Management of prisoners at risk of harm to self, to others and from others (Safer Custody)

This instruction applies to:-

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All public and private prisons and NOMS operated Immigration Removal Centres

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<th>Issue Date</th>
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<td>17 Feb 2012</td>
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Issued on the authority of NOMS Agency Board

For action by Governor/Directors of contracted prisons. In this document, the term Governor/Director applies equally to Directors of contracted prisons. The term prison refers equally Centre Managers of Immigration Removal Centres operated by NOMS.

For information All staff in NOMS HQ and prisons.

Contact riskofharmPSIenquiries@noms.gsi.gov.uk

Associated documents

- PSO 1900 Certified Prisoner Accommodation
- PSO 1400 Incident Management REST (contact Security Group)
- PSI 42/2010 Health and Safety Statement
- PSO 9015 information Assurance
- PSI 49/2011 Prisoner Communication
- PSO 1600 Use of Force
- PSO 6000 Parole Manual
- PSO 8800 Corporate Image/Uniform
- PSI 09/2011 Cell Sharing Risk Assessment
- PSI 58/2010 Prison and Probation Ombudsman
- PSI 1900 Certified Prisoner Accommodation
- PSI 28/2009 Care and Management of Young People
- PSI 2011/11 Incentives and Earned Privilege
- PSI 47/2011 Prison Discipline Procedures
- PSI 08/2010 Post Incident Care
- PSI 32/2011 Ensuring Equality
- PSI 74/2011 Early Days in Custody
- PSI 12/2011 Prisoner’s Property

Replaces the following documents which are hereby cancelled:
- PSO 2700 Suicide and Self-Harm
- PSO 2750 Violence Reduction
- PSO 2710 Follow up to Deaths in Custody

Audit/monitoring:
- Safer Custody Audit

Introduces amendments to the following documents:
- PSO 1400
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EXECUTIVE SUMMARY

Background

1. This instruction replaces PSO 2700 Suicide Prevention and Self-harm Management, PSO 2750 Violence Reduction, and PSO 2710 Follow Up to Deaths in Custody. It sets out the NOMS framework for delivering safer custody procedures and practices to ensure that prisons are safe places for all those who live and work there.

Desired outcomes

2. This instruction aims to:-
   - Identify, manage and support prisoners and detainees who are at risk of harm to self, others, and from others.
   - Reduce incidents of self-harm and deaths in custody.
   - Manage and reduce violence, deal effectively with perpetrators and support victims.
   - Support effective multi-disciplinary case management and sharing of information to reduce incidents of harm.
   - Ensure staff, prisoners and visitors affected by incidents of harm are supported appropriately
   - Ensure appropriate responses and investigations to incidents, which promote learning to prevent future occurrences and improve local delivery of safer custody services.

Summary of main changes

3. This PSI replaces PSO 2700 Suicide Prevention and Self-harm Management, PSO 2750 Violence Reduction, and PSO 2710 Follow Up to Deaths in Custody.


5. PSI 58/2010 Prisons and Probation Ombudsman covers disclosure of documents following deaths in custody and remains in existence.

6. First response, incident management and reporting is covered in PSO 1400 Incident Management.

7. The specification of safer cells is covered in PSI 1900 Prisoner Accommodation.

Mandatory Actions

8. There are mandatory actions throughout the Instruction which are italicised. Where applicable there is also supporting guidance included within the chapters. Chapter 9 has no mandatory actions. It is included in this Instruction as it contains information and guidance which may improve the delivery of safer custody outcomes.

9. Governor/Directors must ensure that the outcomes set out in the Management of prisoners at risk of harm to self, to others and from others (Safer Custody) specification are delivered.

10. In delivering all the outputs set out in the specification/instruction, staff must have regard to equality considerations and ensure that all services are delivered fairly and appropriately. Regard must be given to the protected characteristics defined in the Equality Act 2010, which are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race (including nationality), religion or belief, sex or sexual orientation.
11. Governor/Directors must have procedures in place to identify, manage and support prisoners and detainees who are at risk of harm to self, others, and from others, and to reduce that risk.

12. Governor/Directors must ensure reasonable steps are taken to obtain all relevant information regarding prisoner safety. This information must be recorded, shared and acted upon within the prison and between service providers/agencies.

13. Governor/Directors must have in place a learning strategy to improve local delivery of safer custody and prevent/reduce future incidents of self-harm, violence and death.

14. Following a death in custody, the procedures outlined in Chapter 12 must be followed.

15. Where appropriate, procedures must be in place to encourage family engagement in managing and reducing the risk of prisoners who harm themselves and/or others.

Resource Impact

16. In issuing this instruction and the accompanying Specification, there is no intention to reduce overall costs in this area of work, although Governors/Directors may identify more efficient ways of working in some instances. The Operating Model that accompanies the Specification is not mandatory; following it may entail a different allocation of resources to safer custody teams in some prisons. There are fewer mandatory requirements in this instruction than in previous policies. There is no requirement for establishments to have a further, local policy.

Contact

For further information about this PSI contact Offender Safety, Rights and Responsibilities Group (OSRRG)
Email: riskofharmPSIenquiries@noms.gsi.gov.uk

Approved for publication by:

Phil Copple

pp. Digby Griffith,
Director of National Operational Services, NOMS
Specification Outputs

17. **Prisoners who pose a risk to themselves, to others and/or from others are identified**

   *Staff must follow the procedures in PSI 09/2011 to indentify prisoners who pose a risk to, or from others with regard to cell sharing.*

   *Staff must identify prisoners at risk of self-harm and/or suicide based on the risks and triggers outlined in Chapter 3. They must also check relevant documents for evidence of risk, e.g. the Person Escort Record, pre-sentence reports, NOMIS, and clinical records. Staff should also be aware of age related documentation such as Asset, ROSH (Risk of Serious Harm) and PIF (Placement Information Reports) which are all relevant when identifying risk of self harm to self in under 18 year olds.*

   The majority of prisoners have one or more mental illnesses. Some will also have a personality disorder and/or a learning disability. These prisoners may present as having complex needs and exhibit challenging behaviour. Guidance on the identification and management of prisoners with complex behaviours can be found at Chapter 9.

18. **Staff, prisoners and visitors are aware of the risk identification, assessment and management procedures**

   *Governor/Directors must ensure that staff who have contact with prisoners are aware of the procedures by which prisoners’ risk of harm to self, to others and/or from others is identified, assessed and managed. Specific details on the roles and responsibilities of staff in the delivery of safer custody can be found at Chapter 1.*

   *PSI 09/2011 must be followed for cell sharing risk assessment.*

   Procedures for Assessment, Care in Custody, Teamwork (ACCT) are outlined in Chapter 5.

   Good staff/prisoner relationships are essential to the disclosure of risk of harm by other prisoners and in reducing harm.

   *All visitors must be provided with information that outlines the procedures in place for the identification, assessment and management of prisoners at risk of harm to self, others and/or from others.*

19. **Information is identified, recorded and shared with stakeholders**

   *For the purposes of this instruction, a stakeholder is anyone with an interest or concern in a prisoner at risk of harm to self and others.*

   Information may become available throughout a prisoner’s time in custody which may affect their risk of harm to self, others and/or from others. It is vital that this information is recorded and shared to inform proper decision making.

   *Chapter 2 provides guidance on the recording and sharing of information.*

   Additional guidance on the management of prisoners refusing food and/or who have an Advance Directive in place can be found at chapter 10.
20. **Prisoners are assessed for risk**

*PSI 09/2011 Cell Sharing Risk Assessment must be followed.*

*Prisoners identified as at risk of harm to self must be assessed using Assessment, Care in Custody and Teamwork (ACCT) procedures, which are outlined in Chapter 5.*

21. **Prisoners at risk or posing a risk are involved in the assessment and management processes where safe to do so**

The most effective way to assess and manage risk is through a multi-disciplinary process, in which the prisoner is involved. *Every effort must be made to encourage the prisoner’s full participation, where it is safe to do so. Where this is not possible, reasons must be recorded in the appropriate document, e.g. ACCT.*

22. **Prisoners at risk or posing a risk are managed according to the level and type of risk they pose, up to and including constant supervision.*

*PSI 09/2011 Cell Sharing Risk Assessment must be followed.*

*Prisoners at risk of harm to self must be managed using Assessment, Care in Custody and Teamwork (ACCT) procedures, which are outlined in Chapter 5.*

Where a prisoner’s risk is assessed as requiring constant supervision, the procedures outline in Chapter 6 must be followed.

The use of CCTV to monitor prisoners who are at risk of suicide is a measure of last resort. *Where CCTV is being used to monitor a prisoner at risk of suicide and/or self-harm, the CCTV must be monitored by a member of staff at all times, and entries made in the ACCT document in line with the case review.*

23. **Prisoners affected by incidents of self-harm, violence or a death in custody are identified, risk assessed, managed and supported where appropriate**

*Prisoners who self-harm must be managed using the ACCT procedures* (see 1 above). Prisoners who witness or are affected by another prisoner’s self-harm may become distressed. *Appropriate support must be put in place to promote their welfare.*

*Victims of violence must be provided with an appropriate level of support according to the hurt or injury they suffer. Victims must be informed of the outcome of actions taken as a result of the violence.* Comprehensive guidance on the management of violence in prisons is in Chapter 7.

Prisoners may be affected by a death in custody. Guidance on the actions to be taken to support those prisoners can be found in Chapter 12.

24. **Prisoners have access to identified peer support schemes in relation to managing the risk of harm to self**

Peer support schemes can be an effective tool to complement the support given by staff to at risk prisoners. *Peer support schemes must not replace or undermine good staff/prisoner relationships.* Guidance on peer support schemes can be found at Chapter 4.
25. **Positive staff/prisoner engagement is supported and maintained**

Good staff/prisoner relationships are fundamental to the management of safe and decent prisons. They are integral to the reduction and management of self-harm and violence.

26. **At risk prisoners are encouraged to engage positively with the prison regime and interventions to contribute to the reduction of risk**

Some prisoners who are at risk of harm to themselves or from others may withdraw from the prison regime. **Staff must engage with these prisoners to encourage their participation in the regime and to reduce their risk of social isolation.**

27. **Contracts/Service Level Agreements (SLAs) with third party providers reflect the need for multi-disciplinary working in relation to at risk prisoners**

There are many service providers operating in prisons whose staff may hold vital information about a prisoner who is at risk of harm to themselves, others and/or from others. Information sharing between agencies is key to enabling continuity of care to prisoners at risk.

It is important that service providers are encouraged to contribute to the identification of risk procedures (see 1 above), and multi-disciplinary case management reviews, either in person or in writing. **Where appropriate, contracts or SLAs must include this as a business requirement and key deliverable.**

28. **Staff and visitors who are immediately affected by incidents of self harm, violence or a death in custody are identified and supported**

Staff work very hard on a daily basis to provide care for prisoners who harm themselves and others, including those prisoners who are dying from terminal illness or who die suddenly. There will be occasions when staff dealing with such incidents may benefit from additional support. **These staff must be identified and appropriate action taken, for example referral to Employee Support Services.**

Governor/Directors must ensure that relevant information is shared with visitors affected by incidents of self-harm, violence or deaths in custody, where it is appropriate to do so.

29. **Following a death in custody, near death, act of self-harm or violence towards others, all relevant stakeholders are informed. Where appropriate, their work is facilitated (if applicable) and a record of contact is maintained**

Following a death in custody, **the actions outlined in Chapter 12 must be followed.** This includes the facilitation of any work needed to be undertaken by stakeholders such as participation in investigations by the Police, Prisons and Probation Ombudsman, Health and Safety Executive, or the Local Safeguarding Children Board.

Following incidents of near-death, self-harm or violence, Governor/Directors must consider informing relevant stakeholders taking into account the prisoner’s wishes and the seriousness of the incident.

Information sharing with stakeholders must be recorded.

30. **Serious incidents of self-harm or violence are investigated at an appropriate level.**

There are a range of options available to investigate serious incidents of harm to self or others. **Consideration must be given to the circumstances in which the harm occurred, the**
lessons that can be learned from the incident and its management, and the need to support
those harmed and sanction perpetrators of harm.

In circumstances in which the harm to self or others may cause long-term serious injuries,
advice on the appropriate level of investigation must be sought from OSRRG.

31. Learning from deaths in custody and incidents of self-harm or violence is identified,
disseminated and acted upon

Prisons must have procedures in place to facilitate learning from incidents of self-harm,
vioence and deaths in custody to prevent future occurrences and improve local delivery of
safer custody. Further guidance can be found at Chapter 14.

32. Following a death or near death in custody, or for terminally ill prisoners, initial and on-
going liaison takes place between the prisoner’s nominated next of kin and the prison

All prisoners must be asked to nominate a next of kin who must be updated regularly.
Following a death in custody, the next of kin must be contacted by an appropriate person.
The next of kin must be given an accurate account of what has happened, what will happen
next and an offer to contribute to funeral expenses. Where prisoners have a terminal
illness, they must be encouraged to engage with their families where it is appropriate to do
so.

Where prisoners have suffered sudden life-threatening harm, the prisoner’s wishes on who
they would like to be contacted must be ascertained where possible. In the event that the
prisoner is unable to communicate their wishes, the prison must contact the nominated next
of kin who must be given an accurate account of what has happened.

Further guidance on liaising with families is at Chapter 13 and at Chapter 11 regarding
seriously ill prisoners.
Chapter 1  Roles and responsibilities

All staff in contact with prisoners must be trained to at least ACCT Foundation level. From January 2012 ACCT Foundation will be replaced by Introduction to Safer Custody and new staff must be trained in this. ACCT refresher training must be provided according to local training needs.

All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and / or during the risk management process.

All staff who receive information, including from concerned family members, or observe changes in a prisoner's behaviour which indicates a change in the risk they pose to themselves, to others and/or from others must communicate their concerns immediately to the Residential, Daily or Night Operational Manager, and/or consider opening an ACCT Plan and make a record in an appropriate source e.g. observation book, NOMIS, Security Information Report, ACCT Plan.

All staff must be aware that the preservation of life is the first priority when managing at-risk prisoners. Justifiable decisions on when to enter a cell where life is endangered, particularly at night, must take account of the need to preserve life and should be documented in wing observation books, NOMIS history sheets and ACCT Plans where one is open.

It is the responsibility of all staff to make themselves aware of the location of emergency response equipment for the area that they have been designated to work.

Anti-ligature cut-down tool

All uniformed staff in closed and semi-open establishments must be provided with and carry (whilst on duty) their own personal issue cut-down tool. The Governor/Director must determine whether other prison staff who carry cell keys should also be issued with and carry cut-down tools.

Local procurement arrangements must be in line with national policy. Personal issue cut-down tools must be the Big Fish (9mm). Following a trial of various types of cut-down tools, this tool - and no others - has been confirmed as authorised for purchase as a personal issue cut-down tool. These tools can be purchased through the national iProcurement system. Information and contract details can be found in the Procurement Directorate Procurement Bulletin ST 048/2011. Costs of purchasing new cut-down tools and replacement blades will need to be met locally.

Open establishments are required to have Emergency Response Kits and have a local protocol on cut-down tools appropriate to their risk level.

Staff other than discipline staff may also carry cut-down tools, if it is decided locally to be necessary/desirable, e.g. CARATS staff who regularly attend residential areas, or healthcare staff. Governors/Directors must carry out a risk assessment to decide which other staff, including healthcare staff, must carry their own personal issue cut-down tool.

Cut-down tools, like any other items that may be used as weapons, need to be thoroughly risk assessed and managed to mitigate the risk of harm they could pose to others. Cut-down tools must be stored, marked and used in Accordance with the Accounting and Control Function of the National Security Framework (NSF).

Emergency Response Kits for residential areas

Emergency Response Kits must be available in all residential areas. Prisons, in consultation with their healthcare provider, must determine what items need to be included in them. It is good practice to also have Emergency Response Kits in non-residential areas, based on a local risk assessment.
Residential Managers must provide regular checks of their units Emergency Response Kits and ensure that it is replenished after use. Checks must be documented, signed and dated.

Residential Managers must ensure that night staff are aware of the location of emergency equipment.

Governors / Directors may wish to consider making defibrillator machines more widely available within the prison.

**Safer Custody Teams**

*Each prison must have a Safer Custody Team (SCT) who will have responsibility for the implementation and development of safer custody policy. Their role is to provide assurance to the Governor/Director on all safer custody issues affecting the prison.*

Membership of the SCT will vary between prisons depending on its size, function and the risk profile of the population. These factors will also determine the frequency of Safer Custody Team meetings.

**Safer Custody Team Leader**

*The Governor/Director must appoint a Safer Custody Team Leader (SCTL) who is competent and has appropriate authority to undertake the role. Their main responsibility will be to ensure continuous improvement in the delivery of safer custody procedures by way of data monitoring, policy compliance and learning.*

The SCTL may be best placed to provide management oversight of peer support schemes related to safer custody, such as local Listener and Insider Schemes.

*The SCTL must provide support to staff undertaking specific safer custody roles such as those listed below and including the nominated Family Liaison Officer(s), unless the FLO is not line managed by the SCTL, in which case this support must be provided through the FLO’s line manager.*

The safer custody priorities for each prison will vary according to the function, population, size and churn. It is recommended that each prison holds regular safer custody team meetings chaired by the SCTL. It is for the Governor/Director to decide how frequently the safer custody team should meet. The following items may usefully comprise the agenda, however their priority will be determined by the risks faced by the prison at any given time.

**Safer Custody Team Meetings**

| Data Analysis: | Violence data from Hub looking at local trends and with comparator prisons
Self-harm data from NOMIS and local records, trends in incidents, those self-harming, open/closed ACCTS (refer to chapter 14 for other sources of data) |
| Complex Needs: | Identify and discuss the management of prisoners with complex behaviour (see Chapter 9)
Discuss Security Information Report data to ensure any safer custody matters are being effectively managed |
| Deaths in Custody: | Discuss progress against any relevant action plans
Discuss issues arising from ongoing or impending inquests |
| Learning: | Discuss implementation of any relevant Quick Time Learning Bulletins
Discuss matters arising from Regional Safer Custody Managers Forum |
Discuss any other safer custody related communications from HQ
Discuss findings from quality assurance checks of closed and open ACCT Plans

Peer Support: Matters arising from Samaritans, and other peer support scheme co-ordinators

Governors/Directors of Contracted Prisons

Under PSI 42/2010, Governors and Directors are required to carry out an assessment to identify the number of first aiders and first aid equipment required by their establishment and ensure that a sufficient number of trained first aiders are available at all times. Guidance can be found in The Health and Safety (First-Aid) Regulations 1981.

Governors/Directors must determine whether potential ACCT Assessors are suitable to undertake the role only after they have received the appropriate training, have observed at least one assessment and have been supervised on at least two occasions.

Residential, Daily and Night Operational Managers

Daily and Night Operational Managers must be aware of those prisoners who:

- Are on an open ACCT
- Are subject to constant supervision and what their night time emergency access plans contain
- Are subject to ACCT procedures but also pose a risk to others when their cell is unlocked during the night state e.g. display violence to others as well as self harming.

Constant supervision staff

Staff members carrying out constant supervisions need to be considered competent to provide the level and quality of support designated in the CAREMAP. They should:

- Have good interpersonal and report writing skills and be able to convey to the person at risk that they are valued
- Be able to access immediate support from other staff
- Where the person at risk does not speak English, managers should make every effort to use staff that have language skills that allow some form of communication

It is desirable - but not mandatory - for staff carrying out supervision to be rotated on a regular basis and for sufficient breaks to be provided.

If the supervising member of staff is of the opposite sex to the prisoner, they must be briefed on who to contact should the prisoner need to use the shower or to change their clothes.

It is the responsibility of the supervising member of staff to write appropriate entries in the ACCT document, attend case reviews and provide a full verbal handover to other staff.

All staff involved with the constant supervision must be briefed on

- The prisoner, their specific risks, needs and the care plan
- Details of the Emergency Access Plan
- General emergency procedures including location of alarm bells, summoning assistance (e.g. medical emergency response codes) and location of emergency response kits
- How to access staff support networks
Violence Reduction Co-ordinator (VRC)

The role of the VRC is to support the SCTL in ensuring the prison is compliant with the Zero Tolerance approach to violence. The VRC will work closely with the Suicide Prevention Co-ordinator to ensure that safer custody is embedded across the prison. The VRC monitors trends in violence and the management responses to violent incidents, victims and perpetrators as reported on the Hub. The VRC ensures compliance with the Cell Sharing Risk Assessment procedures by undertaking quality checks of CSRA forms and reviews. The VRC liaises with residential managers and security staff to ensure that those prisoners at risk of harm to others and from others are being properly identified and their risk managed.

Suicide Prevention Co-ordinator (SPC)

The role of the SPC is to support the SCTL in ensuring the prison is compliant with NOMS suicide prevention and self-harm management strategy. The SPC will work closely with the VRC to ensure that safer custody is embedded across the prison. In particular, the SPC will undertake quality checks of open and closed ACCT documents. Liaise with residential managers, security staff and healthcare staff to ensure that at-risk prisoners are being properly identified and appropriate actions taken to manage the risks posed. The SPC monitors self-harm data and be alert to changing trends and the reasons behind those. SPCs may find it helpful to undertake ACCT assessor and ACCT case manager training. They should not, however, fulfil those roles as part of their daily duties unless there is an exceptional need to do so.

Safer Custody Co-ordinator (SCC)

In some prisons, the most effective way to manage safer custody risks is to have one SCC rather than an SPC and a VRC. The role of the SCC will be the combination of the VRC and the SPC.

Safer Custody Administration

The successful delivery of safer custody is enhanced by ensuring that those leading the work are able to access appropriate administrative support. Tasks which may usefully be completed by administration staff are maintenance of ACCT databases, downloading data on violence and self-harm from the HUB and NOMIS respectively, liaising with outside agencies to ensure information is shared, arranging Listener Training and other peer support meetings, and arranging safer custody team meetings.
Chapter 2  Information sharing

Overview

This chapter sets out the procedures that staff will need to follow to ensure that reliable and accurate information is shared with and between appropriate agencies to inform proper decision making.

Information sharing is key to delivering safer custody that is coordinated around the needs of the individual. It is essential to enable early intervention and preventative work, to promote the prisoners wellbeing and for wider public protection. Information sharing is a vital element in improving outcomes for all.

It is of particular importance that information is shared between security departments and healthcare to ensure that appropriate security information is considered by clinical professionals which may affect the overall toxicity of a prisoner in terms of their prescribed and/or illicit drug intake.

The term ‘information’ includes verbal, written and electronic information. The term ‘sharing’ refers to information exchange in any form e.g. on a one-to-one basis, in a group setting or through the exchange of documentation via any media (e.g. paper or electronic).

The failure to transfer information within and between services is a perennial issue and one that receives significant attention from the Prisons and Probation Ombudsman (PPO) in investigation reports and at inquests. Guidance for prisons on disclosure to the PPO can be found in PSI 58/2010.

Verbal disclosure of abuse and confidentiality

Partner organisations often operate disclosure or Confidentiality Statements - and prisons must ensure information sharing takes place in line with such agreements.

Prisons holding young people (aged 15 – 17) must have a Child Protection policy and Information Sharing policy, as described in PSI 28/2009. (PSI 08/2012 from 01/03/2012) These policies will set out the responsibilities of staff, including sharing information, when they become aware that a young person has suffered or is at risk of suffering harm.

Sharing of Clinical Information

All medical information must be managed in accordance with relevant legislation and the NHS Code of Practice on Confidentiality.

Effective information sharing with other agencies (in particular the NHS) and within the Prison Service, is key to enabling continuity of care for individuals as they pass from the community to prison and back again. Prisons holding young people must have effective means of information sharing with Youth Offender Teams, local authorities and the families/carers of young people.

The smooth and legally appropriate flow of confidential information is one of the essential ingredients in achieving a comprehensive and co-ordinated provision of healthcare to prisoners. The increasing emphasis upon and inherent obligations within partnership working makes it imperative to have coherent, flexible and lawful processes for sharing confidential information.

Disclosure of confidential clinical information should normally take place with the consent of the prisoner concerned. Prisoners should normally be made aware of the uses to which their information will be put and with whom it will be shared (unless doing so would prejudice one of the interests set out in the paragraph below).
Disclosure without a prisoner’s consent can also be made if it is considered necessary to protect the individual or anyone else from risk of death or serious harm, or if failing to disclose would be likely to prejudice the prevention or detection of crime or the apprehension or prosecution of offenders.

All healthcare staff have a duty to pass on information that involves issues of patient safety, vulnerability or immediate risk to self or others to relevant staff. In situations where the prisoner’s safety is compromised but they are unable or unwilling to give consent then health professionals have a duty of care and the relevant information may be disclosed to others.

The NHS Code of Practice on Confidentiality contains further information.

Transfer of Information

The safety and wellbeing of prisoners requires that any existing support and care is maintained in their new environment. This includes prisoners transferring between prisons, young people transferring from YOIs into the adult prisons prisoners being released into the community and prisoners being transferred to other institutions. Prisons must ensure that all documentation travels with the prisoner (including transfers and court appearances), specifically any open or recently closed ACCT documents (see Chapter 5 for more information).

Tools and Resources

The Offender Management Unit (OMU) should be the central point of two-way communication between all prison functions. The Security Department and Safer Custody Team are pivotal in sharing information with staff who are undertaking assessments and reviews of a prisoner’s management and progress.

All work and contacts with the prisoner, including healthcare staff, are to be recorded on the NOMIS case recording system, as well as on healthcare systems where appropriate. The principle is that all staff involved with the prisoner share information on risks of harm to self and others. This can be verbally, in reports, requests for information, emails.

Access to case notes is available to everybody with a NOMIS account.

There are a number of data and information tools available to use, including operational tools such as NOMIS, OASys, IRS and management information tools such as the NOMS HUB etc. This list is by no means exhaustive and there may be other sources of data and information both locally and nationally which can be used.

Disclosure of information following a death in custody

Following a death in custody there will be a police investigation, and an investigation by the Prisons and Probation Ombudsman (PPO) and an inquest before a jury. There will be a need to disclose documentation for all of these investigations. Further advice is set out in the Chapter 12 on Actions following a death in custody.

Staff must co-operate fully with requests by the police, the PPO and the coroner for documents.

The access to a deceased person’s health records is set out in the Access to Health Records Act 1990.

Further information about disclosure to the PPO is set out in PSI 58/2010 Prisons and Probation Ombudsman.
Information Assurance

Information Assurance is the term used to describe the arrangements for ensuring that we have adequate security for our information (whether held electronically or in hard copy).

Information Assurance means the confidence that information systems will protect the information they handle and will function as they need to, when they need to, under the control of legitimate users.

Further guidance on Information Assurance can be found in PSO 9015 Information Assurance.

Data Protection Act

The Data Protection Act gives individuals the right to access the personal information the Ministry of Justice holds about them. The Data Protection Act 1998 is not a barrier to sharing information but provides a framework to ensure that personal information is shared appropriately.

The MoJ handles personal information entrusted to us by witnesses, defendants, prisoners, the public, other government departments, our stakeholders and our own staff. In short, everyone we do business with.

Personal information is information about living individuals. It can be a name, address or telephone number. It can also be the type of job someone does, the things people buy or the place they went to school. Personal information is not only factual information about a person, but also expressions of opinion about or intention towards them.
Chapter 3  Risk and triggers

Overview

A prisoner’s risk (or likelihood) of violence, self harm and/or suicide may increase in certain circumstances. This chapter identifies a number of potential triggers which may increase risk of harm to self or others. Where these triggers are identified as being relevant to a prisoner, appropriate action must be taken, i.e. open an ACCT, refer to mental health in-reach team, and/or the safer custody team leader, SPC, VRC, SCC for further advice.

Risk

It is important to be clear about the basic ideas underpinning the notion of risk. Risk relates to a negative event (i.e. violence, self-harm/suicide or self-neglect) and covers a number of aspects:

- How likely it is that the event will occur.
- How soon it is expected to occur.
- How severe the outcome will be if it does occur.

A risk factor is a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur (Best Practice in Managing Risk DoH June 2007). Risk factors can be categorised in a number of ways:

**Static factors** are unchangeable, e.g. a history of child abuse or suicide attempts.

**Dynamic factors** are those that change over time, e.g. misuse of alcohol. Dynamic factors can be aspects of the individual or aspects of their environment and social context, such as the attitudes of their carers or social deprivation. Because they are changeable, these factors are more amenable to management. Dynamic risk factors that are quite stable and change only slowly are called **stable** or **chronic** risk factors.

Those factors that tend to change rapidly are known as **acute factors** or **triggers** and, as they do change rapidly, their influence on the level of risk may be short-lived.

*All members of staff must consider the use of translation services when dealing with prisoners who’s first language is not English and, in particular, when conducting assessments of risk and / or during the risk management process.*

Risk factors for violence

**Demographic factors**
- Male
- Young age
- Socially disadvantaged neighbourhoods
- Lack of social support
- Employment problems
- Criminal peer group

**Background history**
- Childhood maltreatment
- History of violence
- First violent at young age
- History of childhood conduct disorder

**Clinical history**
- Substance misuse
• Personality disorder
• Schizophrenia
• Non-compliance with treatment

Current context
• Early days in custody and following each transfer
• Offence particularly those charged with violence against another person and arson.

All staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence, and take appropriate action. The risk factors for self-harm will not inevitably lead to a prisoner attempting to commit suicide.

Risk factors for suicide

Demographic factors
• Low socioeconomic status
• Unmarried, separated, widowed, recently divorced

Background history
• Deliberate self-harm (especially with high suicide intent)
• Childhood adversity
• Family history of suicide
• Family history of mental illness
• Spouse / partner with terminal illness

Clinical history
• Mental illness diagnosis (e.g. depression, bipolar disorder, schizophrenia)
• Mental health in reach
• Personality disorder diagnosis
• Physical illness, especially chronic conditions and/or those associated with pain and functional impairment
• Recent contact with psychiatric services
• Recent discharge from psychiatric in-patient facility

Psychological and psychosocial factors
• Hopelessness
• Impulsiveness
• Low self-esteem
• Life event
• Relationship instability
• Lack of social support

Current ‘context’
• Early days in custody and following each transfer
• Suicidal ideation
• Suicide plans
• Availability of means
• Lethality of means
• Offence particularly those charged with violence against another person, especially against family members or partners, and arson
• Life sentence / parole board hearing refusal
Risk factors for self-harm

Demographic Factors
- Young Age
- Lack of Social Support
- Unmarried, separated, widowed

Background History
- Childhood adversity / maltreatment (e.g. sexual abuse)
- Family history of mental illness
- History of violence

Clinical History
- Mental illness diagnosis (e.g. depression, bipolar disorder, schizophrenia)
- Personality disorder diagnosis (e.g. borderline personality disorder)
- Physical illness, especially chronic conditions and/or those associated with pain and functional impairment (e.g. multiple sclerosis, malignancy, pain syndromes)
- Recent contact with psychiatric services
- Recent discharge from psychiatric in-patient facility

Psychological and Psychosocial Factors
- Desperate
- Angry
- Sad
- Ashamed
- Hopeless
- Worthless
- Lonely
- Disconnected
- Powerless

Current ‘context’
- Relationship problems
- Recent suicide of someone similar to them
- Violence, intimidation or fear of these
- Parole refusal or other knock-back
- Longer sentence than expected
- Alcohol/drug misuse
- Irrational behaviour, out of touch with reality
- Recklessness
- Hostile rejection of help

Triggers

A trigger is any event that sets a course of action in motion. With regards risks of harm to self and/or others, some triggers may have occurred in the past, whereas others are yet to occur. For example, childhood trauma such as sexual abuse may increase the risk of suicide in later life. The passing of a lengthy sentence which may not yet have occurred may also increase the risk of suicide.

It is important to recognise that some triggers are more identifiable and predictable than others, e.g. sentencing, but staff need to be alert to the hidden triggers, e.g. anniversary of the death of a child.
The existence of a trigger may not necessarily increase a prisoner’s risk. However, it is vital that staff remain alert to the changes in a prisoner’s risk and act when appropriate.

The following list of triggers is not exhaustive but does provide some guidance for staff on known triggers which may increase risk of self-harm, suicide or violence.

- Change in status
- Further charges
- Anniversaries and Key Dates
- Court Appearances, especially start of trial and sentencing
- Bereavement of family or close friends, including exposure to suicide
- Substance Misuse or Detoxification, including alcohol
- Segregation
- Family/Relationship Breakdown
- Transfers between prisons, even progressive moves may increase risk in the early days of a new prison
- Foreign National Prisoners, who are, or are about to be held on an IS91 and those close to deportation
- Licence Recall

After speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decisions on prisoners who pose a risk to themselves or others.

Some sources of information where risk evidence can be found in are detailed in Chapters 14 Learning, and Chapter 2 Information Sharing.

**Understanding prison population safer custody risks**

Understanding your prison safer custody data can be used to identify risk, measure performance and determine priorities. The example information below has been proved from an analysis of the prison estates safer custody data.

**Deaths in custody and self-harm**

- Self-inflicted deaths occur disproportionately during the early stages of custody.
- Younger prisoners self-harm more often than older ones however, it is also the case that younger prisoners tend to spend less time in custody. The higher rate of self-harm among younger prisoners is explained, in part, by the higher rate of churn amongst this group (See 5.6).
- Female prisoners account for some 5.5% of the prison population but 50% of all self-harm incidents.
- Approximately 1% of self-harming prisoners account for 20% of all self-harm incidents.

**Prison violence**

- In the first 14 days of custody, prisoners are less likely to be involved in assault incidents. Once they enter the general prison population they are more likely to be involved in assault incidents, so much so, that by the end of the first month they have become more likely to be involved. However, compared with self-harm incidents, the risk of being involved in an assault incident is more evenly spread throughout time in custody.

**Prisoner age**

- Younger prisoners tend to self-harm and be involved in assault incidents more often than older prisoners while suicide rates among prisoners tend to peak among those in their thirties.
The mean age of prisoners in a particular prison or for a grouping of prisoners is a useful indicator of the levels of violence that might be expected i.e. the younger the prison population, the more propensity there is for violence.

Gender

- Female prisoners self-harm more often than male prisoners and are more frequently involved in assault incidents.
- Female prisoners are less likely to take their own lives in prison custody.
- Female prisoners are more likely to be involved in assault incidents but these tend to be less serious, less likely to involve multiple assailants and more likely to be on staff.

Churn

- Prisoners are more likely to commit suicide, self-harm and be involved in assault incidents during the early stages of custody.
- The risk factor to an individual prisoner is the length of time they have spent in custody.

For groups of prisoners or prisons, this measure is normally presented as churn. To calculate your prisons churn:

- Establishment churn = (First Receptions + Transfers in from other prisons) / Population.

Churn inter-reacts with other factors in a variety of ways:

- Younger prisoners tend to spend less time in custody and therefore have a higher churn.
- Female prisons have a higher churn.
- Establishment churn is a particularly useful in determining whether more or less deaths, self-harm and violence are to be expected in prisons of a similar type. A prison with a relatively high churn will tend to have more self-inflicted deaths, self harm and violence.

This risk may be mitigated by increasing time out of cell, access to employment and education and/or increased staff contact.
Chapter 4 Peer Support

Overview

Effective peer support can contribute to suicide prevention strategies by helping to create a safe, decent and healthy environment with positive prisoner/prisoner and staff/prisoner relationships, where problems can be voiced and addressed and anxiety alleviated. For this reason there are a number of peer support schemes run specifically by prisoners for prisoners. There is an increasing range of schemes, ranging from a prison wide therapeutic community to individual carers for prisoners with disabilities and/or social care needs.

Peer support schemes can be an effective tool to complement the support given by staff to at risk prisoners. They should not replace or undermine good staff/prisoner relationships.

Prisoner Peer Support Schemes must operate with a clear, unambiguous disclosure policy appropriate to the type of scheme provided.

Further guidance on peer support schemes can be obtained from OSRRG.

Peer support scheme

Where a prison is considering introducing a peer support scheme they must give consideration to the following:

- Identify the need, articulate aims of the scheme and define measurable outputs
- Identify a member of staff responsible for the management and maintenance of the scheme
- The monitoring of any scheme
- The eligibility and selection process (which must be published) of peer supporters
- The ongoing staff supervision and support of peer supporters, including debriefing arrangements
- How prisoners will be made aware of the operation of schemes, their objectives and how to access them
- How to publicise peer support schemes. This might involve the wearing of t-shirts or badges or wearing ID cards. The names and photographs of peer supporters could be displayed in key areas such as their cell doors and rotas could be published
- How peer supporters will be made aware of de-selection and appeals processes. Samaritans have a specific process for the withdrawal of services
- The payment to peer supporters. Payment to peer supporters, other than Listeners (who do not receive payment), should not act as an incentive to take on the role and consideration should be given as to whether they should have other jobs in the prison

Training and support

Prisoner Peer Supporters must receive adequate and ongoing training and support for the role.

Third Party Providers of Prisoner Peer Support Schemes must be provided with appropriate training and support.
The SCTL may be best placed to provide management oversight of peer support schemes related to safer custody, such as local Listener and Insider Schemes.

It may be useful to discuss matters arising from Samaritans, and other peer support scheme coordinators at safer custody meetings.

**Listener schemes**

Listeners are volunteer peer supporters selected, trained and supported by Samaritans, to listen and offer confidential emotional support to prisoners in distress. *Where a decision is taken to offer the Samaritans supported Listener Scheme it must be operated in line with the Samaritans Guide to Listeners (from January 2012).* Further guidance on Listener schemes can be obtained from OSRRG.

*The Governor must discuss with the local Samaritans what might trigger a decision to stop a prisoner acting as a Listener.*

It is not appropriate to ask young people under the age of 18 to take on the responsibility of offering confidential emotional support to other young people. Samaritans do not train young people under the age of 18.

*Where a Listener scheme exists prisons must ensure that:*

- **Prisoners have timely access to Listeners wherever located**
- **Prisoners have the facility to contact Samaritans by telephone privately. There must be no cost to the prisoner and the call must not be monitored**
- **Listeners needing to debrief after a call-out, or needing confidential support must have the facility to contact Samaritans by telephone privately**
- **All investigators (including police/Coroner’s officers/PPO investigators) looking into the death of a prisoner who want to interview a Listener must do so only in the presence of Samaritans. It should also be very carefully explained to the investigators, before any interview, that the confidential nature of information shared with a Listener is maintained after death, unless a court subpoenas Samaritans or a Listener**
- **If a Listener is required to attend an inquest, arrangements must be put in place to ensure Samaritans will be available to support the Listener through the hearing**
- **Where there is a dedicated Listener support suite, a protocol must be in place for its use**
- **There is a Samaritans Liaison Officer who can facilitate the provision of support by Samaritans**

No prisoner can take on the role of both Listener and Insider.

Governors should ensure that prisoners being trained as Listeners are not transferred out of the prison whilst they are training and then, are kept on hold for at least six months. Frequent turnover is disruptive to the effective running of the scheme and creates unreasonable training demands on Samaritans who do not have the resources to run training programmes constantly.

A scheme should never be run with only one Listener. For any scheme to be effective the Listener Group needs to be a team and this is rarely possible with less than four Listeners. It is
recommended that a rota is drawn up which ensures at least two Listeners are on duty at any one time.

*When a prisoner, who is high risk on the cell sharing risk assessment (CSRA), requests to see a Listener, staff must make an assessment on a case by case basis as to whether or not a Listener(s) can offer support to the prisoner. In some cases, such as at night, it may be considered appropriate for two Listeners to be present. If it is decided that the prisoner should not be given access to a Listener, additional support such as the Samaritans phone must be offered.*

**Understanding confidentiality**

The principle of total confidentiality is central to the work of Samaritans. This equally applies to Listeners. Without this assurance prisoners may not feel able to approach Listeners and talk freely in an atmosphere of total trust.

There are a number of exceptions to the principle of confidentiality in the following specific circumstances:

- A confidence which contravenes the Prevention of Terrorism (Temporary Provisions) Act 1989, since updated to the Terrorism Act 2000, as amended by the Anti-Terrorism, Crime and Security Act 2001
- Where a contact is attempting to take their own life and where it is clear that they are unable to make their own decision
- Where the contact attacks or threatens the Listener
- Where information is given about acts of terrorism or bomb warnings
- Where a court order (subpoena) is received requiring them to divulge the information

It is Samaritans policy that when prisoners are seriously at risk of suicide they will actively encourage them to seek further help. If the Listener recognises that a prisoner does not wish, or is unable to seek help on their own, then they will attempt to gain the prisoner’s permission to alert staff to the need for help.

Telephone calls and correspondence between prisoners and Samaritans is subject to confidential handling arrangements as set out in PSI 49/2011 Prisoner Communication Services:

**Samaritans**

It is essential that staff do everything possible to help Samaritans volunteers make best use of their time and to reduce avoidable delays in entry to the prison. Every effort should be made to facilitate the swift completion of security clearance procedures, the provision of keys and appropriate training.

Each Samaritans branch will have a Samaritan responsible for its prison work (Branch Prison Co-ordinator) and each region a Regional Prison Support Officer (RPSO) who are members of the National Prison Support Team. Any difficulties that arise should be discussed with the Branch Prison Co-ordinator and then the RPSO.

Samaritans’ volunteer resources are limited. Individual branches are discouraged from supporting Listener schemes unless they are confident they have the resources to continue to do this.

Although it is recognised that the most effective way to offer emotional support to prisoners is providing and maintaining a Listener/Peer Support team; there will be occasions when prisoners
say they will only see Samaritans. A private room should always be made available for a prisoner to speak with Samaritans in confidence.

If staff have concerns about a prisoner, if offering support from a Listener or peer supporter is declined, it is entirely appropriate to request support from the local Samaritans branch.

Sensitivity is required in handling requests for access to Samaritans by telephone, whilst clearly not allowing the system to be abused. It is not appropriate to leave a prisoner with a cordless phone for long periods of time particularly overnight.

**Insiders**

The Insiders scheme involves the training of selected prisoner/under 18s volunteers to provide basic information and reassurance to prisoners new to prison shortly after their arrival in prison. The aim of the Insiders scheme is to help reduce anxiety experienced by prisoners during early days in custody.

Insiders are not an alternative to Listeners; they offer a different but complementary peer support service. It is crucial that Insiders and Listeners understand each other's role and are able to refer to each other.
Chapter 5  Assessment, Care in Custody and Teamwork (ACCT)

Overview

The National Offender Management Service has a broad, integrated and evidence-based prisoner suicide prevention strategy that seeks to reduce the distress of all those in prison, staff, prisoners and visitors. Any prisoner identified as at risk of suicide or self-harm must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures. ACCT is a prisoner-centred, flexible care-planning system which, when used effectively, can reduce risk. The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed.

The identification and management of prisoners at risk of suicide and/or self harm is everyone’s responsibility. Good staff/prisoner relationships are integral to reducing risk. Other factors which are fundamental to reducing risk are regular participation in regime activities, positive family and peer relationships, and referral to appropriate specialist services such as mental health in reach.

The ACCT Process

Identifying Risk and Opening an ACCT

The ACCT form has been revised (to version 5) and will be issued for use with effect from 1 April 2012.

Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form.

The ACCT plan must be passed in person to the Residential Manager, Daily or Night Operational Manager, whilst ensuring the prisoner is kept safe.

Responsibilities of Residential Manager, Daily Operational Manager and Night Operational Manager

Within an hour of the ACCT being opened, the Residential, Daily or Night Operational Manager must:

- Talk to the prisoner and complete the Immediate Action Plan (IAP) to ensure the prisoner is safe from harm.
- Obtain a log number in line with local practice and procedures, which must be inserted in the box on the front cover of the ACCT Plan.
- Inform the relevant staff undertaking safer custody administrative support duties.
- The opening of the ACCT must be recorded within the case notes section of NOMIS giving a brief summary of the relevant issues.
- Record in NOMIS (and a T1:VR in young people’s establishments) and, where retained wing observation books that an ACCT Plan has been opened.
- Inform Healthcare, including the mental health in-reach team where appropriate, so that the opening of the ACCT Plan can be noted in the clinical record.
- Request any relevant information from Healthcare staff which will contribute to the assessment and subsequent risk management of the prisoner.
Arrange for an ACCT assessment to take place and organise the first Case Review.

Ensure that prisoners have been offered, where available, the opportunity to talk to a Listener and/or Samaritans.

Where the prisoner moves location during this first hour the responsibilities outlined above must be undertaken and/or completed by a manager in the receiving department. During night state this will be the Night Operational Manager.

Prisoners who do not speak English must be given access to an appropriate translation service in order to participate in the ACCT process.

When the prisoner is aged under 18 years, the Safeguarding Manager and YOT workers must also be informed. They will advise on the appropriateness of informing the parents/carer/next of kin about the opening of the ACCT Plan, and about whether to make an external referral to Social Services for advice, support or assessment.

Young people aged under 18 years, who are on an open ACCT plan, must be offered appropriate support.

The ACCT Assessment

The trained ACCT Assessor must:

- Interview the at-risk prisoner within 24 hours of the Concern and Keep Safe form being opened. Every effort must be made to engage with the prisoner. However, if the prisoner refuses to be interviewed or is unable to participate in the interview, the ACCT assessor must undertake the assessment based on all available information e.g. pre-sentence reports, OASys, health care information, NOMIS case notes and previous ACCT documents.

- Where prisoners do not speak English, ACCT assessments must be undertaken with the assistance or involvement of an interpreter, or appropriate translation service.

- Ask the prisoner to sign the ‘agreement to sharing information’ on the inside front cover, and (assuming the prisoner has agreed) complete that form. If the prisoner does not wish to sign this or is unable to due to a lack of mental capacity, share only information that relates to the risk and how to reduce the risk.

Record the outcome of the interview in the ACCT Plan.

Attend, whenever possible (if they can not attend they must meet with the Residential /Case Manager prior to the first case review and give a detailed summary of the assessment discussions and key issues), but not chair, the first case review with the at risk prisoner.

First Case Review

The first case review must:

- Be held within 24 hours of the ACCT Plan being opened, ideally immediately after the Assessment interview.

- Be attended and chaired by the Residential Manager, or equivalent and/or the Case Manager (if different), the Assessor, whenever possible, a member of staff who knows the prisoner e.g. wing officer, the person who raised the initial concern, healthcare, and any other member of staff who has or will have contact with the at-risk prisoner and who can contribute to their support and care e.g. staff from Probation, Education, CARATS, psychology, etc. The review should be timely and
not unduly delayed to ensure full attendance. If invited participants cannot attend in person, exceptionally, they can provide a written account of their input.

Be attended by the prisoner unless there are specific reasons why this would not be possible or appropriate. The reason for non-attendance must be documented in the summary of the case review. When the prisoner does attend, they must be encouraged to participate in the review process.

Appoint a Case Manager of minimum grade of Senior Officer or Band 5 Nurse.

Identify the prisoner’s most pressing needs resulting in suicidal ideation or to self-harming behaviour, and identify appropriate actions to address these needs.

Agree the level of risk posed by the prisoner to themselves, taking into consideration all available sources of information.

Agree how the prisoner will be supported.

Consider and agree whether any items which the prisoner might use to self-harm should be removed from them. Removal of items should be kept to a minimum and must never be automatic.

Agree the frequency of, and recording of, conversations, observations and support day and night as the night requirements may be different. These decisions must be set out in clear, plain language on the front of the ACCT document. Do not use codes or jargon. Observations must be at unpredictable times, e.g. twice an hour as opposed to every 30 minutes.

Agree what events/signs or increased risk (if any) will be watched out for and will trigger further action and/or an immediate case review. These must be noted on the inside front cover of the ACCT Plan.

Identify whether a referral for mental health care or drug/alcohol services is needed and make the referral(s). This decision must be explained in the Record Summary of the first Case Review.

Complete the CAREMAP giving detailed and time-bound actions aimed at reducing the risk posed by the prisoner.

The outcome of the case review must be notified to the prisoner and a copy of the CAREMAP given/offered to them (unless the case review team has decided there are specific reasons not to do so, which must also be documented in the ACCT Plan)

Decide on the timing of the next case review and who will be invited to it. Consideration must be given to inviting the prisoner’s family/next of kin where this is thought to be beneficial, and in the case of young people the YOT must also be involved. This must be noted clearly on the Record of Case Review form. If a referral to healthcare has been made, they must be invited to attend the next case review.

Complete the Initial Case Review checklist to ensure all mandatory actions have been completed, and take immediate action to remedy any omissions.

**Completing the CAREMAP**

The CAREMAP must reflect the prisoner’s needs, level of risk, and the triggers of their distress. It must aim to address the issues identified in the ACCT assessment interview and give consideration to the following:

Level of supervision
Type/place of location, including cell sharing, safer cell,
Health/mental health intervention
Peer support
Diversionary material (in-cell activities)
Time out of cell
Access to the gym and other regime activities
Family contact
Access to Chaplaincy

Each action on the CAREMAP must be tailored to meet the individual needs of the prisoner and be aimed at reducing the risk to themselves and must be time bound.

The person(s) named against each of the ‘actions required’ in the CAREMAP must complete their actions by the date given. Where this is not possible, they must inform the Case Manager who must note this and the new date for completing the action against the relevant entry in the CAREMAP, as well as considering potential heightened risk this may cause.

Day-to-day Management of the ACCT Plan

The ACCT Plan must travel to and from any location the prisoner moves to when he/she participates in activities (e.g. the prisoners’ workplace). This ensures that the receiving member of staff is informed of the prisoner’s risk status and is able to input to the ACCT Plan On-Going Record.

Staff responsible for observing at-risk prisoners will need to ensure they are familiar with the requirements in that individual’s ACCT Plan

Staff must follow the level of observations and conversations as stated in the ‘required frequency of conversations and observations’ box on the front cover of the ACCT. These must be recorded immediately or as soon as practicable thereafter.

The Residential Manager, or equivalent, is responsible for ensuring that conversations and observations are completed as per the requirements set out on the front cover the ACCT Plan.

Staff must actively engage with the prisoner, encouraging him/her to talk and participate in activities where appropriate. The conversations between staff and prisoners must be recorded accurately in the on-going record. A good-quality, meaningful entry can communicate more than pages of meaningless comments.

It is vital that the on-going record contains sufficient information about the progress and well-being of the prisoner. This information is critical to ensure that the risk is being managed appropriately and the CAREMAP remains relevant.

Quality Control of ACCT Plans

Governors/Directors will want to ensure that all ACCT documents fully comply with the procedures set out in this chapter. Version 5 of the ACCT document will contain a quality assurance checklist based on learning from audits and death in custody investigation reports.

The frequency of quality assurance checks will be determined on a case by case basis, for example, if a prisoner is on an ACCT document for a protracted period of time it might be more efficient for the quality checks to be undertaken as part of the case review.

Case Reviews

In addition to planned case reviews, where an ACCT trigger is activated (i.e. event actually occurs) or there are other concerns such as increases in frequency or lethality e.g. from cutting to using ligatures, or information is received from family/friends or other external parties, a case review must be held. The case review will consider if another assessment is required.
The Case Review Team must:

Be multi-disciplinary where possible. The ACCT process will operate more effectively if there is continuity in the attendance of staff from relevant departments/services. For example, if education is seen as a relevant department to attend the review, then every effort should be made to ensure the same member of staff attends the reviews, likewise with healthcare input.

Consider and record progress against the initial CAREMAP, and the prisoner’s general well-being.

Consider whether the prisoner exhibits any additional needs which may require the CAREMAP to be updated.

Review the level of risk presented by the prisoner including the frequency, method and lethality of any self-harm that has occurred since the last review.

Discuss with the prisoner the meaning of any acts of self-harm and options for alternative coping strategies.

Consider whether any items in use that have been removed can now be returned, or if any additional items need to be removed.

Review and record the frequency of conversations and observations, and update these on the front cover of the ACCT Plan.

Update the Triggers box if new information arises.

Update the CAREMAP to reflect the decisions of the case review team.

Decide the frequency of case reviews and record when the next case review (or post closure review) will take place and who should be invited to it.

Make a detailed and accurate record on the Record of Case Review Form.

Location of at-risk prisoners

The type of accommodation required for at-risk prisoners cannot be prescriptive, as much will depend on the facilities available in establishments. Case Managers and Case Review Teams must base their decision on where to locate an at-risk prisoner against the risk they present and the benefits the location may afford them.

Safer cells

The design of safer cells can assist staff in the task of managing those at risk from suicide by ligaturing. Safer cells are designed not only to minimise ligature points, but also to create a more normalising environment.

If considering the use of a designated safer cell as part of a wider care initiative staff must be aware that safer cells cannot deal with the problems underlying a prisoner’s self-harming/suicidal behaviours, and so safer cells can only complement (i.e. not replace) a regime providing individualised and multi-disciplinary care for at-risk prisoners. For further information on safer cells see PSO 1900.

Location in Healthcare

Whilst a prisoner is located in Healthcare, the ACCT Plan must be managed in line with the above procedures.
If a move to normal location is likely within a foreseeable timescale, the ACCT must remain open until the move has taken place and the prisoner has settled in their new accommodation.

When a move from healthcare is planned, a pre-discharge Case Review must take place before a prisoner is returned to normal location.

The Residential Manager (or Case Manager if different) from the receiving residential unit must be invited to the pre-discharge review. If this is not possible, a representative from the residential unit must attend in order to ensure that all relevant information and risk is shared and understood.

The Case Manager must complete the ‘Review Prior to Discharge from Healthcare’ form and update the CAREMAP, frequency of conversations and observations and trigger factors on the front cover as required.

Location in Segregation Unit

Prisoners on open ACCT plans must only be located or retained in Segregation Units only in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include others options that were considered but discounted.

The ACCT plans must be reviewed as soon as it is practicable prior to location in the Segregation Unit or immediately thereafter. The review must be undertaken in line with the procedures outlined above.

If a move to normal location is likely within a foreseeable timescale, the ACCT must remain open until the move has taken place and the prisoner has settled in their new accommodation.

When a move from a Segregation Unit is planned, a pre-discharge Case Review must take place before a prisoner is returned to normal location.

The Residential Manager, or equivalent (or Case Manager if different) from the receiving residential unit must be invited to the pre-discharge review. If this is not possible, a representative from the residential unit must attend in order to ensure that all relevant information and risk is shared and understood.

The Case Manager must complete the ‘Review Prior to Discharge from Segregation’ form and update the CAREMAP, frequency of conversations and observations and trigger factors on the front cover as required.

Closing an ACCT

The ACCT Plan must:

Only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so in that the risk posed by the prisoner has reduced.

ACCT Plans must not be closed to facilitate a transfer to another prison or within 72 hours of a planned transfer. Where a transfer takes place within the post-closure period, the receiving prison must be informed about the recent ACCT and the need for them to undertake the post-closure review.

When a prisoner on an open ACCT is discharged from custody, the final case review must consider what support can be offered in the community from other agencies and persons e.g. Probation Service, Drugs Services, Healthcare professionals, Social Services, Youth Offending Team (where applicable). Relevant information must be shared with the appropriate agencies. The CAREMAP must be updated to record the actions taken. When a young person is due to be released from custody and on an open ACCT or in the post closure phase, the case manager
should attend the Young Person’s release preparation meeting (1 month before the release date). The purpose of this is to discuss with the YOT/Family/Carer and young person the risks posed in the community. In addition, the final case review must be faxed/ emailed to the YOT prior to the Young Person being released. Entries on NOMIS and eAsset must be made demonstrating that this has occurred.’

Post-Closure Reviews

The date of the first post closure interview is a matter for the case review team to decide but must be within 7 days of closure.

When a prisoner has been transferred during the post-closure phase, the receiving prison must allocate a case manager and arrange for the post-closure review to take place.

The post-closure interview must review the CAREMAP and the progress made by the prisoner since the ACCT was closed. This must be recorded in the ACCT plan.

In all cases, the Case Manager must decide at the end of the post closure interview whether there needs to be any further reviews and the frequency of them.

The closure must be recorded within the case notes section of NOMIS giving a brief summary of the relevant issues.

The Case Manager must ensure that the central registration point (e.g. control room), Healthcare and staff undertaking ACCT specific safer custody administrative support duties are informed of the closure.

The closed ACCT Plan must remain on the wing until completion of the post closure interview(s). Once it is confirmed there are to be no further post closure interviews the closed ACCT Plan must be stored safely in the F2050 core record.

An ACCT plan can be re-opened at any point following closure if the risk posed by the prisoner is deemed to have been increased. The Case Manager must determine whether or not the circumstances for re-opening are different from that of the original plan and whether or not a new assessment needs to be undertaken.
Chapter 6  Constant supervision

Overview

Constant supervision is where a prisoner is under constant supervision by a member of staff who provides appropriate levels of support in order to reduce the risk of suicide or potentially fatal self-harm. **Constant supervision must only be used at times of acute crisis and for the shortest time possible.** The process of being constantly supervised by a member of staff can be de-humanising which may increase risk.

The need for constant supervision

Constant supervision is a response to an immediate suicidal crisis and therefore is intended to be in place for the shortest time possible. An acute suicidal crisis is often temporary.

The following reasons for the use of constant supervision are intended as guidance only as each case should be considered individually by the Case Management Review Team and not in isolation by any one person:

- Serious attempts and/or compelling preparations for suicide e.g. making a ligature, hoarding medication and/or writing a suicide note
- Credible expression of a wish to die
- A recent and credible attempt to take own life e.g. both in prison and recently prior to imprisonment

Constant supervision may be used on an interchangeable basis. For example, a prisoner could be placed on constant supervision overnight and on less frequent observation during the day while involved in activities.

Constant supervision can only be authorised by the Daily Operational Manager or the Senior Clinical Manager after consultation with each other and the decision documented in the ACCT Plan.

During periods where the Daily Operational Manager and/or the Senior Clinical Manager are not in the prison (i.e. night state), authority for constant supervision can be given by the Night Operational Manager or Senior Nurse following consultation with each other. **The Daily Operational Manager must be informed at the earliest opportunity.**

**Where the prisoner is already under the care of the Mental Health team, the lead clinical consultant must be notified at the earliest opportunity in order that they can engage therapeutically and advise of any clinical support needed.**

Gated Supervision Cells

**Gated cells must only be used when a prisoner requires constant supervision in order to receive concentrated attention designed to reduce their risk of suicide or fatal self-harm.**

*The decision to accommodate a prisoner in a gated observation cell and on constant supervision must be recorded in the ACCT Plan.*

Prior to locating a prisoner in a gated cell, the cell must be searched and this must be recorded in the ACCT plan.

**A prisoner must remain in the gated cell for the shortest time possible and this must be documented on the CAREMAP by the person authorising the constant supervision.**
Case Management Reviews

One aim of the case review is to reduce the level of supervision required progressively, substituting alternative supports, as the prisoner’s condition improves. *When a decision is taken to place a prisoner on constant supervision, a case management review must be undertaken as soon as practicable, unless the decision was taken as part of a case management review.*

*For the first 72 hours, a multi-disciplinary case management review must be held daily. The review must be chaired by a competent manager who has the appropriate authority to make decisions. The Daily Operational Manager or Residential Manager and a member of the nursing staff (or senior clinical manager) must be in attendance, as well as any other relevant staff. Given the acute crisis that the prisoner will be experiencing, continuity of membership of the review team will be an important consideration in order to reduce the prisoner’s distress.*

If a prisoner remains on constant supervision for longer than 72 hours, the case management review team will decide upon the regularity of future reviews and record this in the ACCT document.

If a prisoner’s behaviour is particularly challenging, or is subject to constant supervision for 8 days or more, they will be managed with the additional input of an Enhanced Case Review (see Chapter 8).

*The prisoner must be seen by a doctor at least once in every 24 hour period.*

Emergency Access Plan

The Case Review team will provide authority, in the form of an Emergency Access Plan, for staff to intervene when a prisoner who is under constant supervision engages in potentially fatal self-harm or attempts suicide. *The plan must detail actions for the supervising member of staff to take, including how to raise the alarm, entering the cell during the day and night, use of force to prevent self-harm and the provision of Personal Protection Equipment (PPE). Emergency Access Plans must be tailored to the individual and not provided from stock.*

Interaction

*The member of staff conducting supervision must actively engage with the prisoner, encouraging them to talk and participate in activities where appropriate. Talking, playing games, accompanying the prisoner onto the exercise yard (subject to risk assessment) should all be considered.*

The ACCT Case review team must document in the Care Plan details of how the prisoner will engage with purposeful activity and contact with family and friends.

Contact with home and the community may provide an important source of support and provide further information for staff. Contact should therefore be facilitated wherever possible and appropriate.

Access to Regime Activities

For the purposes of this section, regime activity refers to all activities usually available to all prisoners, e.g. visits, chaplaincy, gym, learning and skills places.

Participation in regimes activities can significantly reduce a prisoner’s risk of harm to themselves and should be encouraged. *Where the regime activity is in-cell, the constant supervision must remain in place.*
Subject to the decision-making of the multi-disciplinary case review, the levels of observations can be reduced during the out-of-cell activity. For example, a prisoner may be subject to constant supervision whilst in a cell but the observations may be reduced to four times per hour during a regime activity, then returned to constant supervision when back in the cell.

Prisoners subject to constant supervision and who participate in regime activities out of the cell must be subject to searching in line with local security strategy searching requirements.

When on an Open ACCT, Items which a prisoner is allowed to have must be agreed by the case review team. Where there is information that suggests a prisoner has or may have acquired items/objects with which they could harm themselves, which have not been agreed/risk assessed, they must be searched and the items removed.

Use of Alternative Clothing

Alternative clothing must only be used as a measure of last resort and for the shortest possible time. This measure must not be used for young people in custody. Consideration needs to be given to alternatives, such as locating a prisoner who is considered to be at high risk of suicide and likely to use ligatures from torn clothing, in a safer or constant supervision (gated) cell with high levels of staff observation (and access to some activities).

Placing an at-risk prisoner in alternative clothing must trigger an enhanced case management review. It may also trigger a mental health review and increased interactions.

Reasons for the use of alternative clothing must be documented in the ACCT plan.

Where the case review team has decided that alternative clothing must be used, removal of the prisoner's normal clothing must be done by persuasion and negotiation. Where this is not possible, and it is considered that there is no other way of preventing the prisoner from taking their own life, control and restraint techniques may be used to forcibly undress the prisoner. This would amount to a planned use of force and PSO 1600 Use of Force Segregation applies.

Prisoners must not be left in alternative clothing during any activities that bring them in contact with other prisoners because of the risk of ridicule. Normal clothes are to be re-issued during these times and increased levels of observation relied upon to reduce the risk of suicide and/or self-harm.

Use of in-cell CCTV for prisoners at risk of suicide and/or self-harm

The use of in cell CCTV is not synonymous with the constant supervision of prisoner at-risk of suicide. This section only covers the procedures that must be followed for the use of in cell CCTV for those prisoners at risk of suicide and/or self-harm.

The use of in cell CCTV in prisons is covered in the Prison Rules, specifically Rule 50A (YOI Rule 54) which states:

(1) Without prejudice to his other powers to supervise the prison, prisoners and other persons in the prison, whether by use of an overt closed circuit television system or otherwise, the Governor/Director or Director for contracted prisons may make arrangements for any prisoner to be placed under constant observation by means of an overt closed circuit television system while the prisoner is in a cell or other place in the prison if he considers that:
A. such supervision is necessary for -
   1. the health and safety of the prisoner or any other person
   2. the prevention, detection, investigation or prosecution of crime or
   3. securing or maintaining prison security or good order and discipline in the prison
and
B. it is proportionate to what is sought to be achieved.
(2) If an overt closed circuit television system is used for the purpose of this rule, the provisions of rules 35C and 35D shall apply to any material obtained (disclosure and retention of material).

*Cells which have CCTV installed must have clear signage notifying the prisoner that they are being monitored. Where CCTV is used to monitor a prisoner at-risk of suicide and/or self-harm, the CCTV must be monitored at all times.* It is vital that the prisoner also understands this and a note made in the ACCT Plan to that effect, signed by the prisoner. Failure to do both of these may result in the surveillance being construed as covert, which would require authorisation from a Secretary of State under the Regulation of Investigatory Powers Act.

The circumstances in which the use of in-cell CCTV might be considered appropriate and proportionate with regards to potentially fatal self-harm and/or suicide are:

- When a prisoner is subject to constant supervision but behaves in such a way that poses a risk to the safety of staff.

- When the level of observations are being reduced from constant supervision by a member of staff, the use of in cell CCTV may be an appropriate step-down in order to continue to assess the risk posed by the prisoner following the removal of interactions with the supervising member of staff. *Where in cell CCTV is used as a step down from constant supervision the length of time for its use must be decided by the case review team.*

- *Where in cell CCTV is being used to monitor a prisoner at risk of suicide and/or self-harm, the in cell CCTV must be monitored by a member of staff at all times, and entries made in the ACCT document in line with the case review.*
Chapter 7  Management of violence

Overview

This chapter provides guidance on the effective management of violent prisoners. It outlines the management information required to understand violence in prisons, the tools available to tackle violence, and guidance on how to reduce the risk posed by the most violent prisoners.

NOMS is fully committed to zero tolerance to violence in our prisons. Violence is not acceptable in any form. Everyone has the right to live, work and develop in a safe environment which is free from fear of abuse, harm or oppression.

*Every verbal or physical act of violence must be challenged. Appropriate sanctions for perpetrators must be applied robustly, in a fair and consistent manner. Victims must be supported and protected.*

*Any sanctions applied must have authority under the Prison or YOI Rules. IEP reviews, adjudications and segregation have appropriate authority. If sanctions are applied (such as removal from association or loss of privileges) as part of local policies without the authority of an IEP review or an adjudication hearing, they are likely to be unlawful.*

Management Information

Violence is unevenly distributed around the prison estate. It is therefore essential that there is a detailed understanding of violence in individual prisons and comparisons are only made with prisons of a similar function and operational capacity. More information can be found in the Safety in Custody Annual Statistics on the Ministry of Justice website.

In order to reduce violent incidents, it is vital that comprehensive management information is collected, analysed and acted upon. The Violence Management Report (VMR) on The Hub provides detailed data on violent incidents and the management response to them. Analysis of this data will generate a detailed overview of violence management from which trends can be identified and action plans developed.

Tips on analysing VMR data

The Hub provides data that can be analysed at Directorate, Regional and prison levels. The data can be cut by month, year-to-date or other specified time blocks. Comparisons can also be made with other prisons although care should be taken to account for function, size, and population demographics particularly age and churn.

The VMR contains a number of data sources from which trends can be identified. In prisons with a high volume of violent incidents, it may be helpful to undertake regular assessments of when and where violent incidents are occurring. It may also be useful to analyse the location of prisoners assessed as “high risk” on the CSRA to ensure that those at a higher risk of harm to others are dispersed around the prison. This information can be downloaded from NOMIS. (Please see chapter 14 for other sources of data)

Tools to tackle violence

*All incidents of violence must be challenged be they physical, verbal and/or emotional.* There a range of options available to staff starting with speaking to the prisoner concerned to make them aware that their behaviour will not be tolerated and that sanctions may be imposed. The sanctions may be used incrementally or in combination, depending on the seriousness of the incident and/or the wishes of the victim.
Sanctions available to staff include:

**Use of Incentives and Earned Privileges.** Full guidance on running an effective IEP scheme is covered in PSI 11/2011. Given the importance of promoting a safe environment in prisons for all who live and work there, the use of IEP may be used alongside other sanctions, where the evidence supports such action.

Double Jeopardy – this is the prosecution of a person twice for the same offence. This would occur only if a prisoner was adjudicated upon and then automatically downgraded on IEP without a proper review taking place. Similarly, prisoners cannot have their IEP status downgraded as an adjudication award.

The adjudication system and the IEP scheme are two different processes. It is possible for a single breach of the Prison Rules, e.g. an assault, to result in both an adjudication and an IEP review, the outcome of the latter which might be a downgrade in IEP level. In order to avoid double jeopardy, the critical issue is that the IEP review takes place in line with PSI 11/2011 and that the downgrading is not automatic.

**Adjudications.** The adjudication system is covered in PSI 47/2011. Adjudications are the lawful method of punishing breaches of the Prison and YOI Rules either by an operational manager or an Independent Adjudicator.

**Referral to police.** Any alleged crime can be reported to the police either directly or through the local Police Intelligence Officer. *Where the victim of a violent incident is a prisoner, their wishes must be considered.* There are approximately 15,000 violent incidents in prisons each year. It would place a significant and unreasonable demand on police resources to investigate all these incidents. In many cases a more immediate and effective outcome would be gained by use of internal systems. However, it is recommended that the more serious violent offences are referred to the police.

Anyone living, working or visiting a prison could be a victim of violence. It is vital that systems are in place to support victims. The support available should be appropriate to the hurt or injury they suffer. Where practicable, it is recommended that victims are advised of the outcomes of any action taken following the incident.

In addition to the above sanctions, it may be necessary to undertake further internal investigations in order to learn lessons, prevent future occurrences and improve local delivery of safer custody.

As well as sanctioning violent behaviour, it is vital that prisoners are encouraged to address the causes of their violent behaviour. These may include:
- referral to offending behaviour programmes coordinated by offender supervisors,
- work with suitably skilled offender supervisors,
- interventions approved under effective regimes,
- referrals to healthcare or mental health teams,
- counselling via Chaplaincy, group work, 1-1 interview with VRC etc.

**Local management of violence.** Multi-stage approaches should only be used if a prison can demonstrate that this approach to managing a violent prisoner is more effective than other approaches. *Staff must engage with prisoners rather than just observe.* Covert surveillance is not recommended, but if considered appropriate would require a RIPA authorisation. Advice on the use of covert tactics under the Regulation of Investigatory Powers Act (RIPA) is available from the National Intelligence Unit by email to centralauthoritiesbureau@nomss.gsi.gov.uk.

*Interventions used locally must be implemented under appropriate authority, such as the IEP or adjudication policies.*

Consequences
Staff must continually remind prisoners of the consequences of their own actions ideally through face to face contact. Prisoners must be made aware that information relating to their involvement in violent acts will be recorded in NOMIS and is available to all staff undertaking assessments on them. This could jeopardise sentence progression i.e. future parole decisions, re-categorisation, ROTL, restoration of remission, HDC etc.

Victims

Zero tolerance focuses on perpetrators of violence and the action which must be taken against them. NOMS also has a duty of care to those affected by violence.

Staff victims of assault will require support according to the hurt or injury they suffer. Support within NOMS is provided by Employee Support and details can be found on the My Services website. Staff or managers can contact Employee Support directly by phone on 0845 607 2034 (VPN 7288 3300) or by email at employee.support@hmps.gsi.gov.uk

Prisoner victims of assault also require support. It is known that victims of assault can become perpetrators themselves so effective support can be seen as a preventive as well as a supportive measure.

Victims of violence may display some of the following traits:
- Reluctance to leave cell
- Cell is empty of personal possessions
- Disruptive behaviours displayed by a prisoner in order to remove himself from potential violence or conflict e.g. to segregation unit

Positive measures to address the above traits could be:
- Encourage proximity to staff while on association or movement between activities to promote safety and build self-confidence.
- Check in cell possessions against the prisoner’s property card (this can also be applied to perpetrators)
- Speak to the prisoner to ascertain any underlying concerns for safety
- Address poor personal hygiene
- Support prisoners to gain employment in order to be self sufficient and not rely on other prisoners
- Encourage victims to reflect on their own behaviours that may result in acts of violence or confrontation from others

Support from staff will help in the following ways;
- The self-esteem of prisoners is promoted.
- Seeking help is promoted as a positive and powerful action.
- Confidentiality is assured and circumstances that change this are explained.
- All reports are taken seriously and dealt with appropriately.
- Prisoners are given regular opportunities to report concerns.
- Prisoners are given feedback on how the issues have been dealt with.
- Prisoners sense decency, justice and security.
- Good staff/prisoner relationships underpin communication.

Management of violent prisoners

The majority of prisoners who are physically violent towards others, will generally only commit one such offence. In most prisons, the majority of such incidents will occur within the first few weeks following reception. For the majority of these prisoners the imposition of the sanctions outlined above may be sufficient to modify their behaviour.
There are some prisoners whose level of violence poses such a risk to the safety of others that they may benefit from a multi-disciplinary case management approach. It is vital that these prisoners are identified. The number of prisoners who may fall in scope for such an approach will vary by size and function of prison. Prisons could consider using the case management approach for prisoners who display the most challenging or violent behaviour. This is expected to be a small minority of the population or an individual who would be identified through local violence data.

The most effective management of these prisoners will be through multi-disciplinary case management. The main purpose of this is to articulate the risk posed by the prisoner, identify factors which trigger their violent behaviour and develop a management plan which aims to reduce risk and change behaviour. Further information on risks and triggers can be found at Chapter 3.

Unlike the ACCT case management approach, no forms have been produced. Therefore, decisions and actions for a prisoner who is being case managed must be entered in NOMIS. The initial assessment and number of reviews should be decided by the case manager team. There is no specified time for cases to remain open but evidenced improvement in a prisoner’s behaviour will not be seen quickly.

Gangs

A wide variety of prisoner groups are sometimes referred to as “gangs”. These can range from serious organised criminal networks through to unorganised, informal peer groups. Within prisons the term is sometimes applied to groups of prisoners who are affiliated with street-gangs in the community.

The term is also sometimes used to refer to groups of prisoners with no street-gang associations, who form cliques or groups in prison. These types of groups can exist for different reasons, operate in different ways and pose different risks. The way prison staff respond to the risks posed by these types of groups may need to be different.

Not all gang-affiliated prisoners will pose the same type, or level of risk. Simply belonging to a gang is unlikely to fully explain why an individual is involved in violence, and does not describe their full range of individual risk factors or triggers. Effective offender management involves assessing an individual’s risk and offending behaviour needs. Gang affiliation should be considered within the context of the full range of the individual’s offending behaviour and resettlement needs.

The presence of street-gang offenders in a prison may cause concerns about different behaviours such as the dealing of drugs, intimidation or violence. Local solutions should be developed from a good understanding of the problems at a local level.

Offending behaviour can change over time and in different contexts. Street-gang offenders may behave differently in a prison context, and the relationship dynamics between street-gangs can change. It is important to understand the nature of gangs at a local level, and monitor changes in group dynamics over time.

Whether gangs or groupings exist at a local level, it is important to remember that a management response will be more effective if aimed at addressing individual behaviour.
Chapter 8 Enhanced case management

Overview

Many prisoners present challenges to staff and other prisoners in their day to day lives. This chapter is aimed at those prisoners whose behaviour is so challenging and disruptive that they need additional case management in order that their risk of harm to self, others and/or from others is managed within the normal custodial regime. The behaviour will often prompt multiple referrals to Healthcare and the mental health team. Prisoners with complex behaviour may be subject to ACCT procedures for multiple and severe self-harm and/or suicide attempts, or may spend lengthy periods of time in the Segregation Unit or in Healthcare due to extreme acts of anti-social behaviour.

This chapter does not mandate that prisons manage persistent extreme anti-social behaviour by using an enhanced case review process. However, it has been shown that such a process can be very effective in reducing prisoners’ risk of harm to others as well as to themselves. The use of an enhanced case management approach will allow staff to respond more effectively to the prisoner’s individual needs to help reduce or modify their challenging behaviour.

The enhanced case review team must include a duty operational manager, or above.

Prisoner Behaviours

Governors have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners under the enhanced case management process. It is therefore recommended that, when prisoners display any of the types of behaviour listed below, they are managed under the enhanced case review process:

- Prolific, sustained and/or extreme incidents of self-harming behaviour (usually requiring medical intervention)
- Prolonged active suicidal intent - from time to time being managed on constant supervision
- Extreme and persistent demonstration or assessment of risk to staff and/or other prisoners
- Continual offences against discipline
- Managed on offences against discipline
- Managed on enhanced levels of unlock.
- And/or
- Have been subject to constant supervision for 8 days or more
- Have been involved in multiple incidents of fire-setting

The Enhanced Case Review Team

The Enhanced Case Review Team will involve all relevant disciplines and include more specialists and a higher level of operational management than a typical ACCT Case Review Team. Enhanced Case Management can also be used for prisoners displaying violent behaviour (see Chapter 8). The essence of case management is to provide a flexible but consistent approach to achieve the desired changes in a prisoner’s behaviour.

- A member of the mental health team or doctor (where the prisoner is already being managed by secondary mental health services, and wherever possible it should be their mental health care co-ordinator)
- The Residential Manager, Healthcare, Special Unit or Segregation Unit in which the prisoner is located. If the prisoner has moved frequently between Healthcare, Segregation Unit and the Residential Unit, it is advised that representatives with experience of their behaviour from all the locations should attend the first enhanced case review team meeting
• An appropriate psychologist. Psychologists, both clinical and forensic, often have valuable expertise in assessing and managing people with personality disorder and/or in behavioural management

• All specialists (e.g. education, Offender Manager/Supervisor) who work with the prisoner including, where involved, CARATS, RAPT or Therapeutic Community Therapists

• Offender Supervisor/key worker

• An appropriate member of the chaplaincy team.

• A member of the Independent Monitoring Board (IMB).

The prisoner must be involved in case reviews, as far as is practicable. Every effort must be made to secure attendance at meetings. In exceptional circumstances, where a member of staff is unable to attend and their contribution is vital, a written account should be submitted.

**Family Involvement**

Depending on the circumstances, involving family members may prove beneficial, if carefully managed. Families can provide vital insights into a prisoner’s behaviour and motivations (see chapter 13).

Family members can be involved in enhanced case reviews in a number of ways, e.g. through telephone contact with the case manager; via the Offender Manager, or in person at the enhanced case reviews.

**Mental Health Team**

It is essential that health and mental health assessments establish any underlying physical or mental health triggers for the prisoner’s behaviour so that these can be discussed at the enhanced case review.

It is advised that assessments are regularly revisited to ensure that changes in health and mental healthcare needs are promptly identified and any changes to mental capacity are noted and acted upon.

**Care Planning and Behaviour Management**

Consistent, integrated care by all staff involved with the prisoner is critical and the case review will need to ensure care planning enables staff to provide this as well as setting out the normal planning expected in a case management plan.

The care provided must include an active, on-going, determined attempt to engage the individual and build a positive relationship. The Case Review Team should identify a particular member (or members) of staff (ideally a skilled and experienced mental health nurse or other mental health worker) or a key worker to do this.

The case review team should consider all the evidence available and specifically, discuss with the prisoner and record appropriately:

• Their own perception of the reason they self-harm or become violent (including triggers) and;

• Identify ways in which their self-harming or violent behaviour can be improved.

• Encourage the prisoner to actively engage with the care/action plan
Decisions on the frequency of reviews will take into account the prisoner’s current mental state, prescribed medications and their effects and assessment of risk (constant supervision review timings are mandated elsewhere in this instruction).

**Support Mechanisms for Staff and Prisoners**

Managing complex behaviours can be extremely stressful for staff and other prisoners exposed to it. It is important to support staff dealing with prisoners with complex needs. This might include regular debriefs, group discussions, access to occupational health or counselling services. See PSI 08/2010 on Post Incident Care.

It is equally important to consider support mechanisms for any prisoners affected by the behaviour. Using peer support schemes such as Listeners or Insiders can be useful. For more intensive support, refer the affected prisoner to Healthcare and/or the Mental Health In-reach team.
Chapter 9  Complex behaviour

Overview

This chapter provides guidance on the effective management of those prisoners whose behaviour is so challenging and disruptive that they cannot be managed within the normal custodial regime. Their behaviour may often prompt multiple referrals to Healthcare and the mental health team. Prisoners with complex behaviour may often be subject to ACCT procedures for multiple and severe self-harm and/or suicide attempts and may spend lengthy periods of time in the Segregation Unit or in Healthcare due to extreme acts of anti-social behaviour. Additional guidance can be found at chapter 8.

Not all prisoners with complex behaviour will require case management under ACCT or an enhanced case management approach. However, in most instances the use of case management will allow staff to respond more effectively to the prisoner’s individual needs to help reduce or keep their challenging behaviour to manageable levels.

For transfers under the Mental Health Act, please see the documents entitled ‘Good Practice Procedure Guide: The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act’ which can be found on the Department of Health website.

The NOMS has developed two mental health training modules which can be accessed through Training Services. The information in this chapter provides a brief overview of some of the more common illnesses and behaviours which may be exhibited by prisoners.

Understanding Mental Health and Mental Illness

*Mental health* is a state of emotional and social well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively or fruitfully, and is able to make a contribution to his or her community (The World Health Organisation, 1999). It is the emotional resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well being and an underlying belief in our own and others’ dignity and worth.

*Mental illness* is a disturbance in thinking, feeling and behaviour that causes the person harm and significantly disrupts their daily living. It is a general term that refers to a group of illnesses, in the same way that heart disease refers to a group of illnesses affecting the heart. The term “mental illness” covers a wide spectrum, from the worries and grief we all experience as part of every day life, to the most bleak, suicidal depression or complete loss of touch with every day reality.

The information provided in this chapter is not intended to be comprehensive, further information on mental health/illness can be obtained by reference to the NOMS Introduction to mental health awareness and Enhanced mental health awareness training modules, or the DH Mental health awareness training module.

Understanding Depression

Depression is prevalent in society. Around 1 in 10 people suffer depression with around 1 in 50 suffering severe long term illness and its consequences can be serious. The condition involves disturbances in mood, concentration, sleep, activity, appetite and social behaviour. The individuals’ thinking is dominated by themes of pessimism, worthlessness, helplessness and hopelessness which, in turn, hugely increase the risk of suicide and/or self-harm.

Thinking of suicide is very common in depression but it is much better talked about than ignored. The key features of depression are:
- Disturbances in Mood
- Poor Concentration
- Sleep Problems
- Changes in Social Behaviour
- Changes in Appetite

Symptoms of anxiety or nervousness are frequently present and, where the person is severely depressed, physical symptoms may be more prevalent.

Some prisoners may use drugs and/or alcohol (including home brewed) as a way of masking painful feelings.

Depression is also one of the commonest mental health problems in older prisoners and can manifest in either difficult behaviour, self harm or self neglect. Combined with the early stages of dementia this can lead to a number of older prisoners being difficult to manage and a risk to themselves and others. Further guidance on Depression, Dementia and on Working with Older Prisoners can be found at on the Equalities Group Intranet webpage.

When a prisoner is prescribed anti-depressant medication, you should be aware that:

- They take at least two weeks before they ‘kick’ in and as much as six weeks for the full effects to be felt. Therefore, do not assume that the suicide risk is reduced once a doctor has started prescribing for a depressed prisoner.
- Once the mood of a very depressed prisoner starts to lift, they may become (temporarily) more, rather than less, likely to kill themselves. This is because severe depression saps motivation to do anything, including killing oneself.
- If anti-depressants are helping keep depression at bay, it is very important that medication is taken regularly and as prescribed by the doctor. Every wing needs a system, agreed with Healthcare, whereby prisoners who do not collect their anti-depressants or anti-psychotic medication are followed up to find out why.

When managing a prisoner suffering from depression, the following should be considered:

- Location in Healthcare if the depression is severe.
- Certain types of therapies e.g. cognitive therapy.
- Supportive therapy where the prisoner is given an opportunity to talk about the problems associated with the depression and encouraged to become more active (exercise).
- Referral to chaplaincy for pastoral support
- Provide activities in and out of cell in order to distract the individual from negative thoughts and help with building confidence.
- Where the depressed prisoner is located on normal location, treatment should include advice from Healthcare to wing staff about how best to manage the prisoner.
- It is advised that management plans consider the possible causes of increased depression e.g. fear of intimidation / violence, entering into or increasing prison debts, loss etc.

**Understanding Autism and Asperger Syndrome**

Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. There are over half a million people in the UK with autism, around 1 in 100 people. Autism appears to affect more men than women.
Asperger syndrome is a form of autism. People with Asperger syndrome are often of average or above average intelligence. They have fewer problems with speech but may still have difficulties with understanding and processing language.

The three main areas of difficulty which all people with autism share are sometimes known as the ‘triad of impairments’. They are:

- difficulty with social communication.
- difficulty with social interaction.
- difficulty with social imagination.

People with autism may also experience over- or under-sensitivity to sounds, touch, tastes, smells, light or colours.

Further information on working with disabilities can be found on the Equalities Group Intranet site.

**Understanding Schizophrenia**

Schizophrenia is a mental disorder that affects the way the prisoners brain processes information. A prisoner experiencing Schizophrenia will not see or understand things in the same way as other prisoners. They may have difficulty experiencing appropriate emotions, acting in an appropriate manner or perceiving reality.

Schizophrenia is a long-term mental health condition that causes a range of different psychological symptoms. These include:

- hallucinations - hearing or seeing things that do not exist
- delusions - unusual beliefs that are not based on reality and often contradict the evidence
- muddled thoughts based on the hallucinations or delusions
- changes in behaviour

Some side effects of anti-psychotic medication can be distressing and the prisoner should be closely monitored and it is advised that any prisoner with a psychotic illness, such as schizophrenia, who is located on normal location should have a named member of the Healthcare team (a mental health professional where possible), who is responsible for liaising with, and advising, the residential manager (or delegated member of staff) on the prisoner’s care.

When a prisoner is diagnosed as being acutely mentally ill, consideration should be given by healthcare staff to referring the prisoner for assessment with a view to obtaining a place for them in a psychiatric unit/hospital. In the meantime, they should be managed appropriately to meet their needs with appropriate levels of mental health nursing and planned activity during the day. This does not mean an automatic move to a healthcare bed or another prison location as many people can be managed safely in general population and isolating them can serve to exacerbate the illness.

Where the prisoner is relatively stable and it is therefore decided to locate them on normal location, the following provides some advice on management techniques:

- Calm approaches e.g. turn your UHF radio down to avoid any unnecessary distractions.
- High levels of noise, stress & expressed emotion can bring on psychotic episodes.
- Location with a carefully chosen cell mate who is known to be a calming influence.
- How the individual will spend their day.
- How regular access to medication can be ensured and who will take action if the individual does not take their medication.
Advice to all staff about interacting with the individual including; reducing confrontation unless it is necessary to prevent harmful and disruptive behaviour, responding gently with reassurance and giving clear concise instructions.

- Know what triggers are relevant to that individual.
- How to deal with residual symptoms i.e. sometimes the individual is still hearing voices but to a lesser degree of intensity. Find out from healthcare, what strategies may be useful to help the person cope in this situation.
- Sometimes the content of the delusion is very bizarre and rather than talking with the prisoner about the content it is often helpful to switch to ask how the person is feeling with the experiences they are having.

Staff should be aware that prisoners suffering from psychotic illnesses may:

- Not be in contact with reality therefore, will find it difficult to adhere to the regime
- Present as dishevelled in appearance and will be difficult to motivate to self care
- Become non-communicative which may be interspersed with agitation / excitement for no apparent reason
- Appear to be talking to others who are not there
- Sing, wail, pace or be suspicious of others
- Have an erratic sleep pattern and tend to sleep by their cell door
- Unintentionally or intentionally provoke others because of their bizarre, inconsistent behaviour.

Understanding Personality Disorder

Personality disorder is a recognised mental disorder. Studies have estimated that it affects between 4 and 11% of the UK population and between 60 and 70% of people in prison.

The NOMS Practitioners Guide to Working with Personality Disordered Offenders (January 2011) has been produced to support offender managers. However, it is also likely to be useful for prison staff and can be downloaded from the MoJ and DH websites.

It provides information about personality disorder and practical advice on how to manage people who can be extremely challenging. It also considers the effect this work can have on staff wellbeing, identifying the signs and consequences, and suggesting how staff can protect themselves.

The guide is of particular use to staff working with offenders who present a high risk of violent or sexual offence repetition and of causing harm to others. Personality disorder is linked to these behaviours. It is also more likely to be present in offenders who:

- are recalled to prison
- accumulate adjudications
- drop out of or fail to make progress in accredited programmes
- complain about staff
• self-harm
• are transferred to secure NHS settings, and
• cause staff to go off sick.

The age at which a diagnosis of personality disorder can be made is subject to some debate. It is considered that young people below the age of 18 are still within a period of major developmental change during which personality traits may change, and therefore the diagnosis of personality disorder diagnosis at that age is uncertain.

Since 2006, NICE guidance on treatment of personality disorder has been published and the revised Mental Health Act of 2007 has removed the so-called ‘treatability test’ for detention of offenders with personality disorder.

Understanding Dual Diagnosis

The term ‘dual diagnosis’ refers to people diagnosed with mental health problems, who also use alcohol or street drugs (illegally produced drugs or illegally obtained prescription medicines). It may, for instance, include someone diagnosed with a psychotic illness who uses cannabis; or someone who is depressed and drinking heavily or using stimulant drugs (such as amphetamine or cocaine) in order to feel more socially confident.

Health professionals sometimes disagree about when to apply the term. Some believe that any substance use by people with mental health problems is likely to lead to increased symptoms, and is therefore problematic. Others accept that drinking and drug use is more common amongst people with mental illness than it used to be, and are more flexible about it.

There is no standardised treatment for dual diagnosis, largely because it ranges across such a large number of problems and involves both substance misuse services and mental health services.

People with this combination of problems often have a lot of additional difficulties, which are not solely medical, psychological or psychiatric. They are more likely to come into contact with mental health services, in crisis, with problems relate to social, legal, housing, welfare and ‘lifestyle’ matters. Medically orientated services can’t always help with multiple non-medical problems like these, which often reflect the social stigma that people with dual diagnosis face. They are not only drug users, but also mentally ill: two of the most stigmatised groups in society.

In a move away from medical definitions, the term 'complex needs' is often used when people have these complicated social and lifestyle problems. To tackle these complex needs, successfully, often requires a more holistic, joined up approach, from several different directions at once.

Learning Disabilities

Prisoners with learning disabilities or learning difficulties are likely to need additional support and reasonable adjustments to allow them to cope with and understand the demands of prison life.

Making small communication changes can have a powerful effect on the lives of prisoners who struggle to communicate. For example, providing written rules and instructions that they can understand will help prisoners to avoid breaking the rules accidentally.

A learning disability, in most cases, should not be ‘medicalised’ in prison. The healthcare team will need to meet the prisoner’s healthcare needs, as with all prisoners. They should ideally inform the
Disability Liaison Officer (DLO)/ Equalities and Diversity Officer, and any other staff working with a particular prisoner, of any concerns or support needs that they have identified.

Potential problems can be avoided by each prison ensuring it has in-house support, with certain staff taking on particular responsibilities (such as the Disability Liaison Officer, healthcare, education, Mental Health In-Reach teams, etc).

There is also potential for support from other prisoners (through peer support schemes) and from other prison roles such as the prison chaplain and IAG (Information and Advice Guidance) workers.

Equalities PSI 32/2011 ‘Ensuring Equality’ sets out the framework for the management of prisoner equalities issues to ensure that the MoJ meets its moral duty and legal obligations. In addition to the PSI, further information can be found on the Equalities Group intranet site.

**Communicating more effectively with a prisoner who has Learning Difficulties**

- Always explain to the person exactly why they are in a new situation, what they should expect and when this will happen. Try using their name at the start of each sentence. This is very important during violent or refractory incidents where the perpetrator may not understand the instructions they are being given.
- Visual aids (drawings, photos, a calendar for dates) and clear, simple, slow, focused language (spoken or written down) will help to increase the person’s understanding. Avoid using jargon.
- Emphasise key words and use concrete terms not abstract terms, for example, “At breakfast time” rather than “early on”.
- Break large chunks of information into ‘bite size’ pieces and ensure you give the person time to understand the information.
- Prepare the person for each stage of the communication, for example, “David, I will now ask you some simple questions” or “David, I will now explain what we are going to do."
- Be patient and calm whilst communicating, do not rush the person you are talking to as they may need longer to process the questions and think about their answers.
- Try to use open-ended questions rather than closed (restricting) ‘yes/no’ questions and avoid double-negative statements or vague questions such as “You were not in your cell, were you?”
- Be aware that repeating questions may suggest to the prisoner that they have given the wrong answer to questions that have already been asked.
- During interviews or assessments, prisoners with learning disabilities may answer “Yes” to all questions in order to please. As a result, it is important that, at some stage, the interviewer asks the same question but in a different way or to ask the person to explain what they think the question means.

It is advised that prisoners with learning disabilities are managed by a multi-disciplinary team under the case management process so that all recognised professionals and disciplines are aware of their needs and can formulate an appropriate management plan.


**The Mental Capacity Act 2005 (see Chapter 10 on food refusal and refusal of medical treatment)**

The Mental Capacity Act 2005 protects people who cannot make decisions for themselves e.g. due to a learning disability or a mental illness. The Act does not apply to young persons in custody under the age of 18yrs.
It provides clear guidelines for carers and professionals about who can take decisions and in which situations.

The Act is relevant to the management of people engaged in life-threatening or persistent self-harm in custody, through regular mental health assessments and involving Mental Health In-Reach Teams (MHITS) in Enhanced Case Reviews.

Chapter 10  Management of prisoners who refuse food and/or fluids and medical treatment

Overview

Some prisoners may decide to refuse food and/or fluids, or medical treatment for a variety of reasons. These decisions will be valid provided that the prisoner is deemed to have the mental capacity to make the decision. Mental capacity can only be assessed by a healthcare professional.

Sometimes prisoners will make an advance decision to refuse medical treatment while they still have the mental capacity to do so and before they need a particular treatment. These are often referred to as Advance Directives, Living Wills or Do not Resuscitate Orders (DNRs).

It is important that prisoners’ wishes to either refuse food and/or fluids or medical treatment are taken seriously and properly recorded. The information must be recorded, shared and remain accessible to all relevant staff.

The decision to refuse food and/or liquids is akin to refusing treatment and is therefore not considered in law to be a form of self-harm. The relevant case law distinguishes between a person who refuses food and a person who for example hangs themselves. The key judgment, prior to the Mental Capacity Act 2005, is Secretary of State for the Home Office v Robb [1995] 2 WLR 722.

However, the ACCT process may provide a useful way of recording the care offered to such a prisoner and facilitate the sharing of information. Every effort must be made to try and find out why the prisoner is refusing food and/or fluids and address the reasons for their refusal.

An advance directive cannot be put in place to allow a prisoner to self-harm or attempt suicide.

Mental Capacity

The Mental Capacity Act 2005 provides clear guidance that any individual has the legal right to refuse any treatment including food and/or fluid or resuscitation if they are mentally capable. The Act states that a person is assumed to have capacity unless it is established that they lack capacity and must not be considered unable to make a decision merely because they make an unwise decision. The Act does not apply to young persons in custody under the age of 18yrs.

Lack of capacity

Section 2(1) of the Act states:
‘For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.’

This means that a person lacks capacity if:
• they have an impairment or disturbance (for example, a disability, condition or trauma) that affects the way their mind or brain works, and
the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

**Fluctuating or temporary capacity**

Some times a person's capacity may fluctuate – this means that their problem or condition gets worse occasionally and affects their ability to make decisions. For example, a person with a psychotic illness may have delusions that affect their capacity to make decisions at certain times but disappear at others. Temporary factors may also affect someone's ability to make decisions. Examples include acute illness, severe pain, the effect of medication, or distress after a death.

**The Court of Protection**

An application to the Court of Protection may be necessary for a number of reasons including for situations where ongoing decisions may need to be made about the welfare of a person who lacks capacity to make decisions for themselves.

The Court of Protection has powers to:

- decide whether a person has capacity to make a particular decision for themselves; and
- make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions

The Court of Protection has the power to make a declaration / ruling on specific issues. For example, it can make a declaration as to whether a person has capacity to make a particular decision or give consent for or take a particular action or accept or refuse treatment at the time it is proposed. It can also decide whether an advance decision to refuse treatment is valid.

While waiting for the court decision, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration in the prisoner's condition. The court has emergency procedures to deal with urgent cases quickly.

**Mental Capacity to make an advance decision**

For most prisoners, there will be no doubt about their mental capacity to make an advance decision. In some cases it may be helpful to get evidence of a prisoner's capacity to make the advance decision. It is also important to remember that capacity can change over time, and a prisoner who lacks capacity to make a decision now might be able to make it in the future.

**Food refusal**

Understanding why a prisoner might refuse to eat and/or drink, and managing the amount they eat and/or drink, can be very difficult for prison staff. The effective management of such prisoners will be through a multi-disciplinary approach.

The Department of Health publication, *Guidelines for the Clinical management for people refusing food in Immigration Removal Centres and Prisons*, gives guidance to prisons on managing prisoners who may be refusing food and/or fluids. The guidance includes details on the legal aspects and the physical effects of food and fluid refusal. It also covers the most effective practical and clinical management of individuals during and following a refusal to eat or drink.

Many prisons have in place a food refusal log. An example can be obtained from OSSRG.

**Advance Decisions (including Advance Directives/ ‘Do not resuscitate’ (DNR) orders/notices/ Living Wills**

An advance decision to refuse treatment must be valid and applicable to current circumstances.
Prisoners can only make an advance decision if they are 18 years of age or over and have the mental capacity to make the decision. They must say what treatment they want to refuse, and they can cancel their decision – or part of it – at any time.

Some prisoners who refuse food and/or fluids may decide to set out their wishes to refuse food and fluids until their eventual death in an ‘Advance Directive’.

Some prisoners, particularly those who have a terminal illness may decide to put a ‘do not resuscitate’ notice or order in place which means that they must not be resuscitated if they collapse.

‘Do not resuscitate’ notice or order

If a Do Not Resuscitate Notice (DNR) is put in place this means that resuscitation must not be attempted. Every Primary Care Trust is required to have in place a DNR policy which will be applicable to healthcare services in prisons.

What should be included in an advance decision?

There are no particular formalities about the format of an advance decision. It can be a written or verbal instruction and should set out what treatment is to be refused. Where the advance decision is made to any member of staff, other than a healthcare professional, the information must be recorded and shared with healthcare.

Some prisoners may also want to get legal advice. This will help them make sure that they express their decision clearly and accurately. It will also help to make sure that people understand their advance decision in the future.

Involving the prisoner’s family

For any prisoner who is refusing food, fluids and/or treatment it is important to involve the prisoner’s family (provided they have given consent) in the ongoing support of the prisoner.

Chapter 11  Management of prisoners who are terminally or seriously ill

Overview

Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner, engaging with their next of kin or nominated person and providing support for staff.
**Prisoners who have a terminal illness must be encouraged to engage with their families or a nominated person where it is appropriate to do so.**

Many prisons will have in place palliative care arrangements for prisoners who are terminally ill. Further details can be found below.

Some prisoners may apply for early compassionate release, but may not meet the requirements or may chose not to apply. Chapter 12 of PSO 6000 sets out the details for prisoners applying for early release.

**Family engagement and contact with the next of kin**

*Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill.* It is good practice for a log of the contact with the family to be maintained. *Where prisoners have suffered sudden life-threatening harm, the prisoners’ wishes on who they would like to be contacted must be obtained where possible.*

*In any event where the prisoner is unable to communicate their wishes, the prison must contact the next of kin or a nominated person who must be given an accurate account of what has happened, including treatment given, whether the prisoner is in hospital, and information about visiting the prisoner.*

Where the prisoner is hospitalised, it may be helpful for the nominated member of staff to meet with the family to provide information, which may include discussing the escorting arrangements including whether the prisoner is handcuffed or not. This information will reduce the distress of the family and aid their understanding of prison escorting procedures.

**Palliative care for prisoners with a terminal or serious illness**

In July 2008, the Department of Health published the End of Life Care Strategy - promoting high quality care for all adults at the end of life. Its aim is to provide people approaching the end of life with more choice about where they would like to live and die. The strategy requires that prisons provide appropriate end-of-life care to prisoners.

The National End of Life Care Programme (NEoLCP) is the NHS organisation responsible for promoting good practice and training on end of life care.

The NEoLCP published a good practice guide in September 2011 entitled ‘Route to success in end of life care – achieving quality in prisons and for prisoners’. The guidance provides a tool to help prison staff and health and social care professionals working with people nearing the end of life in prison. The tool emphasises the need for all those involved in a person’s care to work across service boundaries to identify those nearing the end of life and respond accordingly.

The guide sets out some of the specific issues facing those involved in the care of prisoners. These include:

- The safety of the environment
- Policies around access to symptom control medication and use of morphine or syringe drivers
- Does a prison officer have to be present at all visits/treatments and at death?
- What is the process for considering compassionate release?
- Access to training and support for prison staff
- Are there policies to protect the dignity and privacy of people nearing the end of life

Family involvement for terminally ill prisoners
For those prisoners who may not be released before they die, it is important that prisoners are able to maintain closely contact with their family or a nominated person. With the prisoner’s agreement, the family should be kept informed and updated on the prisoner’s condition particularly if there is deterioration in their condition.

Consideration of early compassionate release
It is important to discuss this with the prisoner, as an application may take some time, or the prisoner may not wish to apply.

‘Do not resuscitate’ orders
Prisoners are able to be involved in the decisions made about the care they receive and in some cases make a decision not to be resuscitated.

A prisoner may decide to have a ‘do not resuscitate order’ (DNR) in place. It is key that information is recorded and that if a DNR is in place this information is shared with staff in order that the prisoner’s wishes not to receive treatment are respected. See chapter 9 for further details.

Staff support

*Prisons must ensure that appropriate support is available to staff working with terminally ill prisoners and those who are seriously ill.*
Chapter 12  Actions following a death in custody

Overview

Following a death in custody it is vital that the incident is reported promptly and accurately, including the appropriate notification of the next of kin. *Management of a death in custody must follow the instruction in PSO 1400 Incident Management and all relevant stakeholders must be informed.*

*Staff must co-operate fully with all investigations following a death, including those by the police, the Prisons and Probation Ombudsman (PPO), the Health and Safety Executive (HSE) where applicable and the coroner’s inquest.*

For reporting and internal management reasons, a death in custody also includes those prisoners who die in an outside hospital or a hospice whilst released on temporary licence (ROTL) for medical reasons. There will usually be a PPO investigation and an inquest. For prisoners released on other types of ROTL, on early release on compassionate grounds and following discharge from custody, external investigations may follow. It is, therefore, vital that all prison documents are retained.

*Prisons are required to have a nominated member(s) of staff to liaise with family members or a nominated person and assist stakeholders with their investigations.* In order to maintain role clarity and professional boundaries, it is advisable that the member of staff undertaking the investigations/inquest liaison role does not undertake the FLO role.

Information on family liaison is set out in chapter 13 of this PSI.

Reporting

*Following a death in custody prisons, in line with PSO 1400 Incident Management must promptly notify:*  
- the police  
- next-of-kin and any other person the prisoner has reasonably nominated to be informed. *Where no known next of kin is identified, prisons must take reasonable steps to trace any family members*  
- the coroner  
- the Deputy Director of Custody, the Director of High Security Prisons, the Deputy Director of Contracted Prisons, Head of Prisoner Escort Custody Services as applicable  
- Press Office, making clear whether next-of-kin have been informed.  
- National Operations Unit by telephone and later on NOMIS/IRS

This is not an exhaustive list. Please refer to PSO 1400 Incident Management which sets out in greater detail who must be notified following a death in custody

Immediate Actions

*Once a death has been verified by a qualified person, prisons must follow their local contingency plans on deaths in custody.*
All deaths in custody are treated as suspicious by the police. This is particularly important when a death has occurred in a shared cell. Care must be taken when relocating cell-mates as there may be vital forensic evidence which must be preserved.

The cell sharing risk assessment of the cell-mate must be reviewed in line with PSI 09/2011.

Appropriate care and support must be offered to the cell-mate and any other prisoners directly affected by the death, including all those on open ACCT documents.

Retain, and securely store in a locked cabinet with signed access only, all documentation (except for the clinical records, see below) relating to the deceased prisoner for investigations by the police, the PPO and the coroner’s inquest – see details below on retention of documents.

Staff directly involved in the incident, particularly those who were first on scene, must complete Incident Report Forms as soon as is practicable.

Retention of documents

There may be a considerable delay between the death and the inquest. The coroner may ask for documentation not requested by either the police or the PPO. It is crucial therefore that prisons retain all documentation relating to the death in custody.

As soon as possible after the death, all documentation must be gathered together and securely stored in a locked cabinet with signed access only until after the inquest. This will include:

- Copies, or originals if not removed by the coroner, of the F2050 ACCT documentation
- Observation books
- Staff detail documents
- Local policies and protocols in operation at the time of the death must be retained, in particular policies on suicide prevention, IEP and segregation
- Contracts with the local PCT
- Any evidential CCTV footage, pin phone records and cell bell logs.

Clinical records (to include all the health records such as Care Plans and dental records) must be retained by healthcare staff.

A checklist detailing the documentation to be retained can be requested from OSRRG.

All documentation handed over, must be signed for, and copies kept by the prison. A copy of all documentation provided to the coroner should also be sent to the Treasury Solicitor.

All documents must be retained for a period of 20 years after the inquest has concluded, for the purpose of civil litigation.

Supporting Staff

In line with PSI 08/2010 Post Incident Care a ‘Hot Debrief’ must be held immediately after the all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including Healthcare staff, should be invited. It may be useful to keep a record of those who attend.

A ‘Critical Incident De-brief’ must be held in accordance with PSI 08/2010

Governor/Directors are reminded that staff affected by a death in custody may require support at any time and on more than one occasion, including during police and PPO investigations, and during and after the completion of the inquest.
Samaritans are available to give support to prison staff who may be experiencing anxiety or distress following a self-inflicted death.

Support for Prisoners and Listeners

Prisons must ensure that they have procedures in place to support prisoners who have been affected by a death in custody.

It is crucial that local Samaritans are able to see the Listener team as soon as possible after a death. If a Listener is asked to see the police, Coroner’s officer, or an Investigating officer after a death, Samaritans should be present at the interview and on the rare occasion that a Listener is called to give evidence at an Inquest Samaritans should also attend.

Governor/Director’s actions

Following a death in custody Governor/Directors must:

- write a personal letter of condolence to the family which must include an invitation to the family to visit the prison
- offer to contribute to reasonable funeral expenses (see below)
- notify OSSRG when a disciplinary investigation arising from a death in custody is commissioned
- write to the family once the final response and action plan to the draft PPO report has been agreed, and again following the conclusion of the inquest
- Following police authorisation, arrangements must be made to hand over the prisoner’s personal possessions and monies to the appropriate person (see Chapter 13). Items should be listed and appropriately packaged, i.e. not in an HMPS plastic bag. It is advisable to ask the person to sign for receipt of the possessions. The person should be told if any items are being retained as evidence at the inquest and cannot be released immediately.
- Arrange for the chaplain or other religious leader to offer to hold a memorial service for the family, other prisoners and staff, both employed and contracted (subject to any specific faith considerations and the views of the family, staff and prisoners).

Funeral Arrangements

Prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3,000. The only exceptions where the family has a pre-paid funeral plan or is entitled to claim a grant from other government departments e.g. Department of Work and Pensions.

As a guide, reasonable funeral costs may include:

- funeral director’s fees
- hearse
- simple coffin
- cremation/burial fees, this does not include the cost of the burial plot
- Ministers fees (although the Governor may consider offering the services of their own Chaplain to conduct the service).

Reasonable costs do not include the following:

- headstone
- embalming / chapel of rest for viewing the deceased
- flowers
• transportation for mourners
• clothes for the deceased and/or mourners
• a wake or other hospitality related to the funeral
• obituary notices
• order of service sheets

All funeral expenses must be paid directly to the funeral directors upon receipt of an original invoice.

A deceased prisoner’s monies must not be used to meet the costs of their funeral.

**Investigations following a death in custody.**

**Police investigation**

The police investigation will have primacy over other investigations. The police have a memorandum of understanding with the PPO as to how an investigation will proceed when there is a possible or actual crime.

A protocol relating to police investigations of deaths in custody has been agreed by the NOMS with Association of Chief Police Officers (ACPO). ACPO also have a protocol with the Health and Safety Executive regarding deaths in custody.

*OSRRG and the Deputy Director of Custody must be notified if the police decide to interview any member of staff under caution and if staff are charged by the police with an offence.*

**Prisons and Probation Ombudsman (PPO) investigation**

The PPO investigate all deaths that occur in prison and young offender institutions.

The PPO’s terms of reference can be found in PSI 58/2010.

After each investigation the PPO produce a report, a copy of which is passed to the coroner and the family for consideration prior to the inquest taking place. An anonymised report is published on the PPO’s website after the inquest has concluded.

There are usually three stages to the PPO investigation all of which are co-ordinated by the National Safer Custody Managers in NOMS.

1. Where an identified member or members of staff are criticised in the draft report, in line with the PPO’s terms of reference the PPO “will normally disclose an advance draft of the report, in whole or part, to the relevant authority in order that they have the opportunity to make representations (unless that requirement has been discharged by other means during the course of the investigation)”

2. A draft report will be disclosed to all parties. *It is at this point that prisons must undertake a factual accuracy check and respond to any recommendations in the action plan.*

3. A final report will be issued which includes the completed action plan. The NOMS provides the PPO with a follow up to the action plan after six months.

**Serious case review (deaths of young people under 18)**

Following the death of a young person in custody the establishment must have procedures in place for informing the Local Safeguarding Children Board, who will undertake a serious case review. Further guidance is available in PSI 28/2009. (PSI 08/2012 from 01/03/2012)
Inquest

There will be a Coroner’s inquest before a jury following all deaths in custody. The purpose of an inquest is to find out by what means and in what circumstances a prisoner came to their death. An inquest is inquisitorial and not adversarial and cannot apportion blame to named individuals. The verdict does not in itself determine any issue of civil or criminal liability.

There may be a considerable delay between the death and the inquest.

A presentation for staff to help prepare for an inquest is available from OSRRG.

Legal representation

In line with paragraph 12.2.3.(b) of the Code, the National Offender Management Service (NOMS) provides representation through the Treasury Solicitor’s Department (TSol) for all employees who are required to attend an inquest following a death in custody, provided that there is no conflict of interest. For the majority of inquests, TSol and Counsel will represent the interests of all staff required to give evidence without the need for separate representation.

Legal representation for staff who are required to give evidence at an inquest will automatically be provided by TSol unless otherwise notified by OSRRG (e.g. when no witnesses are called to give ‘live’ evidence).

TSol is unable to act for PCT staff or for contracted prison staff but can act for controllers of contracted prisons.

Conflict of interest

Where a conflict of interest arises and it is decided that the TSol and counsel are unable to represent the member of concern, separate representation will be provided. Decisions as to whether a conflict of interest exists will be made on a case by case basis. If a conflict of interest is identified, there will be a presumption that the NOMS will exercise its discretion to fund the costs of separate legal representation for the staff involved, unless certain circumstances exist.

Comprehensive guidance on conflict of interest can be obtained from OSRRG.

Pre-inquest Review (PIR)

Prior to the inquest the coroner may decide to hold a ‘Pre Inquest Review’ (PIR). The parties to the inquest will normally attend the PIR which will cover a number of issues including: the date and timetable for the inquest; witnesses; disclosure and the scope of the inquest.

TSol and counsel will attend the coroner’s pre-inquest review. A representative from the prison may also attend.

Prison conference

Prior to the start of the inquest, the TSol and counsel will attend the prison to meet with staff witnesses.

Staff witnesses

All staff are required to give evidence at an inquest if requested by the coroner. Legal representation will be provided for staff (see above).
Staff must not wear their uniform to the inquest but dress smartly. Further information can be found in PSO 8800.

Prisoner witnesses

The coroner may decide to call prisoner witness(es) to the inquest. In many cases the coroner will not have a secure court. If a secure court is required arrangements will need to be made by NOMS with the coroner for the most appropriate way of hearing the prisoner’s evidence, i.e. by use of a secure court or through a video link if possible.

Prisons are required to produce prisoners whose attendance has been requested or summoned by the coroner.

If a prisoner ‘Listener’ is called as a witness Samaritans must be notified so that they can attend the inquest and support the Listener.

Family inquest costs

The family may request that the prison pays for their costs associated with attending the inquest. This may also include accommodation and subsistence. There is no requirement for the prison to pay these costs.

Actions following inquests

The following must be notified of the inquest verdict:

Deputy Director of Custody, Director of High Security Prisons, Deputy Director of Contracted Prisons, Head of Prisoner Escort Custody Services as appropriate
OSRRG
Press Office
Young Peoples’ Team (if appropriate)

Under Coroner’s Rule 43, a coroner can write to the appropriate authority (i.e. MoJ) to raise any issues they believe should be addressed to help prevent future deaths. The statutory deadline for response is 56 calendar days. Governor/Directors must forward any Coroner’s Rule 43 letters to OSRRG who will lead on the response, liaise with the prison and any other policy groups and send the final response to the coroner.
Chapter 13  Family engagement and liaising with families following a death in custody

Overview

NOMS recognises that strong support from families and friends can make an enormous difference to prisoners who are at risk of harm to themselves, to others and/or from others. Families can provide vital information to prison staff about a prisoner’s well-being, particularly if they are feeling depressed or suicidal. Successful engagement with families can reduce the risk posed by prisoners. Families can also provide essential support to prisoners who are terminally or seriously ill.

All families are different; they can include “chosen” as well as biological members and will have their own dynamics. Any approach to the family should be done in accordance with individual needs and may include providing different members of the same family with information.

This chapter provides guidance on working with families and the actions to be taken with families following a death in custody.

Identifying next of kin and supportive persons outside of prison

Prisons must record a next of kin or nominated person to contact for each prisoner during the reception/early days process. This information must be kept up-to-date (see also PSI 74/2011 Early Days in Custody). It should be noted that prisoners may identify more than one next of kin or family member who they wish to be contacted.

Family contact

Family support and liaison work is currently undertaken by a range of staff in prisons, and for different purposes. Prisoners who pose a risk of harm to themselves, others or from others, must be encouraged to communicate with their families, or allow staff to share information with them relevant to the risk they pose. In some cases, family contact will be inappropriate. However, there may be a nominated contact who can provide a supportive role in reducing the risk posed by a prisoner.

Where prisoners at risk of harm are subject to ACCT monitoring or enhanced case reviews for violence management purposes, (if the prisoner has consented), consider inviting a family member or nominated contact to contribute to the risk management process.

Provision of information for families

Some prisons have created information leaflets that appear in court cells and courts for prisoners and their families. The prisoners’ leaflet outlines what happens upon arrival at prison and how they can contact their families. It also provides telephone numbers for Samaritans and the Chaplain. The families’ leaflet covers the same issues but also includes key information about the Visitor Centre.

Families and friends of prisoners may have concerns about their well-being. Information on how they can notify the prison about those concerns must be made available, e.g. on Visiting Orders, in the Visitors Centre, Gate, Visits Hall and/or on recorded messages on the prison’s switchboard.

Engagement with families of seriously or terminally ill prisoners

Where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, they must be encouraged to engage with their families or nominated person where it is appropriate to do so. It is recommended that prisons ensure that arrangements are in place for
an appropriate member of staff to engage with families of prisoners who are either terminally or seriously ill. See chapter 11 for further information.

**Liaison with families following a death in custody**

**The role of the Family Liaison Officer (FLO)**

*Prisons must have a nominated Family Liaison Officer (FLO).* The grade of this member of staff is less important than having the right person who is able to handle what if often a very difficult situation sensitively. The following personal qualities make individuals suitable for selection:

- Good interpersonal skills
- Good communication and listening skills
- Being confident and self-assured
- Being empathetic
- Being able to negotiate complex relationships
- Being able to manage their own stress
- Ability to work alone with minimal supervision and with delegated authority
- Being flexible and non-judgemental
- Emotionally resilient
- Understand the importance of confidentiality

In order to maintain role clarity and professional boundaries, it is advisable that the Suicide Prevention/Safer Custody Co-ordinator or the Investigations/Inquest Liaison Officer do not undertake the FLO role.

The role of the FLO is to be a named point of contact for the family. Their role will start from the point that the news of the death is broken to the family. They will then maintain contact with the family, and provide information and practical support where appropriate. If the family do not want contact with the prison, their wishes must be respected.

A NOMS FLO training course is available, but is not mandatory. Further information about the course can be obtained from Training Services.

*The FLO must be provided with support either by the Safer Custody Team Leader or through their line management (see Chapter 1 on Roles and Responsibilities).*

**Maintain FLO log book**

*A log book recording contact with the next of kin must be opened when the FLO is first deployed to the family.* Every contact with the family and their representatives should be recorded wherever possible. Log entries need to be an accurate and transparent record and should be written up as soon as possible after a meeting. The Prisons and Probation Ombudsman (PPO) may wish to see the log-book as part of their investigation.

As a minimum, logs should contain the following information:

- Dates and times of all contacts/meetings
- Method of contact and venue
- Details of who initiated the contact
- Details of the purpose of the contact and any information exchanged
- Details of any non-family members present at the meeting (exercise discretion in finding out who they are)
- What the Family Liaison Officer has told the family
- Every request, question or complaint that the family makes and follow up action
- Strategy agreed with supervisor and any agreed changes
- Tactical decisions, for example, about the delay or withholding of information and the reason
Attempts to contact the family or their representatives, including those without success or which were refused or declined and any reasons given

Informing next of kin

Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.

Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison.

If a face-to-face prison notification is not possible or where another prison’s FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable.

Prior to a visit to the family taking place, the police should be informed and, if necessary, be asked to escort the team or remain nearby.

In the case of a suspected homicide the police are also likely to deploy their own FLO so a coordinated approach must be in place.

It is vital that accurate information about the prisoner’s death is given to the next of kin. Inaccurate information given at this stage can cause unnecessary distress and suspicion and can undermine the prison’s ability to build a relationship with the family.

Before a decision is made about how to meet the family, consideration must be given to the following factors:

- Speed
- Safety of staff
- Who is the family?
- Is there more than one branch of the family?
- Are there children?
- Mental/physical health of the bereaved family
- Location and distance from the prison
- Possibility of the news being leaked by other prisoners.
- Media Interest
- Culture/ethnicity/religion
- Level of likely hostility in the neighbourhood/family home
- Advice of police/probation local to the family home
- Nature of the death
- Availability of suitable staff member(s)
- Advice of police at the scene
- Time of day/night

Before meeting the family, the FLO must:

- Be familiar with the details of the death
- Be familiar with the prisoner’s history
- Gather as much information about the family as possible, such as any known family composition or group dynamics, cultural or lifestyle considerations, religious beliefs or possible communication requirements in terms of language or disability
- Be familiar with any information that could affect the liaison role, such as community tension, previous police involvement with the victim and/or family members
- Liaise with the Coroner’s Officer if time permits

The visit to the family should not be unduly delayed by the gathering of the information identified above.
Depending on the families reaction to the news of the death or to the visit, a judgement will need to be made as to how much information should be given at this first meeting. At the first meeting the family must be informed of the death, written contact details given and arrangements made for a subsequent meeting. Either at this, or a subsequent meeting the following should be touched on:

- Arranging to identify the deceased (if not already done)
- Arranging to view the deceased if they wish to do so. It is better to arrange this before the post mortem if possible by liaising with the Coroner’s Officer. The FLO should offer to accompany the family when they view the body if they wish and, if appropriate, do so first in order to warn the family what to expect
- The family should be told of their right to have a medical representative present at the post mortem and that they should ask the Coroner’s Officer about this
- Giving or facilitating initial practical support for the family
- Facilitating the family’s wishes to visit the scene
- Informing the family of organisations that can offer practical advice/support and bereavement support
- Arranging the next meeting and providing the family with written contact details
- Leaving appropriate written material with the family to reinforce what they have been told
- If the family is concerned about media intrusion, suggest that they make a single statement, perhaps providing a photograph, to only one newspaper. Seek advice from Press Office (if necessary)
- The family should be told that the Prisons and Probation Ombudsman will be conducting an independent investigation into the death and that their Family Liaison Officer will also contact them; and explain the difference between these roles

If the family ask questions about the inquest refer them to the Coroner’s Officer. Leave appropriate information leaflets with the family.

If there is information that cannot be released for example because the police have asked for some information to be kept back, explain why this is necessary and if the answer is unknown give a commitment to provide the information at a later date.

The PPO’s FLO will usually contact the family after the funeral has taken place.

No identifiable next-of-kin

When a prisoner has no recorded next-of-kin, reasonable steps must be taken to trace any family, this may include:

- liaising with the coroner and the police
- contacting the relevant embassy if applicable
- checking with other prisoners
- reviewing prisoner records for visits, letters, phone calls
- contacting the prisoner’s solicitor
- placing an advert in the local paper of the prisoners last known address

When there is no identifiable next-of-kin, or where the prisoner’s next-of-kin has disowned the body, the Coroner will inform the local authority who, under Section 46(1) of the Public Health (Control of Disease) Act 1984, has a statutory obligation to dispose of the body. The local authority concerned may ask for a contribution from the prison towards the cost of disposal, and prisons are encouraged to meet such costs (usually around £1,000). When the prisoner dies in hospital, the hospital should be asked if they wish to contribute to the local authority’s costs.

The funeral

Subject to the wishes of the family, it is appropriate for the FLO and other members of staff to attend the funeral. They may lay a wreath on behalf of the prison after seeking the wishes of the
family. The FLO should not attend if there is a risk of upsetting the family or to their personal safety.

**Repatriation of the body or ashes of a foreign national prisoner**

*Prisons must offer to pay reasonable repatriation costs of the body or ashes of a foreign national prisoner.*

The average cost of the simple repatriation of a body from the UK to another country is £1,200 excluding the freight charge which will vary depending on the destination. Simple repatriation includes a zinc lined coffin, international embalming and transfer to the airport. It is down to the discretion of Governors as to whether costs such as freight charges, transfer of the body from the receiving airport, and any family travel, are met.

If the ashes are not to be sent as freight, Governor/Director’s may wish to consider paying for a member of the family to collect the ashes.

Further information should be sought from the either the Funeral Director or the Coroner.

**Deceased prisoners' property**

*The deceased prisoner’s property must be removed from the cell, stored and recorded in line with PSI 12/2011 Prisoner’s Property*

The person legally entitled to receive property left by someone who has died is their “legal personal representative” (LPR), who will obtain a Grant of Probate if the deceased left a will or a Grant of Letters of Administration if the deceased died intestate (that is, without making a will). If a deceased prisoner left a large estate (over £5000) and/or there is a dispute as to who is legally entitled to it, property and monies should only be handed over to LPRs on production of the Grant (of Probate or Letters of Administration).

This procedure, however, while correct in law, will be disproportionate (and insensitive) where a deceased prisoner left only a small estate and it is clear who is entitled to it. This will be typical in the case of many self-inflicted deaths that occur early in custody when the prisoner has items only of clothing and a few personal possessions of limited value. There is unlikely to be a will in these cases and relatives should not be put to the trouble and expense of obtaining a Grant of Letters of Administration. In such cases it will not be necessary to require a Grant (of Probate or Letters of Administration) to be produced before handing over the property to the appropriate person. This might be a person nominated by the prisoner or the family (as defined elsewhere in this guidance).

Sometimes items such as letters, particularly ‘suicide notes’ are needed as evidence, which means that the people for whom the letters were intended may not be able to see them until quite some time after the death. The Coroner does not have to give a copy of any suicide note to the person it was addressed to, although he/she usually will if possible. The reasons for this may be the mental capacity or age of the addressee or that disclosure of the contents of the letter could be prejudicial to police inquiries. The original can usually be released some months after the inquest if no appeal follows. Copies of documents exhibited at the inquest subsequently become available to properly interested persons. If it is not clear who is entitled to these items or if there is a dispute among family members as to who is entitled, advice from the Coroner should be obtained. Suicide notes may also contain a person’s instructions for their funeral. The FLO should liaise with the Coroner about this issue if required.

Where there is no identifiable next-of-kin see PSI 12/2011 Prisoners Property, paragraphs 2.30 to 2.32 for guidance on the storage and/or disposal of unclaimed property and money.
Returning property to the family

The FLO must return property/monies of the deceased to the family as soon as the Coroner authorises this. A list of the items handed over should be kept and a receipt obtained from the family.

The FLO must consult the family about how they would like to retrieve their relative’s belongings. Some families like to collect them themselves from the prison, others appreciate having them delivered to their home. Some families like to have clothes laundered, others want them just as they are. In either event, pack them neatly in a suitable bag or container, not a black sack or a bag recognisable as prison issue.

Ending contact with the family

Contact with the family should be brought to an end at an appropriate time; this may not be until some time after the inquest. While the FLO should try to establish a good relationship with the family, he/she should take care not to allow the family to become over reliant on him/her. It is a professional relationship, not a friendship. Ending contact with the family needs to be well timed and executed, but remain caring and considerate. Some families retain contact with the prison for some time after a death either to commemorate anniversaries or they become involved with prison activities. They should continue to be treated with respect and consideration and if the FLO moves on, he/she should pass details of the case and relationship with the family to his/her successor.

Sample leaflets for the family

A number of organisations can provide assistance at both a local and national level. FLOs should do their own research about these agencies and how they operate locally in order to give families informed advice.

Families can be given written information that they can refer to in their own time. Some useful information is below. FLOs should familiarise themselves with this material and make use of it as appropriate to individual family’s needs. They can also be used as a basis for producing local leaflets relating to their prison.

- Sample A outlines the role of the FLO and provides a list of organisations that may be able to assist the family
- Sample B outlines post mortems and the funeral
- Sample C outlines the inquest, Coroners, solicitors and financial assistance for legal representation

These sample leaflets can be obtained from OSRRG.

The FLO should assess the correct time to introduce this information.

Other information that may assist a FLO:

- NHS Booklet “Help is at Hand” a guide aimed at people who are affected by suicide or other sudden traumatic death
- A guide to Coroners and Inquests, available on www.direct.gov.uk
- Local Coroner’s leaflet if available
- Deceased Register. A free service offered to the bereaved at the time of registering the death to help avoid unwelcome post and telephone calls. FREEPOST MID20909, Derby, DE1 1ZN
- INQUEST leaflet. Available from INQUEST on 0207 263 1111
- INQUEST information pack (available on line or by post, free to families)
- Victims Voice leaflet “Sudden death and the Coroner: Coroner’s post mortem and inquests”. Available from Work and Pensions Guide D49 “What to do after a death in
England and Wales”. Available free of charge from any local office of the Works and Pensions Department

• Department of Health leaflet “A guide to the post mortem examination”. Phone 08701 555455, email doh@prolog.uk.com

• Department of Work and Pensions booklet entitled ‘What to do after a death in England and Wales’

Murder/manslaughter

Home Office booklet given by Police FLO to families but containing useful reference material for Prison Service FLO “Advice for bereaved families and friends following murder or manslaughter”. Telephone 0870 241 4680

Support after Murder and Manslaughter information pack. Telephone 020 7735 3838
Chapter 14   Learning

Overview

NOMS is committed to promoting active learning across the organisation. It is important that we learn from incidents in prisons, such as a deaths in custody, as well as incidents in which prisoners suffer harm or their care is compromised.

*Prisons must have procedures in place to facilitate and disseminate learning from incidents of self-harm, violence and deaths in custody to prevent future occurrences and improve local delivery of safer custody.*

Deaths

It is vital that learning occurs from all deaths in custody in order to reduce future occurrences. *At a local level, prisons must undertake an analysis of evidence from investigations by the Police, the Prisons and Probation Ombudsman and any others that might be locally commissioned.* Whilst recognising that Inquests will occur some time after a death, there will be learning in narrative verdicts and Rule 43 letters. *The analysis must contribute to the continuous improvements in the prevention and reduction of deaths in custody.*

Self-harm

Learning from self-harm behaviour is vital in terms understanding individual patterns of behaviour and trends across a prison. The monitoring of individuals behaviour may allow, among other things, an insight into patterns such as preferred method, timing, triggers, severity, and mood changes. This information may form part of the ACCT process and contribute to understanding such behaviour across the prison. For example, an analysis of local self-harm incidents may show trends in time, place, method and triggers influenced by local population moves.

Other issues related to self-harm that might inform local learning include the monitoring of the number of ACCT forms raised, and where raised and how long they are kept open.

Violence

Violence is unevenly distributed around the prison estate. It is therefore essential that there is a detailed understanding of violence in individual prisons and comparisons are only made with prisons of a similar function and operational capacity. More information can be found in the Safety in Custody Annual Statistics on the Ministry of Justice website. In order to reduce violent incidents, it is vital that comprehensive management information is collected, analysed and acted upon.

The Violence Management Report on The Hub provides detailed data on violent incidents and the management response to them. Analysis of this data will generate a detailed overview of violence management from which trends can be identified and action plans developed.

In prisons with a high volume of violent incidents, it may be helpful to undertake regular assessments of when and where violent incidents are occurring.

Investigations

There are a range of options available to investigate serious incidents of harm to self or others. *Consideration must be given to the circumstances in which the harm occurred, the lessons that can be learned from the incident and its management, and the need to support those harmed and sanction perpetrators of harm.*
Focus Groups
Regular consultation with staff and prisoners on safer custody matters can usefully complement the data analysis outlined above. For example, prisoners may be able to contribute to local learning on factors effecting changes in safer custody data.

Other sources of information
The following list of examples is by no means exhaustive and there may be other sources of data both local and national which could inform local polices:

- Investigations (Serious Self Harm & Serious Assaults)
- NOMS Performance Hub including the Violence Management Report
- Prisons & Probation Ombudsman (PPO) fatal incident investigations
- Inquest verdicts and Coroner’s Rule 43 letters
- Violence Data (SIR, IRS, PNOMIS, Hub)
- Chief Inspector Reports (HMCIP)
- Measuring Quality of Prison Life (MQPL)
- Standards Audits
- Adjudications Data
- IEP Data

Safer Custody Meetings
The sharing of learning between agencies is key to enabling continuity of care to prisoners at risk and ultimately making the prison a safer place in which to live and work. It is recommended that ‘learning’ is a standing agenda item at all safer custody meetings. This would ensure that active consideration is given to the learning cascaded from OSSRG through the regional safer custody meetings and the wider NOMS learning strategy.

To ensure informed and constructive discussion, attendees at local safer custody meetings might find it helpful to receive relevant data in advance as it will give them the opportunity to interrogate the information and raise any questions.

Effective ways to share learning
Governor/Directors may wish to disseminate learning through the following means:

- Daily Governor/Director’s meetings.
- Wing briefings.
- Safer custody meetings.
- Partnership Board meetings
- Notices to staff.
- Notices to Prisoners.
- Governor/Director’s information notices.
- Individual prison intranet sites.

The National Safer Custody Managers and Learning Team
The National Safer Custody Managers (NSCMs) are part of Offender Safety, Rights and Responsibilities Group in NOMS HQ. They provide Deputy Directors of Custody with advice on safer custody policies, and other areas where they have a direct link to the delivery of safer custody. They also provide the interface between HQ Policy and the operational line.

The NSCM team hold responsibility for analysing and co-ordinating responses to Prisons and Probation Ombudsman (PPO) investigation reports. Themes from the reports are extracted, good practice disseminated across the estate and ‘lessons learned’ reflected in policy and practice.
The team publish Quick Time Learning Bulletins on timely national learning. These can be found using the search engine on the NOMS intranet. The team also lead on Learning Days that are held throughout the year which focus on specific policy areas such as violence reduction and learning from deaths in custody.

**Regional Safer Custody Forums**

All regions have Safer Custody Managers meetings which are held on a quarterly basis. They are important forums where learning is shared with prisons across the region in order to promote continuous improvement within safer custody.

The meetings also provide a forum in which to discuss provision for particularly challenging prisoners and enable a consistent approach to managing prisoners with complex needs across the region.