclusions in 2004 of the Joint Parliamentary Committee on Human Rights that 'distress caused by detention adds to […] vulnerabilities' (Joint Committee on Human Rights – Third Report, Session 2004-05, para. 368) and HM Chief Inspector of Prisons in 1996 who argued that 'prison can exacerbate mental health problems' (HMCIP (1996) 'Patient or Prisoner? A New Strategy for Health Care in Prisons'. London: HMCIP). See also: Liebling, A. (2006) 'The Role of the Prison Environment in Prisoner Suicide and Prisoner Distress' in Dear, G. (ed) *Preventing Suicide and Other Self-Harm in Prison*. London: Palgrave-Macmillan, pp. 16–28. Liebling, A. (2007) 'Prison Suicide and its Prevention' in Jewkes, Y. (ed) *Handbook on Prisons*. Cullompton, Devon: Willan Publishing, pp. 423–446. Harvey, J. and A. Liebling (2001) 'Suicides and Suicide Attempts in Prison: Vulnerability, Social Support and Ostracism' *Criminologie* 34(2): 57–83.

[17] Singleton, N. et al. (1998) 'Psychiatric Morbidity among Prisoners in England and Wales'. London: Office for National Statistics.

[18] The comparable rate among the general public is 4 per cent: Wiles, N. et al. (2006) 'Self-Reported Psychotic Symptoms in the General Population' *The British Journal of Psychiatry* 188: 519–526.

[19] Ministry of Justice (2013) 'Gender Differences in Substance Misuse and Mental Health Amongst Prisoners'. London: Ministry of Justice.

[20] Lader, D., N. Singleton and H. Meltzer (2000) 'Psychiatric Morbidity Amongst Young Offenders in England and Wales'. London: Office for National Statistics.

[21] Fazel, S., P. Bains and H. Doll (2006) 'Substance Abuse and Dependence in Prisoners: a Systematic Review', *Addiction* 101: 181–191.

[22] Ministry of Justice (2013) 'Gender Differences in Substance Misuse and Mental Health Amongst Prisoners'. London: Ministry of Justice.

[23] Prison Reform Trust (2010) 'Bromley Briefings Prison Factfile: December 2010'. London: Prison Reform Trust.

[24] Ministry of Justice (2012) 'The Pre-Custody Employment, Training and Education Status of Newly Sentenced Prisoners'. London: Ministry of Justice.

[25] Williams, K., V. Papadopoulou and N. Booth (2012) 'Prisoners' Childhood and Family Backgrounds: Results from the Surveying Prisoner Crime Reduction Longitudinal Cohort Study of Prisoners'. London: Ministry of Justice Research Series.

social isolation as individual risk factors for SID.[26] As we have described (above), these are characteristics that research has shown to be highly prevalent among the prisoner population. However, as Liebling has shown, there is more SID risk in the prison system than can be accounted for by imported vulnerabilities alone.[27] This is because of prisoner turnover (among those serving short sentences)[28] coupled with research that has shown that SID risk is greatest among prisoners during the first month of custody.[29] The amount of risk presented by an individual therefore depends not only upon what s/he imports by way of characteristics and background but also upon what stage s/he is at within sentence.

## 1.3. Prison Induced Stress and Protecting Agents in the Current and Emerging Prison Context

These imported vulnerabilities coalesce with, and are shaped by, the prison environment, the challenges of 'doing time' and the quality of relationships between prisoners and prison staff, all of which can induce stress or act as protective agents.[30]

There has been significant recent change to the prison landscape, which is shaping all prisoners' experiences of custody. By drawing upon the operating costs of privately managed prisons and publicly managed prisons that have been subject to competitive tendering, the National Offender Management Service (NOMS) has implemented a Specification, Benchmarking and Costing programme (SBC). SBC has developed 'output descriptions' and maximum budgets to which all prisons of a similar category must adhere. Over the last two years these benchmarked standards have been implemented across Category B local and Category C training prisons and work is underway to prepare and implement benchmarks across the rest of the estate. Benchmarking has coincided with the implementation of 'New Ways of Working'; a new approach to how prisons are staffed and how the prison 'core day' is delivered.[31]

The combined effects of Benchmarking and New Ways of Working have been to reduce most prisons' budgets and the size of their workforces. NOMS estimated that one in 20 of its staff would take a

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[26] Hawton, K., K. Saunders and R. O'Connor (2014) 'Self-Harm in Prisons in England and Wales: an Epidemiological Study of Prevalence, Risk Factors, Clustering and Subsequent Suicide' *Lancet* 383: 1147–1154.
[27] Liebling, A. (1995) 'Vulnerability and Prison Suicide' *British Journal of Criminology* 35(2): 173–187.
[28] In 2013, 37,527 people entered prison to serve sentences of less than or equal to six months: Ministry of Justice (2014) 'Offender Management Statistics Annual Tables 2013'. London: Ministry of Justice, Table A2.1a.
[29] Ministry of Justice (2014) 'Safety in Custody Statistics England and Wales: Update to December 2013'. London: Ministry of Justice, pp. 11–13. See also Towl, G. (1999) 'Self-Inflicted Deaths in Prisons in England and Wales from 1988 to 1996'. *British Journal of Forensic Practice* 1(2): May. Towl found that 10 per cent of prisoners who kill themselves do so within 24 hours of arrival into custody.
[30] Liebling's model of the prisoners' pathway to suicide, discussed further in Section 2 and included in Appendix 1, sets out the complex relationship between vulnerability, prison-induced stress, situational triggers and protecting agents. The complexity of this relationship is also reflected to some degree in NOMS Safer Custody documentation (e.g. PSI 64/2011: 17–21).
[31] NOMS (2013) 'Business Plan 2013–2014'. London: NOMS: http://www.justice.gov.uk/downloads/publications/corporate-reports/noms/2013/noms-business-plan-2013-2014.pdf.

voluntary early redundancy package through the Voluntary Early Departure Scheme (VEDS). In practice, more staff than anticipated have taken the package with the consequence that many prisons are under-staffed (with fewer than their Benchmark Target staff).[32] Staff in this study variously described the current situation to us as a 'starvation of resources', 'a crisis' and 'an emergency' (see Section 2 for a description of our methods). In some of the establishments we visited during the course of this project we had described to us, and observed, senior managers undertaking prison officer work such as facilitating movements or serving meals. Regimes were curtailed at all of the prisons we visited with the consequence that many prisoners were locked in their cells for most of the day.

By way of response, during the summer of 2014 NOMS re-recruited some of those whom it made redundant to form a 'focused, flexible reserve capability among former staff'.[33] Together with staff who have been drafted to work on a detached duty basis away from their home establishment, this 'reserve' workforce has been attempting to 'bridge the gap' until some of the 1,700 prison officers that NOMS has aimed to recruit during 2014 and 2015 are available to work. In the interim, the regime offered to prisoners has remained curtailed at most prisons.

Many of our interviewees[34] in this study described under-staffing from VEDS as being compounded by high staff sickness, some of it through work-related stress. Many managers also described fresh difficulties in recruiting and retaining staff on new (less attractive) terms and conditions of employment:

> Benchmarking has put us between the devil and the deep blue sea. We've had to implement it even though we know it's damaging the prison. On paper things look much better than they are. In reality about a quarter of our staff are unavailable to work through sickness, with stress, restricted duties, maternity leave, etc. As soon as we recruit, we lose our detached duty staff but we can't use our new recruits for seven weeks because they're training. And that's presuming they stay working for us once they've been trained. Some of them realise that they could earn the same money working nights at Tesco without running the sort of risks you face working here. (Manager)

Managers also reflected upon the difficulties the current staffing context is causing them in reducing their ability to challenge poor practice among their staff:

> Lots of good staff left with VEDS and that's left a core group of staff who are motivated by money not care. With benchmarking that core group is now spread thinner and can't be carried so they feel uncomfortable and challenged. But our [management] challenge, and what's making it difficult to hold them to

[32] See the Parliamentary Under-Secretary for Justice's response to the Shadow Secretary of State for Justice's question in which he sets out the number of prison officer vacancies (band 3 to 5 officers) as of 30 June 2014 at each prison against the Benchmark target: HC Deb, 5 November 2012, cW 212856: http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2014-10-31/212856/.

[33] http://www.theguardian.com/society/2014/jul/20/moj-recruits-redundant-staff-ease-jails-crisis.

[34] Quotes are presented from interviews in this section for illustration of broader trends and issues. Our interview methods are described in detail in Section 2 of this report.

> account, is understaffing. They use that as an excuse and we're a bit hamstrung because we are so short-staffed at the moment. Some staff know that, and are using it to their advantage. (Manager)

The broader criminal justice context is also in flux and uncertain. The competitive tendering exercise for all probation services through Community Rehabilitation Companies is still ongoing.[35] Further change in prisons is on the horizon as NOMS has committed to outsource prison works and resettlement services.[36] The criminal justice landscape is also highly politically charged. Prison life has been affected by recent changes to 'toughen up'[37] prisoner privileges through the introduction of a new 'entry' level on the Incentives and Earned Privileges Scheme. This change restricts 'privileges', such as family visits, access to in-cell television, access to private cash and time out of cell for association, and mandates the wearing of a prison uniform during the first two weeks of sentence.[38]

Prison work remains challenging and new challenges are emerging both from policy change and changes to the prison population. There are heightened risks of alienation among young offenders and difficulties for prison staff in maintaining control.[39] There has also been rapid growth in the number of older prisoners (partly caused by the increase in convictions for historic sexual offences) and there is evidence to suggest that prisons are finding it difficult to meet these new needs.[40] Anecdotal evidence suggests that new psychoactive drugs, particularly synthetic cannabis known as 'Black Mamba' and 'Spice', have increasingly been used in prisons over the last year or two.[41] Their consumption is undetectable using any of the currently available testing technology and little is known about the health effects of these drugs or how best to treat individuals who are taking them. Their proliferation in prisons is a source of new instability, disorder and violence.[42] Prison staff and managers must find ways of implementing these

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[35] See http://www.justice.gov.uk/transforming-rehabilitation/competition.

[36] NOMS (2013) 'Business Plan 2013–2014'. London: NOMS: http://www.justice.gov.uk/downloads/publications/corporate-reports/noms/2013/noms-business-plan-2013-2014.pdf.

[37] https://www.gov.uk/government/news/toughening-up-prisoner-privileges.

[38] NOMS (2013) 'Incentives and Earned Privileges Scheme: PSI 30/2013'. London: NOMS.

[39] See, for example, HMCIP (2014) 'Report on an Unannounced Inspection of HMYOI Glen Parva'. London: HMIP.

[40] See House of Commons Justice Committee (2013) 'Older Prisoners' Fifth Report of Session 2013–14, Volume I. London: The Stationery Office Limited.

[41] From our ongoing work in prisons we understand the use of these drugs to be widespread across the prison estate but little has been written about this. Many prison staff at all of the prisons we visited during the course of fieldwork for this study reported concerns about the use of these drugs in their prison.

[42] See, for example, HMCIP (2014) 'Report on an Unannounced Inspection of HMP Altcourse'. London: HMIP, p. 5: 'the availability of drugs, particularly new psychoactive substances (so-called 'legal highs' such as 'Spice' and 'Black Mamba'), were a significant factor in much of the violence, and these had also been the cause of regular hospital admissions.' See also HMCIP (2013) 'Report on an Unannounced Inspection of HMP Oakwood', London: HMIP, p. 25.

policies and managing and leading through these new challenges. Many are finding their work in the current circumstances difficult.[43]

This context is relevant and important to understanding SID. Applying Liebling's theoretical model of pathways to suicide, high-quality relationships with staff can act as protecting agents against SID. Experienced staff in sufficient number to enable them to engage relationally with individual prisoners can reduce prison-induced stress by securing order, facilitating family contact and purposeful activity, and reducing anxiety by providing support and practical assistance. Several studies have attested to the essential role prison staff play in the prevention of SID in prison, through a combination of their attitudes and values towards self-harm, and their skills in managing suicide risk.[44] An evaluation of the Safer Locals Programme in 2005 showed that staff culture impacted upon the implementation of suicide prevention strategies. Findings from this evaluation indicated that in a 'traditional' staff culture (characterised by distant and unapproachable relationships between staff and prisoners) staff identified prisoners at risk of SID as 'attention seeking' or 'manipulative' rather than vulnerable, thereby reducing opportunities for monitoring SID risk factors and increasing distress, which was correlated with average suicide rates.[45] Other research in prisons has found that even when staff have expertise,[46] some lack confidence in their abilities to identify suicide risk and there are concerns that feelings of individual accountability can lead to mechanistic compliance with procedures even if this does not in fact result individual prisoners being safeguarded.[47]

Understanding staff approaches to, and experiences of, suicide is therefore essential in understanding how suicide can be prevented in prisons. Given the staffing and regime impacts of Benchmarking, New Ways of Working and VEDS, new questions arise about the extent to which, and ways in which, these changes might be reshaping the prison landscape and the professional orientation and practices of prison staff in ways that are relevant to SID. Even within the challenging current circumstances, variation in SID rate[48] and variation in responses and processes for managing SID between prisons,[49] suggest that there is potential for improvements to practice that this study seeks to identify and explore.

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[43] See A. Liebling and B. Crewe, 'The Role of the Governing Governor' (forthcoming, spring 2015).

[44] Liebling, A. (2006) 'The Role of the Prison Environment in Prisoner Suicide and Prisoner Distress' in Dear, G. (ed) *Preventing Suicide and Other Self-Harm in Prison*. London: Palgrave-Macmillan, pp. 16–28. Liebling, A. (2008) 'Why Prison Staff Culture Matters' in Byrne, J., D. Hummer and F. Taxman. (eds) *The Culture of Prison Violence*. Boston, USA: Allyn and Bacon Publishing, pp. 105–122.

[45] Liebling, A. et al. (2005) 'An Evaluation of the Safer Locals Programme: Final Report': http://www.crim.cam.ac.uk/people/academic_research/alison_liebling/SaferCustodyReport.pdf. Liebling, A. (2008) 'Why Prison Staff Culture Matters' in Byrne, J., D. Hummer and F. Taxman (eds) *The Culture of Prison Violence*. Boston, USA: Allyn and Bacon Publishing, pp. 105–122.

[46] Birmingham, L. (1999) 'Prison Officers Can Recognise Hidden Psychiatric Morbidity in Prisoners' BMJ 319: 853.

[47] See, for example, Liebling, A. (1992) *Suicides in Prison*. Routledge: London; Liebling, A. and H. Krarup (1993) 'Suicide Attempts in Male Prisons'. London: Home Office.

[48] See 'Deaths in Prison Custody 1978 to 2013'. Table 1.16: Self-Inflicted Deaths by Establishment 1978–2013: https://www.gov.uk/government/statistics/safety-in-custody-statistics-quarterly-update-to-june-2014.

[49] Noted in previous studies and observed in this study. See further Sections 4 and 6.)

It was within the context of increased rates of SID and a desire to better understand current practice that the Justice Secretary announced an independent review into self-inflicted deaths in National Offender Management Service custody of 18–24 year olds and invited Lord Toby Harris, Chair of the Independent Advisory Panel on Deaths in Custody to conduct it. The reason for the explicit focus on 18–24 year olds, which frames the remit of the Review and this project, was because of the following factors:

- **Transition**: Young adults are transitioning to adulthood and may still be adapting to adult responsibilities and adult services. Transfer of information between CJS services is inconsistent and there are two points of transition for many 18–24 year olds, as many transfer again at 21 from YOIs to adult prisons.
- **Transfers between other services**: Many young adults also face changes in other services, including in particular from Child Adolescent Mental Health Services to adult mental health services.
- **Maturity**: Some 18–24 year olds have distinct needs and are developing in their maturity.

The Independent Review into self-inflicted deaths of 18–24 year olds (also known as the Harris Review) focuses on issues such as vulnerability, effective communication and information sharing, safety, staff prisoner relationships, family contact and staff education and training. The next section sets out the research questions for this project that flow from these objectives.

# 2. Methodology

## 2.1. Research Questions

In this study we sought to answer six key research questions in relation to 18–24 year olds that were identified by the Harris Review when they commissioned this research:

1. What does being 'at risk' of SID mean to prison staff? What do prison staff see as the relevant risk factors for SID? How do prison staff identify relevant risk factors for SID?
2. What arrangements are staff aware of for identifying and managing SID risk? How well do staff think the processes are working? Are there any suggestions for improvement?
3. What training have staff had in identifying and managing prisoners who are at risk of self-harm or SID? Do staff feel this is adequate?
4. Do staff understand what they should do if they have concerns about a prisoner? How prepared do staff feel about identifying, managing and caring for young adults at risk of SID?
5. Do staff know how to access support? Is staff support adequate?
6. Where staff have direct experience of SID, what happened, what lessons were learned and what changes, if any, were made to operational practice?

We addressed all questions, although information relevant to answering some questions is distributed across sections of this Report. To assist the reader we outline which research questions are addressed at the start of each section in the Report. Broadly speaking, question one is addressed in Section 3, questions two and four are addressed in Section 4, question 3 is addressed in Section 5, and questions 5 and 6 are addressed in Section 6. Suggestions for improvement are detailed throughout, though particularly in Section 7.

## 2.2. Method

We were asked by the Harris Review to conduct 40–50 interviews with staff across four or five establishments. Ultimately, we conducted 47 formal interviews (each lasting on average 50 minutes), six focus groups (one with prisoner Listeners,[50] five with staff and each lasting on average 60 minutes), and intensive participant observation (which included observing 15 ACCT Reviews, two of which were

[50] Listeners are prisoners who receive training from the Samaritans to enable them to support their peers through listening. See further http://www.samaritans.org/your-community/our-work-prisons/listener-scheme.

complex) across five prisons during 11 days of fieldwork. From this we generated over 400 pages of field notes in addition to 28 interview transcripts, which were analysed thematically and by prison staff role and length of prison work experience. [51]

Ethnographic-style methods and a ground-up, inductive approach were used to collect and analyse data. Interviews and discussion-based encounters were semi-structured and unstructured. This strategy of having 'conversations with a purpose' was intended to allow interactions and interviews to be comfortable to the participant in order to build rapport, despite the sensitivity of the study's subject.[52] Data were generated through extensive field notes from each site, transcripts from audio-recorded and non-audio-recorded interviews and focus groups, and document analysis. Data were collected and analysed through a grounded theory-inspired ongoing and cyclical process.[53] This approach was selected in order to gather information that could be triangulated with existing evidence and theory. In accordance with grounded theory procedures, data were regularly reviewed, coded, categorised and analysed both manually and dialogically within the team.[54] These procedures then acted as an ongoing guide for the course of research inquiry by continually validating and strengthening the data collection process and subsequent interpretations.

A semi-structured interview schedule was used (see Appendix 2), which we developed in light of our discussions with and direction from the Harris Review, our knowledge of the literature and prisons, and our previous experience of conducting research in prisons. We decided that a semi-structured approach was most appropriate because we wanted to allow space for development and encourage views to be shared on themes beyond those that we had included explicitly in the interview schedule. We used the same schedule to structure focus group discussions, save for the Listener group, which arose opportunistically and for which our staff-centred schedule was inappropriate, though we explored similar themes.

Prisons included in the study were selected in consultation with the Review (see Table 2.1 for a complete list). Each selected prison accommodated at least some 18–24 year olds. Most had high SID rates, though at least one was included because it had a low SID rate so as to increase our chance of capturing better practice. One of our sites housed females and two were local prisons. The Harris Review Secretariat established initial contact with each prison from which point the research team continued access discussions. We spent two days in the first prison, three days in the second and third prisons and two days in the fourth. One day was spent in the fifth (female) prison by two members of the fieldwork team during which time eight interviews and one staff focus group were conducted (Table 2.1). We highlight this to acknowledge that our data from the female estate is more limited. We recognise that there may be

[51] Operational Support Grade (OSG) staff did not form part of our formal interviewee pool. However we did engage OSGs for extended conversations during our participant observation activities in multiple prisons.

[52] Burgess, R. G. (1984) *In the Field: An Introduction to Field Research*. London: Allen and Unwin, at p. 102.

[53] Strauss, A. and J. Corbin (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage.

[54] Cresswell, J. W. (2009) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (3rd ed). Thousand Oaks, CA: Sage.

different dynamics and challenges around self-harm and SID among female prisoners.[55] Our data do not enable us to explore this in detail. The lead three authors of this report drew keys at all selected prisons to facilitate thorough and efficient fieldwork and to minimise any disruption to the prisons resulting from us needing escorts.

During access negotiations with each prison we requested advance copies of key documentation such as Safer Custody audits and policies and Her Majesty's Chief Inspector of Prisons (HMIP) and Measuring the Quality of Prison Life (MQPL) reports. This helped to contextualise each prison and understand in advance of fieldwork something of its policy approach to identifying and managing SID risks. We also asked for interviews to be arranged with a range of key personnel who had particular responsibility for the management and prevention of deaths in custody. These included the Governing Governor, healthcare staff, members of the staff training team, safer custody staff, suicide prevention coordinators, ACCT assessors and reviewers, family liaison officers, members of the staff care team and chaplaincy staff. We also requested each prison to facilitate a lunchtime focus group with approximately ten staff to include wing officers and any other available staff with experience or ideas about the prevention of deaths in custody.

All members of staff whom we interviewed or who participated in a focus group had some experience of SID. They were not selected on this basis but we know from previous and ongoing prison research that most prison staff have been involved in a SID at some point during their careers. We circulated a draft Notice to Staff text to all establishments for them to use to explain to staff our purpose in the prison and invite staff to participate in the focus group (see Appendix 3). Outside of those in the key roles that we identified and requested to speak to, staff volunteered to participate in the study and we sampled additional interviewees or informal discussions opportunistically, following interesting and relevant lines of inquiry as they arose. Focus groups and interviews were generally conducted in offices that each prison had provided for our use. However, in some cases we interviewed staff in their own offices. By making these advance arrangements we hoped to use our (limited) time in each prison to maximum advantage, to ensure that we spoke to all members of staff in key roles and saw as much as possible in the prison, undistracted by too many administrative or logistical issues.[56] The research approach was reviewed formally by the research ethics committee of the Faculty of Law at the University of Cambridge and also by RAND Europe's ethics advisory group.

The purpose of our participant observation was to engage less formally with staff and prisoners and to observe working practices. From previous research experience we know that there can be a 'gap' between the views that staff declare and their practices.[57] We also wanted to visit key areas of each prison that are

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[55] Ministry of Justice (2014) 'Safety in Custody Statistics England and Wales: Deaths in Custody to September 2014'. London: Ministry of Justice. Hawton, K. et al. (2014) 'Self-Harm in Prisons in England and Wales: an Epidemiological Study of Prevalence, Risk Factors, Clustering and Subsequent Suicide' *Lancet* 383: 1147–1154.

[56] Notwithstanding staff shortages and tight research timetables, all of the prisons that we visited during the course of this study were highly supportive of our work and we were given generous access to everyone we wanted to talk to. We are very grateful for this.

[57] Liebling, A., D. Price and G. Shefer (2010) 'The Prison Officer'. Cullompton, Devon: Willan Publishing, 2nd edition.

particularly relevant to safer custody, including reception, induction wings, healthcare and, because of the complex relationship between poor behaviour and SID,[58] segregation units. We visited safer cells and Listener suites. Opportunities for deeper engagement in processes and meetings that seemed relevant to our research questions were identified through conversations with staff and prisoners. We attended a Safer Custody meeting and a Listener meeting. We observed five healthcare assessments in Reception. Between the fieldwork team we observed 15 ACCT reviews or assessments, including two complex needs reviews, at three of our five fieldwork sites. It was not possible to observe ACCT assessments or reviews at all sites because there were not always any assessments or reviews taking place during our fieldwork period.

Table 2.1: Prison sites and associated fieldwork activities

| Prison | Prison details | Fieldwork activities |
|---|---|---|
| A | • Local, Category B<br>• Holds adults and young offenders<br>• Capacity range: 500–750 prisoners<br>• Publicly managed<br>• Male only | • 10 interviews<br>• ACCT reviews observed |
| B | • Holds adults and young offenders<br>• Capacity range: 500–750 prisoners<br>• Publicly managed<br>• Male only | • 10 interviews<br>• 2 staff focus groups (one with officers, one with chaplaincy) |
| C | • Holds young offenders only<br>• Capacity range: 750–1,000 prisoners<br>• Publicly managed<br>• Male only | • 12 interviews<br>• 2 focus groups (one with staff, one with Listeners)<br>• ACCT reviews observed |
| D | • Local, Category B<br>• Holds adults and young offenders<br>• Capacity range: 1,000-1,250 prisoners<br>• Privately managed<br>• Male only | • 8 interviews<br>• 1 staff focus group<br>• ACCT reviews observed |
| E | • Holds adults and young offenders<br>• Capacity range: 250–500 prisoners<br>• Publicly managed<br>• Women only | • 8 interviews<br>• 1 staff focus group<br>• ACCT reviews observed |

## 2.3. Appreciative Inquiry

Our approach to research design and fieldwork was appreciative, by which we mean that we drew throughout upon Appreciative Inquiry. Appreciative Inquiry is a 'strengths-based' method that focuses on

[58] Liebling, A. et al. (2005) 'An Evaluation of the Safer Locals Programme: Final Report': http://www.crim.cam.ac.uk/people/academic_research/alison_liebling/SaferCustodyReport.pdf.

the best of 'what is'. It is a useful tool for exploring the best of what 'could be' without encountering the oppositional tendencies of questions that are phrased 'unappreciatively' in 'problem mode'.[59] Although the focus of Appreciative Inquiry is on best practice, this approach invariably enables discussion of instances where attitudes or practices are less than 'best'. We did not encounter any difficulty in obtaining critical insight from staff about current approaches or suggestions for improvement in this study. We recognised that the sensitive nature of this research, and the high profile of the Review to which it contributes, might cause staff to feel that they had an interest in answering our questions in ways that reflect the best of themselves, their co-workers and their prison. From our previous research with prison staff, and the relevant literature on SID in custody and prison staff culture, we also recognised that a focus on deaths and instances where 'things went wrong' can cause staff to feel unrecognised for the good work they do in preventing deaths in custody. This is because when prison officer work is at its 'best' it is often invisible: power is exercised confidently but 'lightly'.[60] A purely 'problem-oriented' approach risked that staff would refuse to engage, or engage only superficially with our questions.

We therefore adopted an appreciative approach, which focused upon identifying strengths and good practice (the conditions under which SID was best prevented) and exploring ways in which the best of 'what is' could be grown. In all interviews we invited staff to begin talking to us about their experiences and views of SID by reference to an example of where SID had been prevented. Staff readily volunteered insight into how current approaches, processes or constraints were problematic from an SID prevention perspective. However, by orienting our fieldwork appreciatively, we hoped that the tensions and difficulties staff experience around managing SID would be put into context. We hoped that staff would experience their discussions with us as affirming and focused upon a positive trajectory for future development. We saw this as an important part of ensuring the proper ethical care of our research participants.[61]

### *2.3.1. Limitations*

This research was commissioned as an exploratory study and therefore was not intended to be generalisable. We did not visit any open or high security prisons, and we spent less time at the one female establishment that we visited than we did elsewhere. However, in light of the time constraints under

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[59] Bushe, G. (2011) 'Appreciative Inquiry: Theory and Critique' in Boje, D., B. Burnes and J. Hassard (eds) *The Routledge Companion To Organizational Change*. Oxford: Routledge, pp. 87–103. Ludema, J., D. Cooperrider and F. Barrett (2000) 'Appreciative Inquiry: the Power of the Unconditional Positive Question' in Reason, P. H. and Bradbury (eds) *Handbook of Action Research*. Thousand Oaks: Sage, pp. 189–199.

[60] Liebling, A., D. Price and G. Shefer (2010) 'The Prison Officer'. Cullompton, Devon: Willan Publishing, 2nd edition and Crewe, B., A. Liebling and S. Hulley (2014) 'Heavy-Light, Absent-Present: Rethinking the "Weight" of Imprisonment' *The British Journal of Sociology* 65(3): 387–410.

[61] Liebling, A., D. Price and C. Elliott (1999) 'Appreciative Inquiry and Relationships in Prisons' *Punishment & Society* 1(1): 71–98. Liebling, A., C. Elliott and H. Arnold (2001) 'Transforming the Prison: Romantic Optimism or Appreciative Realism?' *Criminology and Criminal Justice* 1: 161–180. Robinson, G. et al. (2012) 'Doing "Strengths-Based" Research: Appreciative Inquiry in a Probation Setting' *Criminology and Criminal Justice* 13(1): 3–20. The ethical dimensions of this project were thoroughly reviewed by RAND Europe's ethics committee and the Faculty of Law ethics committee at the University of Cambridge.

which this study was conducted, and its objectives, we would argue that we collected data from a good range and number of prisons relevant to the age group under study. Furthermore, we know from our ongoing work in prisons for other research projects that many of the challenges the five prisons in our study were experiencing (staff shortages, resource depletion and overcrowding, for example) are occurring nationwide. There is also strong resonance between our findings and findings from previous studies. In our view therefore, it is reasonable to assume that the findings presented here are relevant to, and may resonate with, the views, experiences and practices of prison staff at other establishments and beyond the 18–24 year old prisoner age group.

However, we do especially acknowledge the distinctive nature of self-harm and suicide among imprisoned women, which is not, in our view, fully explored in our data. As such, data from the single female establishment included in this study should not be interpreted as generalisable. Nonetheless, just as for the male prisons, our instinct by reference to our previous and ongoing prison research is that many of the challenges experienced at the single female site may be experienced elsewhere. Our results may therefore resonate with staff views and experiences at other female prisons.[62]

We also recognise though that our Appreciative Inquiry-based approach has some limitations. This approach tends to be less effective in organisations where members hold deeply seated and unexpressed resentments. This limits their ability to fully consider opportunities for improvement, especially if the resentment is associated with an element of real or perceived, and unredressed fairness. Although some of our interviewees did express some levels of dissatisfaction or resentment towards their job, the prison, or the Prison Service, their critical assessments of their work environment was normally with a view to how it could be improved. We thus do not believe our use of Appreciative Inquiry adversely impacted upon the quality or value of their input.[63]

## 2.4. Terminology and Analytical Framework

Before turning to present our findings, we wish to briefly clarify our use of terminology throughout the remainder of this Report, and also identify the basis of our analytical approach.

### *2.4.1. Terminology*

First, we recognise that we were asked to explore SID, rather than suicide. We understand that 'SID' refers to any death of a person who has apparently taken his or her own life, irrespective of intent. SID is therefore a broader term than suicide since it also includes accidental deaths as a result of the person's own

[62] See, for example, Ministry of Justice (2014) 'Safety in Custody Statistics England and Wales: Deaths in Custody to September 2014'. London: Ministry of Justice. Hawton, K. et al. (2014) 'Self-Harm in Prisons in England and Wales: an Epidemiological Study of Prevalence, Risk Factors, Clustering and Subsequent Suicide' *Lancet* 383: 1147–1154.

[63] See also, Bushe, G. (2001) in Cooperrider, D., P. Sorenson, D. Whitney and T. Yeager (eds) *Appreciative Inquiry: An Emerging Direction for Organizational Development*. Champaign, Ill: Stipes.

actions.[64] However, from our previous prisons research, we knew that many prison staff do not use, or really understand, this expression. In our previous experience, which was affirmed during the course of this study, many prison staff use the term 'suicide' to encompass unintended, accidental deaths as a result of a prisoner's own actions. Consequently, we found the term SID generally inaccessible in the field and preferred to talk about suicide. For this reason we use the terms suicide and SID interchangeably in the analysis that follows though in all cases we do so intending to imply the broader definition of SID (in common with the prison staff with whom we have spoken).

Second, we recognise that we were not asked to explore self-harm. In the field, however, we found it impossible to 'hive' off self-harm from SID. There is in practice a close relationship between self-harm and SID[65] and, as will be explored further below, most staff identified self-harm as a risk factor for SID. Consequently, some of our data refer to self-harm and SID though our focus throughout was upon the latter.

Third, in presenting quotations throughout this Report we have used occupational descriptors that are as precise as possible without risking identifying individual participants. We have used the term 'Manager' to denote the Custodial Manager grade upwards, including the Senior Management Team and Governing Governor. 'Safer Custody staff' includes managers. Quotations are drawn throughout this Report from all of the prisons that we visited in the course of this study. To protect the anonymity of interviewees we are not able to specify establishments alongside quotations.

### 2.4.2. Analytical Framework

Throughout the Report we examine the data through an analytical framework based on Liebling's theoretical model of the prisoners' pathway to suicide (see Appendix 1). This model shows a tri-part interaction of components that contributes to the likelihood for suicide: vulnerability, situational triggers and prison-induced stress. The model indicates that despite a heightened state of vulnerability from these components, there are protective agents that can decrease the likelihood for a self-inflicted death. The model identifies these protective agents as: visits and contacts with family; constructive occupation in the prison; support from other prisoners, staff, probation and Listeners; good inter-departmental communication; valued and professionally trained staff; and hopes and plans for the future.[66]

Previous research based on this model indicates that positive risk management in preventing suicide in prisons recognises and emphasises that some prisoners import vulnerabilities into the custodial setting (for example, depression, anxiety, learning disabilities or substance misuse), and that institutional factors (for

[64] Ministry of Justice (2014) 'Safety in Custody Statistics England and Wales: Deaths in Custody to September 2014'. London: Ministry of Justice, p. 10.

[65] See, for example among adolescents, Hawton, K., K. Saunders and R. O'Connor (2012) *Lancet* 379: 2373–2382 and Hawton, K. and A. James (2005) 'Suicide and Deliberate Self-Harm in Young People' *BMJ* 330: 891–894.

[66] From Liebling, A. (1997) 'Risk and Prison Suicide' in Kemshall, H. and J. Pritchard (eds) *Good Practice in Risk Assessment and Risk Management Volume 2*. London: Jessica Kingsley Publishers, p. 200.

example, overcrowding, bullying, negative staff culture, isolation or lack of family contact) may exacerbate these, leading to an elevated risk for self-harm or suicide.[67]

By contrast, practice that has been identified in previous research as less effective occurs when prison staff locate the causes of suicide in the individual only, rather than recognising the pressures generated by the environment and how these may interact with imported vulnerabilities. Poorer SID outcomes have been found to be associated with higher numbers of prison staff within an establishment who approach SID risk as mostly a mental health problem, or who emphasise the potential for prisoners to use self-harm and SID as tools of 'manipulation'.[68] Prior research has found that this individual-centred view 'led to the underestimation of the power [staff] had to effect change for prisoners who were at risk as a result of such pressures'.[69] There is a considerable body of empirical research that has substantiated this theoretical model of how imported vulnerabilities can be aggravated by situational or environmental stressors distinct to the prison setting.[70] While a full literature review and comparison of models of prisoner suicide risk management was not within the scope of this research, we recognise that other models exist.[71] Nonetheless, we feel this model is particularly suited to understanding the role of staff in suicide risk management, in line with the goals of this research.

By interpreting the evidence gathered in this research in light of this model, at points within this Report we identify practice or attitudes as promising or positive. Conversely, at points within this Report we suggest that based on this model certain staff views or practices appear less likely to produce effective SID risk management. Such statements in this Report do not reflect evidence of a validated causal connection between staff opinion or practice and a subsequent effect on outcomes, such as reductions or increases in suicides or levels of prisoner wellbeing. Rather, statements about promising practice are intended as an indication that staff views or practices do (or do not) align with broader evidence from the literature

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[67] See especially Liebling, A. et al. (2005) 'An Evaluation of the Safer Locals Programme: Final Report': http://www.crim.cam.ac.uk/people/academic_research/alison_liebling/SaferCustodyReport.pdf

[68] Liebling, A. et al. (2005) 'An Evaluation of the Safer Locals Programme: Final Report': http://www.crim.cam.ac.uk/people/academic_research/alison_liebling/SaferCustodyReport.pdf.; Liebling, A. (2008) 'Why Prison Staff Culture Matters' in Byrne, J., D. Hummer and F. Taxman (eds) *The Culture of Prison Violence*. Boston, USA: Allyn and Bacon Publishing, pp. 105–122.

[69] Liebling, A. (1998) 'Managing to Prevent Prison Suicide: Are Staff at Risk Too?' in Kamerman, J. B. (ed) *Negotiating Responsibility in the Criminal Justice System*. Carbondale, IL: Southern Illinois University Press, pp. 68–86.

[70] See also, for example: Thomas, J. et al. (2006) 'Self-injury in Correctional Settings: "Pathology" of Prisons or of Prisoner? *Criminology & Public Policy* 5(1): 193–202; Slade, K. and R. Edelman (2014) 'Can Theory predict the Process of Suicide on Entry to Prison? Predicting Dynamic Risk Factors for Suicide Ideation in a High-Risk Prison Population', *Crisis* 35(2): 82–89; and Hawton, K. et al. (2014) 'Self-harm in prisons in England and Wales: An Epidemiological Study of Prevalence, Risk Factors, Clustering, and Subsequent Suicide', *Lancet* 383: 1147–1154.

[71] For example, the Cry of Pain (CoP) model focuses more heavily, though not exclusively, on identifying risk factors unique to the individual's situation (as outlined in Slade, K. and R. Edelman (2014) 'Can Theory Predict the Process of Suicide on Entry to Prison? Predicting Dynamic Risk Factors for Suicide Ideation in a High-Risk Prison Population', *Crisis* 35(2): 82–89), whereas Liebling's model places a comparatively higher emphasis on prison-specific factors.

outlined above regarding factors that contribute to better (or worse) outcomes in terms of prisoner wellbeing, risk management and suicide reduction.

As with any dynamic risk assessment process, we appreciate that assessing risk of SID is difficult and complex. The complexity and uncertainty involved in this kind of risk assessment has challenged academic researchers for decades,[72] and at no point do we intend to suggest that there are simple solutions to these issues. We hope that our approach in attempting to present an account of staff attitudes and practices that seem most likely to prevent deaths in custody will prove helpful to the Harris Review Panel when thinking about areas for growth and improvement.

We turn now to present our findings. Unless explicitly stated otherwise our findings are not limited to the 18–24 year old age group. As will become apparent, this is because prison staff did not identify many differences directly related to age in how they identified and managed SID risks. Without prompting from researchers regarding the influence of prisoner age on SID risk, age was not raised by interviewees and prison staff described their views and approaches as applicable generally across all prisoner age groups.

[72] See e.g. Kemshall H. and J. Pritchard (1997) *Good Practice in Risk Assessment and Risk Management Volume 2.* London: Jessica Kingsley Publishers.

# 3. Conceptualising Risk of Self-Inflicted Death and Identifying Risk Factors

The data in this section primarily address research question one, reviewing how prison staff conceptualise SID risk factors. The section is divided along the sub-components of this question, which are:

- What does being 'at risk' of SID mean to prison staff?
- What do prison staff see as the relevant risk factors for SID?
- How do prison staff identify relevant risk factors for SID?

The data in the chapter are organised under headings aligning with each of these questions. As noted in Section 2, there are suggestions for improvement based on these findings identified in this chapter and each subsequent chapter, and further overarching suggestions are outlined in Section 7.

Key Findings in this Section:

- SID risk was perceived by the majority of staff interviewed to be complex and unpredictable.
- There was some variation between interviewees in how SID risk was understood. Some staff expressed views that were in accord with the available evidence on practices that may prevent self-inflicted deaths in custody: a promising conceptualisation of risk that was more likely to lead to actions that reduced SID. Based on previous empirical studies SID risk is best understood as nuanced, dynamic, reactive and environmentally contextual. Findings from interviews, in accordance with existing theoretical models, suggest that this conceptual model was empowering for staff because it enabled them to feel that they could make a difference.
- An alternative understanding of SID risk that appears less effective is binary, static, purposive and individual-centred. Staff expressing these kinds of views were fatalistic about SID and felt disempowered regarding their abilities to reduce incidence of SID.
- Although identifying SID risk was difficult, because staff felt that most prisoners were in some senses 'risky', good practice put prisoners in a 'big picture' context and looked for subtle changes in behaviour.
- For staff, age was not seen as a directly relevant factor for understanding or identifying SID risk. However, youth was seen as an indicator of immature coping mechanisms and of impulsivity that makes risk assessment more difficult.
- Examples of promising practice in identifying risk factors were observed where staff identified risk factors for SID through good information flowing into and within the prison.

- The key areas for improvement in respect of information appeared to lie in how information was used and shared among and between units (especially information derived via healthcare and reception processes).
- Consistent with findings from Liebling's previous studies, prison staff universally identified staff prisoner relationships as the key to identifying and managing risk. 'Jail craft' was learned through experience more than training. There was strong agreement that staff capacity to form and sustain high-quality staff prisoner relationships that supported SID prevention had been adversely affected by Benchmarking and New Ways of Working.
- Staff reported that risk identification was made more difficult because there were not enough staff on wings, and because the staff who were present were less effective than they could be in identifying risk markers or individuals who may be vulnerable. This was most frequently attributed to inconsistent staff detailing, the use of agency or detached duty staff and low staff morale.

## 3.1. What Does Being 'At risk' of SID Mean to Prison Staff?

### SID risk is complex and unpredictable

Suicide risk was seen universally by prison staff as complex, in the sense of being difficult to predict. However, within this broad complexity we were able to identify in the data two predominant 'rival' conceptions of what SID risk meant to prison staff; one that was a binary, static, purposive and individual-centred model (which, based on Liebling's theoretical model, we suggest is related to less effective practice) and another that was a more nuanced, dynamic, reactive and environmental model (promising, or more effective, practice). Differences in conception of risk shaped staff perceptions of the source of SID risk complexity.

### Staff who conceptualised SID risk as nuanced, dynamic, reactive and environmentally contextual described feeling empowered that they could make a difference

Some staff saw suicide risk as complex and unpredictable because of its highly dynamic and contextual nature. Staff who saw risk in this way described it as 'not a science – there's lots of art in it' (Prison Officer). It was seen as changing subtly over time, in ways that have become harder to detect in the current resource depleted environment (see Section (c), below). Although high risk suicide periods were seen as an intensely distressing experience for prisoners, these staff recognised that they were usually only temporary: 'We just have to keep them safe for long enough, get them through the real crisis, so then we can start working with them and changing things for the better' (Safer Custody).[73] Reflecting Liebling's

[73] This is reflected in the literature, particularly in Hawton's work on suicide among young people. For references see n.65, above.

models of distress,[74] suicide risk was seen as highly contingent upon a wide range of environmental factors, all of which needed to be carefully and simultaneously managed. Staff emphasised the potential of the prison environment, and relationships between staff and prisoners, to induce or alleviate stress:

> If we get the prison right – if we provide opportunities for numeracy, training, qualifications, we offer them hope, and we have good relationships that demonstrate care and that we're not giving up on them then we can massively reduce deaths in custody. (Manager)

There are echoes in this of Chiswick's view that the problems with HMP Glenochil's suicide prevention procedures in the mid 1980s were 'a management problem' not 'a psychiatric problem'.[75] In other words, he was arguing as our interviewee above does, that management can make a real difference to the prevalence of SID in prison.

This group of staff saw all self-harm and threatened suicide as problematic. They did not draw any distinctions between 'types' of self-harm and suicide, preferring instead to see all self-harm and suicide as 'tragic'; a 'last means of resort for the disempowered' (Prison Officer). Although some staff in this group thought that prisoners self-harmed or attempted suicide purposively, as 'a cry for help' (Prison Officer), their understanding of purpose emphasised the fulfilment of 'needs' over 'wants' (or manipulation – on which see further below):

> Some of the reasons prisoners are on ACCT are that had their personal officer done what they should have done in the first place, sorted their app or whatever, then there would be no need to do something extreme and be on an ACCT. The system is forcing some prisoners to become extreme because that's the only way they can get the help they need. (Manager)

There was also recognition that self-harm and suicide attempt was, at times, purely reactive; a 'cry of pain' rather than 'for help':[76] 'Sometimes they're just so overwhelmed and in such a dark place that they let it out by harming themselves or trying to kill themselves' (Prison Officer). A small minority of staff presented even more nuanced understandings of self-harm and suicide, discussing with us, for example, prisoners' use of 'cutting' as 'a coping mechanism' or food and medication refusals by prisoners who wish to end their lives. As one Manager asked, 'How do we define self-harm? Tattoos? Piercing? Where do we draw the line?' Some staff felt that the current system for managing self-harm and suicide risk gave them too little discretion in supporting prisoners for whom self-harm or death was a 'rational' choice, in the sense of it serving a purpose for the prisoner. They felt obliged to put such individuals on Assessment, Care in Custody and Teamwork (ACCT) books but questioned whether this was a good use of resources or an appropriate 'moral' institutional position.

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[74] See Appendix 1 and Liebling, A. et al. (2005) 'An Evaluation of the Safer Locals Programme: Final Report': http://www.crim.cam.ac.uk/people/academic_research/alison_liebling/SaferCustodyReport.pdf at p.19.

[75] As reported in Liebling, A. (1992) *Suicides in Prison*. London and New York: Routledge, p. 4. HMP Glenochil is a prison located in central Scotland.

[76] Prisoner quoted in Liebling, A. (1997) 'Risk and Prison Suicide' in Kemshall, H. and J. Pritchard (eds) *Good Practice in Risk Assessment and Risk Management Volume 2*. London: Jessica Kingsley Publishers, pp. 188–204 at 191.

This nuanced, dynamic, reactive and environmental risk narrative was more prevalent among managers and staff in 'specialist' roles, particularly Chaplaincy and in some Safer Custody teams, than among wing staff.

### An alternative understanding of SID risk that appeared less effective was binary, static, purposive and individual-centred. Staff who held this view were fatalistic about SID and felt disempowered regarding their abilities to reduce incidence of SID

Staff who felt SID risk was more binary, static, purposive and individual-centred less frequently believed that they could prevent SID. This conception predominated among some wing staff, particularly those without specialist Safer Custody roles or experience, although it was shared by some specialist staff across the establishments.

For these staff SID risk focused upon an individual's characteristics, to the exclusion of environmental impacts, situational triggers and potential protective agents. This group of staff either did not mention, or placed little importance upon, the environment or themselves as inducers or reducers of SID risk: 'Those who really want to do it [kill themselves] will do it anyway, there's nothing we can do' (Manager). Staff posited a binary distinction between the 'genuine' minority and the 'maladaptive' majority. The maladaptive were purposive 'manipulators',[77] who had learned to 'play the system' and who 'cut up just to get a smoker's pack'.[78] On the whole, manipulators were seen as making 'empty threats' to 'get what they want': 'A YO [young offender] on basic threatening suicide is your classic someone who wants to get some privilege back and knows how to use the system to get it.' (Prison Officer).

There was a subgroup of staff within this group who recognised that some 'manipulative' self-harm or attempted suicide happened in order to secure environmental improvements. The most commonly cited improvements sought were securing access to a television (for prisoners on basic level Incentives and Earned Privileges (IEP)) or a more relaxed regime (because many of the prisons we visited used their induction wings to house their prisoners on ACCT books[79]). However, these staff conceived the relationship between the prison environment and self-harm or SID as being about satisfying 'wants' ('luxuries') rather than 'needs'. The correlation between self-harm or attempted suicide and suicide was generally underestimated by staff in the four male prisons we visited: 'If men mean it [to commit suicide], they don't cut, they hang.' (Safer Custody staff). Self-harm was associated with manipulation more than genuine SID risk: prisoners who know that by 'doing silly little cuts' or saying 'I'm going to kill myself' prison staff are obliged to open an ACCT: 'the system opens itself up for manipulation' (Prison Officer). 'Most cutters won't commit suicide – they are just attention seekers' (Prison Officer). The complexity of SID risk for this group of staff lay in finding appropriate institutional responses to the problem of prisoners who were using self-harm or suicide risk to 'get what they want'.

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[77] We were told by some staff that they were not supposed to use this language. NOMS was reported to prefer the term 'goal-oriented'.

[78] A 'smoker's pack' contains rolling tobacco, rolling papers and matches.

[79] Some staff thought that this practice was problematic. See further Section 4, below, 'Managing Risk of Self-Inflicted Death'.

By contrast, this group of staff thought that the 'genuine' minority 'would do it [self-harm or suicide] anyway', without warning, or would deliberately mislead staff by behaving as if all was well. 'The ones who are most likely to do it [kill themselves] won't show any signs' (Prison Officer). 'If someone is genuinely going to kill themselves then they are not going to tell you. In fact they will often do the opposite of distress.' (Prison Officer). Many staff described being able to tell the difference between a 'genuine' and 'manipulative' prisoner through experience: 'You can tell a lot by what a prisoner asks for first. If all he is after is cigarettes, chances are that he's trying it on' (Manager). Some staff recognised that this sort of (manipulative) behaviour sometimes resulted in death, but these suicides were seen as the results of determined prisoner misadventure, which made them unpreventable: 'manipulators who take it too far' (Prison Officer) and prisoners who 'stand there with a noose around their neck waiting for you to check on them, then jump and hope you save them but we don't always get there in time' (Prison Officer). A minority of (more senior) staff described feeling 'courageous enough to resist manipulation' by not opening ACCT documents on these 'types' of prisoner though most acknowledged that this was a high risk strategy. Most wing staff in this group expressed a resented and begrudging acceptance that they should follow the process and open an ACCT even for those prisoners who they saw as 'just' manipulators.

The problem of prisoners using self-harm or threatening suicide for instrumental reasons was also recognised by staff who expressed a more nuanced approach to conceptualising SID risk. However, this group of staff described such behaviour as fairly rare and mostly motivated by satisfying 'needs' rather than 'wants', which ought to be taken seriously. Most staff in this group felt that the risk of a prisoner 'getting his own way' was unimportant given what was at stake: 'I'd rather be manipulated than stand up before a Coroner's Court and justify why I refused to give a TV to a man who told me he was in crisis' (Safer Custody staff).

## 3.2. What Do Prison Staff See As the Relevant Risk Factors for SID?

### Although identifying SID risk was difficult, because staff felt that most prisoners were in some senses 'risky', promising practice put prisoners in a 'big picture' context and looked for subtle changes in behaviour

How prison staff conceptualised SID risk shaped their views about relevant risk factors and their approaches to identifying them. Staff employing promising practice that was in line with literature on effective SID risk management reflected upon how changes to the prison environment might be influencing Safer Custody. The most common examples of risk factors stemming from the environment and mentioned by these interviewees were bullying and borrowing. Many of the interviewees in this group reflected upon how decreased opportunities for paid work in prison was driving prisoner borrowing to cover the costs of tobacco or drugs, which increased bullying and violence when loans were defaulted

upon and thereby increased SID risks.[80] Others talked about how the availability and impossibility of detecting new drugs such as 'Spice' was leading to new SID risks because prisoners did not understand the potency of these new drugs.

More experienced staff described SID 'warning signs' as reflected in both positive and negative changes in behaviour, encompassing in respect of the former an elevated and 'carefree' mood: 'It's like the weight of their pain has lifted off their shoulders' (Manager). Less experienced or non-specialist staff tended to focus mostly upon negative changes. These commonly included a prisoner not ordering canteen or giving away their canteen, poorer personal and cell hygiene, a disinterest in planning for the future (exemplified by no longer booking visits) and poorer interactions with staff. When conducting ACCT assessments and reviews staff described looking for evasive body language, poor eye contact and indications that the person 'is not planning for the future in any meaningful way' (Safer Custody staff). Staff identified high risk categories or triggers as including status change (from remand to convicted), first night in custody, receipt of a long sentence (described as upwards of eight to ten years), prisoners who had mental health diagnoses and prisoners who were being bullied. 'Situational triggers' were discussed by some staff, most commonly 'bad phone calls' or 'Dear John letters'. However, these were raised less often than the individual presentation factors described above and, where they were raised, it was more often by Safer Custody staff or managers than by wing staff.

Notwithstanding these indicators, staff reflected upon the difficulty of using them in practice because they thought that many prisoners were vulnerable and 'risky': 'It's hard because you can find signals for everyone. Most people are fairly low mood in prison – because they're in prison' (Prison Officer). 'Everyone has off days. That doesn't mean everyone's going to kill themselves' (Prison Officer). Some staff described the 'hard' cases where individuals had been 'well managed through the ACCT process, waited a few days after the post-closure review and then committed suicide' (Prison Officer). For this group of prisoners suicide was described as a 'determined effort' and staff generally felt that little could be done to help them. Our impression, informed by the literature,[81] was that some staff (particularly wing staff) overestimated the size of this group of prisoners, perhaps as part of a self-protective narrative that helps staff cope with being involved with SID (see further below at Section 6, 'Responding to Self-Inflicted Death').

### Age was not seen as a directly relevant factor for understanding or identifying SID risk. However, youth was seen as an indicator of immature coping mechanisms and of impulsivity that makes risk assessment more difficult

[80] The extent to which borrowing and bullying among prisoners, as reported as problematic by staff, varied considerably from site to site. Nonetheless, bullying and borrowing was mentioned in all establishments, except the female prison where borrowing was not mentioned.

[81] See particularly Liebling's typology of prison suicide, which suggests that the 'poor copers', the group for whom staff can do most to protect against SID, amount to approximately 45 per cent of the prison population. See further Liebling, A. and H. Krarup (1993) 'Suicide Attempts in Male Prisons'. London: Home Office.

Age was not seen by any of our interviewees as a directly relevant factor for understanding or identifying SID risk. This is consistent with the existing literature, which has not isolated age as a directly relevant or important variable in the prisons context.[82] Staff views were complex regarding age and its links to vulnerability. After some probing, interviewees were able to identify certain factors that may contribute to general risk. Younger prisoners were not seen to be a higher risk, *per se*, but may possess other vulnerabilities or risk markers (when comparing them with adults). Age was rather seen as an indicator of 'impulsivity', 'rashness' and 'volatility': this group was described as 'struggling to respond when they are told "no"' and 'wanting immediate gratification'. 'YOs are more impulsive, more rash' (Manager). Difficulties that young people were experiencing outside the prison walls were seen as imported into prison:

> There is an institutional loop for many of these young prisoners – care to custody and back again. It's a difficult population and it's a lot more complex from when I started 20 years ago […]. Now you have to consider the cultural or social context that they're coming from.' (Manager)

Staff identified a risk with some younger prisoners that difficult social backgrounds in the community can 'overshadow' and 'become overbearing' in custody. By contrast, they felt that this was less of a problem with older prisoners because they had had time to mature beyond the immediate circumstances in which they had grown up. Some staff described younger prisoners as coming into prison at points of great flux and developmental importance in their lives. Many life events were crystallising during their times in custody, some of which were described as having a direct bearing upon SID risk, such as mental health: 'This is a prime age for mental health issues to come out and coming to prison triggers a lot of this. Coupled with drug use, it's a tangled mess' (Manager). Staff described how 'boys' were learning how to become 'men' by reference to a 'false perception rather than real understanding of what being a man is' (Manager): 'They're still figuring out who they are and how to interact with others' (Manager). Consequently bullying was seen by many staff as a particular problem for younger prisoners, which generated additional vulnerabilities: 'Bullying is a real problem for this age group. Nobody wants to be the weakest so it creates a pool of exceptionally vulnerable young men' (Manager).

The consequences of this for SID were that younger prisoners generally were thought to have multiple vulnerabilities and their volatility made the assessment of risk more complex. Younger prisoners were also thought to have fewer, or less mature, coping mechanisms than older prisoners, particularly when confronted by an environment that is highly structured by rules, such as prison. Undeveloped coping mechanisms rather than age *per se* were seen as a risk factor for SID: 'It's harder for them to see the future, or a future beyond these walls […]. They haven't built up the same resiliency or ties' (Safer Custody staff). 'Younger prisoners are often not as confident in expressing their emotion and reaching out for help. They internalise how they're feeling, then explode, sometimes just over a bag of crisps' (Safer Custody staff).

[82] Ministry of Justice (2014) 'Safety in Custody Statistics England and Wales: Deaths in Custody to September 2014'. London: Ministry of Justice, p. 8. See also, Prisons and Probation Ombudsman 'Learning Lessons Bulletin: Fatal Incident Investigations, issue 6: Young Adult Prisoners', July 2014.

However, some staff reflected upon this also being true for some older prisoners. Age therefore was seen by some staff as less helpful and relevant to SID than maturity: 'We really need a flexible, responsive maturity test. There are some 24 year olds who I think need to stay with YOs and some 18 year olds who'd do better with adults' (Manager). There was recognition though, particularly among Safer Custody staff, that many younger prisoners have specific vulnerabilities and needs. The relationship between violence and vulnerability was seen as especially close among young offenders. Consequently it was seen by these staff as particularly important that violence and vulnerability should not be compartmentalised within the approach taken to Safer Custody for younger prisoners (see further below at Section 4, 'Managing Risk of Self-Inflicted Death').

## 3.3. How Do Prison Staff Identify Relevant Risk Factors for SID?

### Staff identified risk factors for SID through good information flowing into and within the prison

Reception was a key area through which information flowed into the prison. Staff showed us 'alert codes' on the computer record for each prisoner that indicated risks of self-harm or SID from previous stays in custody. Prison escort staff brought with each prisoner a 'Person Escort Record' (PER) and, where available, information about previous convictions from the Police National Computer (PNC). The PER included markers for self-harm and SID. Staff told us that previous convictions may be relevant to their decision about whether to put a prisoner on an ACCT or whether they could share a cell with another prisoner (known as a Cell Sharing Risk Assessment: CSRA). When appropriate opportunities for observation arose, we watched the collection of detailed and useful information about a person's familial, occupational and social background by healthcare staff during healthcare assessments in Reception. At some of the prisons we visited, informal information sharing agreements existed between Safer Custody Teams about transferring prisoners. Such practices thrived because of individual relationships rather than because of any formalised systemic enablement or support for them.[83] However, in what we observed, and in what staff described, there generally seemed to be a good level of potentially available information about self-harm and SID risk coming into the prisons we visited.[84]

Findings indicate room for improvement in how information relevant to risk is used, the quality of information gathered during the reception process and the extent of information sharing by healthcare. Based on interviews and observations across all sites, the key areas for improvement appeared to lie in how information was used and shared. In at least two prisons, some staff did not understand what the 'alert codes' meant and many staff highlighted delays in receiving PNC information. In some of what we

[83] We were told by some staff that they used to be able to look up the background of transferring prisoners in advance of their arrivals through C-NOMIS but this was withdrawn due to abuse. Some staff suggested to us that it would be useful to reinstate this facility but restrict access to Safer Custody managers to avoid any abuse.

[84] Such information included: present or persistent self-harming and/or suicidal ideation; familial issues or incidents; displays of erratic or worrisome behaviour exhibited during transport or in the courtroom; other stressors that may evoke anxiety or trigger self-harming. Although the amount of information was often substantial, Reception staff did not always connect it with other personal details, add it to NOMIS, or communicate it effectively to wing or Healthcare staff.

observed there seemed to be a lack of holistic thinking in how information was recorded, used and communicated. For example, during observations in one prison a PER was received that included healthcare markers for 'anxiety and depression'. Reception staff did not make provision for any specialist healthcare follow-up or information sharing with the induction wing despite these markers. Staff felt that this information did not require them to undertake further self-harm or SID risk assessment because the self-harm and SID risk box on the PER was blank. In the view of the research team, this information should have been communicated to staff on the induction wing to flag potential vulnerabilities. Conversely, because a prisoner had banged his head against the wall in the escort van, and had done so in the past before, an ACCT book was 'automatically' opened for him in Reception, despite him communicating clearly that his actions were caused by drug withdrawal.

At every site, to varying degrees, the detailed background information collected about each prisoner by Healthcare staff was not shared with prison staff, unless Healthcare staff decided to open an ACCT or send the prisoner to a detoxification wing. This was despite much of it being unrelated to the prisoner's healthcare. In some cases this was because Healthcare staff did not know how to share relevant information in a meaningful way and pre-existing systems did not facilitate information sharing:

> We don't spend enough time looking or just observing or trusting our instincts […]. We need better documentation and communication. If someone comes to me without shoes on, that's a problem and a warning sign. But who do I tell that to? (Healthcare)

In other cases wing staff who told us that they wanted access to more of the information collected by Healthcare said that 'medical in confidence' is used indiscriminately to prevent information sharing: 'We need to have more confidence to challenge the blanket ban of medical in confidence' (Prison Officer). Prison staff also reported that working alongside a legally distinct healthcare provider, with its own constraints, objectives and practice, can be an obstacle to information sharing because everyone is 'arse covering' and 'protecting their own kingdoms'.[85] Some Healthcare staff expressed similar frustrations that prison staff do not understand their role as care providers and, at times, do not facilitate their ability to deliver healthcare services.

This reported lack of information sharing between prison and Healthcare staff seems particularly problematic because of the helpful information we observed being collected and not shared and because there was a sense among some healthcare staff that they could collect better information relevant to SID from prisoners than uniformed staff. This was because Healthcare staff thought that prisoners generally felt more comfortable to 'open up' to them than to prison staff:

> Prisoners don't like to look or feel vulnerable in the presence of uniformed staff 90 per cent of the time. They'd rather break down in front of civilian staff like

[85] All prisons have commissioned healthcare services managed by external providers. For further information regarding healthcare organisation, services, and prisoner access to healthcare within prisons, refer to: http://www.justice.gov.uk/downloads/about/noms/work-with-partners/national-partnership-agreement-commissioning-delivery-healthcare-prisons2013.pdf and https://www.gov.uk/healthcare-for-offenders.

> me. You have to establish a good therapeutic relationship so the prisoner can feel comfortable feeling vulnerable. (Healthcare)

There was evidence from what was described to us, and what we observed, that effective practice in initial healthcare assessment could support open relationships with prisoners. Healthcare staff described effective practice as approaching each prisoner with individual care: 'Don't just read the healthcare assessment checklist; put it in a conversation' (Healthcare). Some healthcare staff described 'bending the rules' to ensure that their patients' immediate healthcare needs were satisfied as quickly as possible (and we observed instances of this in practice, such as a prisoner who was suffering heroin withdrawal symptoms who was given immediate priority and resources [drugs and personnel] were mobilised to provide immediate treatment to alleviate his distress).[86]

Our fieldwork suggests that Reception is therefore a critical area for information relevant to a prisoner's wellbeing to be gathered, processed and communicated and we have highlighted areas where information did not appear to be used or shared in ways that best support SID prevention. Our more general impression was that the importance of Reception to Safer Custody was not always reflected in the quality of the Reception area's environment or the professional orientations of its staff. One Prison Officer described Reception as 'an inherently dehumanising sausage factory'. We recognise that Reception is a particularly challenging area for local prisons because of the high numbers of prisoners they process but we observed significant material and cultural differences between the Receptions that we visited, including between the two local prisons that we visited. We observed some staff practices and attitudes towards self-harm and SID that seemed to reject the possibility of, or responsibility for, SID prevention; for example in one indicative encounter a member of Reception staff described prisoners on ACCT books as 'the rubbish'.

At some of the establishments we visited prisoners on ACCT were interviewed in rooms that provided little, if any, privacy. This is problematic for several reasons: prisoners described feeling uncomfortable disclosing sensitive information within earshot of other prisoners; and offices that did not offer privacy (either they were out in the open or in an office space where the door(s) were left open) were often used as walk-through spaces for staff, which meant that interviews were interrupted as staff walked through, picked up forms, or filed folders. This seemed likely to adversely impact upon the quality of information gathered during interviews and consequently the accuracy of risk identification and assessment.

### Prison staff universally identified staff prisoner relationships as the key to identifying and managing risk, and relevant 'jail craft' was learned through experience more than training

Beyond external sources of information, prison staff considered 'jail craft' (the knowledge, skills, expertise and judgement that prison staff acquire 'on the job') and 'knowing your prisoner' to be the most important mechanism for identifying self-harm and suicide risk. Prison staff universally identified staff

[86] The importance of using discretion in applying rules is echoed in the literature, particularly in analyses of best practice in Prison Officer work. See particularly Liebling, A., D. Price and G. Shefer (2010) 'The Prison Officer'. Cullompton, Devon: Willan Publishing, 2nd edition and Crewe, B., A. Liebling and S. Hulley (2014) 'Heavy-Light, Absent-Present: Rethinking the "Weight" of Imprisonment' *The British Journal of Sociology* 65(3): 387–410.

prisoner relationships as the key to identifying and managing risk. Relationships between wing staff (Prison Officers) and prisoners were seen as crucial: 'It's all about knowing your prisoners. It's hard to explain but you need to understand where they're at, what makes them tick, how they're feeling. You need to talk to them and be able to notice when something's not right' (Prison Officer).[87] Staff described experience as more important than training in learning these skills: 'You pick up the ability to sense if things are not right on the job' (Safer Custody staff). 'Prison Officers are experiential learners. They have real skill in understanding body language and interactions but this is sometimes seen as a bit 'pink and fluffy' so I think most are naturally reticent to describe their work and expertise in managing risk' (Manager). There was recognition among some staff that some deaths had been prevented because of 'luck' or a 'funny feeling', more than the use of any particular expertise, as in cases where staff have to recount their prisoners because the roll is incorrect and in the course of recounting discover someone attempting suicide.

### There was strong agreement that staff capacity to form and sustain high-quality staff prisoner relationships that supported SID prevention had been adversely affected by Benchmarking and New Ways of Working.

There was strong agreement across prison staff grades and functions that staff capacity to form and sustain high-quality staff prisoner relationships that supported SID prevention had been adversely affected by Benchmarking, New Ways of Working and under-staffing as a result of these combined changes and VEDS. These issues were universal to all prisons we visited, and were raised by interviewees without prompting. As one Manager put it 'I feel like saying "HELLO!" There aren't enough staff. It's a no brainer. I can't understand why we are all scratching our heads.' 'To be able to achieve what we need to achieve we need more staff' (Prison Officer).

Staff described the principal impacts of these new staffing constraints as that (a) there were too few staff, and (b) the staff who were present were less effective. Too few Prison Officers on wings meant that there was too much work to be done to allow for quality engagement with prisoners. As a Chaplain put it, 'Natural [SID] prevention is having a conversation but dialogue can no longer take place.' Expressing similar sentiment a Manager said:

> Constructive engagement and dialogue is what makes a difference. The New Ways of Working has massively impacted on our ability to engage with prisoners. There are too many blind spots on the wings and not enough staff […]. I do believe that every contact matters; I really do believe that […]. Staff are good at ACCTs but don't have time to have the conversations.

Staff also described staff shortages as enabling bullies to 'rise to the top', which they linked to increased violence and SID vulnerability.[88]

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[87] Although an over-reliance upon individual presentation in the face of documented risk factors also may be problematic. See further Section 4, below, 'Managing Risk of Self-Inflicted Death'.

[88] Ministry of Justice statistics support the impression of prison staff that violence has increased. Between June 2009 and June 2010 there were 175 assault incidents per 1,000 male prisoners compared with 182 between June 2013

New Ways of Working meant that wings in the publicly managed prisons that we visited had lost their dedicated Senior Officers. Senior Officers were now managing multiple wings and some staff described this as adversely affecting SID prevention because SOs had acted as a 'focus point for [ACCT] case management' on each wing and nobody had filled this 'gap'. In some establishments included in the research it was seen as no longer possible to resource Personal Officer Schemes,[89] which many wing staff and managers described to us as potentially useful and important for identifying and managing SID risk: 'The Personal Officer Scheme went with Fair and Sustainable. It used to be quite helpful actually for us because personal officers would pick up on things and do the case management entries on ACCTs for their prisoners' (Manager). At other establishments the Personal Officer Scheme had been retained but was described as fairly ineffective: 'All it really means is a couple of lines on a form every two weeks or so. We haven't got time to do anything more than that now' (Prison Officer). At one establishment, the face-to-face interaction prisoners would have had with their Personal Officers had been replaced by a paper application process: 'We use apps for personal officer work now and we get the night staff to deal with them. But they don't know the prisoners' (Prison Officer).

In response to our question about what change would most assist staff in preventing more deaths in custody, many staff asked for the time they need to do their job 'properly': 'Just the time to identify those in need or at risk is the problem. We are good at managing but not the identification' (Prison Officer). Some staff described an 'obsession' with ensuring that prisoners are out of cell: 'It's a case of unlock at all costs' (Prison Officer) and 'the regime is everything' (Prison Officer). These staff questioned whether this determination to run the prison according to the national 'core day' irrespective of local staffing constraints was helpful for ensuring that vulnerable prisoners were safeguarded:

> 'The [Prison] Service is so busy trying to do what they think helps prisoners that they forgot to ask what prisoners actually want' (Prison Officer).
>
> They're obsessed with prisoners being out of cell all the time. I'm not saying we shouldn't make sure they are out of cell for a good bit of the day but putting them behind their doors gives staff time to manage the ones that can't cope. Some of them don't want to be seen to be talking to staff or not coping in front of everyone else on the landing. We used to be able to have a private word with them when they were banged up and we'd be doing our fabric checks and searches.' (Prison Officer)

Finally, it is worth noting the practical difficulties that can be caused by low staffing levels in terms of responding to incidents of distress. In a small number of interviews as well as during visits to wings, staff reflected on the added challenges of responding to distress at times when there are reduced staffing levels,

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and June 2014. Equivalent figures for assaults on staff per 1,000 male prisoners were 34 in the year ending June 2010 and 40 in the year ending June 2014. See Ministry of Justice (2014) 'Safety in Custody Summary Tables to September 2014'. London: Ministry of Justice, spreadsheet 4 'Summary (Assaults)'.

[89] The Personal Officer Scheme provided each prisoner with a designated officer. This officer would take responsibility for their prisoners' care and progress, as well as answer questions, help to facilitate opportunities and access to activities and offer general support during their time on the wing.

for example at night and during lunchtimes. In one instance staff reported that nighttime staffing levels often left one prison officer with responsibility for up to 180 prisoners over two wings. This left officers feeling unable to deal with multiple incidents during these times. We also witnessed this difficulty in action at one prison, where a prisoner had requested to speak to a Listener during lunchtime lock up, but access to the Listener was delayed significantly because the single officer on duty could not unlock the Listener or distressed prisoner until another officer had been called from another wing.

### The problem was not just too few staff on wings but that the staff who were present were less effective than they could be because of inconsistent staff detailing, the use of agency or detached duty staff and low staff morale

Wing staff explained the problem was not just too few staff on wings with an unreduced workload but also that the staff who were present were less effective than they could be. Three key themes emerged from the data in this respect. First, wing staff were operating less effectively because they were being detailed inconsistently: too few staff meant that there was little predictability in where staff were working and this decreased opportunities for building relationships with a stable group of prisoners and identifying SID risks.

> You're lucky now if you're on the same wing so you can get to know your prisoners. I used to stand by the server and watch them coming down for dinner and I'd notice if one of them didn't make a cheeky comment. But now I don't know who usually makes cheeky comments – I don't know what's their normal so it's much harder to notice when something's up. It's so frustrating. (Prison Officer)

> Because of shift patterns there is no continuity any more. If I know a prisoner gets really stressed before he's released, and he's being released next Thursday, who do I tell? I can't tell anyone because I'm not sure who will be on detail and I don't even know where I'll be […]. Even though I know this prisoner – we've known each other for years – I can't honestly tell him that I'll be there for him or that he can come to me with his problems. It's really frustrating and it's not good for his wellbeing, or mine.' (Prison Officer)

Second, too few 'regular' wing staff meant that most of the prisons we visited had to rely upon detached duty and agency staff. This raised problems similar to inconsistent detailing in terms of discontinuity of care and lack of knowledge about individual prisoners. Detached duty staff were unable to access the computers in many of the prisons we visited so were unable to answer prisoners' questions. Detached duty staff were also seen less 'invested' in the prison and so would be less likely to 'go the extra mile' in being proactive about SID prevention: 'They just expect to do the basics: it's not their wing, it's not their prisoner' (Prison Officer). At some of the prisons we visited agency staff were used to do constant ACCT watches (of prisoners felt to be at such high SID risk that staff constantly observe and engage with them through transparent cell doors). Some staff told us that some of these agency workers could not speak English, which clearly affected their ability to engage and support prisoners in crisis.

Where staffing shortfalls were covered internally (rather than by using agency or detached duty staff), there was evidence that the areas from which staff were redeployed were adversely affected. Many Safer

Custody staff expressed particular concern about this because it had reduced their ability to do any proactive Safer Custody management (see further Section 4 below, 'Managing Risk of Self-Inflicted Death'). It was not always clear that redeployed staff had the necessary specialist skills to work on wings. In some cases redeployed staff were given responsibility for undertaking all ACCT checks on a wing but these staff had not received any specialist training. Some did not have cell keys so were attempting to hold a 'meaningful conversation' through cell doors. Finally, wing staff were operating less effectively because of low morale. Many felt 'burned out' and for some, this was negatively affecting their professional practice. Some staff had moved from a 'relational' model of working (centred upon meaningful engagement with prisoners as individuals) to a model that was much more 'transactional' (centred upon 'unlocking', 'moving', 'feeding' and 'banging up'): 'I don't have the pride or satisfaction in my work like I used to. I just turn up and leave now' (Prison Officer). This 'transactional' model of working is less likely to support SID risk identification because staff do not engage meaningfully with prisoners so do not recognise changes in behaviour or do not make themselves available to prisoners in crisis as a trusted source of support. For some managers the effects of recent policy changes and current circumstances upon staff practice were unsurprising. As one Manager asked, 'If staff are barely supported to function themselves, how can they take good care of prisoners?'[90]

[90] All three of these sentiments were expressed across each site in the present study, and to our best knowledge from other research projects, these experiences and circumstances are common to other prisons in England and Wales. There is mounting evidence that staffing shortages are linked to decreased safety and morale, and have been widely noted in HM Inspectorate Prison reports particularly over the past 18 months (refer to the most recent HMP Hewell HMIP report: http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/11/Hewell-web-2014.pdf). Several unpublished and forthcoming reports by the University of Cambridge Prisons Research Centre have highlighted the connection between staff culture, staffing shortages, perceived safety and quality of life for both staff and prisoners. A recent study led by Gail Kinman, Director of the Research Centre for Applied Psychology at the University of Bedfordshire, has found high levels of work-related stress and poor psychological wellbeing among prison staff. See: http://www.beds.ac.uk/news/2014/november/independent-survey-of-prison-officers-reveals-staff-totally-demoralised?utm_content=bufferba0cb&utm_medium=social&utm_source=facebook.com&utm_campaign=buffer.

# 4. Managing Risk of Self-Inflicted Death

In this section we examine the ways in which staff managed SID risks and by what kinds of mechanism. This chapter addresses research questions two and four. These are:

- What arrangements are staff aware of for identifying and managing SID risk? How well do staff think the processes are working? Are there any suggestions for improvement?
- Do staff understand what they should do if they have concerns about a prisoner? How prepared do staff feel about identifying, managing and caring for young adults at risk of SID?

Given the predominance of ACCT processes within our interviews we have divided the chapter into two sections. The first looks at **the ways in which SID risks were managed** in the establishments we visited, looking at ACCT as well as non-ACCT tools for SID risk management. The second section focuses specifically on the **role of ACCT and how this interfaces with other risk management mechanisms**.

Key Findings in this Section:

- With some notable exceptions, SID risk was generally managed reactively more than proactively. Among the staff interviewed, there was widespread underestimation of the potential for early intervention. ACCT dominated approaches to managing SID risks and few staff identified opportunities to work proactively.
- Prison staff described the impacts of too few staff and a lack of continuity in how staff were detailed as reducing capacity for proactive SID risk management and the quality of support ACCT could provide to vulnerable prisoners.
- Relationships between violence and vulnerability were thought to be particularly complex among younger prisoners and made risk assessment particularly complicated.
- Prisons and Probation Ombudsman (PPO) recommendations were thought to be 'too aspirational' by some staff. Staff were looking for an achievable model of good practice in managing SID risk that recognised the vulnerability of most prisoners and the constraints of the prison environment.
- Where staff described ACCT used at its 'best' (and as is consistent with prior research in this area), staff exercised professional discretion confidently but defensibly to tailor the process to individual needs and position ACCT within a suite of other risk management options.
- Where staff fear of blame for SID was high there was limited use of discretion by prison staff and a dependency on ACCT developed. Staff across most establishments suggested that many ACCTs were opened and few closed. In a majority of the prisons we visited staff felt that

there were too many open ACCTs and as a consequence of that, the quality of support from ACCT for prisoners that really needed it suffered.

- Effective practice, as it was articulated by staff and is supported by the literature, approached the ACCT process as a normative exercise in care, which required high levels of professional judgement, rather than a form of procedural compliance. ACCT was seen as one of a suite of other vulnerability management tools. Its purpose was not just to manage immediate crisis but rather to help someone in a long-term journey towards human flourishing.
- At its best, multidisciplinary collaboration during the ACCT process was seen by staff as a 'bio-social-medical model' in which holistic individualised care through communication and common goals were the collective objectives.
- Staff expressed frustration at having too little time for personalised, integrated care. Complex contractual relationships with other service providers in prison in some cases caused confusion and hindered collaboration.
- Where ACCT was seen by staff as one of a suite of other vulnerability management tools, this appeared to encourage more effective practice regarding the use of ACCT. This particularly included the use of prisoner support through Listeners and Healthcare Champions. Staff recognised some of the potential risks of ACCT for future vulnerability.
- There was general acknowledgement that managing the SID risks of some prisoners exceeds the limits of what ACCT and prisons can do or are resourced to do.

## 4.1. How, And In What Ways is SID Managed?

With some notable exceptions SID risk was generally managed reactively more than proactively. There was widespread underestimation of the potential for early intervention. ACCT dominated and non-ACCT vulnerability management options were generally underdeveloped.

Overall, our data indicated that there was a general focus on reactivity, rather than proactivity when managing suicide risk. There was a widespread lack of understanding about, or underestimation of, the potential significance for prevention and early intervention. Some staff were aware that prevention and early intervention could be managed (to a certain degree) through good quality work on the wings, primarily through staff-prisoner relationships, though this was strained under current working patterns (as discussed above in Section 3). Similar to Liebling's previous research findings, staff in this study did not feel especially confident that they possessed, or could easily acquire, skills in identifying and managing suicide risk.[91] Most felt uncomfortable or lacking in confidence when we asked them to articulate or

[91] See Liebling, A. (1998) 'Managing to Prevent Prison Suicide: Are Staff at Risk Too?' in Kamerman, J.B. (ed) *Negotiating Responsibility in the Criminal Justice System*. Carbondale, IL: Southern Illinois University Press, pp. 68–86; Liebling, A. and H. Krarup (1993) *Suicide Attempts in Male Prisons*. London: Home Office; see also Section 5, below, on 'Staff Training'.

discuss their expertise in identifying and managing risk. As a result, staff described managing SID risk largely reactively (to instances of threatened or attempted self-harm or suicide) and mostly by using the ACCT process. ACCT was seen as the only available 'official' technique available to prison staff in the direct management of SIDs, which appeared to promote a reactive orientation. Other management techniques, which are not explicitly suicide management techniques, such as bullying prevention and violence reduction policies, were seen by some staff as indirectly relevant to SID risk management owing to staff perceptions of a close relationship between SID and violence. There was considerable difference in the quality of SID risk management across the research sites. As we discussed above in Section 3, staff who focused upon an individual's characteristics, to the exclusion of environmental impacts, situational triggers and potential protective agents, viewed and managed risk in a procedural and limited way, with little scope for early identification or intervention: 'If someone is going to do it [commit suicide], they're going to do it. That's their choice and there's not much we can do about it' (Safer Custody staff). This relationship between understandings of risk and practices in managing risk has been highlighted in previous studies.[92] For staff who viewed prevention as part of 'the bigger picture', risk management was applied more holistically with some staff implementing resourceful and innovative strategies:

> Knowing your prisoner is the heart of everything; the heart of being an officer […]. You have to get to know what the real issues are – what matters most for that person. And the only way to achieve that is through talking and spending time with them. You can manage their risk by working together – ask the prisoner what would help him to cope better and go from there. (Safer Custody staff)

Although staff rarely described the approaches to their work described in the quotation above as 'interventions' or 'preventative', some promising practice strategies were being developed and exercised. Staff recognised these as innovative and useful tools for suicide prevention (in a context of limited and reducing resource for prisoner activity) and some of their ideas find support in the literature in terms of reducing incidence of SID and self-harm (see particularly in this respect Liebling's theoretical model in Appendix 1). 'Distraction packs', developed in one of the prisons included in the study, were one example of this. These packs were designed for prisoners on the basic Incentives and Earned Privileges (IEP) level (who therefore had a limited regime and possibly no television) or those identified as 'poor copers'. The packs included colouring sheets, word searches, and number puzzles designed to help those who may not otherwise have the capacity or capital to occupy themselves in their cell during lockup. The impact of these packs on reducing SID or self-harm has not been evaluated and we do not suggest that they are a substitute for more meaningful activities. Rather, this was a low-cost, low resource and creative intervention established by one prison's Healthcare team with an aim to 'provide an alternative outlet' for

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[92] Liebling, A. (1997) 'Risk and Prison Suicide' in Kemshall, H. and J. Pritchard (eds) *Good Practice in Risk Assessment and Risk Management Volume 2*. London: Jessica Kingsley Publishers, p. 200.

See also McDowell, A., T. Lineberry and M. Bostwick (2011) 'Practical Suicide-Risk Management for Busy Primary Care Physician'. *Mayo Clinic Proceedings,* 86(8): 792–800.

anxiety or boredom, and it appears promising if used within a wider regime aimed at promoting prisoner wellbeing.

Despite feeling strained and resource depleted – which was common among all prisons in the study – prisons that were judged by the research team to be implementing promising risk management practice attempted to engage vulnerable prisoners in a variety of ways, and understood that purposeful activity and 'keeping busy' were crucial in occupying prisoners' minds and bodies:

> Opportunities for prisoners to make meaning and the development of hope can massively reduce the numbers of those self-harming […]. These men are going to be our neighbours – let's be constructive now. (Manager)

These pockets of understanding of the potential for prevention and early intervention were primarily concentrated among some Safer Custody and Healthcare teams. Preventive strategies ranged from arts projects, to animal therapy, to other sensory programmes intended to calm and manage stress. Simpler, but still in our view helpful, strategies implemented by officers on the wings were typically oriented around ensuring prisoners prone to self-harming or 'acting out' from boredom were kept busy:

> I try to get them out [of their cell] whenever I can and give them something to do – even if it's basic, like sweeping, or mopping, or painting. It keeps them busy. It's when they're locked behind their door alone for long stretches that they often get stuck in their own head and it just magnifies everything. (Prison Officer)

### Prison staff described the impacts of too few staff and a lack of continuity in how staff were detailed as reducing capacity for proactive SID risk management and the quality of support ACCT could provide to vulnerable prisoners

As outlined in Section 3, a lack of continuity in staffing resulting from regular redeployment and New Ways of Working impacted all of the prisons we visited and at every level. For SID risk management, this was a particular concern for Safer Custody and Violence Reduction teams, who were often deployed from their posts to cover staff shortfalls elsewhere. Staff felt this made it difficult to make progress in their specialised roles, and made it more challenging to maintain close working relationships with other departments within the prison. In one prison this was reported to have had an adverse impact upon working relationships between Safer Custody and Healthcare: 'Since New Ways of Working we don't have the time to go to all the meetings and integrate properly' (Safer Custody staff). At another prison, Safer Custody staff rotated roles and posts within the prison, which created a sense of disjuncture and an inability to follow-up and follow-through with prisoners and their needs. One Safer Custody staff member noted: 'I never know what to expect day to day. I could be working on the wings, or deployed somewhere else to cover. It's very frustrating to me and to prisoners.' Having to cover other areas of the establishment, often at short notice, to help serve meals, unlock prisoners, or facilitate movements, made it more difficult for Safer Custody staff to follow-up with bullying victims and perpetrators, at-risk phone call actions, or referrals from unit staff or work areas.

Pro-active capacity for prevention management was reported by staff to be squeezed by low staffing levels and a lack of consistency from available staff adversely affected the quality of support for vulnerable

prisoners, resulting in poor attendance of ACCT assessments and low quality or inadequate ACCT observations: 'We've got willing people but we've not got the time to do it' (Safer Custody staff):

> Benchmarking gave us [number] safer custody staff, but as a unit of [number] res [residential staff]. So I have [number] staff who are doing the safer custody role but who don't want to do it, and aren't motivated to do it. I can have different staff morning and afternoon – and that's assuming I get them at all. (Safer Custody staff)

### Relationships between violence and vulnerability were thought to be particularly complex among younger prisoners

Part of the difficulty staff described in understanding, identifying and managing distress, especially with prisoners aged 18–24, is the complex relationship between 'bad behaviour' and vulnerability (see also Section 3.2 on the complexity of risk assessment in respect of younger prisoners). Some staff felt that the relationships and interactions between vulnerability, aggression and bullying were particularly complex among younger prisoners. Some staff felt that there was too little national recognition of bullying and its relationship with SID:

> National policies no longer recognise bullying, it's all been put under violence reduction because we don't want to use the term bullying any more. But it happens and it causes violence and self-harm and suicide risks. We've started developing a local initiative around interventions for perpetrators of violence and better support for victims. It's in its infancy but we hope it will drive down violence. (Manager)

Younger prisoners were seen as challenging, largely because of their immaturity and volatility, which meant that vulnerability could be conflated with aggression. One Manager remarked: 'They have a spiky nature and we need compassion and realism about the prisoners we are dealing with so we don't withdraw or stop engaging when the going gets tough.' There was widespread recognition that the task for prison staff of consistent engagement despite patterns of bad behaviour had become more difficult because of staff shortages, inconsistent detailing of staff and low staff morale.

Some prison staff at a minority of the prisons that we visited described a nuanced understanding of the links between violence and vulnerability. At these prisons staff, particularly Safer Custody teams, recognised the importance of violence reduction. This resulted in innovative and resourceful ways to address vulnerability that is manifested through, and results from, violence. Examples of such techniques involved peer mediation, mentoring, deconstructing behaviour patterns, and physical exercise like boxing or gym circuits to expend excess energy. Such techniques acknowledge that there is not a simple dichotomy between strength and vulnerability – young adult men are often both the aggressor and the victim.[93] As noted in Section 3, this dichotomy is partly bound up in perceptions among young prisoners about becoming 'men':

[93] See the Prisons and Probation Ombudsman 'Learning Lessons Bulletin' (July 2014) for a discussion on poor behaviour and bullying in and among young adult prisoners.

> You can't compartmentalise vulnerability and violence in safer custody, particularly with [young offenders]. They're still figuring out who they are and how to interact with others. They are boys who are trying to be men and mostly have a false perception rather than real understanding about what being a man means. They're not confident in expressing emotion and reaching out for help so they internalise things. Then sometimes they just lash out over really silly things, like a packet of crisps. That's when I need my staff to not just take things like that at face value. It might just be about the crisps but it might also be telling us something important about how that person's feeling and what he needs. (Safer Custody staff)

All of the male establishments in the study were in the midst of working out the best policy for how to house their young offenders when adults were also held in the prison. There was some evidence that the integration of young offenders and adults improved the behaviours of the young men ('The older guys act as a stabiliser' – Prison Officer; 'Adults won't put up with that nonsense – they are very good at challenging the lads when they're out of line' – Manager), which was described by staff as having indirect potential benefits for Safer Custody in respect of providing more mature role and coping mechanism models. However, this arrangement was not considered to be successful in all cases and several prisons were reviewing or revising their current housing schemes. In at least one prison, it was noted that the presence of young offenders on the wings was bringing the behaviour of adults down, especially for those on the cusp between young offender and adult. Each prison was having to address the particular needs of their distinct populations and consider whether separation, integration, or some combination of the two (depending on individual prisoner assessments) was the best fit. Young offenders were described as 'volatile', 'impulsive' and 'poor copers' in relation to adults. These characteristics, which present as SID risks, are managed via the integration of adult offenders with young adult offenders with the intention of neutralising these young adult risks. However, its measured effects by staff interviewed were mixed.

### Prisons and Probation Ombudsman recommendations were thought by some staff to be 'too aspirational'. Staff were looking for an achievable model of effective practice in managing SID risk that recognised the vulnerability of most prisoners and the constraints of the prison environment.

When asked about the recommendations provided by the Prison and Probation Ombudsman (PPO) in regard to managing SID risk, many staff did not feel that the suggestions were helpful. In some cases staff felt that they were 'too aspirational', which meant staff felt defeated, rather than assisted, by them. Staff preferred to have clear(er) and more achievable goals for risk-management. One interviewee summarised their view about the orientation of 'good' SID risk management as:

> You can't provide an environment where death is impossible – and even if you could, it wouldn't be humane. But there is lots that can be done to make death less likely even in the fairly bleak environment of a prison. (Non-Operational staff)

Some staff felt that PPO recommendations did not recognise the inherent and practical constraints imposed by the prison environment.

## 4.2. What Is the Role of ACCT and How Did This Interface with Other Risk Management Mechanisms?

### Where ACCT was seen by staff to be best used, staff exercised professional discretion confidently but defensibly to tailor the process to individual needs and position ACCT within a suite of other risk management options

Although the quality of implementation of ACCT varied across each research site (as described below), the ACCT document dominated the ways in which SID was managed. Generally, staff found the ACCT document and the associated procedures 'useful', 'a helpful guide' and believed that it was 'saving lives'. It was widely acknowledged that 'ACCT can't catch everyone' and 'some will slip through no matter what', though most agreed it was 'good for catching those who need extra care'. Staff described effective practice as using professional discretion with ACCT and tailoring the process to the needs of each individual, within a suite of other risk management mechanisms. In light of our underlying theoretical model, the research team shared this good practice perspective of interviewees. Staff who approached ACCT in this way thought best practice entailed confident but defensible use of discretion and professional judgement:

> It feels like audits push us away from individualising the ACCT process. They push a 'one model fits all approach' so we get criticised in our audit for not having family involvement or a chaplain involved in every ACCT review. But I'm not going to bring in a Chaplain when the prisoner has said he's atheist and doesn't want to see one. And I'm not going to bring in his family if they are the source of his issues or he doesn't want them there.' (Safer Custody staff)

> Some staff only engage with ACCT superficially. They just tick their boxes. I'd like to strip ACCT back to the basics, back to what really matters which is prisoner communication and engagement – making someone feel cared for and listened to; giving someone hope and confidence that things will get better. (Manager)

> A prisoner whose self-harm is due to temper or anger could be helped with intensive anger management rather than placing him on an ACCT which drains time and resources but does not address the fundamental risk. (Prison Officer)

### Where staff fear of blame for SID was high there was limited use of discretion by prison staff and a dependency on ACCT developed. This meant that many ACCTs were opened and too few closed so that there was insufficient support from ACCT for prisoners in greatest need

Less effective use of ACCT entailed little exercise of discretion, and treated the ACCT process as a tick-box exercise (a procedural approach). We found evidence of this across all prisons included in this study.[94] Staff describing the use of ACCT in this way expressed a (false) sense of security in the ACCT process: a

[94] This resonates strongly with Liebling's work on some of the detrimental potential effects of Inquests upon staff practice. See, for example, Liebling, A. (1998) 'Managing to Prevent Prison Suicide: Are Staff at Risk Too?' in Kamerman, J. B. (ed) *Negotiating Responsibility in the Criminal Justice System*. Carbondale, IL: Southern Illinois University Press, pp. 68–86.

belief that simply by having opened an ACCT document, that staff would escape liability or repercussions, should a suicide occur. The number of open ACCTs varied considerably from site to site, though three of the four male prisons had over 20 open during the period of fieldwork, which staff told us was (too) high.[95] Indiscriminate or 'fear-driven' opening and closing of ACCT documents was common to all prisons in this study, but the problem was particularly apparent in prisons where a suicide or inquest had occurred recently, or the Coroner's hearing was approaching. In these establishments, where fear of liability for deaths was high and staff did not feel confident in using discretion, a dependency on ACCT had developed. ACCT had become synonymous with defensibility ('should you get called to Coroner's Court you better have opened that book' [Prison Officer]) or as a tool to 'cover your ass' (Prison Officer).

According to some staff at a majority of the prisons we visited, ACCT had also become a 'substitute for mental health': 'At least you know that once you've opened it [an ACCT book] someone from mental health will have to come and see him'; 'Extra obs[ervations] serves as a reminder to us that he needs to be checked on more' (Prison Officers).

> ACCT has replaced staff on the wing. We used to have capacity to manage things on the wing, nip stuff in the bud without resorting to ACCT. But now because we haven't got the staff we just use ACCT as a way of saying 'this guy needs some help' but not necessarily because he's really suicidal or wants to self-harm. (Prison Officer)

ACCTs had also become a sort of 'quick fix' for behaviour management: 'We open ACCTs because we've got to be seen to be doing something and we haven't got enough time to deal with it now' (Prison Officer).

Staff identified a number of contributing factors as to why some prisons had a particularly high number of open ACCTs. The drivers of a high use of ACCT included a PPO rule that any previous self-harm or SID marker, irrespective of age and severity of previous incident, was to have an ACCT opened upon arrival into the prison. From our discussions with staff it would seem that this rule was not universally adhered to. Some prisons used greater discretion in applying this recommendation and made a point 'to understand the circumstances' of each prisoner by asking in-depth questions about previous incidents, the likelihood for it happening again, and assessing current feelings of wellbeing. As noted above, some staff felt such PPO suggestions were too aspirational and unrealistic in practice:

> Some of the PPO recommendations end up making ACCT a paper exercise – you don't have the time to do the process properly because there are so many ACCTs open […] Opening an ACCT on every prisoner with a history of self-harm coming through reception is a ridiculous recommendation. (Safer Custody staff)

One prison had established a blanket rule regarding prisoners entering with a domestic violence charge. Staff were required to automatically open an ACCT for these individuals, which resulted in large numbers

[95] There is little guidance as to the 'right' number of open ACCTs. The appropriate number will vary between prisons and over time. There are risks in both having too few and too many ACCTs open at any given time.

of ACCTs being opened, and often closed within 48 hours. Having so many ACCTs opened at once caused a negative impact upon quality – a 'dilution' of impact, as staff came to see it as 'just another ACCT'. In several of the prisons we visited, agency or Operational Support Grade (OSG) staff had been brought in to assist with the ACCT workload by, for example, observing prisoners on constant watches or undertaking regular interval observations. Although this freed up wing staff, the effectiveness and quality of ACCT management by staff who were unfamiliar with procedures and the prisoners in their care compromised the process, according to interviewees:

> To be honest some of the [agency] staff who come in to do our constant watches don't speak English and they hardly write anything in the paperwork because they don't really interact with the prisoner. The attitude seems to be 'well at least he is still alive'. (Manager)

In one prison under particular strain with the high number of ACCTs concentrated in their induction unit, two OSGs had been brought in to conduct the observations and keep the ACCT book entries up to date. Neither of these members of staff had cell keys, which meant that the prescribed 'conversations' that were supposed to be meaningful and engaging, had to be conducted through the cell door and without a full visual of the prisoner's cell.

Many ACCTs were opened and remained open due to a fear of closure. Staff were often uncomfortable making the judgement to close an ACCT for fear that it would have to be justified in the Coroner's Court 'and nobody wants that on their shoulders'. This meant that a number of individuals who did not pose an immediate or even moderate risk of self-harm or suicide were kept on an ACCT, thus continuing to cause strain on staff. A sense of 'exhaustion' and a 'desensitisation effect' when sitting through so many Reviews in a single day, or day after day was expressed by some staff:

> After a while you just can't care any more; you've exhausted your [mental] resources. That's not fair to the prisoners, and certainly isn't helping their quality of care, but it's the reality of the current climate. There are not enough of us to go around so we're pulling double-duty. (Safer Custody staff)

With high numbers of open ACCTs, the procedures often became meaningless or rote, with little attention to detail or quality of entry. A reliance upon the summary of ACCT on the National Offender Management Information System (NOMIS) rather than original source documentation developed as a way to save time, but as some staff recognised this caused the quality of their information to be 'watered down', and risked that critical details would get missed.

Fear of facing an inquest was a significant driving force for many staff when opening or closing an ACCT:[96]

[96] This fear of Coroner's Courts among prison staff has also been a strong theme in Liebling's work. See, for example, Liebling, A. (1998) 'Managing to Prevent Prison Suicide: Are Staff at Risk Too?' in Kamerman, J. B. (ed) *Negotiating Responsibility in the Criminal Justice System*. Carbondale, IL: Southern Illinois University Press, pp. 68–86.

> Do everything you can not to get in the Coroner's box. For some of us that means good practice, humane care and using best judgement. For some officers, they think that means ticking the ACCT boxes and that's it. (Manager)

> The Coroner's Court is frightening. I've been there before. I will open an ACCT on any self-harm. (Healthcare)

> It's daunting. You feel you are being personally judged so you can't help but worry about it. You've got five different lawyers all asking questions. Then you've got questions from the coroner and maybe the jury. And none of them know anything about what prison is really like. You come out of it feeling blamed and never wanting to go back there again. (Manager)

Staff who had been questioned in inquests described the experience as 'unnecessarily awful', 'daunting' and that 'it made me question everything I did, even when I knew I did the right thing'. A minority of staff who had been to Coroner's Court felt that the experience had been professionally developmental and that their practice had been shaped for the better:

> Every Prison Officer should go to a Coroner's Court because it would make some staff realise how inappropriate their attitudes are of thinking 'it will never happen to me'. It would make them realise the importance of taking those few extra minutes to do an ACCT properly and understand the reasons why we should do the things we do. (Prison Officer)

Many staff who had first-hand experience of Coroner's Courts, either from having to give their own testimony, or as a family or Coroner's liaison, recommended that exposure to the inquest process would be beneficial for training purposes:

> Every Officer should have to go to Coroner's Court [as part of training] to have that exposure and understanding of how procedures need to be defended. Then they'd get it. That's why we have these procedures – to keep us out of that box. (Safer Custody staff)

### Practice that appeared most effective approached the ACCT process as a normative exercise in care, which required high levels of professional judgement, rather than a form of procedural compliance. The purpose of ACCT was not just to manage immediate crisis but rather to help someone in a long-term journey towards human flourishing

In contrast to staff who viewed ACCT as a form of procedural compliance ('ticking your boxes will keep you out of the Coroner's box'), others saw ACCT as a normative (values-driven) exercise in care, a practice that was values- or humanity-driven ('you need to make the right and best decision depending on the prisoner'). Some staff expressed a moral imperative in opening ACCT, despite pressures from other departments or staffing groups: 'I don't care if it's more paperwork. I open an ACCT if it's the right thing to do. I know the officers don't always like that but I have to sleep at night' (Healthcare).

Younger staff without as much experience or developed 'jail craft' reported that they felt out of their depth and lacked the appropriate expertise to handle complex or challenging ACCT cases. Staffing shortages were linked to the inability of older staff to 'take the time and really show the new staff how it's done'

(Prison Officer): 'There's no time now for older, talented staff to bring the young staff on – to demonstrate best practice and give them something to emulate, a model to work to' (Non-Operational staff). Many staff felt unable to close an ACCT because the restricted prison regime did not allow opportunities for prisoners to progress and reduce vulnerability, or enable staff adequately to address the needs of those on an ACCT. One staff member noted:

> It's a self-perpetuating circle: the tighter the regime gets, the more people are put on ACCT, the harder it gets to do ACCT properly. The more serious incidents we have the more risk averse we become, the more ACCTs we have and the more support for real cases gets weakened. (Staff forum)

From our observations and in the view of many interviewees, it was apparent that there was an overreliance on ACCT and the false sense of security it provided had turned ACCT into a tick-box exercise for some; according to our theoretical model, such a procedural approach is less likely to promote effective SID risk management. As staff described, and in some cases as we observed, this reduced the ACCT procedures into vacuous or often meaningless exercises. The prevalence of ACCT had a tendency to displace the need for professional judgement through qualitative assessment and detailed engagement, as well as poor quality engagement with the document (through, for example, making vague or generic observational written entries or providing a poor written record of conversations or observations).[97] In certain prisons it was suggested that this audit or 'assurance driven' approach to ACCT was widespread and exacerbated complacency in staff:

> Lazy staff will always be lazy in their ACCT entries. They're lazy in their work so they're no different when it comes to ACCT. Some of their entries are shocking. (Manager)

This procedural orientation towards ACCT was described by several interviewees in a way that indicated some loss of humanity, or loss in understanding of the 'stakes' where an ACCT is opened:

> You just have to switch off and think about procedures. I know that sounds terrible, but it's true. I don't see a person there, I think, have I done everything I need to do procedurally to protect me and my staff. (Safer Custody staff)

> Deaths or near misses honestly don't bother me. I just think, don't die because it's a lot of work for me. If you choose to do it, it's on you – you decided to do it and it's not our fault. (Safer Custody staff)

> Our approach to ACCT is audit and assurance driven. We focus on how ACCT documents are completed, the process, rather than the outcome which is determined by the quality of interactions between staff and prisoners. (Manager)

> [A poor ACCT review is] one where the reviewer doesn't offer the prisoner any constructive help. They just use the review for information gathering and going

[97] The research team read through at least five ACCT documents at each site. We also discussed with staff at all sites how they record their observations and what kinds of details they include in their observations of, and conversations with, prisoners on ACCT.

> over old ground which results in unhelpful and sometimes inappropriate things being put on the Caremap, things that can't ever really be achieved so the ACCT can never be closed. ACCT reviews are supposed to be constructive, about moving forward not just going through the motions and writing any old thing down. (Safer Custody staff)

In general, the ACCT entries we witnessed or reviewed were quite poor, by which we mean they were often brief and of limited or no informational value. Staff provided us with examples of where the 'safety measures' that ACCT is intended to ensure had failed because of poor reporting or poor application of the procedures. One staff member recounted how a prisoner had been dead for hours in his cell from a ligature that was hidden behind his neck and under his shirt, despite the two rounds of evening 'observations'. Another example was given where staff had done two interval observations and noted both times that the prisoner was 'in bed'. It was eventually discovered that the prisoner had concealed a razor blade under his duvet and had been self-harming during the period of staff observation. These are more extreme than average examples, but nonetheless highlight the need for quality observations and vigilance.

More commonly cited examples of 'poor' ACCT entries included 'came out for breakfast', 'came out for tea', 'talked to another prisoner':

> It needs to be more of a story than an event – for example, did he eat on his own? Did he eat all of his food? […] Some staff are just going through the motions with ACCT without the care or urgency that is supposed to be behind it. (Manager)

Where practice was seen through our model as better, staff infused ACCT with values and mobilised it in positive and constructive ways, particularly as part of a suite of other vulnerability management tools. These staff saw ACCT not as an end in itself, but as a 'one tool in the toolbox of management strategies' and in a context of 'the bigger picture':

> You have to talk beyond the paperwork; find out what the real issues are […]. The ACCT book is a useful tool, but the value comes from conversation; from developing rapport and trust. That's when you get to what's really going on. From there you can work out the best plan for that individual. (Safer Custody staff)

> Going through the motions with ACCT should just about keep someone safe in the short term but it won't make someone better. It's only when you really take the time to use ACCT properly and identify someone's motivators and understand their background that you can use ACCT to move someone forward. We need to stop using ACCT in default mode, just to keep someone safe, and start using it more in enhanced mode, to work towards long-term improvement.' (Manager)

> Assessing is about getting someone to open up and give you information so you can identify issues. Then you've got to follow those issues through. I don't just fill in paperwork and leave it on someone's desk. I go and find the SO, talk to him and explain what needs to happen and why. If a prisoner is in crisis but is on basic and I think he needs a TV I'll say he needs a TV. (Safer Custody staff)

> ACCT is supposed to help with individual needs, but we have so many that this often works against the original aims of having an ACCT; the objectives have been lost and like so many other processes, this has turned into a tick box exercise without any real consideration of the person or their risk. (Safer Custody staff)

These staff recognised that ACCT was not just about stopping suicide; it was rather about going beyond the immediate crisis and getting someone back on their journey towards long-term improvement and what we might call 'human flourishing'.[98]

Staff described how these more promising practices were developed through professional confidence and a willingness to take ownership of decisions, as well as a normative understanding of why certain procedures were appropriate or a 'best fit' for the situation:

> The most important things for ACCT to be used successfully are consistency and ownership […] Officers need confidence in their decision and to feel that they've made the best decision possible for that individual. (Manager)

> Staff need to think about why they are doing things and realise that our responses can be escalated if need be, but we shouldn't go in all guns blazing when it's not appropriate […] We shouldn't be putting cutters or constant watches in anti-rip clothing[99] because cutters aren't ligaturing and we're constantly watching the others so we can quickly intervene if we need to. There's a tendency for some staff to go straight to the most serious response because then they don't have to think about it and they think that leaves them in the clear if something happens. It's easier and quicker to go to extremes than individually risk manage and justify your decision. (Manager)

> So long as the decision is defensible that's what matters. It may not be protocol but if it's the right thing to do then we should do it because the consequences of not doing it are probably much worse than doing it. (Manager)

Some members of staff who expressed discomfort with ACCT procedures or their need to exercise professional judgement when making such decisions, framed it in terms of trying to balance humanity and practicality with safety. Getting this balance 'right' was identified as one of the challenges of doing this work well: 'Staff are split in two really – on one side a human being and on the other a professional. They've somehow got to find a way to let both sides through' (Non-Operational staff).

### Staff identified tensions between healthcare and prison models of 'best practice' in suicide prevention

[98] Drawing upon, for example, Liebling's lecture to the Prison Phoenix Trust: 'Can Human Beings Flourish in Prison?' 29 May 2012: http://www.theppt.org.uk/documents/Can%20Human%20Beings%20Flourish%20in%20Prison%20-%20Alison%20Liebling%20-%20May%202012.pdf.

[99] Anti-rip clothing cannot be ripped or torn to make ligatures.

Interviewees and the research team identified some tensions between models of 'best practice' on the wings versus a medical or Healthcare orientation. One Manager exemplified this tension by describing a Healthcare model of Safer Custody as entailing more regular use of Safer Cells, segregation units (for self-protection, increased visibility of prisoners and the provision of a 'low stimulus' environment), and anti-rip clothing. Healthcare staff echoed this perception of differences in how SID risk is best managed, arguing that the Healthcare approach was preferable because it 'takes away temptation' and 'removes the physical focus for pain'. Staff expressed that a more effective approach was demonstrated by Officers and Managers who used 'common sense discretion' in thinking through the sorts of risk that are best managed through the use of Safer Cells:

> If I have a cutter, why would I put them in an anti-ligging cell? He's not at risk for ligaturing. This is just going to make him even more uncomfortable, and that cell could be used for someone who is truly at risk for stringing up. (Prison Officer)

### At its best, multidisciplinary collaboration during the ACCT process was seen by staff as a 'bio-social-medical model' in which holistic individualised care through communication and common goals were the collective objectives

As the name implies, 'teamwork' is core to ACCT. Interviewees mentioned a number of benefits and challenges to making ACCT processes multi-disciplinary. The benefits of creating an interdisciplinary team of professionals from around the prison to manage risk through ACCT were that it enabled a 'whole person approach' with 'more eyes and ears' on the prisoner and issues at hand. At its best, this model of working represented a 'bio-social-medical model' (a term offered by an interviewee from Healthcare) in which holistic care through communication and common goals were the collective objectives. Other prison staff described a similar model in a variety of ways, like 'a holistic approach', or as a process to 'address the mind and body'.

One example of promising practice highlighted by several interviewees across sites was the continued integration of the ACCT Assessor in the review process. Interviewees identified that a 'good' Assessor typically held the greatest amount of detailed and historical information about the ACCT prisoner from their initial and intensive assessment meeting. Thus, keeping the Assessor active in the ongoing review process enabled the team to reap the benefits of rapport and information gathering and sharing, as well as a sense of consistency for the prisoner. Where appropriate and beneficial, family input into the ACCT process (attending a review, supported forum or scheduling an additional visit to address pressing concerns or risk) was viewed as a strength, especially for the 18–24 year old age group who often had strong ties to parents (compared with older prisoners where links to spouses or children may be stronger).

Promising practice in ACCT teamwork also recognised that extended interdisciplinary inclusion was not always necessary or helpful. Rather, it was the quality of participants that was seen to make the difference. As one Chaplain explained: 'We don't bring in people just for bums on seats here. Only if there's a healthcare issue would we bring in healthcare. Equally, if the prisoner's CoE (Church of England) there's no point bringing in the Imam.'

Some of the challenges to making ACCT processes multi-disciplinary revolved around staff scheduling, availability, information sharing and the consistency in staff present for ACCT Reviews. In the three male

prisons in which we observed ACCT reviews, there was difficulty in 'gathering all of the players', especially Healthcare and mental health workers, who were often overbooked and many had to sit in on multiple ACCT reviews in one day.

### Staff expressed frustration at having too little time for personalised, integrated care

A lack of time was a recurring theme, especially as it pertained to the quality of care with ACCTs, from the initial Assessment, to the Reviews, to writing up notes and following up with prisoners. Everyone in one staff forum agreed that 'there is no time in our day for individualised care', which made some staff feel as though they were professionally compromised. A lack of time for personalised care was exacerbated by there being too few ACCT Assessors, stretching the few who were trained, able and available and causing delay between an ACCT being opened and the Assessment being completed. Some staff expressed frustration about the rule that anyone less than Band 3 can no longer be an ACCT Assessor.[100] Managers echoed this and noted that good staff were prevented by this rule from doing a good job; lower bands have more capacity and flexibility to do ACCT work and could therefore be an asset to ACCT management. However, many staff highlighted that there wasn't just a need for more assessors, there was a need for 'good assessors; those serious about this duty'. One Manager argued that selection for being an ACCT assessor should be based upon 'skill and motivation', which s/he felt was not currently always the case because of the band related restrictions.

### Complex contractual relationships with other service providers in prison in some cases caused confusion and hindered collaboration

Staff at a majority of the prisons we visited described complex contractual relationships – particularly in regard to Healthcare and mental health care – as impeding high-quality ACCT service provision. Prison staff were not sure who did what, who they could ask or which services are offered through which branch of the Healthcare department. There was some evidence of fairly high staff turnover and funding cuts in some Healthcare departments, which made it difficult for staff to keep up to date and have access to sufficient expertise. This also impacted on the quality and consistency of information gathering and sharing regarding prisoners, as well as a lack of continuity of care for those on ACCT (for example, a different or new nurse showing up to each ACCT Review). There were some instances of practice that appeared to be less effective where staff described the ACCT process as a 'game' between prison staff and the Healthcare provider in which each was 'waiting for the other to blink first and make the call that the prisoner needs to be put on constant watch because that dictates who picks up the bill for staffing the watch' (Safer Custody staff).

### Staff identified effective practice where ACCT was seen as one of a suite of other vulnerability management tools, which particularly included the use of prisoner support through Listeners

[100] The prison staff hierarchy is organised in grade bands from Band 1 (Cleaners) through Band 3 (Prison officers) to 11 (Governor grades). There is a general rule that to be an ACCT assessor you must at least be a Band 3, thus excluding Band 2 especially, which includes Operational Support Grade and support services staff.

### and Healthcare Champions. Staff recognised some of the potential risks of ACCT for future vulnerability

There was a general lack of confidence in using non-ACCT options, largely because of the fear generated from having a 'death on your hands' and the perception attached to it that an open ACCT would protect you from blame or responsibility. Prisons with practices seen by staff as more effective had developed a 'suite' of escalating management options, with an emphasis on an integrated approach. The development and use of these allowed staff to use their best judgement and professional discretion in applying 'what fits best for the individual': 'Good management comes from utilising resources from Chaplaincy, Gym, Healthcare. Identify the problems and then try to manage with common sense' (Manager). In essence, more effective practice adopted a Caremap or care plan with or without an open ACCT with a number of options for managing the prisoner's vulnerabilities. Examples of this encountered in the prisons participating in this study included a strategy that specifically tackled anti-social behaviour through interventions based in Safer Custody, arrangements for ACCTs in particularly complex cases were reviewed regularly by an interdisciplinary team, and vulnerability lists to alert staff and departments of those who may be at a heightened risk (though perhaps not risky enough to warrant opening an ACCT).

Other important mechanisms for managing risk in combination with ACCT were the use and deployment of prisoners as 'Healthcare Champions' and Listeners. All of the prisons in this study employed Listener schemes and many staff recognised the value of these positions. Positive working relationships between prison staff and Listeners were generally described by staff as a feature of prisons that were better placed to identify and manage SID risk:

> We've got a good group of listeners. Their conversations with other prisoners are confidential but they would trust most staff enough I think to drop a hint if there was a risk of self-harm or suicide. Just discretely, something like 'you're going to keep your eye on that one aren't you boss?' or 'I'd check in on him in a few minutes if I were you'. (Prison Officer)

Staff recognised that prisoners, particularly those who may be feeling anxious or in distress, may feel more comfortable talking with a peer. At best, Healthcare Champions and Listeners were strategically placed across the prisons (on each wing) and in key areas of the prison, such as Reception. They were used intensively during the induction process. Prisoners felt that Listeners were beneficial: 'I know where the Listener lives on my wing – I can request to see him any time. Staff are good about that' (Prisoner). Practice seen by staff as more effective in SID prevention enabled the discretionary use of Listeners to support high risk CSRA prisoners who were in crisis by putting two Listeners in a cell together with the high risk prisoner, using a Listener's suite. Where this was not possible the Samaritans' phone was used.

Healthcare Champions were used at a few of the prisons we visited and, much like the Listener scheme, these prisoners were widely believed to be an asset to staff and prisoners. Champions were positioned strategically in Reception and assisted in taking weight, blood pressure and other basic assessments. This allowed for a more casual and comfortable initial engagement with Healthcare, and Champions were able to have conversations with prisoners while assisting staff in other healthcare processes. This also enabled Champions to pick up on identifiers that staff might have missed, or didn't have access to (like picking up drug use through tracks, for example). Prisoner to prisoner contact was described by staff and prisoners as

fostering a unique rapport and offering a more sincere form of support because prisoners could say with real conviction 'I know what you're going through'. At one site, Healthcare Champions were able to earn a qualification that could be used upon release from prison, further 'professionalising' and legitimising this role.

Across all the prisons visited, interviewees described Listeners as integral to managing SID risk, and how they were systemically beneficial to staff and the regime. Staff were quick to note who the Listeners were on their wing and provide examples of how they assisted staff in identifying and managing risk. Listeners not only supported prisoners in need, but they were able to learn from each other and identify systemic issues that impeded access to care or services. At a Safer Custody meeting that we observed, two Listeners participated and identified 'what works' and areas for improvement. They expressed concerns that they were not always being let out of their cell (in part because of the fluidity of staff on duty as well as detached duty being unfamiliar with who is to be let out), that the Listener duty rota was not always adhered to (thus, some Listeners were being deployed more often and some were not having the opportunity to develop or share their skills), that there were too few Listeners for the prison and that Listeners were not well distributed across the prison wings.

As a whole and across the sites, Listeners were institutionally supported in their tasks through the provision of tea, coffee and, at times biscuits, to use when helping prisoners in need, though there was variation in the extent to which this was realised in practice. Staff and Listeners alike expressed concern about the difficulties they were experiencing (following staff cuts) in finding staff to facilitate Listeners. These difficulties were (described by interviewees and observed by the research team as) particularly apparent when a Listener is requested during lock up and there are inadequate staff to enable a prisoner to be escorted to the Listener's cell without calling for other staff to come from other wings. Some experienced Listeners were enthusiastic about doing more for other prisoners by, for example, running focus or discussion groups about such topics as emotional resilience, healthy relationships and managing anger.

### Some staff recognised the potentially negative impacts of being on an ACCT and adopted practices that sought to mitigate these risks

For some prisoners, there were potentially negative impacts of being on an ACCT. Some staff recognised that 'being put on the orange book' could increase stigma, ostracism or increased vulnerability, but the perceived alternatives were too few or inadequate:

> Putting someone on ACCT is saying to the whole wing that this person is suicidal. It can be isolating and sometimes pressurises that prisoner even further. But putting him on the ACCT is easier than not because we haven't got time to deal with it any other way and if something went wrong and you hadn't opened it then you won't have a leg to stand on. (Prison Officer)

Staff that were sensitive to these issues made an effort to 'use the orange book discreetly' in order to minimise its stigmatising effects: 'With this age group [18–24 year olds] in particular, additional markers of vulnerability – like being on the orange book – increases risk' (Safer Custody staff). We were told that these concerns are not formally addressed or recognised in national policy. Some staff recognised the risks

that perceptions of vulnerability for those on ACCT could cause for identifying and managing SID risk. These staff reported strategies such as attempting to keep ACCT books out of immediate sight of other prisoners, conducting ACCT interviews and assessments in private spaces, and attempting to conceal the orange folder when transporting it around the prison (though this was not easily achieved because the ACCT book does not fit into a standard sized envelope). Such staff recognised that 'some prisoners will tell you what they know you want to hear in order to stay off one [an ACCT] or to get off of one if they're already on it' (Prison Officer). Reduced staffing levels meant that staff felt that some prisoners in crisis might now feel unable to voice their concerns for fear of staff indiscretion: 'Staff don't have time to be discrete now so prisoners keep things to themselves instead of risking exposure' (Prison Officer).

### There was general acknowledgement that managing the SID risks of some prisoners exceeds the limits of what ACCT and prisons can, and are resourced, to do

A general concern expressed by staff at every establishment was that regardless of what procedures were in place, managing SID risk in some cases exceeded the limits of what ACCT and prisons can, and are resourced, to do. Prisons hold a disproportionately high amount of vulnerable individuals at risk for self-harming or suicide.[101] Specialist facilities within prisons are limited and in some of the prisons we visited staff felt that they needed more Safer Cells and more specialist equipment such as televisions in boxes that cannot be tampered with for those who tend to smash up their cell and self-harm. The research team encountered very complex, psychiatric cases in all of the establishments we visited, several of whom were awaiting beds in secure hospitals. Prison staff described to us delays in diversion to secure hospitals through sectioning due to a lack of beds in community psychiatric services. In the interim, staff attempted to make do with the available space and resources their establishments offered. However, this often led to areas of the prison being used as unofficial wings for the most vulnerable, in conjunction with other functions, such as induction or segregation.

For prisons where induction and vulnerable prisoners were combined, staff recognised that this impacted upon all incoming prisoners as they saw and cohabitated with seriously disturbed or harmed/harming prisoners. Staff described that seeing someone else harm themselves could lead to anxiety and self-harm, and undermined one of the aims of induction as easing prisoner anxieties and stress.[102] For the prisons in our study, using induction as this type of multipurpose function also undermined the message that prisoners were not allowed to stay on induction long term. This arrangement also created some anxiety for those who felt vulnerable but were 'not vulnerable enough' to remain in induction and were to be moved to the main wings. This was a precarious arrangement and although many staff believed this to be 'the best option given the circumstances', it did not seem ideal or sustainable, especially as the numbers of complex cases appeared to be increasing.

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[101] See further: 'The Mental Health of Prisoners: A Thematic Review of the Care and Support of Prisoners with Mental Health Needs' (October 2007), London: HM Inspectorate of Prisons; 'The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system' (April 2009), London: Department of Health.

[102] See Liebling, A. (2007) 'Prison Suicide and its Prevention' in Jewkes, Y. (ed) *Handbook on Prisons*. Cullompton: Willan, pp. 423–446.

# 5. Staff Training

In this section, we explore what light our data shed upon the role, nature and effectiveness of training for prison staff in identifying and managing SID risks. This section addresses research question 5:

- What training have staff had in identifying and managing prisoners who are at risk of self-harm or SID? Do staff feel this is adequate?'

The findings around training are organised under three headlines, relating respectively to the interaction between **work experience and formal training**; the **ACCT foundation training**; and **availability of Safer Custody training**.

Key Findings in this Section:

- There was strong consensus among interviewees about the importance of work experience to their ability to identify and manage SID risks but staff welcomed more and improved training.
- The content of current ACCT foundation training was described as too focused on procedure at the expense of mental health awareness.
- Staff felt that Safer Custody training was too infrequent, often curtailed because of staff shortages and delivered too much by way of presentation or e-learning rather than providing opportunities for discussion and reflection upon best practice.
- Prison staff suggested training could be improved by providing more focused mental health training as well as training involving role-plays and question and answer sessions.

## Experience is important but more training would be welcomed

Although many prison staff cited experience as more important than training for identifying and managing SID risks, certain staff, particularly those with specialist roles, emphasised the (potential) importance of training in equipping them with the necessary skills to prevent deaths in custody: 'Experience is the best training, but basic knowledge from formal training is necessary in the beginning' (Safer Custody staff). 'Nothing really prepares you for a suicide; it's training and experience that drives it all home' (Safer Custody staff).

There was a general perception among those staff who felt that training was important, that mandatory staff training in its current form was too limited: 'There is never enough training' (Manager). Many staff also thought that mandatory training emphasised the provision of control and restraint (C and R) skills and the security aspects of the job with limited time and resource invested in Safer Custody training or,

less still, in broader development training such as (as one Manager suggested) on desistance to support the 'every contact matters' agenda:

> I would say absolutely atrocious to be honest. We have our mandatory training that we have to do, the C and R and stuff like that takes precedence over everything. We try and do one-to-one training'. (Safer Custody staff)

In many instances we were told by operational staff that the only self-harm or SID-related training available to them was a limited and non-mandatory ACCT Foundation Course. This outlined basic ACCT principles and processes, including for example, the differences between an observation and a conversation and how to record actions and findings in an ACCT document. We were told that the course incorporated only limited mental health awareness training.

### The content of current training was described as too focused on procedure at the expense of mental health awareness

Staff felt that the ACCT foundation course mainly focused upon the procedural aspects of the ACCT process rather than identifying and managing SID risk more broadly:

> It seems to be much more about people making sure that they have followed procedure, and there is a lot of emphasis on that and I think even at Safer Custody meetings, a lot of emphasis is on the procedure, on adhering to the book rather than necessarily [doing what's right for that individual]. Which is different for us, coming from healthcare settings, because generally clinicians tend to work within guidelines and suggestions, rather than necessarily saying, 'Well, we must 100 per cent follow that protocol'. (Healthcare)

> Well, there's what we call the ACCT Foundation Training, which touches on this issue. But I think that's about it, really. And the ACCT Foundation Training is, as the name suggests; it focuses on the ACCT document and processes around ACCT. I don't think there's much other training, really, on suicide prevention and on how to recognise those signs. (Chaplaincy)

Within this procedural focus, some training staff expressed frustration that ACCT and CSRA training manuals had not been updated since 2011. Staff across several establishments also asked for clearer communication through ACCT guidance documentation about the differences between versions of ACCT and rationales for any revisions. While some staff felt that the fifth version of ACCT was an improvement upon the fourth, other staff were unsure about whether they had understood the changes to mean the same thing as staff at other establishments: 'this defeats the purpose of standardisation in practice and protocols – we may be interpreting these revisions differently than other prisons' (Manager). Certain staff, particularly more senior and Safer Custody staff, felt that the procedural orientation of ACCT training inadequately emphasised the 'impact' and 'aftermath' of deaths in custody:

> We are in charge of lives here and it doesn't stop with death; lots of people are affected after the fact, and some for a long time. […] Our actions have a knock-on effect; it impacts on lives on the outside too and I think some staff aren't as aware of this as they should be. (Manager)

Many prison staff felt that too little information was given about mental health awareness and management in the ACCT course. This was seen by staff as an important omission because they identified mental health problems as one of the common characteristics of prisoners at risk of SID. Some staff reported feeling unsure about 'what mental health looks like'. At some of the establishments we visited staff expressed a lack of confidence in when and how to obtain mental health input from specialist healthcare staff. Training could provide a useful opportunity for solidifying confidence and good practice in this respect.

> […] if you spoke to someone with Asperger's or ADHD, they [prison staff] are not going to know what it's about. Very few will know, unless they've dealt with it personally. That's a failing. I think there should be more mental health training, especially for this group as well, and drugs, the drugs that are coming through now. I'm not saying they're all in here, but they've been used to drugs from an age of, I don't know, 12/13, and drink. It all manifests itself in this damaged mind-set. No, I think we've still got a lot to learn about mental health.' (Safer Custody staff)

Some staff also reported feeling underprepared by their ACCT training for what to expect after a SID: 'I don't think there's enough training given to staff about the process and what's going to happen [after a SID]' (Manager). This can cause confusion, as in this example that an officer shared with us: an officer was surprised that she was prevented from going anywhere near the cell of the deceased prisoner even though the body had been removed by a medical team. This prison officer felt that such confusion could have been avoided by more thorough preparation through training for what happens after a death in custody.

### Staff felt that Safer Custody training was too infrequent, often curtailed because of staff shortages and delivered too much by way of presentation or e-learning rather than providing opportunities for discussion and reflection upon best practice

Beyond the content of foundational ACCT training, within interviews prison staff regularly described the frequency, duration and mode of delivery of the ACCT foundation course as problematic. Staff across all of the prisons we visited told us that they formerly received foundation ACCT training every year but now received it just once every three years. Interviewees also reported difficulties in being able to attend training because of staff shortages. In some cases, we were told that this had led to the cancellation of scheduled training sessions:

> Training is a big issue. Again, it depends how many staff are available to go on to the training. […] Safer Custody is not mandatory training. So the mandatory training, C and R and […] is it fire? I think they're the mandatory ones. So they generally take precedence over the Safer Custody training. But we do what we can. (Safer Custody staff)

When staff are able to attend training, we were told that the course was compressed from four to five hours to one or two to enable them to return to their normal duties as soon as possible. Staff reported that the curtailed format of training displaced opportunities for discussion, peer learning and reflection upon

good practice. Some felt that this was compounded by how the course was delivered. Staff described 'death by presentation' and an emphasis upon 'e-learning', which some staff described as 'a waste of time':

> The latest craze is e-learning so they do it all through a computer, which isn't my way of learning at all and it's not a lot of staff's either. [Interviewer: Why is that?] Because it's seen as a tick box. They don't read it. There are no quizzes. There's no comeback. There's no way of asking questions if they don't understand anything. (Prison Officer)

> You've also got training on the computer, which is called e-learning, which is how a lot of our training has now gone and personally I think it's a waste of time. I don't think doing an hour course on a computer is beneficial to me because I'll get bored, the phone rings, and in the end I just go through it lip service when actually by talking to somebody I'm learning from real experience and they've got my attention. (Manager)

Many staff felt that role-play in their ACCT training would be more useful, as would discussion so as to share concerns and best practice by reference to concrete examples, including of where things went wrong. 'Staff have good skills but sometimes lack life skills [particularly new and young staff] – role-playing in training would help these kinds of interpersonal skills to strengthen' (Manager). The Family Liaison Officer (FLO) training course was praised for its simulation of real life scenarios with professional actors. Some FLOs suggested that it might be a helpful model upon which to develop ACCT training. While some (induction) wing staff had chosen to undertake additional training in their own time, such as in adult care through the Prison Officers' Association's (POA) 'Learning' department, this was not common amongst interviewees.

Some of the staff we spoke to had volunteered to be ACCT assessors alongside their regular roles. We were told that ACCT assessor training goes beyond foundational ACCT training in including instruction about how to undertake an interview assessment of a prisoner who has been identified as being of heightened risk of suicide and 'level 2' mental health awareness training. In common with ACCT foundation training, ACCT assessors asked for more regular refresher training than every three years as is current practice. They suggested that refresher training should be held annually to enable current issues to be discussed, such as the implications of Spice for Safer Custody, and new ways of assessing and supporting prisoners to be shared:

> The last ACCT training I did was probably, realistically, about seven years ago. It doesn't say you have to be refreshed every year, you just have to be trained, that's the issue. Whereas I personally think case managers and stuff like that should be trained, should be refreshed every year or so. The same with staff, the foundation courses and stuff. ACCT awareness should be done at least once every year I personally feel, but it's not being done. (Safer Custody staff)

Due to the infrequency with which assessor courses were held, staff reported that they were often booked up quickly. Some non-assessor staff questioned why ACCT assessment training was given only to those with specialist roles. They felt that there would be benefits to all staff having ACCT assessment training: it would provide them with skills that they used and needed in their everyday work and having more ACCT

assessor trained staff would avoid detailing problems and delays in getting assessments completed for prisoners identified as being at risk of SID or self-harm.

# 6. Responding to Self-Inflicted Death

In this section we present findings about how prisons respond to SID and the availability of staff support. This addresses research questions five and six:

- Do staff know how to access support? Is staff support adequate?
- Where staff have direct experience of SID, what happened, what lessons were learned and what changes, if any, were made to operational practice?

We have organised the data in this section along two lines, first looking at **institutional responses** to SID in custody, and then examining participants' accounts of **individual responses** to SID, including personal experience of SID and participants' experiences of other staff responses to SID.

Key Findings in this Section:

- Deaths in custody can adversely affect future management of SID risk. Staff described a more 'defensive' professional and institutional reorientation and an erosion of confidence following a death in custody, stemming particularly from their fear of inquests. This adversely affected the ability of staff to provide high-quality support for vulnerable prisoners.
- At best SIDs were seen as catalysts for reflection and changes to practice that made suicide prevention more likely. Adequate support for staff in preparing for inquests was identified as important in securing positive oriented learning experiences from deaths in custody, though some 'straightforward' lessons from inquests had not been learned.
- Being involved with a death in custody has significant impacts upon the emotions and practices of prison staff. Staff can feel unfairly blamed 'when things go wrong' and unrecognised for their successes in preventing deaths.
- Many prison staff preferred to find support from colleagues rather than the Staff Care Team following a death in custody. Some questioned whether a Care Team of peers was the right form of support. There are risks for future suicide prevention where staff become hardened or disengaged by exposure to death.

## 6.1. Institutional Responses

### Deaths in custody can adversely affect future management of SID risk

SIDs have profound impacts upon the prisons in which they occur often resulting in what staff described as a 'defensive' professional and institutional reorientation and an erosion of staff confidence. There are

risks that experiences of SID can negatively affect a prison's capacity for future prevention. This is because the 'trauma' (Manager) of SID can result in its poorer future management. As Chiswick et al. noted in 1985, the institutional anxiety caused by SID can make it more likely that the prison will experience another death in custody:

> They [deaths in custody] tend to follow a pattern: after the first one or two incidents, both staff and inmates become sensitive to the possibility of suicidal behaviour; staff anxiety rises and leads to increased surveillance and security, which may be counter-productive; among inmates, the initial shock gives way to an acceptance of self-injury and suicide, so that at times of stress it becomes a more likely reaction.[103]

The potentially negative institutional impacts of SID were emphasised in the data from this study. Staff described negative changes in the general prison climate following SID: 'Any death affects the tone of the prison. It becomes quiet and flat' (Non-Operational staff). More significantly, staff described a more 'defensive' professional and institutional reorientation and an erosion of confidence following a death in custody, stemming particularly from (staff fear of) inquests. In some of the prisons we visited this had led to the adoption of local Safer Custody policies such as mandatory rules about opening ACCT books for prisoners with particular convictions (such as for domestic violence). In other cases similar mandatory rules had resulted from recommendations from the Prisons and Probation Ombudsman (PPO) (such as for prisoners with any marker of previous self-harm or suicide attempt on their record – however isolated or historic).

Despite good intentions, there was no doubt among the staff with whom we spoke that such policies and 'over cautious' practices had contributed significantly to the proliferation of open ACCTs, with the resultant diminution in their quality (as described above, in Section 4). The potential for positive learning from deaths in custody and inquests seemed weakened where recommendations or findings made by the PPO or Coroner were seen as inappropriate, unrealistic or a reflection of being poorly informed about the 'realities' of prison life: 'We are sometimes the victims of our own stupidity – not doing things, or more often documenting things, that we should have done. But other times the PPO overplay the significance of their recommendations. They have to be seen to be doing something' (Manager).

### SIDs could act as catalysts for reflection and changes to practice that made SID prevention more effective. Adequate support for staff in preparing for inquests was identified as important in securing positive oriented learning experiences from SID

At best, SIDs were seen by prison staff as catalysts for a process of thorough, institutional-level reflection upon processes and practices, which supported change that makes suicide prevention more likely. There was some evidence of this in our data, though this narrative was more common among Managers than

[103] Chiswick D. et al. (1985) *Report of the Review of Suicide precautions at H.M. Detention Centre and H.M. Young Offenders Institution, Glenochil, Edinburgh*. London: Her Majesty's Stationery Office, p. 16. For further research on 'suicide contagion', see also: Cheng Q., H. Li, V. Silenzio and E. D. Caine 'Suicide Contagion: A Systematic Review of Definitions and Research Utility.' *PLoS One*. 2014 Sept. 26 9(9).

Prison Officers. In response to a death at one of the establishments we visited, the prison had overhauled its support framework for vulnerable prisoners, which included measures to address anti-social behaviour and bullying (a significant risk factor identified by both staff and prisoners for SID, see further Section 3). First Line Managers[104] were being retrained and mentored and a new system for qualitative analysis of ACCT paperwork had been developed to locate strengths and weaknesses in how SID risks were being identified and managed, and how practice could be improved. A new requirement for mandatory input from a healthcare professional had been instated for all first ACCT reviews.

Some staff, particularly Safer Custody staff and managers, reflected upon the potential for improved practice through staff attending inquests:

> Once staff have gone to an inquest it makes them more conscious about the quality of written evidence and its importance. Too many times I've heard coroners describe entries that are inadequate […] for example looking through the spy hole and just writing 'on left hand side'. Then the coroner thinks well was he breathing? Was he moving? They should write something like 'no movement, tapped on glass, got a response'. (Prison Officer)

> When I do risk work now I'm more cautious about explaining exactly what I'm doing and thinking because I know I won't be able to remember it 1 or 2 years on and be able to justify my actions. I check things now, and then check them again (Manager)

These more positive oriented learning experiences were seen as more likely where staff were adequately prepared and supported for their appearances at Coroner's Courts. In some of the prisons we visited Safer Custody departments or Staff Care Teams provided staff with pre-inquest booklets and training about what to expect and how to behave during inquests. Certain managers we interviewed reported organising visits to Coroner's Courts to prepare staff to give evidence and to allay their fears:

> I also arrange a visit to the Coroner's Court, to the main court, to go and let them [staff] see it because it is quite daunting to walk in there. I mean the first time I opened this orange door I was like, 'Oh my', and I'd been in a Coroner's Court twice. So from personal experience I knew about it but actually going into this one […] was like – it takes your breath away really because it's so vast […]. What I do is I take them around the court first of all, so we go and see the jury room, we go and see where the family sit, we go and see where our counsel and we will be based for the duration of the court […]. Then I take them into the court and I allow them to go anywhere and everywhere in the court, so no area in that court should hold any fear for them at all. If the coroner instructs the jury to go to the jury room they know what the jury room looks like, what their surroundings are like and what's expected of them. I let them sit in the coroner's chair if they want to and go and see his rooms at the back, and so, again, nothing's out of bounds to them. (Manager)

[104] In this context, FLMs work regularly with prisoners and represent the initial point of contact in the management system including middle and senior management. Their primary responsibility is to ensure safe and secure environment and translating local safer custody policies (IEP and violence reduction strategies) into practice.

Inquests were nevertheless challenging for all prison staff. Interacting with the family of the deceased was particularly challenging in some cases:

> I've had a member of staff and their partner contact me and say that they were concerned for their safety […] I've never known it before. I've always known we've been to court and we've shown our faces, names, and all the rest of it, but obviously if there's a lot out there on Facebook and in the media and that this person is particularly at risk because they live [near] the family. (Safer Custody staff)

Staff shared with us examples of where families and prison staff had overcome difficulties by better understanding each other's situation. In one case, the family of a deceased prisoner was described as 'coming over to shake the hands of prison staff by the end of the week'. In another case, the mother of a deceased prisoner maintained a close relationship with a member of prison staff who facilitated her laying flowers in the prison chapel each year to mark the anniversary of her son's death. The ability of prison staff to face and manage these sorts of relational challenges following a death in custody, and their perceptions of support and training in managing these difficulties, seem to us to be relevant in thinking about the responses of institutions and their staff to SIDs.

### There was nevertheless evidence across all prisons we visited that some 'straightforward' lessons from inquests had not been learned

Notwithstanding some evidence of positive change to practice following inquests, there was some clear evidence, and frustration especially among Managers, that some staff, particularly wing staff, were not learning 'pretty straightforward lessons' from inquests. The most commonly cited examples of this were poor ACCT book entries or staff not documenting their interactions and observations at all:

> It's like the prisoner sleeps on a rotisserie because he used to lay on his front, lay on his side, lay on his back, lay on his other side. (Manager)

> If it's not written down then it hasn't happened. Staff need to think about what they're writing; ask themselves if a stranger picked up the file tomorrow does what they've written reflect care? (Manager)

## 6.2. Individual Responses

### Being involved with a death in custody has significant impacts upon the emotions and practices of prison staff. Staff can feel unfairly blamed 'when things go wrong' and inadequately recognised for their successes in preventing deaths

We know from the literature, as well as from what we observed and had reported to us during fieldwork in this study, that witnessing SID, self-harm and violence is a too common occurrence in the working lives of many prison staff.[105] This affects the emotions, attitudes and behaviours of staff:[106] 'If you didn't

[105] Bennet, J., B. Crewe and A. Wahidin (2008) *Understanding Prison Staff*. Cullompton, Devon: Willan Publishing.

feel the impact of what you do, you wouldn't be human' (Manager). 'Repeated exposure to death doesn't make you used to it – staff are traumatised every time' (Safer Custody staff).

When prison staff feel, with the benefit of hindsight, that they could have done more to prevent a SID and thus feel culpable, this can have a deleterious effect on officers' wellbeing and subsequent work behaviour. Based on her previous empirical research, Liebling observed that:

> Staff perceptions of their own accountability in inquest situations can leave them feeling defensive, resentful, and exposed. Officers have long memories, and perceived injustices or instances of unfair criticism in a public arena may reduce their behaviour to an obsession with procedures.[107]

Effective and timely support for staff who have been involved in managing a SID is therefore ethically important as well as important to ensure that future professional effectiveness in SID prevention is not undermined.

Prison staff generally reported high levels of personal resilience following deaths in custody, 'near misses' or incidents of self-harm. However, beyond the immediate aftermath of an incident, staff identified inquests and the lead up to them as particularly difficult periods. The delay of one to two years between a SID and inquest was described as unhelpfully 'hanging over' prison staff. Once an inquest date is announced, emotions and memories that staff have repressed as part of their coping strategy were described as 'resurrected': 'Inquest dates bring suppressed memories and experiences back to the fore' (Staff Care Team). Staff described to us struggling with feeling that they are made responsible through inquests for a wide array of complex individual cases for whom prison is the 'end of the line': 'We have to deal with the results of all of society's screw ups' (Safer Custody staff). Staff expressed frustration about society 'not thinking about rehabilitation and safety holistically', using prison 'unnecessarily' (such as 'for a £1 confiscation order') or in ways that are inappropriate because of a prisoner's healthcare or social needs. The 'invisibility' of the prison's 'best' work and a lack of recognition of 'success' in suicide prevention were sources of further frustration:

> Literally all the time we are preventing suicide. We actually do it extremely well and I don't think that's anywhere near widely enough recognised. You never hear of the success stories. You only ever hear of the failures. Our staff are very good at preventing suicide. (Chaplaincy)

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[106] Crawley, E. M. (2004) 'Emotion and Performance: Prison Officers and the Presentation of Self in Prisons' *Punishment & Society*, 6, 411–427. See also a recent study led by Gail Kinman, Director of the Research Centre for Applied Psychology at the University of Bedfordshire, which has found high levels of work-related stress and poor psychological wellbeing among prison staff. See: http://www.beds.ac.uk/news/2014/november/independent-survey-of-prison-officers-reveals-staff-totally-demoralised?utm_content=bufferba0cb&utm_medium=social&utm_source=facebook.com&utm_campaign=buffer.

[107] Liebling, A. (1998) 'Managing to Prevent Suicide: Are Staff at Risk Too?' In Kamerman, J. (ed), *Negotiating Responsibiity in the Criminal Justice System*. Illinois: Southern Illinois University, pp. 68–86 at 81.

### Many prison staff preferred to find support from colleagues rather than the Staff Care Team following a death in custody. Some questioned whether a Care Team of peers was the right form of support. There may be risks for future suicide prevention where staff become hardened or disengaged by exposure to death

In locating support all staff were aware of Staff Care Teams[108] but many reported choosing not to engage with them at all, or only to a limited extent. For some staff this was because they found support in their colleagues[109] or in other prison staff, particularly chaplains. Other (particularly wing) staff reported that this was because they were unaffected by SID and therefore did not need help: 'he's not a family member, he's just a number' (Prison Officer).

> There are official areas for staff support but I don't need it really. I know it sounds cold but I've just learned to switch off. When someone dies they just become the trigger for a process and lots of paperwork for me. You've just got to get on with it, get the job done. (Safer Custody staff)

Showing this kind of disengagement might lead to poorer future practice in risk management through hardening attitudes that may displace care and values-driven engagement with mechanisms through which prisoners are supported, such as ACCT.

Engagement with Staff Care Teams was reported more among non-uniformed prison staff than uniformed staff. While some staff indicated that their non-engagement with Staff Care Teams was due to not requiring support or preferring other avenues for support, such as from close colleagues, other interviewees indicated concerns about the confidentiality and quality of the service provided by Care Teams. Some members of Staff Care Teams acknowledged the influence that their approach could have upon the level of staff engagement with their services. The importance of appearing neutral and respecting confidentiality were emphasised: '[Staff Care Teams] need a proven record in retaining the confidence of staff because their confidence in you is the most critical barrier to them coming to us for help' (Staff Care Team). Some members of Staff Care Teams felt that they needed more training to support staff more effectively:

> At the moment there isn't actually a sort of up-to-date care team training package. It's basically just standard care team training. So it's more aimed for new members. So at the minute there isn't sort of any refresher training. I mean it's quite a long time since I did my original training so to offer a refresher package I think would be really good. (Staff Care Team)

Some staff questioned whether a peer led support service was appropriate, suggesting that a fully professional service, independent of peers and the Prison Service would be better as speaking with professionals 'gives you a legitimate right to fully offload' (Prison Officer). Other staff felt that

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[108] Refer to Prison Service Order 8150 (pso_8150_post_incident_care_for_staff.pdf) for a full description of the role of Staff Care Teams. These teams are responsible for incident aftercare for all staff. They make available confidential debriefing, general support and follow-up, as well as referrals to Occupational Health and counselling services.

[109] This finding is common to Kinman et al.'s recent study in n.106, above.

notwithstanding the institutionalisation of Staff Care Teams across the Prison Service, there was a lack of support for staff in practice following a death in custody. Some staff said they were expected to carry on with their jobs with limited or no practical support (e.g. taking the shift or day off to get over the event, and then returning to work as usual) as if they should not feel affected by the death.

# 7. Towards a Model of Better Practice?

In this section, we close the report by summarising areas of **promising practice** that staff identified as effective in understanding and managing SID risk. Subsequently, we review **areas for improvement** that staff raised, with reference where relevant to staff suggestions outlined in previous sections of this report.

As noted at the outset of the report, these suggestions are in line with broader evidence-based models of prisoner wellbeing, risk management and suicide reduction. However, we also recognise that many of the specific suggestions made by staff have not been directly evidenced through systematic research, and in turn we present them as promising rather than necessarily proven or 'best' practice. We nonetheless believe, based on this study and prior research in this area, that these suggestions represent a starting point for development of better, more effective SID risk management and response.

## 7.1. Promising Practice

### Countering 'idleness' among prisoners

Although staff did not identify anything directly particular about the identification and management of SID risk among 18–24 year olds as compared with those over 24,[110] there was wide acknowledgement that the provision of adequate purposeful activity is very important for younger prisoners. Employment and access to the gym were seen as particularly important. Some of the prisons we visited had developed in-cell activities, 'distraction packs' that included Sudoku, crosswords and pictures to colour in, to help occupy prisoners who were poor at coping alone 'behind their door'. Some non-uniformed staff, particularly Chaplaincy staff, expressed frustration at the 'drive for accreditation' of all prison activity. They felt that this had displaced opportunities for volunteers to come and work with prisoners in unaccredited but highly beneficial ways that helped prisoners occupy their time and thereby help to reduce SID risks.

### Integrated services

Where prisons were described by interviewees as working 'at their best', services were highly integrated and communication channels between services within the prison, with relevant outside services and with

[110] As reported in Section 3, staff did note that 18–24 year olds had specific characteristics that may influence their SID risk. However, it should be emphasised that, overall, staff suggested that this age group was not uniquely vulnerable to SID, nor did staff believe that 18–24 year olds necessarily require different management to reduce SID risk.

other prisons were well established and regularly used. Multi-disciplinary approaches were valued not because they 'ticked a box' but because different disciplines were seen as having different strengths than produced support for prisoners that was 'greater than the sum of its parts'. Suicide was seen as 'everyone's concern'.[111] Chaplaincy was seen as 'not just for the religious'. Some Chaplaincy teams were providing mindfulness and meditation classes for example. It was also seen as effective practice for resettlement activities to be integrated, especially when a prisoner's release is imminent because this can be a period of high stress. Healthcare was seen as working at its best when it was fully integrated in supporting vulnerable prisoners, through Healthcare staff attending all relevant ACCT Reviews and assisting prison staff in writing Caremaps. Likewise, prison staff understood the approach of healthcare professionals through attending regular roundtable and mental health meetings. Prisoners' families were valued as sources of relevant information and support for distressed prisoners. Safer Custody staff involved families in ACCT Reviews where they could helpfully contribute. An approach characterised by these approaches to SID risk management were highlighted as promising practices because, based on interviewees' views and wider literature, they were thought to provide the best chance to reduce the likelihood of SID, rather than simply to comply with procedure.

### A package approach to prisoner support

Staff identified the availability of a package of approaches, beyond ACCT, to assist and support vulnerable prisoners as important and helpful in managing SID risks. A specific practice that was seen as valuable in this respect included the generation by Safer Custody, Healthcare, Offender Managers and wing staff of a 'vulnerable list'. Prisoners were included on this list if they did not feel comfortable out of cell because of, for example, bullying, debt or mental health problems. The 'vulnerable list' was an intermediate intervention that aimed to ensure the provision of enhanced support to vulnerable prisoners in a way that resembled an ACCT Caremap but without instigating a full ACCT process.

### Prisoner peer support

Many staff described the use of trusted prisoners to provide peer support as valuable in identifying and managing SID risks. By virtue of their knowledge and experience of 'doing time' peers were seen as able to offer important and authentic insight to new prisoners during periods of typically high risk for SID. Where peer support schemes were most effectively used, Listeners and Healthcare Champions were fully integrated in key areas of the prison such as Reception and Induction. Prisoners were fully informed about Listeners during their induction, sometimes through a DVD produced by the Samaritans. Listeners were also deployed on the wings and prisoners had unrestricted access to them, which was welcomed and facilitated by staff. Listeners had adequate professional training and support from the Samaritans and more experienced Listener peers to feel confident in helping other prisoners to manage emotions and distress in ways that were creative and sometimes perhaps a little 'risky':

> Sometimes I turn the tables on a person who is saying he is going to kill himself. I might ask how he is going to do it and when and that seems to shock them a

[111] See HMIP (1999) *Suicide is Everyone's Concern: A Thematic Review by HMCIP of Prisons for England and Wales*.

> bit and force them into realising that maybe they didn't really mean it. Other times I say OK let's have coffee an hour before you're going to kill yourself. (Listener)

### Careful staffing

Although better practice in line with our underlying theory emphasises the importance of all staff in suicide prevention, there are some areas in a prison and some roles where staff felt that it was particularly important to 'hand pick' staff who exhibited high levels of care and possessed advanced skill in identifying and managing SID risk. Staff highlighted Reception and Induction staff and ACCT Assessors as especially crucial. In respect of ACCT Assessors staff suggested that it was effective to have as part of the team both operational and non-operational staff. In one of the prisons we visited ACCT Assessors were deployed in Reception to conduct assessments on newly received vulnerable prisoners. This reduced delay in the assessment and ensured that any urgent safeguarding measures could be taken quickly.

### ACCT ownership

Staff described to us the importance of 'ownership' in ensuring the effectiveness of ACCT processes and identified named ACCT Case Managers as important means by which ownership was achieved. Case Managers were required to speak to prisoners before ACCT Reviews to explain the process and gather relevant information, communicate Review dates and updates to Safer Custody staff and follow the case through to closure. An ACCT 'meet and greet' form was used at one of the prisons we visited to ensure that staff communicated all relevant information to prisoners about the purpose of ACCT and the process that would be followed and that staff recorded all relevant information they received from prisoners about their anxieties and background. Consistency in ACCT staffing through named Case Managers was described by staff as a strength in that it promoted openness between staff and prisoners, which made it easier to identify and resolve issues. Prisoners were also saved the frustration of having to repeat the history of their ACCT process and what caused the ACCT to be opened at every Review. In some cases Offender Supervisors were used as ACCT Case Managers. Staff described this as a promising practice because the Offender Supervisor had pre-existing knowledge about the prisoner and his family which could be drawn upon to support the prisoner through crisis and better assess risk.

### Learning from mistakes

Staff generally welcomed constructive opportunities for learning from mistakes following a death in custody or a near miss. There was a shared sense that external scrutiny, from the PPO and Coroner's Courts, dominated at the expense of internal learning. Many staff felt that these external processes were thought to be more about locating blame than supporting proactive and constructive future change. Some staff felt that greater use could be made of Staff Care Teams to lead or support internal learning processes. Staff suggested that Staff Care Teams could be used to promote post-inquest internal meetings where lessons learned could be documented and action points taken forward. It was also suggested that they could facilitate more informal discussion about Safer Custody.

> Discussing such incidents [deaths and self-harm in custody] on the wings informally among staff to learn about triggers would be helpful. Listening to colleagues' stories and experiences would help you grow. Retrospective learning

> from such incidents would be great. We do too little of it now – we're always in defensive mode. (Prison Officer)

## 7.2. Areas for Improvement

### Staffing levels and detailing

The areas in which staff most commonly called for improvement were sufficiency and consistency of staffing on wings. Inconsistent deployment and too few staff meant that wing staff felt unable to form relationships with prisoners that enabled them to identify and manage SID risk and unable to devote sufficient time to supporting vulnerable prisoners. Some staff felt overwhelmed by working in these new conditions and described their low morale as reducing their motivation at work. Safer Custody staff also felt that their work (particularly their proactive work) was being adversely affected by too few wing staff because they were being redeployed to cover shortfalls.

### Training

Staff called for improvements to Safer Custody training and many suggested that there was a need for new training about how to manage the particular needs and behaviours of young offenders. They felt that improved training would give staff greater confidence in their professional practice.

In respect of Safer Custody training, staff felt that more frequent refresher foundational and assessor training for ACCT would be valuable. Many staff felt that training ought to be more discursive and reflective, with greater opportunities to share difficulties or ideas about good practice in identifying SID risk and managing risk beyond ACCT. Staff asked for more practical examples of what 'good' ACCT entries and 'meaningful conversations' look like. They also requested more frequent mental health training and a greater emphasis upon Safer Custody issues (particularly mental health and first aid training).

As we understand it from staff, staff working with Young Offenders currently do not receive any specialist training that is tailored to this particular group, despite many staff recognising that there are some differences in needs and behaviours. While staff did not in general feel that Young Offenders (or 18–24 year olds) required a different SID risk management regime, as noted in Section 3, staff were nonetheless able to identify specific needs and characteristics within this group relevant to SID. One Manager observed, for example, that most Young Offenders do not 'drive decency' like adult prisoners do: 'They don't complain, because they don't know better. They are happy to lie in their pits all day and accept poor conditions or not being provided with things that they should be given, like toothbrushes.' Consequently this Manager felt that it was particularly important for staff working with Young Offenders to understand how their behaviour and expectations affect how prisoners behave and what they expect of themselves.

Staff working with Young Offenders might therefore need more training about pro-social modelling. Other staff felt that Young Offender staff training should more thoroughly explore how to resolve conflict with and between young people and how to understand and manage risky and impulsive behaviour, alongside specific knowledge about, for example, autism spectrum disorders or attention deficit hyperactive disorders (ADHD). Some Managers suggested that there ought to be a separate Job

Simulation Assessment Centre (JSAC) for staff working with Young Offenders, modelled on the JSAC for staff working with young children in the secure estate.

### Opportunities for peer learning

Many felt that there were currently too few opportunities for peer learning. Some staff described notes being left in ACCT files from managers who had reviewed them, suggesting areas for improvement. They felt that this was inadequate and sometimes unhelpful because there was no opportunity for discussion to understand properly how to improve for the future. To build upon tailored training for staff working with Young Offenders, some staff suggested that there ought to be Safer Custody and Young Offender fora in which latest developments and good practice could be shared externally between prisons and internally between members of staff and staff groups. Staff suggested that such fora could serve as avenues through which best practice models could be articulated and poor Safer Custody practices could be 'supportively challenged' to avoid staff 'getting into bad habits'. Systemic issues specific to Young Offenders could also be aired, such as the perceived advantages and disadvantages of mixing or separating Young Offenders from the adult population.

### ACCT documents

Staff felt that they would benefit from an explanation of the rationales for revisions to the ACCT document to ensure a consistent and full understanding of the intended effects of any changes.

Some staff suggested improvements to the design of the ACCT document and its text. Many staff questioned whether it was helpful for the ACCT document to be bright orange or so large (too large to fit completely in a transit envelope). Some staff felt that the document ought to be 'normalised' to avoid stigmatising prisoners who were on an ACCT.

Staff suggested the following more specific revisions to the text or format of the ACCT document:

- Next of kin and personal details are already on the prisoner's record on NOMIS. It might not be necessary therefore for this to be duplicated in the ACCT file.
- The box beneath 'What are the concerns?' on the 'Concern and Keep Safe Form' was felt by some staff to be too small. Some suggested that the tick boxes in the left of the box could be removed to enable staff to write more about their concerns.
- Some staff suggested that the 'Immediate Action Plan' be replaced with a mini Caremap. A name prompt could be added in the 'Referral made for assessment and case review organised' tick box at the bottom of this page to record the name of the professional to whom the prisoner had been referred.
- Some staff felt the language used to explain what should be covered in each of the questions during an ACCT Assessment was too 'wordy' and at times too complex (including for example 'precipitated', which some staff did not understand).
- On the 'Record of Case Review' several staff felt that the 'Summary of Review' section was much too small. They felt that the tick boxes above this free text box could be made smaller to give room to explain the summary section.

## 7.3. Conclusion

In this Report we have presented staff experience, knowledge and views on self-inflicted deaths in NOMS custody. We have reported practices that staff identified as promising, as well as those areas where staff see room for improvement. Where possible we have linked these staff views to broader evidence on effective SID risk management, prevention and response, to support future development towards better practice in prisons in England and Wales.

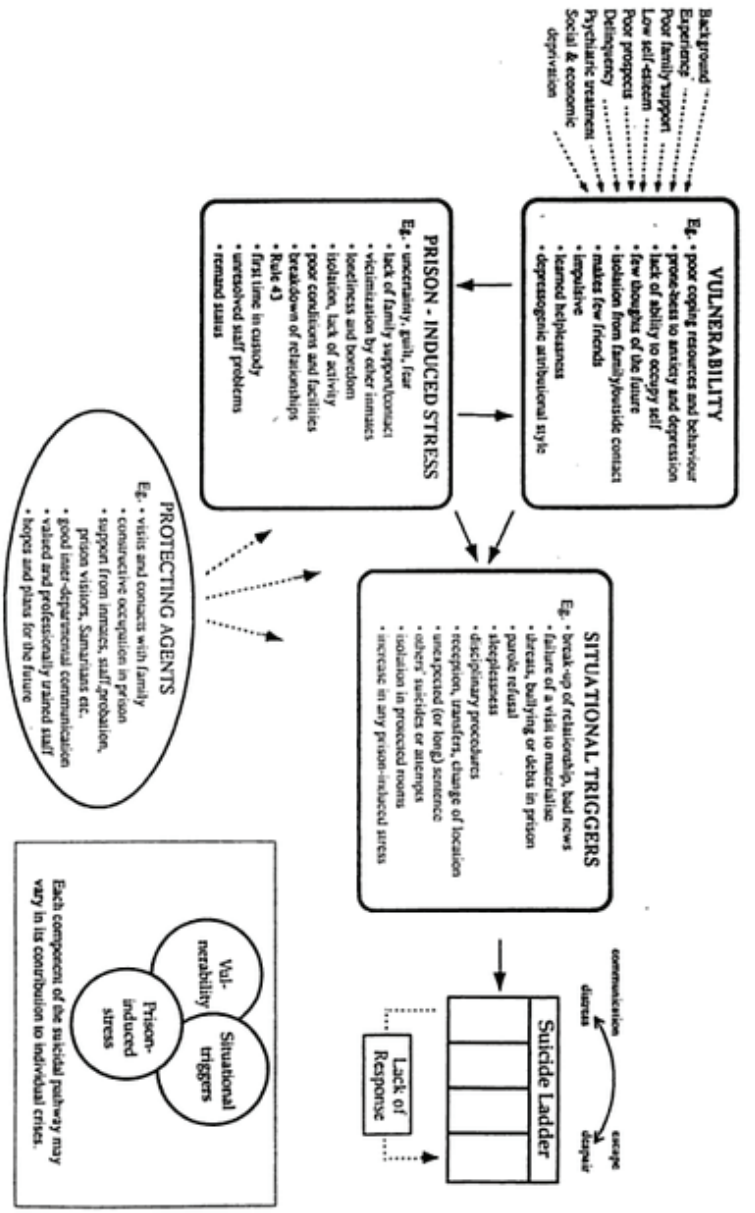
While a number of directions for future development are explicitly or implicitly discussed in this report, we recognise that the prevention of SID is complex and must take into account multiple factors at the individual, institutional and situational levels. We therefore do not suggest that there are simple solutions to this issue, and would argue that any solution needs to include interventions that address these multiple dimensions that contribute to, or mitigate, risk of SID.

Finally, the contributions from prison staff to this study have provided valuable insight into the challenges that staff face and the strategies they have developed to manage the issues of SID among prisoners. As a next step in understanding how to manage SID effectively, we would encourage development of further evidence around the suggestions that staff have identified, so that the knowledge base around SID risk management can move from recognising promising practice to identifying best practices.

# Appendices

# Appendix 1: Towards a Theoretical Model of the Prisoners' Pathway to Suicide

From Liebling, A. (1997) 'Risk and Prison Suicide' in Kemshall, H. and J. Pritchard (eds) *Good Practice in Risk Assessment and Risk Management Volume 2*. London: Jessica Kingsley Publishers, pp. 188–204 at 200.



# Appendix 2: Interview Schedule

*Informed consent – ensure the interviewee understands the nature of the project (voluntariness, anonymity, etc.) and the independence from NOMS and the MoJ of Harris Review, improvement driven motivations not condemnation/blame. Check all interviewee questions are answered and that they are happy to be recorded, and reassure them of right to not answer or withdraw at any time with no explanation needed.*

## Interviewee Background

1. Record basic personal information – M/F, BME, approx. age
2. Potted career history – length of service, time at this present, worked in any other establishments
3. Details of current job role – especially as it relates to SID

*Reiterate interest in talking about experiences, views, knowledge of SID in custody, and particular interest in 18–24 year olds.*

## Personal Experiences

4. What experience have you had of managing suicide (either where there was a risk of one or where suicide was actually attempted / carried out) in prisons and young offender institutions?
5. We would like to ask you to think about a time when you played a part in preventing a suicide / are aware that the prison together prevented a suicide with a younger prisoner (e.g. 18–24). Talk me through it: what happened?
6. Ask interviewee to return to the start of this story that ended in suicide prevention – how did it first come to light that the person was at risk of suicide?

## Managing Risks of SID

7. Relating to your earlier example, once you'd identified that the person was at risk, what happened next?
    - Who did you talk to?
    - What did you do?
    - How did you perceive the particular risk in this situation?
        - How serious did you believe the risk to be?
        - Did you feel able to deal with that risk?

- What skills did you draw upon?
- Is this a typical response to this kind of situation? Why or why not?
- Do you think the procedure is adequate?
  - In all cases? Why or why not?
  - Is it adequate for younger prisoners?
  - Would you suggest anything different?
  - Are there any ways in which the procedure could be made easier or more straightforward? How might this help you do your job?

8. How prepared do staff here feel about identifying and dealing with prisoners who are at risk of suicide?
9. What training is available to staff for identifying warning signs of suicide?
   - How often is it delivered?
   - What has been the most useful training you've received for identifying managing and preventing suicide?
10. What do you think was the most important tool or skill in managing risk of SID?

## Being at Risk

11. More generally, how do you know whether someone is at risk of suicide in prison?
    - Is there anything specific about identifying risk in 18-24 year olds?
      - What background information do you find most important to know about a person when they enter the establishment?
    - Where does that information come from?
      - Do you receive the information you need when you need it?
      - Is there any information you don't receive but would be useful in identifying, managing and preventing suicide?
12. What do you see as the warning signs for suicide in prison?
    - Potential prompts to include:
      - Personal: e.g. mental ill-health, bullying, history of self-harm, challenging behaviour, drugs and alcohol, more subtle factors (e.g. change in behaviour), 'quiet' distress
      - Institutional: e.g. amount of bang-up time, ease of access to drugs, poor communication of individuals' information to staff, staffing levels, access to activity / training / social programmes, quality of and access to health care
    - Which of those warning signs that you've mentioned are the most important? Does this differ between individual situations (18–24)?
    - Which warning signs are hardest to interpret? Or pick up?

13. What made it possible in the earlier case you mentioned to successfully identify the prisoner as at risk?
    - What are the essential conditions for successfully identifying at risk younger prisoners?
14. Are there any ways in which things could be improved to help staff identify suicide risk? Anything particular to the 18–24 group?

## Processes Following a SID

15. Can you reflect on an experience where you or your colleagues responded to a suicide [if no experience of suicide then ask about attempted suicide]? What happened?
    - Who was involved?
    - Interactions with the ombudsman and Coroner?
    - How was the person's family informed? How were they involved?
    - What support was put in place for other prisoners?
    - What support was put in place for staff?
16. On reflection, what parts of this response were most effective?
    - What if anything could have been improved in the handling of this incident?
17. What did you / the prison learn from the incident? Did your professional practice change? Did anything change in the establishment (operational practice and policy)?

## Concluding Questions

18. If you could change anything about the ways in which SID risks are identified or managed, what would they be?
19. Are there any differences between your responses about suicide risk among younger and older prisoners? Why or why not?
20. Is there anything we haven't asked but ought to have asked? Or anything you'd like to add or clarify?

*Close – reiterate confidentiality, anonymity, right to withdraw from the research (for any reason and with no explanation necessary) up until the end of November 2014, check whether respondent has any unanswered questions.*

# Appendix 3: Notice to Staff

## Self-inflicted deaths in custody amongst 18–24 year olds: staff experience, knowledge and views

As many of you may be aware, NOMS has invited Lord Harris to chair an inquiry into how to reduce the number of deaths in prisons among 18- to 24-year-olds. As part of this Inquiry, researchers from the Prisons Research Centre at the University of Cambridge and RAND Europe have been invited into your establishment to learn from staff about their experiences, knowledge and views of deaths in custody. Our findings will help Lord Harris and his team to understand what can be done to help to prevent prison suicide and support staff in this difficult work.

Amy Ludlow, Bethany Schmidt and Thomas Akoensi will be visiting your establishment on [date]. During this time we would like to learn from as many staff as possible so we would be very grateful for your participation in the research. Anything you share with us will remain confidential and will be included anonymously in our final report to the Inquiry. You can express an interest in contributing through being interviewed or participating in a focus group by emailing [name and email address] who will share your details and availability with us. We will also be spending some time talking to staff informally around the prison so please do just stop and chat with us. If you would like to find out anything further about this study, or express an interest in it directly with the research team, please email Amy Ludlow (acl46@cam.ac.uk).

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