Ministry of Justice | Home Office | Department of Health & Social Care

Independent Advisory Panel on Deaths in Custody

"It's time things change": Priorities for detention for the Department of Health and Social Care's suicide prevention strategy

Image courtesy of Koestler Arts

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Introduction

1. The role of the Independent Advisory Panel on Deaths in Custody (IAPDC) is to advise Ministers and officials on how they can uphold their human rights obligations to take active steps to protect lives, prevent deaths, and keep those in the care of the state safe. The IAPDC's remit covers deaths in prisons, during or following police custody, immigration detention, Approved Premises, and those detained under the Mental Health Act.

2. The IAPDC welcomes the opportunity to lead work and recommendations on suicides in detention for the new 10-year suicide prevention strategy under development by the Department of Health and Social Care (DHSC). The previous strategy, published in 2012, was limited in its coverage of suicide prevention in detention settings. Factors which reduce the risk of suicides in the community, such as exercise, a sense of purpose and structured activity, and contact with family and friends, are considerably more difficult in custody.

3. Suicides remain too common in detention settings and, as we were told by a prisoner at HMP High Down, *"its time things change"*. The suicide prevention strategy needs to draw particular attention to the vulnerability of people who are detained, and the very high risk of suicide compared to the general population during, and on release from, custody. The latest figures show:
   - there were **88 self-inflicted deaths in prison** in the 12 months to June 2023 (includes suicides and cases where prisoners unintentionally caused their own death);[1]
   - there were **50 deaths from 'unnatural causes'** (includes self-inflicted deaths) of people detained under the **Mental Health Act** in 2021/22;[2]
   - there were **52 apparent suicides following police custody** in 2022/23;[3] and
   - there was **one self-inflicted death in immigration detention** in 2021 and **zero** in 2022.[4]

4. Robust systematic reviews have been conducted which examine the causes of suicides in prison, as well as those that take place in mental health settings (though the latter is not differentiated by those that take place in detention). Where appropriate these findings have been referenced throughout this report.

5. However, significant gaps in the research remain. To go some way to address these gaps and inform the IAPDC's custodial lead contribution to the strategy, the Panel engaged with experts by experience, practitioners, and stakeholders – including non-

[1] HM Prison and Probation Service and Ministry of Justice, 'Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2023 Assaults and Self-harm to March 2023', 27 July 2023, available here.
[2] Care Quality Commission, 'Monitoring the Mental Health Act in 2021/22', 1 December 2022, p. 71, available here.
[3] Independent Office for Police Conduct, 'IOPC publishes figures on deaths during or following police contact for 2022/23', 28 July 2023, available here.
[4] Home Office, 'Immigration system statistics, year ending June 2023', 24 August 2023, available here.

governmental organisations, academics, and investigative bodies – to obtain their views on ways to prevent suicide in all forms of detention. This engagement involved:

- A roundtable event with almost 60 members of the Ministerial Council on Deaths in Custody's Practitioner and Stakeholder Group including experts from all custodial settings.[5]
- A consultation with current prisoners via a call-out through Inside Time, the national newspaper for prisoners, which sought views on their top three priorities for preventing suicides in prison.
- A call-out for written evidence, in response to which we received submissions from the Howard League for Penal Reform, the Prisons and Probation Ombudsman (PPO), and an expert by experience.
- A survey of Samaritans Listeners and volunteers to get their views on way to prevent suicide in prison.
- Findings from a systematic review and meta-analysis of studies on prevalence and risk factors for suicides in prison led by IAPDC members.

Key themes

6. There is no 'quick fix' for suicide prevention. All policy and operational decisions, even those which appear to have no immediate relevance, must take full account of the impact of any significant change on the safety of those detained.

7. The Panel has identified the following cross-cutting themes from this work:

- **Staff culture, leadership, training, and capacity:** Training for suicide prevention for custodial staff should be trauma-informed and person- rather than process-focused. This would help ensure individuals under their care receive high-quality, compassionate, and personalised support. Training should be informed by people with relevant lived experience as well as bereaved families. Measures to prevent and address staff burnout and problematic cultures are key.

- **Multiagency support and information sharing:** Improved multiagency and multidisciplinary approaches and information-sharing processes are necessary to ensure informed, timely care and support for those entering, in, and released from custody. This includes improving link-up and relationships between agencies working in a single institution, as well as across different stages of the criminal justice system.

- **Self-harm and suicide prevention processes:** Prevention processes must focus on the personalised and holistic needs of the individual and be multiagency and multi-disciplinary. Peer support may have an important role to play. Risks should be recorded in one place to enable easy access to up-to-date information. These

[5] Independent Advisory Panel on Deaths in Custody, 'Practitioner and Stakeholder Group', available here.

should include non-clinical factors, such as negative sentence progression outcomes. Adequate processes are needed to ensure risks are brought to the attention of those with responsibility for reviewing detention, such as in Immigration Removal Centres (IRCs), before the individual reaches crisis point as a result of their ongoing detention. These risks must be responded to promptly and appropriately by staff.

- **Family involvement:** Where appropriate and when full consent is given, family involvement in care planning is needed to ensure individuals in custody are given appropriate support. This would enable a move away from the reliance on self-presentation of individuals to understand risk, which can be misleading and potentially fatal. Technology can play a role in helping individuals to maintain family ties and, in doing so, promote their mental health and wellbeing.

- **The custodial landscape and the untherapeutic nature of detention:** Cells and rooms in places of detention must be safe, with ligature points removed. The use of segregation in custody can increase the risk of suicide and self-harm and is sometimes used disproportionately. Commitments to upgrade and refurbish general hospitals must include mental health settings.

- **A lack of certainty, hope, and purpose:** Individuals held on remand or facing indefinite detention are a vulnerable group. Across detention, access to meaningful routine and regime supports rehabilitation and can promote good mental health.

- **Learning and accountability:** Investigations and inquests into suicides in detention identify repeated failings. The implementation of recommendations – such as improvements to care planning processes for individuals identified as being at risk to suicide, information sharing, medication management, and emergency response procedures – and dissemination of learning are both necessary to prevent future fatalities across detention settings. Better systems are needed to facilitate this. Models for learning should be shared and staff shadowing opportunities facilitated across institutions and places of detention.

- **Facilitating research in custody:** Departments and agencies must enable research in places of detention to build an evidence base to inform interventions.

Staff culture, leadership, training, and capacity

"As soon as I told them that I had borderline personality disorder, I was automatically labelled a liar, an attention seeker, and dangerous." – campaigner and former prisoner

8. Participants at the roundtable called for a compassionate, person-centred approach to managing mental health **across detention settings**. Many stressed the importance of good leadership and positive and trusting relationships between staff and those in detention, with ongoing annual training playing a key role in this. Improved training for prison staff responding to mental health crises was highlighted in the responses to the survey of Samaritans Listeners and volunteers.

9. Training should focus on equipping staff with the tools and confidence to build positive relationships with those under their care, with particular focus given to how they support and manage individuals during a mental health crisis. Staff training should be directly relevant to the detainee experience and could involve the input or voices of service users and bereaved families talking about their experience where appropriate. This was recommended in the review into deaths and serious incidents in police custody undertaken by Dame Elish Angiolini[6] and the review into self-inflicted deaths in custody of 18-24 year olds by Lord Harris.[7]

10. Lord Harris' review also highlighted the importance of good leadership in **prisons**. In its submission to the review, the Prison Reform Trust explained: *"as Coroner's, prisons inspectorate and prison and probation ombudsman's reports have indicated, vulnerability can be exacerbated or reduced depending on the culture and leadership of the specific institution in which the young person is placed".* The review found that some prisons were focused on addressing managerial challenges, such as staffing pressures, at the expense of concerns for the welfare of individual prisoners.[8]

11. Participants at the roundtable also highlighted that some staff, particularly those who are not mental health professionals, display antipathy towards people who harm themselves. A lack of empathy can increase the risk of suicide for already very vulnerable individuals. One participant stressed the importance of education and the availability of toolkits on alternatives to self-harm, such as cold ice and rubber bands, to ensure staff are not merely taking away the means with which some individuals manage their emotions and feelings, thereby increasing their risk of suicide.

12. People with lived experience of detention recalled bullying and mistreatment by **prison** staff. One individual described prison as a *"place of abuse,"* while another told us they were labelled a *"liar"* and an *"attention-seeker"* when they informed staff about their diagnosis of borderline personality disorder. One prisoner at HMP High Down said that

[6] Home Office, 'Report of the Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, available here.
[7] The Harris Review, 'Changing Prisons, Saving Lives: Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds', 1 July 2015, available here.
[8] Ibid.

Safer Custody Teams *"have a laid back stance and do not take prisoners crys [sic] for help seriously when they receive complaints of bullying by prisoners, and especially staff members…if they cannot keep prisoners safe – who else can?"*

13. Similarly, research carried out in Brook House IRC found an *"undercurrent of suspicion or disbelief",* with words such as *"manipulation"* and *"attention seeking"* used by staff during discussions of self-harm. In his review of the welfare of people in **immigration detention**, Stephen Shaw called for training to address *"the dangers of negative staff cultures"*. This would involve annual, mandatory safer detention training for staff who have regular contact with detainees. However, a recent report by the Independent Chief Inspector for Borders and Immigration (ICIBI) shows that negative staff attitudes continue to pervade in IRCs.[9] Importantly, Stephen Shaw's review also called for formal recognition of the emotional toll experienced by staff who engage in self-harm and suicide prevention processes.[10] Staff need to feel supported to be able to provide compassionate, high-quality care.

14. We heard that problems arising from mental ill health (and other conditions such as neurodiversity) are often conflated with non-compliant and challenging behaviour. The written evidence we received from the PPO said: *"when this leads to punitive rather than a therapeutic response, this may only worsen the prisoner's underlying mental ill health"*.

15. The PPO stressed the importance of staff training on emergency responses to instances of serious self-harm and attempted suicide. PPO investigations have highlighted issues relating to **prison** staff not always using the correct emergency response codes when radioing the control room, not having a 'cut-down' tool on their person, and not carrying vital equipment in emergency medical bags.

16. Mental health support should always be bespoke and based on individual need. Participants felt this was particularly important for children and young people in **secure health settings** to ensure they are not given treatments designed for adults. Sir Simon Wessely's review of the Mental Health Act highlighted concerns about risk assessment tools which are *"generic"* rather than tailored to individual need, with *"little evidence"* to support the use of such standardised tools.[11]

17. Training around mental ill health, risk factors for suicide, and human rights is important. During the roundtable event, trauma-informed training was highlighted as a way to help staff improve empathy and engagement with individuals exhibiting self-harming and suicidal behaviours. One participant highlighted the working definition of trauma-informed practice published by the Office for Health Improvement and Disparities (OHID) which states that practice should be sensitive to the trauma that people may have experienced

[9] Independent Chief Inspector of Borders and Immigration, 'Third annual inspection of 'Adults at risk in immigration detention', June – September 2022', 12 January 2023, available here.
[10] Home Office, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', 24 August 2018, available here.
[11] Department of Health and Social Care, 'The Independent Review of the Mental Health Act', 6 December 2018, available here.

and actively seek to prevent re-traumatisation.[12] During a separate engagement exercise, as part of the IAPDC's work to prevent deaths in **police custody**, West Mercia Police stated that they are actively trying to become a trauma-informed organisation, changing the focus from *"what's wrong with you?"* to [13][OBJ]

18. Trauma-informed practice was noted as particularly important for individuals in **immigration detention** who may have fled imprisonment, torture, and/or war in their country of origin, and therefore feel distrustful of state agencies. The detention environment may trigger pre-existing vulnerabilities to mental health problems, with the Royal College of Psychiatrists pointing to the link between immigration detention and the severity of mental ill health.[14] Participants informed us that where alternatives to detention are not available, it is important to get people out safely and through the system as quickly as possible.

19. The IAPDC's 2020 report on the prevention of deaths in IRCs drew focus to the difficulties faced by healthcare staff in understanding and approaching psychological distress experienced by different cultural groups within diverse IRCs. Mental health interventions have often been developed in high-income countries and may deploy unfamiliar approaches to those from different cultures. This may reduce their efficacy.[15]

20. We were told that **probation** staff feel they do not receive meaningful training that is practical and scenario based. Staff want their training to be informed by people with lived experience to ensure the support they give is both purposeful and effective.

21. In response to the independent review into deaths and serious incidents in **police custody** undertaken by Dame Elish Angiolini,[16] the College of Policing highlighted an immersive training package it has developed for custody sergeants and detention officers to reduce the risk of death and adverse incidents in custody. This allows officers to learn and make considered decisions in an environment where they can make mistakes without any *'real world'* consequences. Officers are then given the opportunity to discuss their decisions with peers and consider other possibilities. Evaluation of this approach is important to determine its efficacy and whether similar approaches could be rolled out in other detention settings.

22. Additionally, participants raised concerns in relation to desensitisation and burnout among staff across the detention settings. In its written submission, the Howard League for Penal Reform cited its report on **prison** staff's perspectives on preventing suicide

[12] Office for Health Improvements and Disparities, 'Working definition of trauma-informed practice', 2 November 2022, available here.
[13] Independent Advisory Panel on Deaths in Custody, 'Preventing deaths at point of arrest, during and after police custody: a review of police practice submitted to the Independent Advisory Panel on Deaths in Custody by Police and Crime Commissioners and associated bodies', 2 December 2022, available here.
[14] Royal College of Psychiatrists, 'Detention of people with mental disorders in immigration removal centres (IRCs)', April 2021, p. 7, available here.
[15] Independent Advisory Panel on Deaths in Custody, 'Priorities for a prevention of deaths strategy in Immigration Removal Centres', October 2020, available here.
[16] Home Office, 'Report of the Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, available here.

which described the prison environment as desensitising, brutalising, hardening, and distancing. The report also described prisons as having a culture of negative attitudes towards prisoners, for example, where self-harm is seen as manipulative or attention seeking.[17]

23. Similarly, we were told that high workload has driven a high turnover rate in the **probation** profession. HM Inspectorate of Probation's 2021 report found that only 46% of probation practitioners believed they had a manageable workload, and that high workloads were leading to stress, sleeplessness, and fear of making serious mistakes through overwork.[18]

24. The **prison** population has risen by 3% to 81,806 in the 12 months to 31 December 2022,[19] with projections for it to grow to 98,500 by March 2026.[20] This acceleration in the population has created an imbalance in the staff-to-prisoner ratio. As outlined previously, prisoners cannot be given the compassionate and person-centred support, which has been highlighted as key to preventing suicide, if staff are not themselves receiving support and supervision to relieve the pressures of their job. A marked increase in suicides in 2014[21] coincided with a sharp decrease in prison officer numbers by 15% in 2013/14.[22]

25. Staff must also be adequately supported in the aftermath of a self-inflicted death. Research conducted by the University of Manchester on the experiences of those bereaved by suicide called for evidence-based bereavement training for frontline staff who are likely to come into contact with those affected by suicide, such as prison officers. It pointed to studies which show feelings of anxiousness and uncertainty among staff when faced with those bereaved by suicide. One participant who experienced the death of a prisoner was quoted: *"I was offered no support"* and *"told I 'needed to pull myself together'. After doing the debrief with the staff involved I went home to an empty house, it was horrible. I didn't know who to talk to or what to do. I was never spoken to again by anyone to ask how I was doing after it…"*[23]

26. Postvention initiatives **across detention settings** can build staff skills, knowledge, and confidence to respond to and support those under their care when a death does occur.

27. All custodial settings should make use of a safety impact assessment, developed by the IAPDC and trialled in prisons and in the immigration estate, to ensure adequate account is taken of safety in other upstream policy and operational decisions.

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[17] Howard League for Penal Reform, 'Preventing prison suicide: Staff perspectives', 2016, available here.
[18] HM Inspectorate of Probation, 'Caseloads, workloads and staffing levels in probation services, March 2021, p. 5, available here.
[19] HM Prison & Probation Service and Ministry of Justice, 'Offender management statistics quarterly: July to September 2022', 26 January 2023, available here.
[20] Ministry of Justice, 'Prison Population Projections 2021 to 2026, England and Wales, 19 November 2021', p. 1, available here.
[21] Howard League for Penal Reform, 'Preventing prison suicide: Staff perspectives', 2016, p. 2, available here.
[22] Institute for Government, 'Performance Tracker 2019 – Prisons', 2019, available here.
[23] The University of Manchester, 'From Grief to Hope: the collective voices of people bereaved or affected by suicide in the UK', 18 November 2020, available here.

28. Suggested priorities for the DHSC strategy:

- **Annual, mandatory training should be given to frontline staff to ensure they adopt a person-centred and trauma-informed approach to providing support to individuals under their care. Detention settings should adopt OHID's working definition of trauma-informed practice.**
- **Staff training on responses to mental health crises should involve input from people with lived experience and families bereaved by suicide. Staff themselves should be given the opportunity to inform training content as well.**
- **Detention settings should draw on learning from community postvention initiatives and the postvention initiative in prisons being developed in collaboration with the Samaritans to ensure people in detention and staff are supported when a death does occur.**
- **Safety impact assessments should be introduced across detention settings to ensure that all policy proposals include assessment of their likely impact on the health and safety of detainees and the staff charged with their care.**

Multiagency support and information sharing

"So many times I've been told 'we are not a crisis team, if you need immediate help speak to an officer.'" – prisoner at HMP Parc

29. Progress must still be made on improving information sharing between different teams and professions in individual custodial institutions. This is an ongoing problem which is made worse by IT systems which do not have interoperability and the inability of staff and practitioners to access other agencies' information systems. Participants stated that a lack of a multidisciplinary approach between **prison** officers and healthcare staff and the absence of information sharing between staff and families, where consent has been given by the individual, often leads to the fragmentation of support offered to prisoners.

30. A lack of joined-up support can lead to gaps in care and missed opportunities to reduce the risk of self-harm and suicide. In its written evidence, the PPO cited a lack of multiagency support as one of five keys areas where it makes repeated recommendations. Its investigations have found *"a lack of information sharing and readily accessible medical information about a prisoner has reduced the level of care they received".* The PPO also stated that *"too often"* prison and healthcare staff do not work together to manage and set clear expectations for welfare checks.

31. A prisoner at HMP Parc told us: *"so many times I have been told 'we are not a crisis team, if you need immediate help speak to an officer'. You then speak to an officer who makes a referral to mental health, who will see you 2-3 weeks later when the crisis is over. But in the moment you need help…and then you feel abandoned and without help."*

32. Research has found the strongest set of modifiable risk factors for suicide in prisoners to be clinical ones, including having a current psychiatric diagnosis. Mental health services do not only need to be universally available to people in prison, but also adequately

resourced with effective interventions to address the higher prevalence of mental health diagnoses among prisoners than people in the community.[24]

33. Written evidence from the PPO highlighted the particular importance of multidisciplinary support in the women's estate. A holistic approach involving all relevant professionals is needed to address often complex and diverse needs such as mental ill health, substance misuse, trauma, and fragile relationships. A prisoner at HMP Bronzefield described this as *"complex areas requiring multiagency support, large investment and an overall change in how women are managed throughout the Criminal Justice System".*

34. Participants also highlighted poor information sharing across **different stages of the criminal justice system,** for example between courts and prisons and between prisons and hospitals. Participants said that person escort records (PERs) do not consistently contain relevant and up-to-date information. PERs are vital to ensuring escorting staff and receiving establishments have access to relevant information in order to manage risk and keep individuals safe.

35. A lack of release planning and joined-up support for prisoners as they re-enter the community, particularly for those who have spent a significant period in custody, can increase their risk of suicide. Research has found people released from **prison** are seven times more likely to die by suicide compared to the general population, with the rate of suicide higher after release than during incarceration. Rates of suicide between men and women released from prison are similar, which contrasts with the higher rate of suicide among men in the general population. The risk of suicide among women released from prison is almost 15 times higher than that of women in the general population.[25]

36. Established predictors of suicide among the general population include unemployment, mental ill health, homelessness, low socioeconomic status, and acute psychological distress. These challenges are common among people released from prison and may be particularly pronounced in the first few weeks and months. Existing transitional services are typically based on men's needs and then applied to women, which may not necessarily be effective.[26]

37. A 2019 report by the charity INQUEST stated: *"almost no official attention is paid to those deaths which occur after someone leaves prison".* The report also found between 2010/11 and 2018/19, 662 people died a self-inflicted death after leaving prison, with someone taking their own life every two days in 2018/19. It further stated that people are *"released into failing support systems, poverty, homelessness and an absence of services for mental health and addictions".*[27] A multiagency approach is needed to ensure prisoners have access to safe housing, GP registration, mental health care, and treatment for addictions post release.

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[24] Input from IAPDC members.
[25] Janca E, et al, 'Sex differences in suicide, suicidal ideation, and self-harm after release from incarceration: a systematic review and meta-analysis' (2022) Social Psychiatry and Psychiatric Epidemiology.
[26] Ibid.
[27] INQUEST, 'Deaths of people following release from prison', 18 November 2019, available here.

38. Responses to the survey of Samaritans Listeners and volunteers also drew attention to the need for improved support for individuals who are released from prison so that they are not *"left to defend for themselves".* The importance of continued mental health care and provision of safe and secure accommodation for individuals released featured heavily in the survey responses.

39. Similarly, Sir Simon Wessely review of the **Mental Health Act** found that the process of being detained can be incredibly disruptive to housing, childcare arrangements, welfare benefits, and employment. Patients are at significantly increased risk of suicide immediately after discharge and it is therefore important that a multidisciplinary approach is adopted to ensure the individual has access to services and support in the community.[28]

40. The review of deaths and serious incidents in **police custody** by Dame Elish Angiolini stated that *"being released into the care, or simply company, of another human being could make a difference"* and suggested that relatives, carers, and friends could be contacted – with consent from the detainee – upon release. It also pointed to the need for police forces to form closer ties with key services, such as healthcare and housing, to ensure detainees are signposted or diverted to sources of help.[29]

41. Police officers are not experts on mental health and therefore should not be the sole first responders to incidents of mental health crisis. Instead, they should defer to mental health professionals as these incidents should be treated as medical emergencies. The IAPDC's 2022 report on preventing deaths in police custody found that positive relationships between police forces and mental health professionals, such as custody-based Liaison and Diversion teams or practitioners who support first responders, are of paramount importance. The responses we received from police forces highlighted their awareness of the need for further work, including collaboration across agencies with the NHS, to support the mental health of detainees.[30]

42. We were told that better identification is needed when deciding whether someone who is alleged to have committed an offence needs to be in custody or if they should be detained and transported to a health-based place of safety under Section 135 and 136 of the Mental Health Act. The IAPDC's report found that Police and Crime Commissioners (PCCs) were unanimous in the view that police custody should not be used as a place of safety for those experiencing a mental health crisis or for those under Section 136. We heard from PCCs that there can be difficulty obtaining a bed even when a person has been identified as requiring a transfer to hospital. Norfolk Police stated that this can take over 24 hours, meaning that vulnerable people are often left in the care of staff who are

[28] Department of Health and Social Care, 'The Independent Review of the Mental Health Act', 6 December 2018, available here.
[29] Home Office, 'Report of the Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, available here.
[30] Independent Advisory Panel on Deaths in Custody, 'Preventing deaths at point of arrest, during and after police custody: a review of police practice submitted to the Independent Advisory Panel on Deaths in Custody by Police and Crime Commissioners and associated bodies', 2 December 2022, available here.

not trained to be dealing with a mental health crisis.[31] More mental health beds are needed so that people experiencing a mental crisis can be diverted appropriately.

43. There were 56 apparent suicides following **police custody** between 2020 and 2021.[32] However, as highlighted in our report, apparent suicides following police custody is unlikely to be at the forefront of police officers' minds when working in busy custody suites. Greater awareness and training are needed to enable staff to acknowledge the trauma of detention, particularly for those suspected of, or charged with, specific offences.[33]

44. An end-to-end system of support for vulnerable individuals released from custody is needed, particularly for those who are at higher risk due to the nature of their crime. This must go beyond simple signposting. For example, accusations of child sex abuse and indecent image offences can lead to family estrangement and social isolation, increasing the prevalence of suicidal ideation among this group. The increased risk of suicide among this cohort of arrestees was recognised in Dame Elish Angiolini's review.[34] At its most basic level, support following police custody should ensure individuals arrive home safe, are placed in the care of someone else, or transferred onto other services.

45. Suggested priorities for the DHSC strategy:

- **The transfer of information between different teams in individual custodial institutions, as well as with external agencies and organisations across the criminal justice system, needs to be improved. This should include the revision of robust memorandums of understanding between relevant teams and organisations.**
- **Mental health services need to be universally available to individuals in detention and properly resourced.**
- **Greater resource is required to ensure more hospital beds are available to ensure transfers from prisons or IRCs to hospital for individuals with severe mental health needs requiring hospital treatment are done within the 28-day limit proposed in the draft Mental Health Bill.**
- **Tailored, multidisciplinary support is needed to address the often complex and diverse needs of female prisoners.**
- **Release planning for detainees should be improved to prevent post-custody deaths. This should always involve input from core services, such as health, housing, and addiction treatment. Services should ensure each establishment has staff with clear responsibilities for making sure arrangements to support individuals ahead of release are taking place.**

[31] Ibid.
[32] Independent Office for Police Conduct, 'IOPC publishes figures on deaths during or following police contact for 2021/22', 28 September 2022, available here.
[33] Independent Advisory Panel on Deaths in Custody, 'Preventing deaths at point of arrest, during and after police custody: a review of police practice submitted to the Independent Advisory Panel on Deaths in Custody by Police and Crime Commissioners and associated bodies', 2 December 2022, available here.
[34] Home Office, 'Report of the Independent Review of Deaths and Serious Incidents in Police Custody', January 2017, available here.

- **End-to-end systems of support should be put in place for people leaving all forms of detention. This is particularly important for individuals deemed at higher risk, such as those leaving police custody accused of child sex abuse and indecent image offences. Evaluation of interventions is needed to understand which are most successful and to ensure forces are not simply relying on signposting.**
- **More health-based places of safety are needed to ensure individuals detained and transported under Section 135 and 136 of the Mental Health Act can be managed safely and in a timely manner.**
- **DHSC should lead work with the Home Office to ensure targeted resources and improved systems are in place to make sure mental health professionals, not police officers, are the first responders to individuals experiencing a mental health crisis.**

Self-harm and suicide prevention processes

"Although the ACCT process seeks to support suicidal individuals it mostly just monitors them rather than having means to help them." – prisoner at HMP Bronzefield

46. Assessment, Care in Custody and Teamwork (ACCT) is the care planning process for **prisoners** identified as being at risk of self-harm and suicide. However, we were told that ACCT is *"just a paper exercise"* more concerned with process than individual prisoners' needs, and that policies on who should be involved are sometimes not followed. A prisoner at HMP Bronzefield told us the ACCT process *"mostly just monitors them rather than having means to help them"*.

47. This was also reflected in the Howard League for Penal Reform's written submission which described the process as *"a means of observation as opposed to meaningful engagement"*. It further stated that frequent observations could increase vulnerability and low mood. Similar concerns were raised in Stephen Shaw's report on the welfare of vulnerable people in detention. The reliance of constant watch in **immigration detention** can be *"intrusive and demeaning"* and calls into question the *"justification for [the individual's] continued detention"*.[35]

48. A **prisoner** at HMP Parc told us: *"I sometimes/a lot of the time won't tell staff how I am feeling because I know an ACCT won't help my situation but I know if I discuss openly and honestly how I am feeling they will put me on an ACCT…I am currently on an ACCT which I felt was needed and would give me the support – it didn't!"*

49. Anecdotal information from participants suggests that the ACCT process neither consistently nor effectively identifies prisoners' risk factors and that actions recorded to reduce risk can be too general. In its written evidence, the PPO told us that some of the ACCT care maps it examined during its investigations into suicides did not effectively

[35] Home Office, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', 24 August 2018, available here.

identify or address the prisoner's risk factors. Donna Mooney, whose brother Tommy Nicol took his own life in prison in 2015, told us that when Tommy was transferred to a different prison, staff were not informed that he had just received a negative parole decision which had impacted his mental health.

50. As part of the ACCT process, it is important that detention staff record risks which are not necessarily clinical, such as sentence progression outcomes and lack of family contact. Staff should also consider a range of practical actions to reduce risk, such as healthcare intervention, peer support, family contact, and diversionary activities. As outlined later, families have a vital role to play in care planning processes.

51. Participants outlined that the ACCT process would continue to fail if risks are documented in multiple places. Instead, risks should be recorded in one place to ensure comprehensive and up-to-date information is easily accessible when coordinating care plans. The PPO made reference to the ambition set out in the Prisons Strategy White Paper to create a single digital prisoner record[36] and called for this to include healthcare.

52. The PPO also highlighted an overreliance on prisoners' self-presentation. It identified five areas where repeated recommendations are made, including the early identification of mental health issues. It stated: *"But, too often, assessment by staff on reception or during the first night in custody ignores known risk factors for suicide and self-harm in favour of a prisoner's assurances and presentation".* Similar concerns were raised in HM Inspectorate of Prisons' (HMIP) 2021/22 annual report, which found that a quarter of the prisons it inspected did not conduct the first night safety interviews in private, potentially impacting prisoners' willingness to disclose private information.[37]

53. In **immigration detention**, the Assessment Care in Detention and Teamwork (ACDT) process is used to manage individuals identified at risk of self-harm or suicide. However, roundtable participants raised that individuals placed on ACDT are not automatically referred for a mental health assessment. The Home Office states an assessment should take place urgently if the case review team considers it necessary.[38]

54. The Royal College of Psychiatrists points to evidence that people with pre-existing mental health conditions and vulnerabilities, such as survivors of torture and other forms of inhumane treatment, are at particular risk of self-harm and suicide because of their detention.[39] This view is supported by Dr Rachel Bingham, Clinical Adviser at Medical Justice, who stated that mental health teams in detention are limited to a supportive role. Response to individuals exhibiting suicidal behaviour is custodial – as in, managed through ACDT – rather than therapeutic. She further stated that *"most mental health conditions cannot be managed in detention"*.[40]

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[36] Ministry of Justice, 'Prisons Strategy White Paper', 7 December 2021, p. 31, available here.
[37] HM Inspectorate of Prisons, 'Annual Report 2021-22', 13 July 2022, available here.
[38] Home Office and Immigration Detention, 'Assessment care in detention and teamwork (ACDT): detention services order 01/2022', 17 October 2022, available here.
[39] Royal College of Psychiatrists, 'Detention of people with mental disorders in immigration removal centres (IRCs)', April 2021, available here.
[40] Joint Committee on Human Rights, 'Oral evidence: Human Rights of asylum seekers in the UK, HC 821', 16 November 2022, available here.

55. We were told roundtable participants that there are limits to the efficacy of ACDT. It was suggested that Detention Centre Rule 35 – a mechanism to ensure particularly vulnerable individuals are brought to the attention of those with direct responsibility of reviewing their detention – needs to be considered at an early stage rather than at the point where it becomes apparent that ACDT is not sufficient to keep the individual safe.

56. Issues around the use of Rule 35 were highlighted by the Independent Chief Inspector for Borders and Immigration following inspection of three IRCs between June and September 2022. He concluded that the *"enthusiasm to protect vulnerable people in immigration detention was being held back"* by the unevidenced view held by staff that the Rule 35 process was being abused by detainees as a method to secure their release. The report found that Rule 35 was *"no longer achieving its aim"* and that opportunities to identify vulnerable detainees were missed due to a lack of translators and little information made available about its purpose.[41]

57. Stephen Shaw's report found that *"an exclusive focus upon the formal mechanics of suicide prevention risks underplaying factors that may be more important: the quality of staff-detainee relationships, the range of activities, family contact, anxiety and uncertainty about the future"*. The report raised concerns that ACDT and ACCT mechanisms were designed at a time when the staff-to-detainee ratio was more balanced.[42]

58. Many of the responses we received from **prisoners** stressed the importance of peer support programmes, such as the Samaritans Listener scheme. One prisoner from HMP Frankland said: *"as men we always want to be seen strong but to be honest, we are not and often suffer in silence"*. A Listener at HMP Wakefield told us that individuals struggling with mental ill health *"need to be able to talk about their thoughts and feelings, and as Listeners, we are always available to support them 24/7".*

59. The IAPDC's Keeping Safe report on preventing suicide and self-harm in custody found the positive impact the Listener scheme can have on the volunteer as well as the prisoners they are helping to support. One prisoner described the difficulty he had during his first six months in prison, taking overdoses and *"fighting the system".* However, he said becoming a Listener, a role that *"puts a lot of trust in me",* helped him to feel better in himself.[43]

60. The importance of peer support initiatives was also highlighted by roundtable participants. For example, a meaningful way to engage prisoners on issues such as substance abuse and suicidal ideation is through former prisoners, with whom they can relate. However, HMIP's 2021/22 annual report highlighted a third of prisons it inspected

[41] Independent Chief Inspector of Borders and Immigration, 'Third annual inspection of 'Adults at risk in immigration detention', June – September 2022', 12 January 2023, available here.
[42] Home Office, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', 24 August 2018, available here.
[43] Independent Advisory Panel on Deaths in Custody, 'Keeping safe - preventing suicide and self-harm in custody: Prisoners' views collated by the IAP', December 2017, available here.

did not have sufficient numbers of Listeners. Even when they were available, restrictions and staff shortages meant that prisoners were not routinely unlocked to see them. Only 36% of prisoners who responded to HMIP's survey said it was easy to speak to a Listener.[44]

61. This issue was also highlighted by Samaritans volunteers who stated that issues such as a *"lack of ringfenced Listener space"* and Listeners *"not being allowed out of their cells to do their jobs"* as barriers to effectively operating the scheme in prisons. One respondent felt that Listeners should be *"better valued and allowed the freedom to do their jobs".*

62. Suggested priorities for the DHSC strategy:

- **Detention staff involved in care planning processes should make sure that non-clinical risks, such as negative parole outcomes and a lack of social visits, form part of self-harm and suicide prevention conversations and actively inform interventions.**
- **Safety interviews and assessments should always take place in private to encourage detainees to share information about their mental health, wellbeing, and any concerns they may have openly and honestly.**
- **Risks should be recorded in one place to enable easy and quick access to up-to-date information on detainees' vulnerabilities and needs. This should include healthcare information. Plans contained within the Prisons Strategy White Paper to create a single digital prisoner record should be fast tracked.**
- **Detention settings should review processes to ensure a multidisciplinary approach is taken to supporting the mental health needs of detainees. Healthcare staff should be involved in self-harm and suicide prevention processes to ensure support is not fragmented.**
- **Information on the Rule 35 process should be translated into a variety of languages and be readily available for detainees in immigration detention. An independent review of Rule 35 should be commissioned with the importance of protecting those at risk of suicide and self-harm, as recommended by the ICIBI. This review should involve health partners.**
- **Individuals in immigration detention placed on an ACDT should be automatically referred for a mental health assessment.**
- **Self-harm and suicide prevention processes should be used at an earlier stage than when the detainee is at the point of crisis in order to maximise the efficacy of interventions.**
- **Leadership in individual prisons should take responsibility to ensure peer support programmes, particularly the Samaritans Listener scheme, are in place, supported, and prioritised.**

[44] HM Inspectorate of Prisons, 'Annual Report 2021-22', 13 July 2022, available here.

Family involvement

"It is really difficult for men and women not to be with their families. It causes a lot of distress, plays in your mind, and can have such an impact that you can lose the will to live." – prisoner at HMP Frankland

63. Roundtable participants reiterated the importance of family involvement in preventing suicides **across detention settings**, as well as the role third sector organisations can play in facilitating meaningful engagement. Where appropriate and with consent given, families should inform advance care planning for their loved ones. This is particularly important for individuals arriving in custody who might be scared, in a state of extreme mental health need, or otherwise unwilling to share information, and therefore not best placed to give details about their mental health or safety triggers.

64. This was highlighted in Lord Farmer's review of **prisoners'** family ties which found that *"a supportive relationship with at least one person is indispensable to a prisoner's ability to get through their sentence well".* The review highlighted the importance of family contact – not only between the prisoner and their family, but also between the family and the prison – to reduce the risk of self-harm and suicide. It stated that families can provide a vital role in information gathering regarding prisoners' mental health and risk to self, which prisons should be drawing on *"instead of dismissing or ignoring them as currently often happens"*.[45]

65. We were told that prisons often cite the absence of consent as the reason why families are not involved in the ACCT process. Efforts should be made to obtain consent from prisoners earlier in the criminal justice process to help facilitate family involvement in the process. Consent should be kept under review as individuals may change their mind about consent given or withdrawn for a variety of reasons, including feelings of shame and guilt. Families will often know what support should be given. A participant provided the example of a parent who said music helps the wellbeing of their autistic son in prison, something the prison staff were unlikely to otherwise know.

66. Additionally, families' access to Safer Custody Teams is important to ensure concerns about prisoners' wellbeing are shared proportionately and identified promptly. One former prisoner told us that it took their family two days before they were able to get through to the team, while the Howard League for Penal Reform highlighted frequent issues finding someone to speak to directly, with callers put through to voicemail or told their message will be passed on. It is important to ensure that phone lines are working and properly staffed. Lord Farmer's review recommended a *"dedicated phone line which is listened to and acted upon".*[46] Interventions such as the Pact prisoner helpline may help this, and equivalent setups should be considered **across detention settings**.

[45] Ministry of Justice, 'The Importance of Strengthening Prisoners' Family Ties to Prevent Reoffending and Reduce Intergenerational Crime, August 2017, available here.
[46] Ministry of Justice, 'The Importance of Strengthening Prisoners' Family Ties to Prevent Reoffending and Reduce Intergenerational Crime, August 2017, available here.

67. In-cell technology was regularly identified as an important intervention to ensure people in detention can maintain regular and consistent contact with their families. This was one of the most common suggestions we received in our consultation with **prisoners**. One prisoner at HMP Frankland told us that there are four phone booths serving over 100 prisoners which limits their access to, and time spent on, the phone with their loved ones.

68. The PPO highlighted in-cell technology as particularly important during the early days of custody, an especially vulnerable time. In 2021, 21% of self-inflicted deaths occurred within the first 30 days of custody, highlighting just how vulnerable people are when they first arrive at prison.[47] As a prisoner at HMP Chelmsford described: *"coming to prison can be a very challenging experience, especially for first time prisoners".* Custodial settings should draw from learnings from COVID-19 to facilitate the availability of technology to allow detainees to contact their loved ones.

69. This was also mentioned in Lord Farmer's review which stated that the inability to speak with family members on the phone can be *"catastrophic"* for vulnerable prisoners. The review cited several families bereaved by suicide who hold strong beliefs that the death of their loved ones in prison could have been prevented by having access to telephone contact. Its recommendations included the adoption of a flexible approach to allow vulnerable prisoners to contact their families until in-cell telephony is rolled out across the prison estate.[48]

70. A lack of access to social visits is associated with an increased risk of completed suicide. Prison policies can contribute to a lack of such visits, including restricting visits or imprisoning someone far away from the prisoner's home and community.[49] A prisoner at HMP Chelmsford told us that *"families travel hours – miles away to visit their loved one's for just one hour, how pathetic!"*

71. Stephen Shaw's report referred to the benefit of regular family contact for individuals in **immigration detention** deemed at risk of self-harm or suicide, for example those on an open ACDT. He cited two cases where a lack of contact with children was the prime factor in the individual's risk of self-harm.[50] According to Medical Justice, ACDT lacks involvement from IRC healthcare teams and the charity recalled being told to *"phone security"* when attempting to raise self-harm concerns about a detained person.[51]

[47] HM Prison and Probation Service and Ministry of Justice, 'Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2021, Assaults and Self-harm to September 2021', 27 January 2021, available here.
[48] Ministry of Justice, 'The Importance of Strengthening Prisoners' Family Ties to Prevent Reoffending and Reduce Intergenerational Crime, August 2017, available here.
[49] Input from IAPDC members.
[50] Home Office, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', 24 August 2018, available here.
[51] Medical Justice, 'Harms in detention', available here.

72. Suggested priorities for the DHSC strategy:

- **Where appropriate and with consent, families should routinely be involved in ACCT reviews and care planning processes for individuals identified at risk of self-harm or suicide. Staff must facilitate this and respond promptly to issues raised.**
- **Consent to contact families about mental healthcare concerns should be sought from individuals early on during their detention and kept under review.**
- **Places of detention must have working, adequately resourced phone lines to ensure families can promptly escalate concerns about prisoners' wellbeing. A dedicated phone line for families should be introduced across all detention settings.**
- **In-cell telephony should be rolled out across the prison estate. In the interim, a flexible approach should be taken by staff to ensure vulnerable prisoners can contact their families as a means of support.**
- **Individuals in IRCs without close family ties should be empowered to access support provided by charities supporting detainees.**
- **Where possible, individuals should be detained close to their homes, families, and communities to ensure they have access to support. Where this is not possible, schemes to facilitate visits, such as help with travel costs and accumulated visits, should be amplified as well as video-calling facilities offered as an alternative.**

The custodial landscape and the untherapeutic nature of detention

"Nobody's mental health can get better in segregation." – campaigner and former prisoner

73. The majority of self-inflicted deaths in custody are by use of ligatures. There is strong evidence from in-patient psychiatric units regarding the impact of introducing ligature point reduction programmes leading to a reduction in suicides, particularly by hanging.[52] Similarly, the significant reduction in deaths from 49 to 31 between 1998-99 and 1999-2000 is attributed to the removal of ligature points in police cells which led to reduced self-inflicted deaths by hanging.[53] Such programmes should be replicated **across detention settings**.

74. Participants highlighted that some **secure health settings** are not sufficiently therapeutic and offer patients little to do on the wards, with patients sometimes feeling worse upon discharge. Government commitments to upgrade, refurbish, and build more hospitals must include mental health services if it is to achieve parity between physical and mental health.

[52] Input from IAPDC members.
[53] Home Office, 'Report of the independent review of deaths and serious incidents in police custody', 30 October 2017, available here.

75. During a separate consultation with PCCs as part of the IAPDC's work to prevent deaths in **police custody**, we were told that the physical state of some custody suites is not supportive to the wellbeing of those in crisis. However, Nottinghamshire Police, Gloucestershire Police, Humberside Police, and Hampshire Police drew attention to the refurbishment and improved designs of their custody suites. Meanwhile, Avon and Somerset Police recognised the beneficial effect alterations to physical surroundings have on individuals in detention. Alterations include painting cells to muted tones and replacing lighting so that it can be adjusted for colour, warmth, and brightness. Similar work should be replicated across police forces.[54]

76. Segregation is sometimes used in detention as a means to prevent self-harm and suicide. However, anecdotal evidence from participants suggests that segregation can have the opposite effect, exacerbating mental ill health and feelings of isolation and hopelessness. One person with lived experience of **prison** told us it is *"inhumane"* to be locked up for up to 23 hours a day and that *"nobody's mental health can get better in segregation"*.

77. In its 2021/22 annual report, HMIP found that the majority of prisoners held in segregation had very limited regime time, with only 30 minutes to shower, use the phone, and get fresh air. The report also highlighted the *"poor"* physical conditions in many of the segregation units, with four units inspected by HMIP having an *"unacceptable"* lack of in-cell electricity.[55] A prisoner at HMP Barlinnie described the use of segregation to reduce the risk of suicide as *"barbaric"* and that its *"objective is to mechanically prevent the prisoner from completing suicide, but it hardly contributes to recovery"*.

78. Concerns were raised about the misuse of segregation in **immigration detention** to manage mental illness. However, Home Office colleagues told us about the recent provision of care suites in several IRCs to ensure people in crisis can be appropriately cared for in an environment away from the general population, but one which is not segregated and enables continued access to regimes.

79. Government figures show that black people were almost five times as likely as white people to be detained under the **Mental Health Act** in the year to March 2021; 344 detentions per 100,000 people compared with 75 per 100,000 people.[56] One participant raised concerns about the disproportionate use of detention and segregation of certain groups and told us that in their experience black people are also more likely to be placed in segregation while in secure health settings.

80. Participants raised concerns about the appropriateness of segregation for people with neurodivergent needs, particularly as secure health settings might impair their ability to understand why they are being segregated.

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[54] Independent Advisory Panel on Deaths in Custody, 'Preventing deaths at point of arrest, during and after police custody: a review of police practice submitted to the Independent Advisory Panel on Deaths in Custody by Police and Crime Commissioners and associated bodies', 2 December 2022, available here.
[55] HM Inspectorate of Prisons, 'Annual Report 2021-22', 13 July 2022, available here.
[56] Department of Health and Social Care, 'Detentions under the Mental Health Act', 23 June 2022, available here.

81. Out-of-area placements for patients receiving mental health care was also flagged as an issue of concern. Being hundreds of miles away from their home, community, and support networks can disrupt and prolong patients' recovery and increase their risk of suicide. The *Five Year Forward View for Mental Health*, published in 2016, set a target to eliminate out of area placements by 2020/21.[57] However, a reported 5,800 patients have been sent to inappropriate out of area placements since that deadline passed.[58]

82. Similarly, due to the small number of women's **prisons**, women are often placed in prisons further from their homes in comparison to their male counterparts. This can have a detrimental impact on their ability to maintain ties with their families, receive visits, and be resettled back into the community effectively.[59] *Visiting Mum*, a programme delivered by Pact, helps ensure women inmates from Wales who have to serve their sentences in England stay in touch with their children by arranging visits and providing transport for them. The programme has found to improve prisoners' wellbeing and reduce the risk of self-harm.[60]

83. Moreover, concerns have been raised with relation to the design of prisons, practices, and self-harm reduction strategies with men in mind. Baroness Jean Corston's review of vulnerable women in the criminal justice system stated that women should not be treated as *"add on-s to the male system".*[61]

84. Suggested priorities for the DHSC strategy:

- **Proactive steps should be taken to review and remove ligature points in accommodation across all detention settings.**
- **Physical conditions across detention settings should be improved to benefit good mental health. For instance, examples of good practice are already taking place across several police forces which should be shared with and embedded across all forces as well as other detention settings where appropriate.**
- **Alternative provision is needed to ensure custodial settings can reduce inappropriate use of segregation. Its use should not be a means to prevent self-harm and suicide.**
- **The provision of care suites for individuals in crisis should be rolled out across the immigration detention estate.**

[57] Mental Health Taskforce, 'The Five Year Forward View for Mental Health', 1 February 2016, p. 35, available here.
[58] BBC, 'Mental health patients sent miles due to bed shortage', 16 November 2022, available here.
[59] Home Office, 'The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system', March 2007, available here.
[60] Independent, 'Project helping women in prison stay in contact with children gets funding boost', 20 January 2023, available here.
[61] Home Office, 'The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system', March 2007, available here.

- **Out of area placements for individuals detained under the Mental Health Act should be eliminated, as outlined in the *Five Year Forward View for Mental Health*, to enable patients to receive care closer to their support networks**.

A lack of certainty, hope, and purpose

"When all you have is the basics to look forward to then these basics become the big things." – prisoner at HMP Winchester

85. We asked participants to identify groups at higher risk of self-harm and suicide in custody. **Prisoners** sentenced to indefinite terms under the imprisonment for public protection (IPP) sentence were repeatedly identified as one such group. The risk of a perpetual cycle of imprisonment and sense of unfairness about the disparity between their sentence and the crime exacerbates feelings of hopelessness and uncertainty among this group.

86. Participants also identified individuals held on remand as a vulnerable group due to the protracted uncertainty they face regarding their trials. Data shows that 42% of self-inflicted deaths occurred among the remand population between September 2020 and September 2021, despite individuals on remand making up around 16% of the total prison population.[62]

87. Roundtable members stated that individuals detained under the **Mental Health Act** are also likely to experience a loss of hope due to the indefinite nature of their detention. Rethink Mental Illness highlighted service users' need for a clear and, ideally, binding timetable for discharge so that they are not detained for longer than is necessary. Its report stated the "*discussion of discharge as a realistic prospect, even with those with longer journeys towards that point, has a number of benefits for patients, including better preparedness for community life and the independence, autonomy and therapeutic benefits gained from hope of a future outside of hospital".*[63]

88. Feelings of hopelessness are also common among individuals in **immigration detention** due to uncertainty regarding their immigration status and the prospect of impending removal or deportation. This may be exacerbated by language barriers and a lack of understanding of the system. Family separation and lack of contact may also have a profoundly negative impact.

89. The IAPDC's 2020 report on the prevention of death in IRCs pointed to the negative impact of hopelessness and uncertainty on detainees' mental health. It highlights a joint inquiry by the All-Party Parliamentary Groups on Migration and Refugees in 2015 which heard evidence from over 200 people and organisations. The inquiry found that while

[62] i News, ''Delay and uncertainty is killing people' as remand inmates account for 40 per cent of suicides in prison', 10 January 2022, available here.
[63] Rethink Mental Illness, 'Mental Health Act White Paper engagement report: Service users currently detained under the Mental Health Act', 14 May 2021, pp. 10-20, available here.

detainees may have felt physically safe in their environment, the uncertainty around their cases made them particularly vulnerable.[64]

90. Participants highlighted the need to give **prisoners** something to do or someone to look after within prison to give them a sense of purpose and, in doing so, reduce their risk of suicide. One participant told us that young men, particularly those from working class backgrounds, come into the criminal justice system with little or no hope. A way to meaningfully engage them would be through former prisoners to whom they can relate. Another suggested that support might be better coming from someone who is seen as independent, such as a religious figure or third sector organisations.

91. This sense of purpose was highlighted in Baroness Jean Corston's report which stated that *"motherhood is a factor which appears to protect women in the community against suicide"* but that this is not the case for women in prison, who are either separated from their children or potentially lose the opportunity to have children. The report quoted Baroness Hale who said that motherhood is an important sense of identity and self-esteem and so *"to become a prisoner is almost by definition to become a bad mother".*[65]

92. The COVID-19 pandemic has resulted in disruption to prison regime and everyday routine, including reduced access to work, education, and exercise facilities. A prisoner at HMP Chelmsford told us that prisoners should have daily access to physical activity. They described the prison as poorly equipped and not having *"the bare minimum of a pull-up bar"*. The HMIP's 2021/22 annual report described a lack of purposeful activity and reported that some prisoners continue to be locked up for 23 hours a day or more, despite the lifting of COVID-19 restrictions.[66]

93. Samaritans Listeners and volunteers identified isolation, time spent in cells, and *"not enough jobs or education projects"* as issues which need to be addressed to prevent suicide in prisons. One respondent suggested the introduction of vegetable gardens to ensure prisoners have access to meaningful activities. Similarly, in its written evidence, the Howard League for Penal Reform highlighted findings from the survey of its members who are in prison or who have family in prison, citing the impact of a lack of fulfilling and purposeful regime as well as the minimal time spent outside of cells.

94. We heard from prisoners about the need to receive notification of changes to regime and/or appointments in advance, as last-minute cancellations can increase anxiety and low mood. This was summarised by a prisoner at HMP Winchester who said: *"when all you have is the basics to look forward to then these basics become the big things".*

[64] Independent Advisory Panel on Deaths in Custody, 'Priorities for a prevention of deaths strategy in Immigration Removal Centres', October 2020, available here.
[65] Home Office, 'The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system', March 2007, available here.
[66] HM Inspectorate of Prisons, 'Annual Report 2021-22', 13 July 2022, available here.

95. Suggested priorities for the DHSC strategy:

- **Alternatives to remand and non-custodial sentences should be prioritised, where possible. Sentencing decisions should be informed by high-quality pre-sentence reports. Training for staff is needed to improve the quality of, and thereby increase judicial confidence in, pre-sentence reports.**
- **Indeterminacy for patients detained under the Mental Health Act should be minimised. Where possible, they should be given a clear timetable for their discharge. Similarly, information should be given to detainees in IRCs on the process of their release in a language they can understand.**
- **Detention settings should invest in interpretation services to ensure detainees are able to access information and support and can communicate their emotions and concerns.**
- **Prisoners should be given access to daily activities which promote their sense of purpose and wellbeing. Staff recruitment and retention, to facilitate purposeful regimes, is a key aspect of this.**

Learning and accountability

"The recommendations from the PPO reports…sit on a shelf and collect dust." – Donna Mooney, bereaved family member

96. **Across detention settings** we heard about the need for greater accountability to ensure repeated patterns of failure are addressed and recommendations and findings from investigations and inquests are implemented both locally and nationally. As an example, responses to independent investigations from custodial services sometimes cite the rollout of further training to address failings; however, participants felt it is often not clear what this means in practice for staff or the individuals under their care. Overall, a higher level of accountability over services is needed to ensure meaningful training is enacted.

97. According to INQUEST, at least six inpatients were found hanging at the Linden Centre, a **mental health** facility, between 2004 and 2019 *"despite countless recommendations to make wards safer by eliminating ligature points"*. In 2020 the charity carried out an analysis of a sample of 20 deaths between 2016 and 2019 in adult inpatient wards, 18 of which were self-inflicted. It found repeated failures including 12 cases of *"insufficient risk assessment and management"*, seven cases of *"poor record keeping",* and six cases of *"inadequate observations"*, *"lack of training"*, and "*communication failures"*.[67]

98. The problem of accountability is particularly pronounced in mental health settings due to a lack of dedicated, independent scrutiny. Deaths, including suicides, are investigated by the same trust responsible for the patient's care. The Care Quality Commission is a regulator and does not have a role to independently investigate deaths under the Mental Health Act while investigations under the NHS Improvement Serious Incident Framework remain *ad hoc* and insufficient. This creates an obstacle to effective learning and the necessary action to prevent future suicides.

[67] INQUEST, 'Westminster Hall debate "Deaths within mental health care"', 30 November 2020, available here.

99. Sir Simon Wessely's review of the Mental Health Act noted that the case could be made for having an independent body investigate unnatural deaths under the Act and urged government to return to this issue if progress has not been made. This should now take place.

100. INQUEST has highlighted the *"distinct and dangerous oversight"* of investigation and learning from deaths following release from **prison**. It stated that of the 334 investigations into deaths the PPO commenced in 2018/19, only 12 were the deaths of people under probation supervision. It is worth noting that there were 515 deaths of people on post-custody supervision that same year, demonstrating *"the lack of oversight in this area"*.[68]

101. We were told, **across the detention landscape**, that a statutory, independent body tasked with collating and analysing learning from investigations and coroner-written Prevention of Future Deaths reports is needed to improve national oversight and ensure the potential to save lives is not lost.

102. These issues were highlighted in Sir Simon Wessely's review of the Mental Health Act which noted repeated concerns about a lack of information sharing to prevent future fatalities, with the introduction of national mechanisms being *"crucial"* to ensure this happens.[69] It supported the recommendation made in Dame Elish Angiolini's review to establish a 'National Office for Article 2 Compliance' which would be accountable to Parliament and *"tasked with the collation and dissemination of learning, the implementation and monitoring of that learning, and monitoring the consistency of its application at a national level".*[70] Similarly, INQUEST has repeatedly called for the establishment of a national oversight mechanism to *"capture and act upon the rich seam of data available from well conducted and costly inquests".*[71]

103. The PPO told us it had recently recruited an Implementation Officer to address issues around its recommendations not being enacted. A participant representing Serco, a private provider operating six **prisons**, told us about an information-sharing system across the Serco estate. This involves regular forums whereby Safer Custody Teams come together to learn lessons from their respective establishments and ensure the sharing of good practice and dissemination of learning from incidents of self-harm and suicides.

104. During the roundtable a participant warned against the *"scapegoating"* of individual staff and prisons for what are frequently *"systemic issues"* and the reason why recommendations are repeated. They felt that accountability efforts constrain learning

[68] INQUEST, 'Deaths of people following release from prison', 18 November 2019, available here.
[69] Department of Health and Social Care, 'The Independent Review of the Mental Health Act 1983', 6 December 2018, available here.
[70] Home Office, 'Report of the independent review of deaths and serious incidents in police custody', 30 October 2017, available here.
[71] INQUEST, 'Learning from Death in Custody Inquest: A New Framework for Action and Accountability', September 2012, available here.

and staff openness – key to preventing self-harm and suicide. We also heard about the *"closed nature of custody"* which can entrench, at times, negative practice. Opportunities should be available for staff to shadow in other establishments within the detention setting they operate as well as different places of detention.

105. Suggested priorities for the DHSC strategy:

- **An independent body with an investigative function, similar to that carried out by the PPO and Independent Office for Police Conduct (IOPC), should be established to investigate deaths of people under the Mental Health Act.**
- **Departments should consider the establishment of a function to monitor Article 2 compliance to ensure learning from investigations and inquiries is fully acted on and shared.**
- **Staff shadowing opportunities should be made available across detention settings to facilitate sharing and embedding of learning and good practice.**

Facilitating research in custody

106. There are significant gaps in the evidence base regarding effective interventions and known risk factors for suicide in detention. Research **across detention settings** is essential to ensure there is a robust evidence base for 'what works'. Research processes for application and ethical review should be streamlined and efficient.

107. In **prisons**, further research is needed, from expert groups external to HM Prison and Probation Service, on:
    a. the most effective models for delivering mental health care in prisons;
    b. specific interventions, including pharmacological and psychological for mental health problems in prisons;
    c. environmental risk factors and the impact of, for example, enhancing visits and having better systems for assessing risk in relation to single-cell allocation; and
    d. the impact of a ligature point reduction programme.

108. The 2018 review of the welfare of people in **immigration detention** recognised the difficulty in drawing themes from suicides given the relatively low numbers. However, it called for the commissioning of research into 'near misses' and/or attempted suicides by the Home Office to enable suicide prevention learning from such cases.[72]

109. Suggested priorities for the DHSC strategy:

- **Places of detention must be open to and facilitate research on self-inflicted deaths to develop an evidence base for interventions.**
- **Research should focus on diversity within detention settings, factoring in the different experiences of, for example, women, young people, and ethnic minority groups.**

[72] Home Office, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', 24 August 2018, available here.

- **Research in detention settings which have a lower incidence of completed suicides should focus on 'near misses' and attempted suicides.**
- **DHSC should produce high-quality, disaggregated data on deaths under the Mental Health Act to enable an in-depth understanding of deaths across different population groups.**

Next steps

110. The IAPDC welcomes the opportunity to lead input on suicides in detention and calls for the suggested priorities highlighted in this document to be incorporated into the new suicide prevention strategy. The Panel will continue to work closely with DHSC to ensure these priorities are turned into meaningful action to drive forward a sustained reduction in the number and rate of suicides across all places of detention.

List of suggested priorities for the DHSC strategy

Staff culture, leadership, training, and capacity

1. Annual, mandatory training should be given to frontline staff to ensure they adopt a person-centred and trauma-informed approach to providing support to individuals under their care. Detention settings should adopt OHID's working definition of trauma-informed practice.

2. Staff training on responses to mental health crises should involve input from people with lived experience and families bereaved by suicide. Staff themselves should be given the opportunity to inform training content as well.

3. Detention settings should draw on learning from community postvention initiatives and the postvention initiative in prisons being developed in collaboration with the Samaritans to ensure people in detention and staff are supported when a death does occur.

4. Safety impact assessments should be introduced across detention settings to ensure that all policy proposals include assessment of their likely impact on the health and safety of detainees and the staff charged with their care.

Multiagency support and information sharing

5. The transfer of information between different teams in individual custodial institutions, as well as with external agencies and organisations across the criminal justice system, needs to be improved. This should include the revision of robust memorandums of understanding between relevant teams and organisations.

6. Mental health services need to be universally available to individuals in detention and properly resourced.

7. Greater resource is required to ensure more hospital beds are available to ensure transfers from prisons or IRCs to hospital for individuals with severe mental health needs requiring hospital treatment are done within the 28-day limit proposed in the draft Mental Health Bill.

8. Tailored, multidisciplinary support is needed to address the often complex and diverse needs of female prisoners.

9. Release planning for detainees should be improved to prevent post-custody deaths. This should always involve input from core services, such as health, housing, and addiction treatment. Services should ensure each establishment has staff with clear responsibilities for making sure arrangements to support individuals ahead of release are taking place.

10. End-to-end systems of support should be put in place for people leaving all forms of detention. This is particularly important for individuals deemed at higher risk, such as those leaving police custody accused of child sex abuse and indecent image offences.

Evaluation of interventions is needed to understand which are most successful and to ensure forces are not simply relying on signposting.

11. More health-based places of safety are needed to ensure individuals detained and transported under Section 135 and 136 of the Mental Health Act can be managed safely and in a timely manner.

12. DHSC should lead work with the Home Office to ensure targeted resources and improved systems are in place to make sure mental health professionals, not police officers, are the first responders to individuals experiencing a mental health crisis.

Self-harm and suicide prevention processes

13. Detention staff involved in care planning processes should make sure that non-clinical risks, such as negative parole outcomes and a lack of social visits, form part of self-harm and suicide prevention conversations and actively inform interventions.

14. Safety interviews and assessments should always take place in private to encourage detainees to share information about their mental health, wellbeing, and any concerns they may have openly and honestly.

15. Risks should be recorded in one place to enable easy and quick access to up-to-date information on detainees' vulnerabilities and needs. This should include healthcare information. Plans contained within the Prisons Strategy White Paper to create a single digital prisoner record should be fast tracked.

16. Detention settings should review processes to ensure a multidisciplinary approach is taken to supporting the mental health needs of detainees. Healthcare staff should be involved in self-harm and suicide prevention processes to ensure support is not fragmented.

17. Information on the Rule 35 process should be translated into a variety of languages and be readily available for detainees in immigration detention. An independent review of Rule 35 should be commissioned with the importance of protecting those at risk of suicide and self-harm, as recommended by the ICIBI. This review should involve health partners.

18. Individuals in immigration detention placed on an ACDT should be automatically referred for a mental health assessment.

19. Self-harm and suicide prevention processes should be used at an earlier stage than when the detainee is at the point of crisis in order to maximise the efficacy of interventions.

20. Leadership in individual prisons should take responsibility to ensure peer support programmes, particularly the Samaritans Listener scheme, are in place, supported, and prioritised.

Family involvement

21. Where appropriate and with consent, families should routinely be involved in ACCT reviews and care planning processes for individuals identified at risk of self-harm or suicide. Staff must facilitate this and respond promptly to issues raised.

22. Consent to contact families about mental healthcare concerns should be sought from individuals early on during their detention and kept under review.

23. Places of detention must have working, adequately resourced phone lines to ensure families can promptly escalate concerns about prisoners' wellbeing. A dedicated phone line for families should be introduced across all detention settings.

24. In-cell telephony should be rolled out across the prison estate. In the interim, a flexible approach should be taken by staff to ensure vulnerable prisoners can contact their families as a means of support.

25. Individuals in IRCs without close family ties should be empowered to access support provided by charities supporting detainees.

26. Where possible, individuals should be detained close to their homes, families, and communities to ensure they have access to support. Where this is not possible, schemes to facilitate visits, such as help with travel costs and accumulated visits, should be amplified as well as video-calling facilities offered as an alternative.

The custodial landscape and the untherapeutic nature of detention

27. Proactive steps should be taken to review and remove ligature points in accommodation across all detention settings.

28. Physical conditions across detention settings should be improved to benefit good mental health. For instance, examples of good practice are already taking place across several police forces which should be shared with and embedded across all forces as well as other detention settings where appropriate.

29. Alternative provision is needed to ensure custodial settings can reduce inappropriate use of segregation. Its use should not be a means to prevent self-harm and suicide.

30. The provision of care suites for individuals in crisis should be rolled out across the immigration detention estate.

31. Out of area placements for individuals detained under the Mental Health Act should be eliminated, as outlined in the *Five Year Forward View for Mental Health*, to enable patients to receive care closer to their support networks.

A lack of certainty, hope, and purpose

32. Alternatives to remand and non-custodial sentences should be prioritised, where possible. Sentencing decisions should be informed by high-quality pre-sentence reports.

Training for staff is needed to improve the quality of, and thereby increase judicial confidence in, pre-sentence reports.

33. Indeterminacy for patients detained under the Mental Health Act should be minimised. Where possible, they should be given a clear timetable for their discharge. Similarly, information should be given to detainees in IRCs on the process of their release in a language they can understand.

34. Detention settings should invest in interpretation services to ensure detainees are able to access information and support and can communicate their emotions and concerns.

35. Prisoners should be given access to daily activities which promote their sense of purpose and wellbeing. Staff recruitment and retention, to facilitate purposeful regimes, is a key aspect of this.

Learning and accountability

36. An independent body with an investigative function, similar to that carried out by the PPO and IOPC, should be established to investigate deaths under the Mental Health Act.

37. Departments should consider the establishment of a function to monitor Article 2 compliance to ensure learning from investigations and inquiries is fully acted on and shared.

38. Staff shadowing opportunities should be made available across detention settings to facilitate sharing and embedding of learning and good practice.

Facilitating research in custody

39. Places of detention must be open to and facilitate research on self-inflicted deaths to develop an evidence base for interventions.

40. Research should focus on diversity within detention settings, factoring in the different experiences of, for example, women, young people, and ethnic minority groups.

41. Research in detention settings which have a lower incidence of completed suicides should focus on ‘near misses’ and attempted suicides.

42. DHSC should produce high-quality, disaggregated data on deaths of people detained under the Mental Health Act to enable an in-depth understanding of deaths across different population groups.

About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care, and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel on Deaths in Custody (IAPDC)
- Practitioner and Stakeholder Group

The remit of the IAPDC (and overall of the Council) covers deaths, natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of Approved Premises, and the deaths of those detained under the Mental Health Act in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAPDC, an advisory non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials, and the Ministerial Board. Drawing on research evidence and consultation with members of its Practitioner and Stakeholder Group, experts by experience, and bereaved families amongst others, the Panel provides guidance on policy and good practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAPDC's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Lynn Emslie chairs the IAPDC. The other members are:

- Deborah Coles, Director, INQUEST
- Raj Desai, barrister, Matrix Chambers
- Professor Seena Fazel, professor of Forensic Psychiatry, University of Oxford
- Dr Jake Hard, Clinical Director in HMP Cardiff
- Pauline McCabe OBE, international criminal justice advisor
- Professor Jenny Shaw, professor of Forensic Psychiatry, University of Manchester
- Jenny Talbot OBE, Prison Reform Trust

Juliet Lyon CBE was Chair of the IAPDC until January 2023.

Further information on the IAPDC can be found on its website: https://www.iapondeathsincustody.org.

For more information on this paper – or on the IAPDC more generally – please contact MinisterialCouncilonDeathsinCustody@justice.gov.uk.