National Confidential Inquiry
into Suicide and Homicide by People with Mental Illness

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Dear Colleague

Please find enclosed the Safer Prisons report - A National Study of Prison Suicides 1999-2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness.

The findings in the report are based on information received by the National Confidential Inquiry between 1999 and 2000.

The report includes:

- key findings
- key recommendations
- full details of the project

I would like to thank everyone who has assisted the project, and to ask for your continued support for this important project. I hope that you will find the report interesting.

Yours sincerely

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Safer Prisons

A National Study of
Prison Suicides 1999–2000 by the
National Confidential Inquiry
into Suicides and Homicides
by People with Mental Illness

J Shaw, L Appleby, D Baker

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Executive Summary

This study of suicide by prisoners is a collaboration between the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, the Prison Health Policy Unit at the Department of Health and the HM Prison Service Safer Custody Group (previously Directorate of Health Care and the Suicide Awareness Unit respectively).

A comprehensive national (England and Wales) sample of suicides or suspected suicides by current prisoners was identified from the records held by the Safer Custody Group. In each case, two questionnaires were sent to the prison where the death occurred. One was sent to the prison governor, the second to the prison medical officer. If a psychiatrist had assessed the prisoner, a third questionnaire was sent to him/her.

The period covered by data collection was January 1999 to December 2000. The sample is therefore a 2-year consecutive case series, defined by date of death.

Key findings

Number of suicides

- In two years (1999-2000), 172 suicides occurred among prisoners; twelve prisons, including two young offender institutions, had five or more suicides.

- The 172 deaths included five in the care of the Prison Escort Custody Service.

Suicide method

- One hundred and fifty-nine (92%) suicides were by hanging or self-strangulation.

- The commonest ligature points were window bars; the commonest ligatures were bed-clothes.

Location and timing

- Nineteen (11%) suicides occurred within 24 hours of reception into prison; 55 (32%) occurred within seven days.

- Eighty-five (49%) individuals were on remand.

- Nineteen (11%) were on a vulnerable persons unit.

- One hundred and nine (63%) were located in single cells (this includes 9% who were in a segregation unit); of those in double cells, the cellmate was absent in around a half.

Demographic features

- One hundred and fifty-nine (92%) were male; the proportion of females was highest (14%) in suicides aged 21 and under.
- Nineteen (11%) were from an ethnic minority.

Offence

- Forty-one (26%) had been charged with or convicted of a violent offence.
- In 11 (6%) the offence was murder or manslaughter; 6 of these were serving life sentences.

Prison experience

- Thirty (21%) were known to have been victims of bullying in prison.
- Thirty-two (21%) did not take part in any prison activities.
- Fifty-seven (42%) had received no visits prior to death
- Nineteen (18%) had experienced a recent family bereavement or terminal illness in a family member

General health

- Fifty-four (34%) were found to have a physical health problem or disability at reception.
- The most common illnesses were epilepsy and asthma.

Mental health at reception

- One hundred and ten (72%) had at least one psychiatric diagnosis identified at reception.
- The commonest diagnosis was drug dependence.
- Forty-six (32%) had a second (co-morbid) diagnosis, indicating more complex treatment needs.
- Ninety-five (62%) had a history of drug misuse; 43 (45%) were referred to a health professional in prison.
- Forty-six (31%) had a history of alcohol misuse; 24 (52%) were referred to a health care professional in prison.

- Seventy-eight (53%) had a history of self-harm; 41 (53%) of these were referred to a health care professional in prison.

- Eighty-nine (57%) had symptoms of psychiatric disturbance on reception to prison; of these, 64 (72%) were referred to a health care professional in prison.

- Forty-six (30%) had a history of contact with NHS mental health services; of those 32 (70%) were referred to a health care professional in prison.

- It was unusual for information to be requested from a GP or from mental health services (18 made contact with GP's and 17 with mental health professionals).

Mental health in prison

- Fifteen percent of prison suicides had no further contact with health care staff after reception.

- Forty (25%) had an open F20 52SH at the time of death (indicating recognition of risk).

- At final contact with health care staff, risk of self harm/suicide was thought to be low or absent in 141 (93%) cases.

Prison Health Care Centre Inpatients

- Twenty-seven (17%) suicides were prison health care centre in-patients at the time of death.

- Eleven (6%) were under medium or high levels of observation at the time of death.

Post discharge suicides

- Forty-five (29%) had been prison health care centre in-patients at some point during their prison term; 16 (9%) died within 1 week of discharge from the healthcare centre.

- In twelve (27%) post-discharge suicides, no follow-up appointment was arranged.

Prevention

- Twenty-two (15%) suicides were seen by health staff as preventable.

- Staff indicated that closer supervision, better training, and an increase in use of shared cells could have reduced risk.

Young suicides

- Thirty-one (18%) suicides were aged 21 or under.
- Seven (23%) young suicides died in the first seven days following reception to prison.
- Seven (23%) were located in an adult local prison or remand centre.
- Twenty-one prisoners (68%) were located in a single cell at the time of death.

Recently released prisoners

- In a 4-year study period (1996-2000), 354 people were found to have committed suicide within 1 year of release from prison, i.e. 88 cases per year.
- These deaths clustered immediately after release with 80 (23%) in the first month and 40 in the first week.

Summary: Recommendations

The findings in this report indicate the need for a number of changes to prison health care services, prison regime and environment. We are aware that major intervention studies are needed to show conclusively that these measures will prevent suicide. However, the need for preventive action is urgent and in the absence of such evidence at present, we believe that the details of these cases provide a sound basis for recommendations on good clinical practice.

Circumstances of suicide

1. Prisons should review cells and wards, and remove potential ligature points, particularly where "at risk" prisoners are placed.

2. In areas where there are "at risk" prisoners, consideration needs to be given to the removal of bars from the windows.

3. Policies and practices need to be developed on the removal of potential ligatures from "at risk" prisoners.

4. There should be a review of the materials used as bedclothes within prisons and alternatives should be explored.

Information transfer

5. Information regarding prisoners with prior mental health service contact should be obtained from GPs, mental health services and others within 24 hours.

6. Mental health services and GP surgeries should accept the responsibility to share information with prisons and should no longer impose financial charges.

7. Health and risk related information should be shared with all members of staff within the prison who are responsible for the prisoner.

8. A family hotline should be established within each prison to enable family members to obtain and pass on information regarding suicide risk in prisoners.

Reception

9. Health screening interviews should be conducted in privacy.

10. Screening interviews should be carried out by someone with relevant mental health training.

11. Prisoners should be located in specific reception wings or areas for the first few days of their imprisonment where they are monitored by trained staff and receive the prison induction programme.

Care plans

12. All prisoners who have a history of mental health service care, symptoms suggestive of serious mental illness or a history of self-harm should have a multi-disciplinary care plan initiated at reception.

13. In cases where a prisoner has a pre-existing care plan under the care programme approach, information should be shared between NHS and prison mental health staff immediately following reception.

14. Prisoners with mental disorder, but without severe mental illness or major indicators of risk, should have a simple care plan.

15. A revised system of care planning, including regular risk assessment, should replace the current F20 52SH forms.

Drug and alcohol misuse

16. Dedicated detoxification centres should be set up in prisons to provide more effective programmes and management of those in withdrawal.

17. The establishment of detoxification regimes and programmes should be monitored to ensure prison policy is being implemented.

18. A co-ordinated "dual diagnosis" service should be part of prison mental health care, to integrate mental health services with drug rehabilitation services.

Observation

19. The use of shared cells and gated cells should be expanded; protocols for their use should be developed.

20. Clear criteria regarding levels of observation and movement of prisoners between them should be established.

In-patient and post-discharge suicides

21. Prisons and local NHS in-patient services should jointly monitor delays in transfer to hospital and ensure transfer requests are regularly reviewed and action is taken if delays are encountered.

22. Prisoners with severe mental illness or a history of self-harm should be followed up by health-care staff within 24 hours of discharge from in-patient prison health care settings.

Training

23. All prison officers should be trained in suicide prevention and risk management with a refresher course every three years.

24. Suicide prevention and risk management training courses should be designed to allow more flexible implementation; for example, with the introduction of modular courses tailored to working hours.

Treatments

25. The use of benzodiazepines for the treatment of anxiety or mood disorders in prison should be discontinued and more appropriate treatments instituted.

Aftermath of Suicide

26. A critical incident review involving all personnel should be carried out after a suicide

27. Suitable information from the critical incident review should be shared with the prisoner's family.

Young suicides

28. Young people should not be located in adult prisons in areas where they may have contact with adult offenders, for example, the health care centre or segregation unit.

29. The use of shared cells should be increased within young offender establishments.

Prison Escort Custody

30. Prisoners should be effectively supervised on transfer between prisons or court and prison.

31. Prison escort custody staff should receive mental health or suicide awareness training with a refresher course every three years.

Recently released prisoners

32. The release of prisoners with mental health problems should be co-ordinated with mental health teams outside prison. Care plans should be jointly reviewed by prison and local staff prior to release.

33. Those "at risk" of self-harm should be followed up within a week of release.

About this study

Background and aims

This study of suicide by prisoners is a collaboration between the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, the Department of Health Prison Health Policy Unit and the HM Prison Service Safer Custody Group (previously Directorate of Health Care and the Suicide Awareness Unit respectively). Funding for the project initially came from HM Prison Service Directorate of Health Care and the Safer Custody Group and work commenced in September 1998.

The aims of the project were:

- To conduct a detailed examination of all self-inflicted deaths by current prisoners
- To make recommendations on the recognition, assessment and management of suicide risk and related issues of mental health care
- To identify the training needs of staff.

The emphasis of the project is therefore on mental health and the findings presented in this report reflect this. Most of the findings refer to all prison suicides but there are separate sections on certain sub-groups – for example, young people and people with schizophrenia.

The study does not yet collect equivalent information on control subjects, i.e. individuals in prison who did not commit suicide. Therefore it cannot identify with certainty how prisoners who commit suicide differ from other prisoners. However, the study does collect detailed information on the activities of clinical and other prison services prior to suicide and on patterns of events leading to these incidents. As a result it can say how often certain kinds of problems occur prior to suicide and link these to service responses. For example, the data can tell us how often individuals died with an “open” F20 52 SH form (indicating recognised suicide risk). We can also carry out comparisons within the sample of people committing suicide highlighting the features of suicides in different groups, e.g. suicides in young people compared to those in other age groups. Some of these findings may however reflect differences between all prisoners in these groups, whether or not they commit suicide.

Data collection

A comprehensive national (England and Wales) sample of suicides or suspected suicides by current prisoners was identified from the records held by the Safer Custody Group. All self-inflicted deaths are immediately notified to the Safer Custody Group, before a coroner’s inquest has occurred. As a result, the sample of suicides in this report includes some

that were later given a verdict of misadventure or accident. It is conventional in suicide research to include most or all open verdicts but misadventures and accidental deaths are included only when there is a way of distinguishing the likely suicides from all other deaths with these verdicts. In this study, the notification of self-inflicted deaths allowed us to identify the likely suicides and include these, regardless of inquest verdict.

In each case, two questionnaires were sent to the prison where the death occurred. One was sent to the prison governor, the second to the prison medical officer. If a psychiatrist had assessed the prisoner, a third questionnaire was sent to him/her.

Prison Governor questionnaire
This questionnaire included sections covering:

- Social contacts and visits
- Occupation/education during prison term
- Location in the prison
- Prison practices
- Events leading to suicide.

The governor was asked to ensure completion by the person who knew the prisoner best, usually the wing manager or personal officer.

The Prison Medical Officer questionnaire
This questionnaire included sections covering:

- Demographic details
- Psychiatric history
- Information obtained from the reception medical screening; including history of drug or alcohol misuse, health problems and previous self-harm
- Details of the suicide
- Contact with NHS mental health services, prison medical and psychiatric staff and non-medical prison staff, level of observation, assessment of risk, diagnosis and clinical management
- Final contact prior to death
- Adverse life events
- Events leading to suicide
- Respondent’s view on prevention.

The Prison Medical Officer was asked to complete the questionnaire in consultation with other members of the multi-disciplinary team, where appropriate.

Psychiatrist questionnaire
This questionnaire included sections covering:

- Diagnosis and clinical history
- Final contact prior to death
- Respondent's views on prevention.

Sample
The period covered by data collection was January 1999 to December 2000. The sample is therefore a 2-year consecutive case series, defined by date of death.

Presentation of findings

This report is intended for a broad readership, and the style of presentation aims to balance the requirements of a scientific publication with those of a public document. Many of the main figures are presented in tables of "key variables" and in a series of graphs. The text presents additional specific figures. Ninety-five per cent confidence intervals are included for all estimates in the key variable tables. These indicate the accuracy of each estimate by showing the range of values within which the true figure is likely to lie. Wherever differences are referred to in the text, these are statistically significant. When percentages are quoted, these refer to "valid cases", i.e. those for whom the relevant information was available. In other words, if an item of information was not known about a person, he/she was excluded from the analysis of that item in the sample. As a result, the denominator varies a little in any group of calculations.

Suicide by recently released prisoners

In this part of the study we investigated how many people committed suicide within twelve months of release from prison. A complete sample of suicides in the general population between April 1996 and March 2000 was obtained from the database of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Those who died within 12 months of leaving prison were identified by linking these cases to the prisoner index (this lists dates of leaving prison for sentenced prisoners – remand prisoners are not included). Linkage was based on name and date of birth.

Information about prisons/Glossary of terms

Prisons in England and Wales
There are 135 prisons in England and Wales, including 13 female-only establishments, 4 with both male and female prisoners and 18 male-only young offender institutions. Young offender institutions have an upper age limit of 21 years. Approximately 16% of the prison population are 21 years old or under. Fourteen prisons take male juveniles (15-17 year olds), 5 prisons take female juveniles and 39 prisons take male young offenders (18-21 years old).

Prison categories
Prisoners are given a security category: A,B,C or D. The definition of a 'Category A' prisoner is a person who is considered to be of great danger to the public, the police or the security of the state. Prisoners are categorised on entry into the prison system and are placed at the appropriate level of security. Category D prisoners may be placed in an open prison.

Prison types
Local prisons take prisoners from court, either those on remand, those convicted but awaiting sentence and also those serving short sentences. Dispersal prisons take prisoners with the highest security needs, on remand, convicted but unsentenced and sentenced. Other sentenced prisoners are located in training and open prisons, largely dependent on their security category, usually with movement through the system over the period of the sentence, with reducing security need.

Remand and sentenced prisoners
Remand prisoners are awaiting trial in prison while their offences are being investigated. They have been refused bail usually because they are considered to be at high risk of re-offending or of absconding prior to the trial. In 1999 and 2000 (the period of the study) the average daily remand prison population figures were 12,520 and 11,270, while the average daily sentenced population figures were 51,691 and 52,684. Overall, therefore, the remand population was 19% of the total prison population.

Reception procedures
All prisoners on arrival at prison receive a reception interview during which personal details are recorded, health records are completed and the prisoner is informed of his or her rights within the prison. This is the first point of contact between the prisoner and prison staff.

Suicide prevention policy and F20 52SH forms
In 1992 the Prison Service published The Way Forward, a working paper which was part of the development of a revised strategy towards suicide prevention. The finalised policy, which is still in operation, was

published as CI Instruction 1/94 and was implemented from April 1994. Features of the new policy were:

- a greater responsibility for all prison staff in caring for suicidal prisoners
- introduction of new documentation (the F20 52SH) aiming to identify and then target resources at those at greatest risk of suicide/self-harm.

The F20 52SH is designed to enable prison staff to keep a concise record of the prisoner's care, needs and problems. Regular notes are made about prisoners, which are easily accessible to all prison staff. If the prisoner moves to another wing or prison the document accompanies him/her. When an F20 52SH is active, it is referred to as "open". It can be closed when risk is considered to be reduced.

Vulnerable persons unit
The vulnerable persons unit accommodates prisoners who need to be segregated from the rest of the prison population, usually for their own protection. Prisoners who have committed sex offences or who have testified against co-defendants at trial are usually located here. In addition, prisoners who are expected to have problems coping on other prison wings or who are prone to being bullied may be located here.

Segregation wings
Prisoners who have committed offences within the prison or have been "put on report" are often located here for limited periods of time. They are then usually required to have an adjudication hearing. Adjudication hearings are conducted by the governor; evidence is presented and the prisoner defends himself and may bring witnesses. The outcome may be a minor punishment. Previously a frequent outcome of an adjudication was that extra days were added to the sentence. This procedure has recently changed since the European Court of Human Rights ruled that the practice violates the individual's right to a fair trial (Ezeh and Connors judgement 15th July 2002).

Gated cells/stripped cells/unfurnished rooms
Stripped cells or unfurnished rooms were used in the past to house violent prisoners, those who needed to 'cool off' and suicidal/self-harming prisoners. They contained no furniture or facilities and were free of ligature points. The use of these rooms has now been prohibited for those at risk of suicide. (HM Prison Service 2000, Prison service instruction 27/2000)

Some prisons have gated cells, which are used for suicidal/self-harming prisoners. They have a gate instead of a full metal door, to provide the opportunity to observe and interact more closely with the prisoner.

Deliberate self-harm

Deliberate self-harm describes any deliberate act of self-injury or other harm to self (including overdose), not leading to death. The term covers attempted suicide and minor acts of self-injury.

PRISON SUICIDE FINDINGS

THE SAMPLE

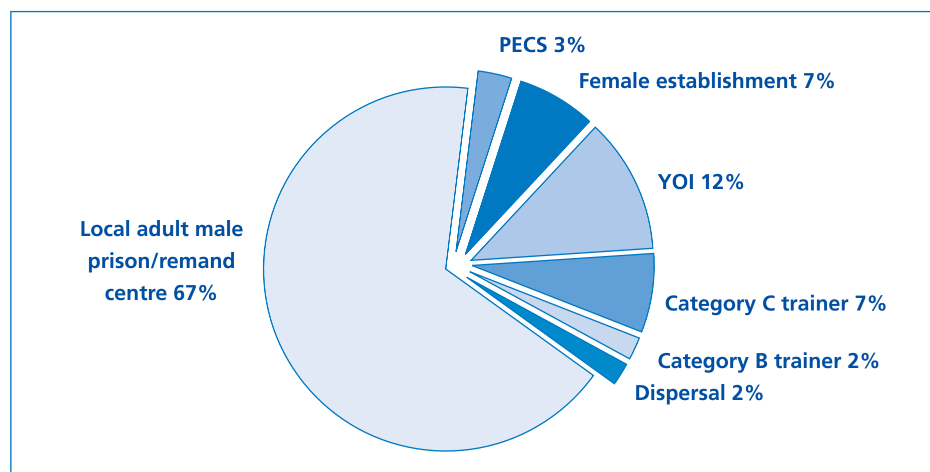
The study was notified of 172 self-inflicted deaths by the Safer Custody Group during the two years from January 1999. This included 95 (55%) cases in which the coroner recorded a verdict of suicide, 24 (14%) open verdicts, 16 (9%) cases of misadventure and 16 (9%) accidental deaths. In 21 cases the inquest was still pending at the time of data analysis. All are referred to as suicides in the remainder of this report. Non-clinical data and figures presented below relate to these 172 cases.

Questionnaires were returned from prison medical officers in 157 cases, a response rate of 91%; and from prison governors in 163 cases, a response rate of 95%. In 42 cases the medical officer identified a psychiatrist. In 29 cases, the psychiatrist returned the questionnaire, a response rate of 69%. When the psychiatrist's questionnaire was not returned, equivalent clinical information was obtained from the prison medical officer. Clinical data and figures presented below relate to these 157 cases.

THE PRISONS

The 172 suicides occurred in 65 prisons. Twenty-six prisons experienced one suicide, 27 had between two and four, and 12 had 5 or more. Of the latter group, 10 were local prisons for adult males and 2 were young offender institutions (YOI). Five suicides also occurred under the Prison Escort Custody Service (PECS). Altogether, 116 (67%) suicides occurred in local prisons for adult males and 20 (12%) in YOI's (fig. 1).

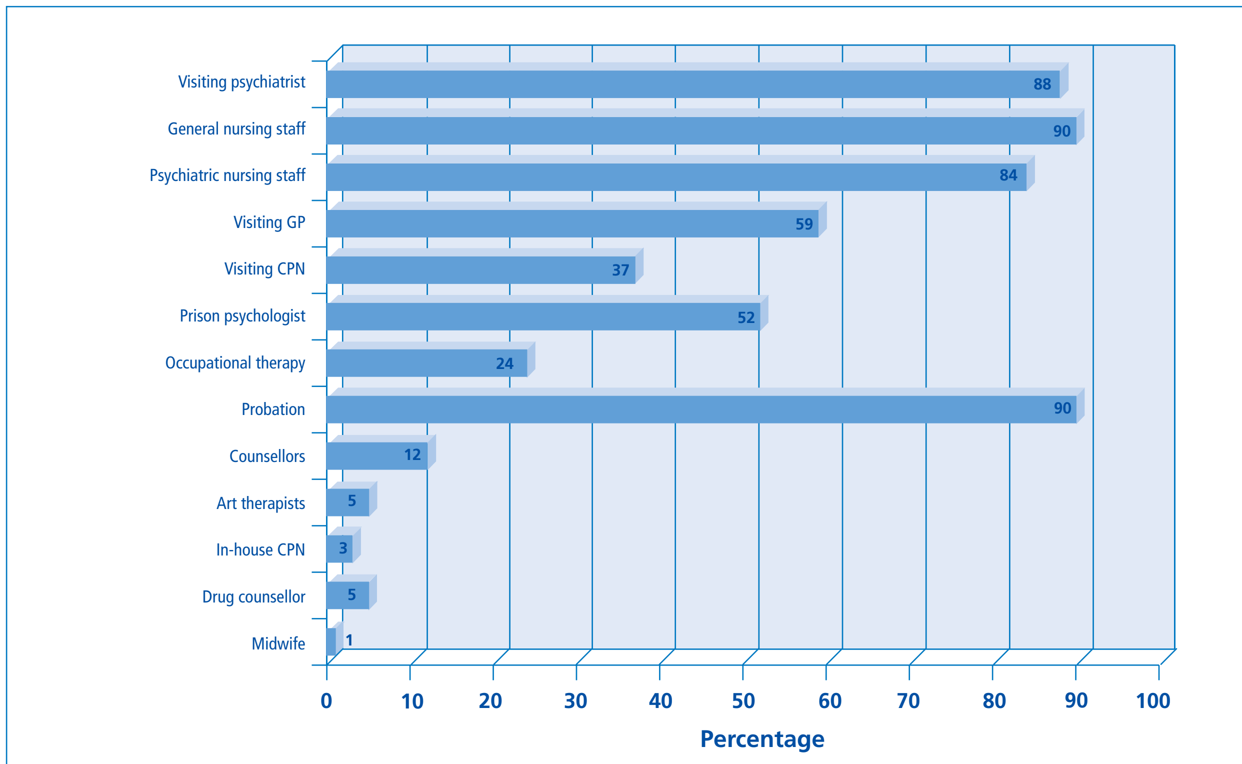
Figure 1: Prison establishment where suicide took place



Of the 65 prisons with at least one suicide in the study period, 64 (98%) had a health care centre on the premises and 59 (91%) had in-patient facilities providing 24 hour care. Fifty-five per cent of in-patient facilities had more than 20 beds while 7% had fewer than 10.

Figure 2 shows the additional support services available in these prisons. Local prisons had the most support services available – for example, 92% had visiting psychiatrists compared to around 80% for other categories of prison.

Figure 2: Support services available in the 65 prisons



In 47 (72%) prisons the health-screening interview carried out at reception took place in a private room or area. Local prisons were less likely to use a private room. Fifty-five (85%) prisons reported that screening interviews were usually carried out by a mental health nurse or prison medical officer. Twenty-nine (45%) prisons reported that over 75% of their wing staff had received training in suicide prevention; 12 (18%) reported a figure of 50-75%, 13 (20%) reported 25-50% and 4 (6%) less than 25%.

THE PRISONERS

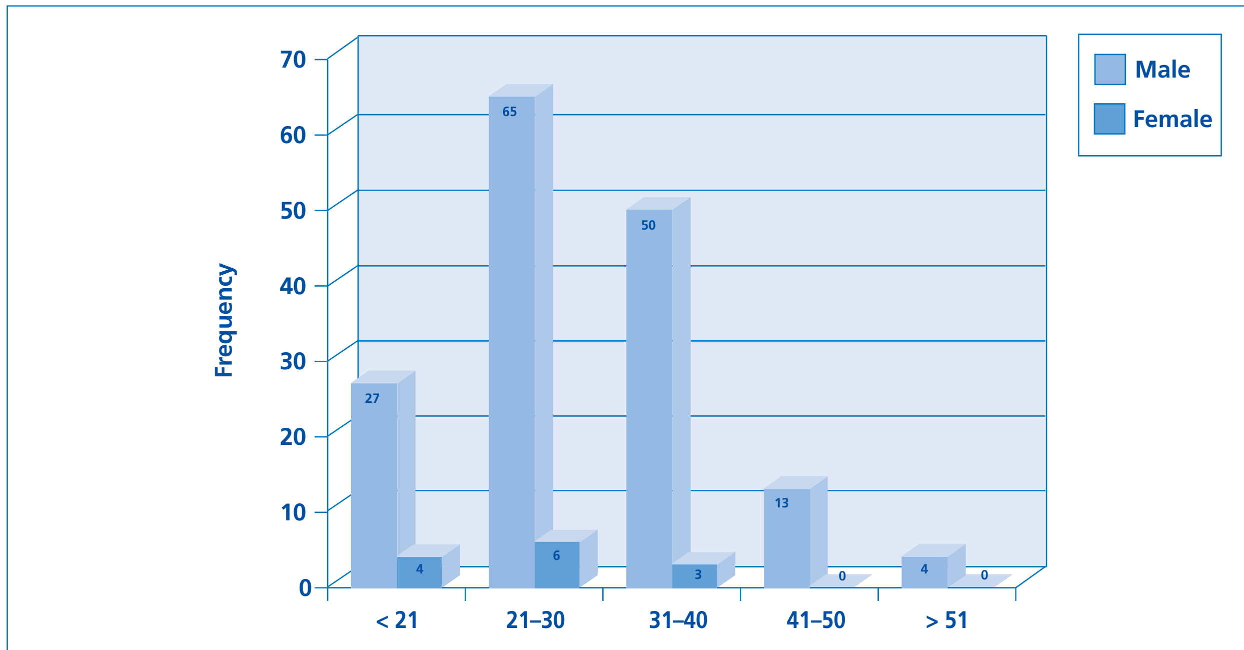
Social characteristics

Table 1 describes the main social characteristics of the 172 prison suicides.

There were 159 (92%) males, a male to female ratio of 12:1 (the male to female ratio in the prison population as a whole is 18:1 (Home Office, Research and Statistics department (RDS). The ratio of males to females was highest in those aged 31-40 (17:1) and lowest in those under 21 (7:1)

(fig. 3). There were no female suicides over the age of 40. Table 2 shows the social characteristics of the 172 prison suicides in each age group.

Figure 3: Age and sex



One hundred and thirty-six (86%) cases were not currently married (fig. 4). Nineteen (11%) were from an ethnic minority (fig. 5). In the prison population as a whole 19% of males and 25% of females are from an ethnic minority (Home Office RDS).

Figure 4: Marital status

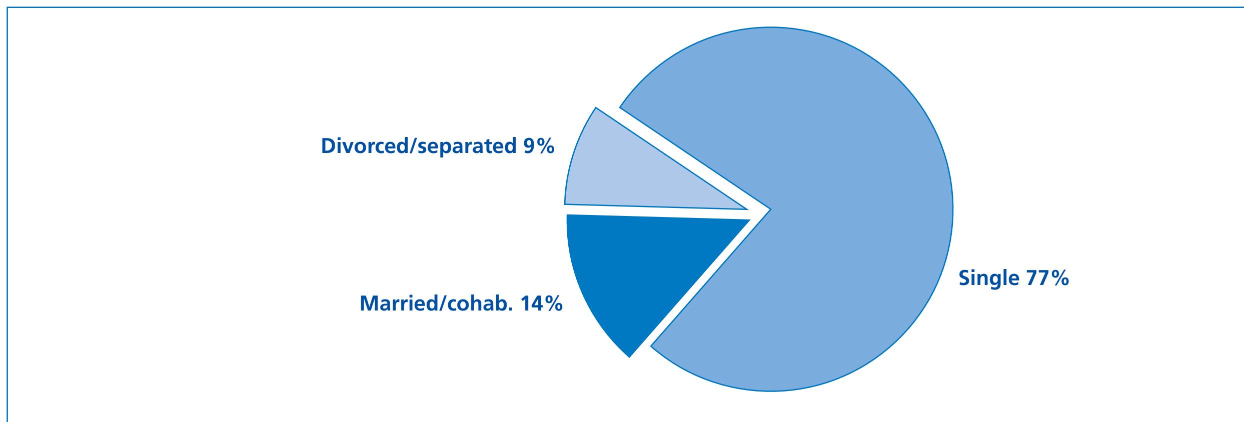
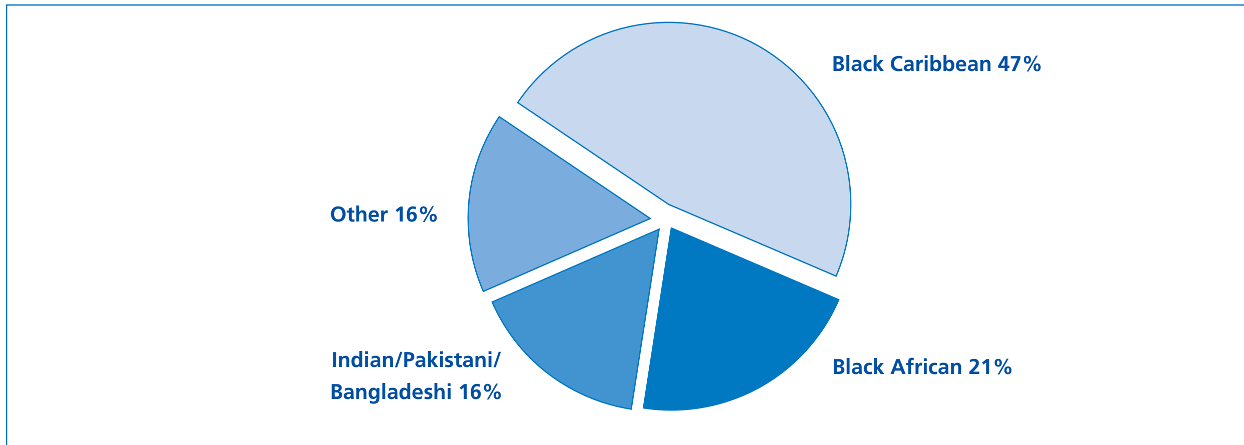


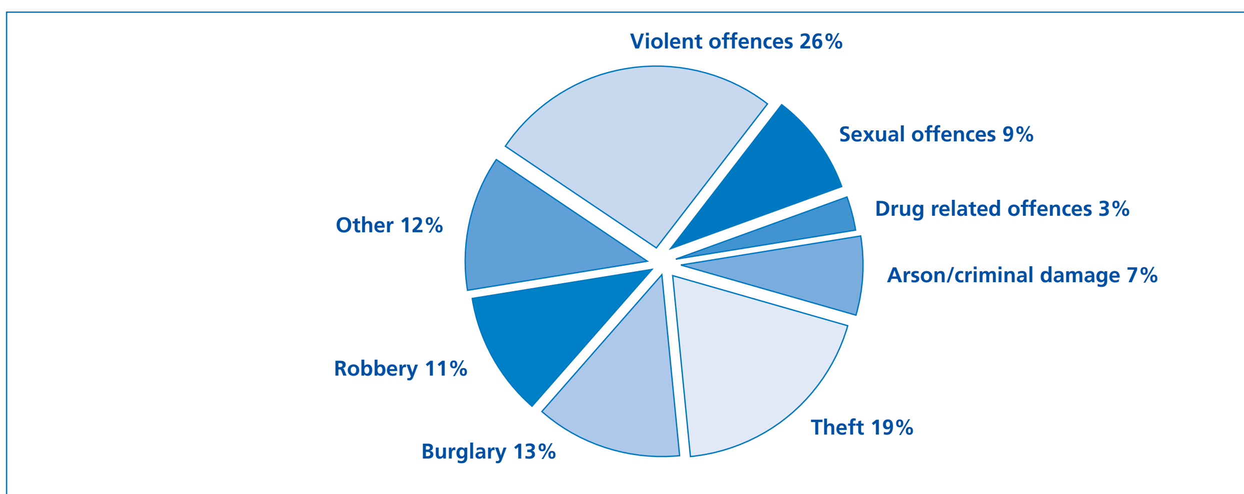
Figure 5: Ethnic origin (not including white)



Offending history

Figure 6 shows the type of offence that led to the current prison term. Forty-five (26%) had been charged or convicted of violent offences (including assault occasioning actual bodily harm (ABH), assault occasioning grievous bodily harm (GBH), other assault, wounding, attempted murder, murder and manslaughter). Eleven (6%) had been charged with murder/manslaughter and 6 with attempted murder. Seven of these 17 had been convicted and 6 had received a life sentence. All of those receiving life sentences had been in the prison for over a year at the time of death.

Figure 6: Offence characteristics



One hundred and thirty-two (77%) prisoners were known to have committed a previous offence, 92 (53%) prisoners had committed at least one previous violent offence.

Table 1: Social and clinical characteristics of all prison suicides

	Total Number 172	valid %	95% CI
Demographic Features			
Age: median (range)	28 (17–75)		
Male	159	92%	(88-96)
Ethnic minority	19	11%	(6-16)
Not currently married	136	86%	(79-91)
Living alone	19	27%	(16-37)
	Number 157	**valid %**	**95% CI**
Clinical Features			
Primary diagnosis			
Schizophrenia & other delusional	10	7%	(3-11)
Affective disorder (bipolar & dep.)	26	18%	(12-25)
Alcohol dependence	5	4%	(0-7)
Drug dependence	39	27%	(20-35)
Personality disorder	15	11%	(6-16)
Any secondary diagnosis	46	32%	(24-39)
Duration of history (under 12 months)	25	16%	(10-22)
Previous admissions to NHS psychiatric hospital	19	14%	(8-20)
History of NHS psychiatric contact	46	30%	(23-37)
Behavioural Features			
History of self-harm	78	53%	(45-61)
History of violence	47	35%	(27-43)
History of alcohol misuse	46	31%	(23-38)
History of drug misuse	95	62%	(54-70)
Prisoners charged with violent offences	41	26%	(19-33)
Prison Mental Health			
Prison hospital in-patients	26	17%	(11-22)
Mental health symptoms at reception	89	57%	(50-65)
F20 52SH forms at the time of death	38	24%	(18-31)
Referred to a psychiatrist in prison	50	32%	(25-40)
Transferred to NHS hospital while a prisoner	4	3%	(0-5)
Contact with services			
Last contact within 24 hours of death	84	56%	(48-64)
Symptoms at last contact	55	37%	(29-45)
Estimate of immediate risk: low or none	141	93%	(89-97)
Suicide thought to be preventable	22	15%	(9-21)

Table 2: Social and clinical characteristics of all prison suicides by age group

	< 21		21- 30		31-40		41+	
	N=31	% (95% CI)	N=71	% (95% CI)	N=53	% (95% CI)	N=17	% (95% CI)
Demographic Features								
Age: median (range)	19 (17-20)		26 (21-30)		35 (31-40)		44 (41-75)	
Male	27	87% (75-99)	66	92% (85-98)	50	94% (88-100)	17	100%
Ethnic minority	4	13% (1-25)	8	11% (4-19)	5	9% (2-17)	2	12% (0-27)
Not currently married	29	97% (90-100)	57	92% (85-99)	40	82% (71-92)	10	59% (35-82)
Living alone	5	42% (14-70)	6	23% (7-39)	6	24% (7-41)	2	25% (0-55)
	N=30	% (95% CI)	N=61	% (95% CI)	N=51	% (95% CI)	N=15	% (95% CI)
Clinical Features								
Primary diagnosis								
Schizophrenia & other delusional	1	4% (0-11)	7	13% (4-21)	1	2% (0-6)	1	7% (0-21)
Affective disorder (bipolar & dep.)	6	22% (7-38)	8	14% (5-23)	10	22% (10-34)	2	14% (0-33)
Alcohol dependence	–	0%	1	2% (0-5)	2	4% (0-10)	2	14% (0-33)
Drug dependence	9	35% (16-53)	20	36% (23-48)	10	22% (10-34)	–	0%
Personality disorder	2	8% (0-18)	7	13% (4-21)	3	7% (0-14)	3	21% (0-43)
Any secondary diagnosis	7	24% (9-40)	19	33% (21-45)	16	36% (22-50)	4	29% (5-52)
Duration of history (under 12 months)	7	23% (8-38)	9	15% (6-24)	8	16% (6-26)	1	8% (0-22)
Previous admissions to NHS psychiatric hospital	3	11% (0-23)	9	16% (6-26)	6	14% (4-24)	1	8% (0-24)
History of NHS psychiatric contact	8	28% (11-44)	19	32% (20-43)	14	28% (16-40)	5	33% (9-57)

	N=30	% (95% CI)	N=61	% (95% CI)	N=51	% (95% CI)	N=15	% (95% CI)
Behavioural Features								
History of self-harm	20	71% (55-88)	32	56% (43-69)	20	42% (28-56)	6	43% (17-69)
History of violence	10	37% (19-55)	15	28% (16-40)	13	31% (17-45)	9	69% (44-94)
History of alcohol misuse	13	48% (29-67)	12	20% (10-31)	14	29% (16-41)	7	47% (21-72)
History of drug misuse	24	86% (73-79)	45	76% (65-87)	24	47% (33-61)	2	13% (0-31)
Prisoners charged with violent offences	2	7% (0-16)	9	15% (6-24)	21	41% (28-55)	9	60% (35-85)
Prison mental health								
Prison hospital in-patients	3	10% (0-21)	10	16% (7-26)	9	18% (7-28)	4	27% (4-49)
Mental health symptoms at reception	17	59% (41-77)	35	58% (46-71)	28	55% (41-69)	9	60% (35-85)
Prisoners on F20 52SH at time of death	7	23% (8-38)	12	20% (10-30)	16	32% (19-44)	3	20% (0-40)
Referred to a psychiatrist in prison	7	24% (9-40)	18	30% (18-42)	16	32% (19-45)	9	60% (35-85)
Transferred to NHS hospital while a prisoner	–	0%	2	3% (0-8)	1	2% (0-6)	1	7% (0-19)
Contact with services								
Last contact within 24 hours of death	14	50% (31-69)	40	67% (55-79)	22	47% (33-61)	8	53% (28-79)
Symptoms at last contact	8	28% (11-44)	23	40% (28-53)	18	38% (24-52)	6	40% (15-65)
Estimate of immediate risk: low or none	25	86% (74-99)	57	95% (89-100)	46	96% (90-100)	13	87% (69-100)
Suicide thought to be preventable	7	26% (9-42)	9	15% (6-24)	5	11% (2-21)	1	8% (0-24)

Physical Health

Fifty-four prisoners (34%) were suffering from a physical disability or physical health problem on reception to prison. The commonest were epilepsy (17%), asthma (28%) and trauma for example previously broken bones, nerve or tendon damage (7%). In (9%), health problems were related to drug or alcohol use (for example cirrhosis, stomach ulcers, Hepatitis C or B).

Mental Health

The main clinical characteristics of the 157 suicides on whom questionnaires were returned are presented in Table 1. The clinical characteristics for each age group are shown in Table 2.

Psychiatric history One hundred and ten (72%) prisoners who subsequently committed suicide had at least one psychiatric diagnosis recorded at reception (fig. 7), the most common being drug dependence. Forty-six (32%) had a secondary diagnosis, and again the most common was drug dependence (fig. 8). Twenty-five (16%) had been ill for 12 months or less (fig. 9); they were most likely to be suffering from a mood disorder.

A history of self-harm, violence, drug misuse or alcohol misuse was common.

Figure 7: Primary diagnosis

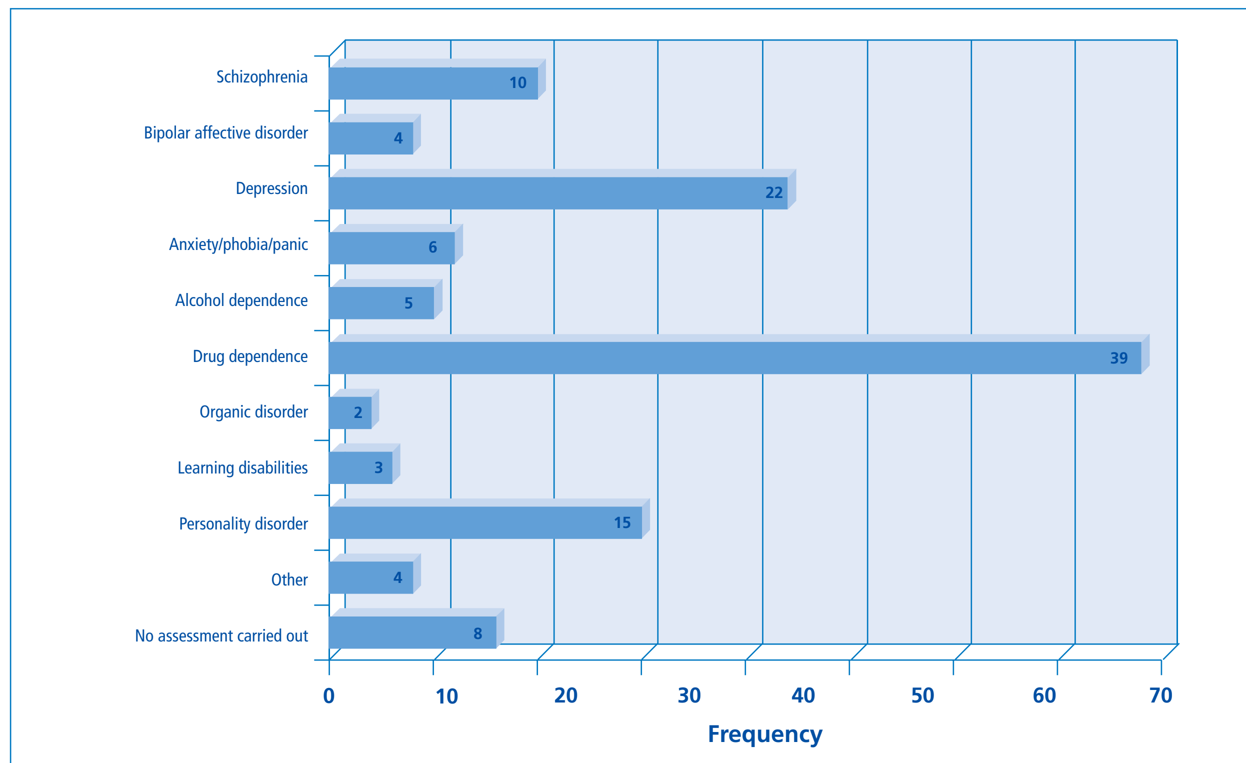


Figure 8: Secondary diagnosis

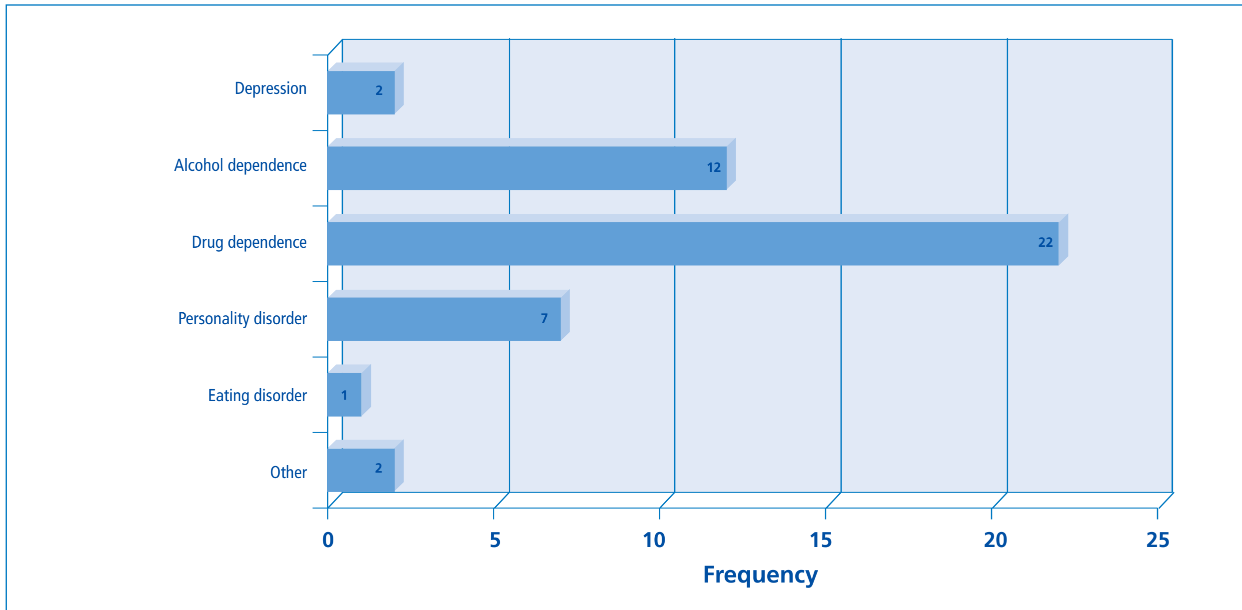
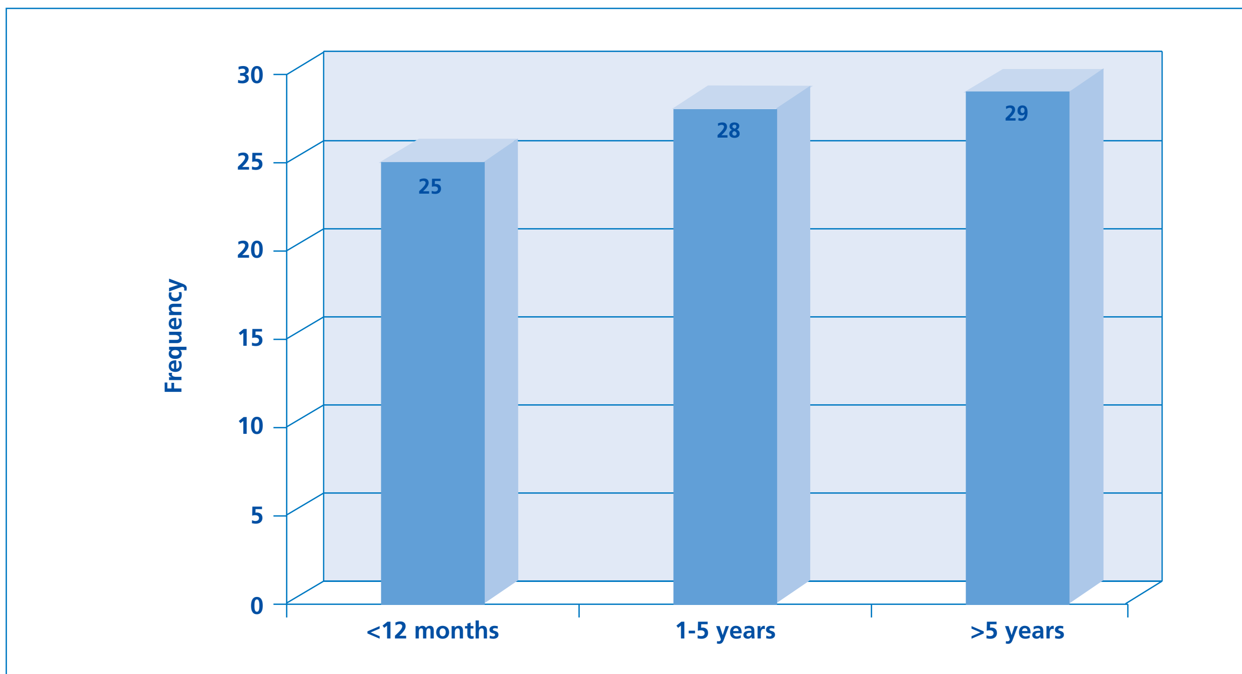


Figure 9: Duration of history



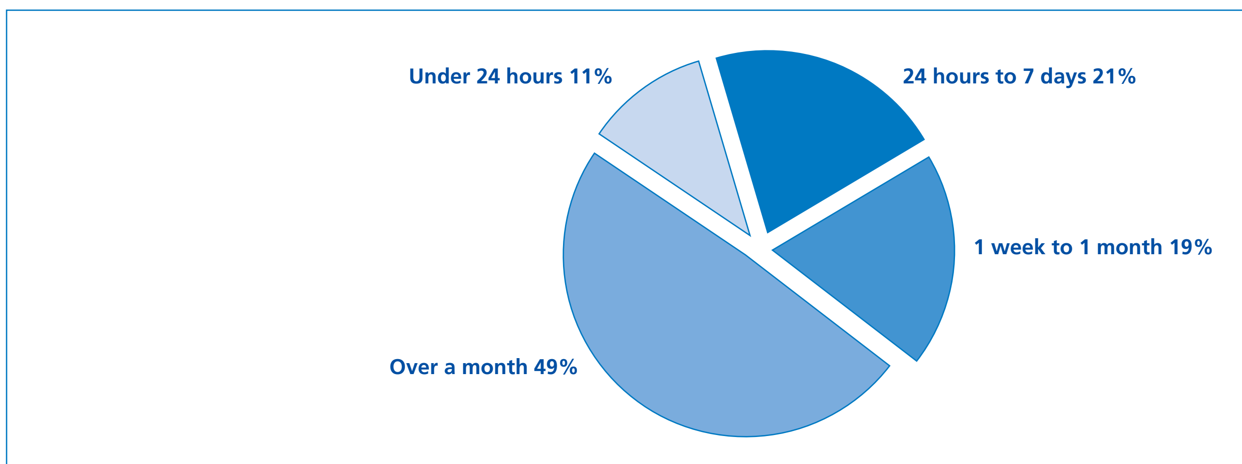
Circumstances of death

Method The commonest method of suicide was hanging or self-strangulation, which occurred in 159 cases (92%). The most commonly used ligatures were bedclothes (56%), shoelaces (13%), items of clothing (9%) and belts (4%). Ligatures were fastened to the window bars (48%), the bed (11%), other cell fittings, i.e. lights, pipes, cupboards, sinks or toilets (13%) or the door (5%). In 2 cases a healthcare centre curtain rail was used.

Thirteen individuals (8%) used a method other than hanging. There were 6 (3%) cases of self-poisoning (2 with an analgesic, 2 with heroin, 1 with a tricyclic anti-depressant and 1 with a beta blocker) 4 (2%) of cutting or stabbing, 1 of burning, 1 of suffocation and 1 other (unspecified).

Timing Information about timing of death is shown in figure 10. Fifty-five people (32%) died within seven days of reception, 19 (11%) within twenty-four hours. One hundred and twenty-one (70%) died on a weekday and 83 (48%) died between the hours of 6pm and 5am.

Figure 10: Time between reception and suicide



Deaths within the first week of custody The social and clinical characteristics of early (within the first week) and late deaths are shown in table 3.

Prisoners who died within the first week were more likely to be charged with an acquisitive offence, to have symptoms at reception, to have a history of drug misuse and to have a diagnosis of drug dependence but were no more likely to have a history of self-harm.

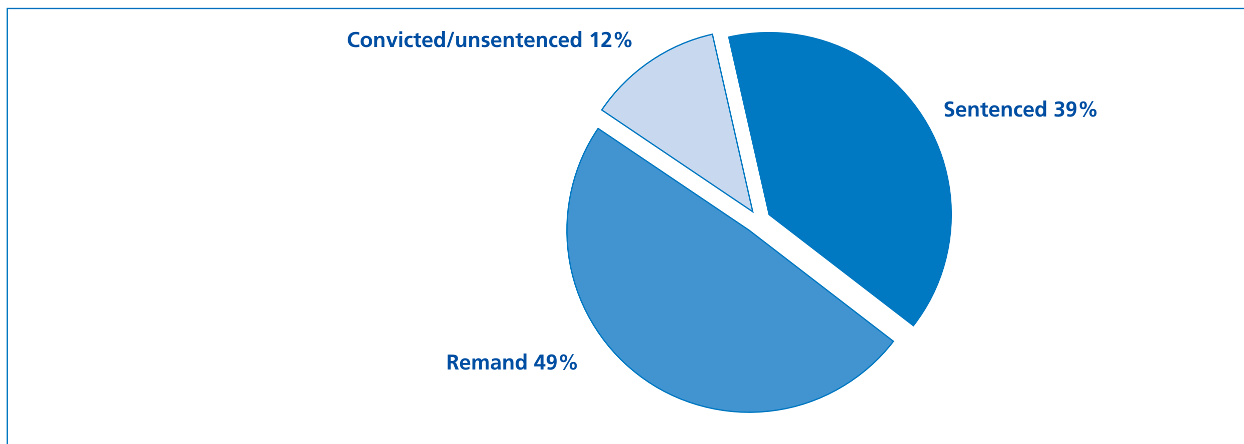
Prisoners who died within the first week were more likely to be in-patients at the time of death, whereas prisoners who died later were

more likely to have had health care admissions, ongoing contact with health care and referral to a psychiatrist.

Final contact within 24 hours of death was more frequent in the early deaths although perception of risk of suicide at final contact was no different. Later deaths were twice as likely to be thought of as preventable.

Status Whilst remand prisoners make up 19% of the prison population at any one time, 49% of suicides were in remand prisoners. A further 20 (12%) had been convicted but not yet sentenced (fig. 11). The social and clinical characteristics of remand/unsentenced prisoners compared with convicted prisoners are shown in table 4. The unsentenced prisoners were more likely to have a history of drug misuse or to be drug dependent and their deaths were less likely to be seen as preventable. Convicted prisoners were more likely to have a history of previous psychiatric contact in the NHS.

Figure 11: Prisoner status



Location Nineteen (11%) were located on a vulnerable persons wing or unit (VPU) at the time of death. A further 5 had been located on a VPU during this prison term and an additional 3 during a previous prison term.

One hundred and nine (63%) were in single cell accommodation. This includes 15 (9%) prisoners who were located on a segregation unit. Of those in shared accommodation the cellmate was absent at the time of death in just over half (30 out of 58 (52%)) (for example, at court, association, work or on exercise).

Review In 104 (66%) cases the prison held a multi-disciplinary review of the case following the prisoner's death. In 10% of reviews there were differences of opinion between staff regarding the quality of prisoner care at the time of death.

Table 3: Social and clinical characteristics of early/late suicides

	Early		Late		Total	
	N=55	% (95% CI)	N=117	% (95% CI)	N=172	% (95% CI)
Demographic Features						
Age: median (range)	28 (17-47)		28 (17-75)		28 (17-75)	
Male	49	89% (81-97)	110	94% (90-98)	159	92% (88-96)
Ethnic minority	6	11% (3-19)	13	11% (5-17)	19	11% (6-16)
Not currently married	41	85% (75-95)	95	86% (80-93)	136	86% (79-91)
Living alone	5	23% (5-40)	14	29% (16-41)	19	27% (16-37)
	N=55	% (95% CI)	N=117	% (95% CI)	N=157	% (95% CI)
Clinical Features						
Primary diagnosis						
Schizophrenia & other delusional	4	9% (1-18)	6	6% (1-11)	10	7% (3-11)
Affective disorder (bipolar & dep.)	4	9% (1-18)	22	22% (14-30)	26	18% (12-25)
Alcohol dependence	2	5% (0-11)	3	3% (0-6)	5	4% (0-7)
Drug dependence	23	52% (38-67)	16	16% (9-24)	39	27% (20-35)
Personality disorder	3	7% (0-14)	12	12% (6-19)	15	11% (6-16)
Any secondary diagnosis	15	33% (19-46)	31	31% (22-40)	46	32% (24-39)
Duration of history (under 12 months)	7	14% (4-24)	18	17% (10-24)	25	16% (10-22)
Previous admissions to NHS psychiatric hospital	4	10% (1-18)	15	16% (8-23)	19	14% (8-20)
History of NHS psychiatric contact	11	23% (11-35)	35	33% (24-42)	46	30% (23-37)

	N=55	% (95% CI)	N=117	% (95% CI)	N=157	% (95% CI)
Behavioural Features						
History of self-harm	25	56% (41-70)	53	52% (42-62)	78	53% (45-61)
History of violence	8	19% (7-31)	39	41% (32-51)	47	35% (27-43)
History of alcohol misuse	8	17% (6-28)	38	37% (28-46)	46	31% (23-38)
History of drug misuse	40	82% (71-92)	55	53% (43-62)	95	62% (54-70)
Prisoners charged with violent offences	4	8% (0-16)	37	35% (26-44)	41	26% (19-33)
Prison mental health						
Prison hospital in-patients	11	22% (11-33)	15	14% (7-21)	26	17% (11-22)
Mental health symptoms at reception	31	63% (50-77)	58	55% (45-64)	89	57% (50-65)
F20 52SH at time of death	14	29% (16-41)	24	22% (15-30)	38	24% (18-31)
Referred to a psychiatrist in prison	4	8% (1-16)	46	43% (33-53)	50	32% (25-40)
Transferred to NHS hospital while a prisoner	–	0%	4	4% (0-7)	4	3% (0-5)
Contact with services						
Last contact within 24 hours of death	37	80% (69-92)	47	45% (36-55)	84	56% (48-64)
Symptoms at last contact	22	46% (32-60)	33	33% (24-42)	55	37% (29-45)
Estimate of immediate risk: low or none	44	90% (81-98)	97	94% (90-99)	141	93% (89-97)
Suicide thought to be preventable	4	9% (1-18)	18	18% (10-26)	22	15% (9-21)

Table 4: Social and clinical characteristics of remand/convicted suicides

	Remand/Unsentenced		Convicted		Total	
	N=105	% (95% CI)	N=67	% (95% CI)	N=172	% (95% CI)
Demographic Features						
Age: median (range)	28 (17-75)		28 (17-49)		28 (17-75)	
Male	97	92% (87-97)	62	93% (86-99)	159	92% (88-96)
Ethnic minority	1	10% (5-16)	8	12% (4-20)	19	11% (6-16)
Not currently married	83	86% (80-93)	53	85% (69-89)	136	86% (79-91)
Living alone	12	31% (16-45)	7	22% (8-36)	19	27% (16-37)
	N=96	% (95% CI)	N=61	% (95% CI)	N=157	% (95% CI)
Clinical Features						
Primary diagnosis						
Schizophrenia & other delusional	6	7% (2-12)	4	7% (0-14)	10	7% (3-11)
Affective disorder (bipolar & dep.)	13	15% (8-23)	13	23% (12-34)	26	18% (12-25)
Alcohol dependence	4	5% (0-9)	1	2% (0-5)	5	4% (0-7)
Drug dependence	29	34% (24-44)	10	18% (8-28)	39	27% (20-35)
Personality disorder	7	8% (2-14)	8	14% (5-23)	15	11% (6-16)
Any secondary diagnosis	27	29% (20-38)	19	36% (23-49)	46	32% (24-39)
Duration of history (under 12 months)	15	16% (9-24)	10	16% (7-26)	25	16% (10-22)
Previous admissions to NHS psychiatric hospital	13	15% (8-23)	6	11% (3-20)	19	14% (8-20)
History of NHS psychiatric contact	25	27% (18-36)	21	34% (23-46)	46	30% (23-37)

	N=96	% (95% CI)	N=61	% (95% CI)	N=157	% (95% CI)
Behavioural Features						
History of self-harm	46	52% (42-63)	32	54% (42-67)	78	53% (45-61)
History of violence	27	33% (22-43)	20	38% (25-51)	47	35% (27-43)
History of alcohol misuse	22	25% (16-34)	24	39% (27-52)	46	31% (23-38)
History of drug misuse	62	67% (58-77)	33	54% (42-67)	95	62% (54-70)
Prisoners charged with violent offences	22	23% (15-31)	19	31% (20-43)	41	26% (19-33)
Prison mental health						
Prison hospital in-patients	15	16% (8-23)	11	18% (8-28)	26	17% (11-22)
Mental health symptoms at reception	56	60% (50-69)	33	54% (42-67)	89	57% (50-65)
F20 52SH at time of death	28	29% (20-38)	10	17% (7-26)	38	24% (18-31)
Referred to a psychiatrist in prison	26	28% (19-37)	24	39% (27-52)	50	32% (25-40)
Transferred to NHS hospital while a prisoner	2	2% (0-5)	2	3% (0-8)	4	3% (0-5)
Contact with services						
Last contact within 24 hours of death	59	66% (56-76)	25	41% (29-53)	84	56% (48-64)
Symptoms at last contact	34	37% (27-47)	21	37% (24-49)	55	37% (29-45)
Estimate of immediate risk: low or none	88	95% (90-99)	53	90% (82-98)	141	93% (89-97)
Suicide thought to be preventable	9	11% (4-17)	13	22% (11-33)	22	15% (9-21)

Prison experience

One hundred and nine (66%) prisoners had been in only one prison during their current prison term, while 5 (3%) had been in more than five.

Thirty (21%) prisoners were reported to have been victims of bullying. One quarter had had an adjudication against them during this prison term.

Thirty-two (21%) did not take part in any activities whilst in the prison. This was more often the case in local prisons. However, one quarter of these died within 24 hours of reception into prison and a further quarter within the first week, perhaps before activities had commenced. In addition remand prisoners are not required to work. Of those who did take part in activities, 47 (38%) went to work, 35 (28%) were receiving education and 55 (44%) took part in leisure activities.

Fifty-seven (42%) had not received any visits during their prison term. Another 15 (11%) had received visits less than monthly. However, in many cases the prisoner may have died before visits could be established.

There had been regular contact (at least twice during the month before death) with a wide range of staff other than health-care professionals. This included the prison chaplain (40%), listener (28%) and probation officer (26%).

Antecedents

Respondents were asked to detail events in the three months leading up to suicide. Figures 12 and 13 show the clinical and social antecedents of all suicides. In 10 (6%) cases no antecedents were noted. Antecedents can be divided into those indicating a change in behaviour, and life events. The former (figure 12) included expression of suicidal ideas (44, 30%), act of deliberate self-harm (38, 26%) clinical relapse (35, 24%), misuse or withdrawal from drugs (47, 31%), misuse or withdrawal from alcohol (10, 7%) and suspicion of drug use (21, 15%). Adverse life events (figure 13) included family or relationship problems (23, 21%), court appearances (29, 27%), the offence itself (15, 14%) and bereavement or terminal illness of family member (19, 18%). Thirty (21%) were reported to have been bullied. Thirty-three (21%) prisoners left a suicide note.

Figure 12: Clinical antecedents

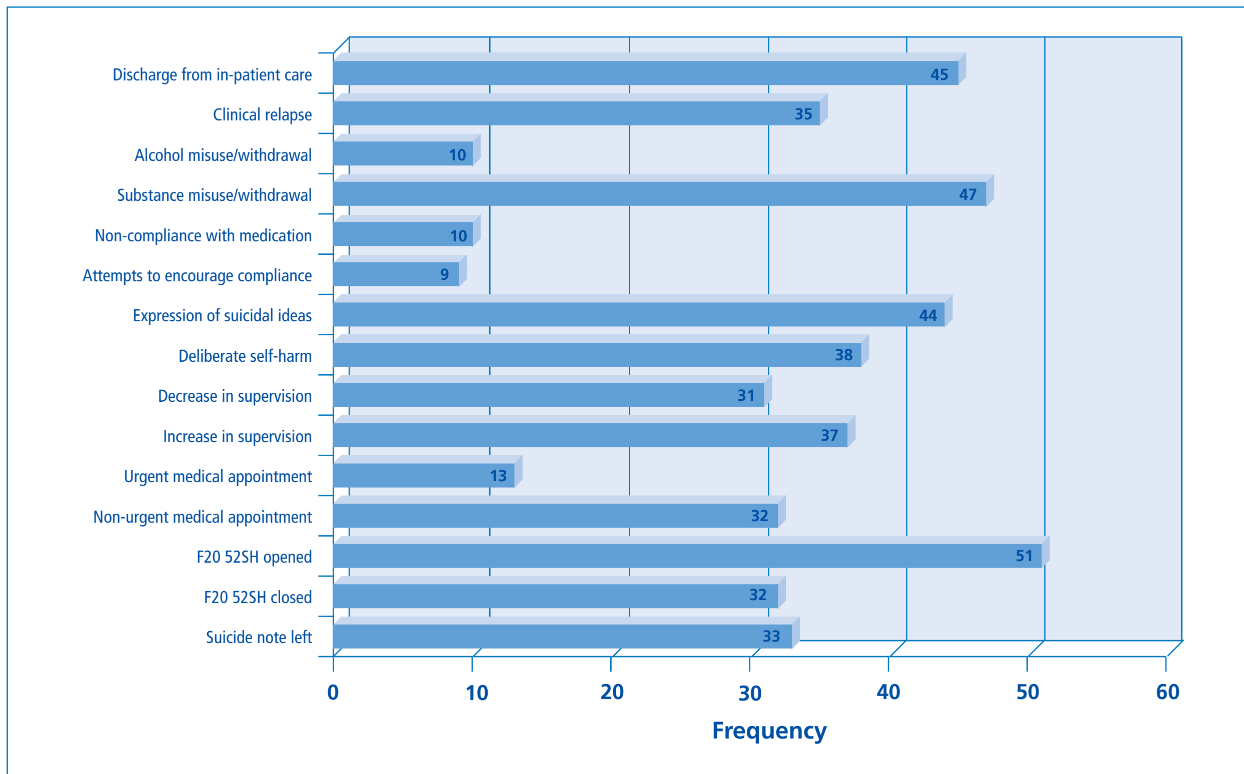
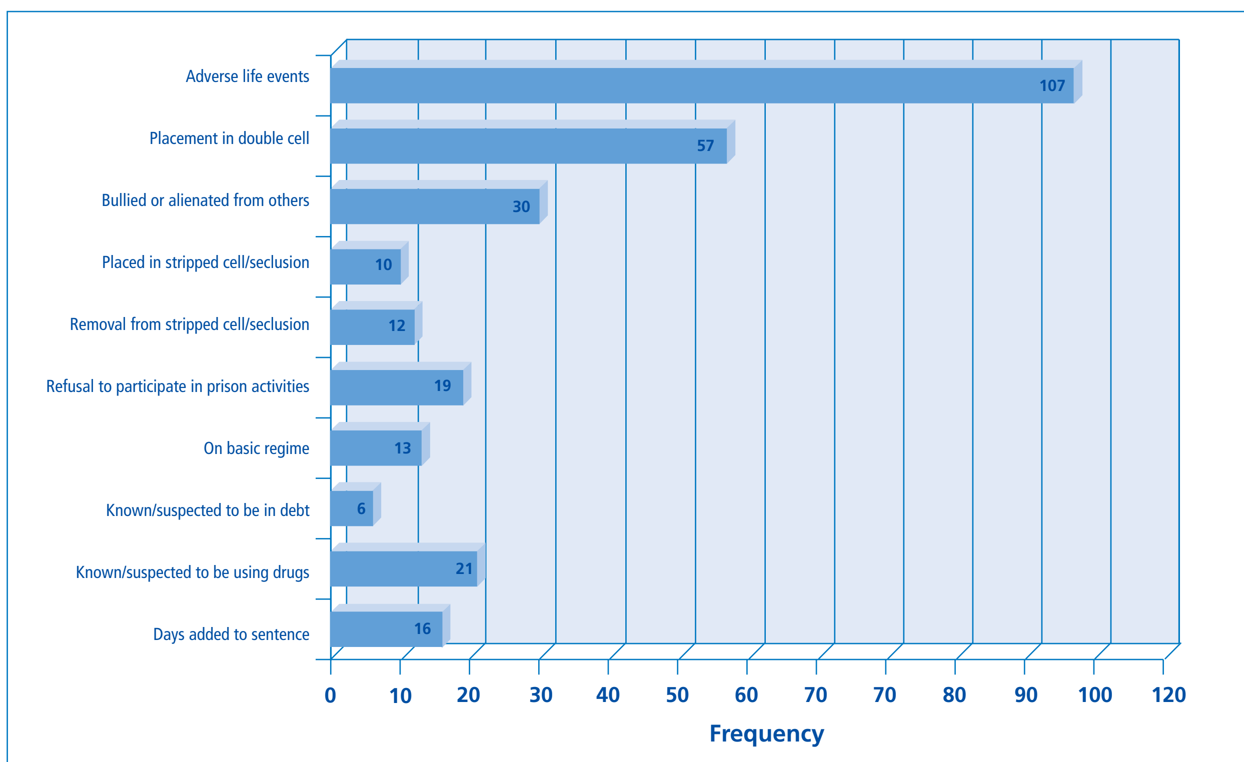


Figure 13: Social and situational antecendents



RECEPTION SCREENING

History of mental disorder Forty-six (30%) were found at reception to have a history of contact with NHS mental health services of whom 19 (14%) had been in-patients. Of those with a history of contact, 32 (70%) had an F20 52SH opened and 32 (70%) were referred to the prison doctor or medical officer.

Information sharing Forty-three (28%) prisoners reported at reception that they had no GP. Of the 110 in whom it was recorded that they had a GP, he/she was contacted for information in 18 cases; in only 10 did this happen within one week of reception. Of the 46 prisoners with a history of contact with NHS mental health services, an attempt was made to contact the mental health service in only 17 (37%) cases.

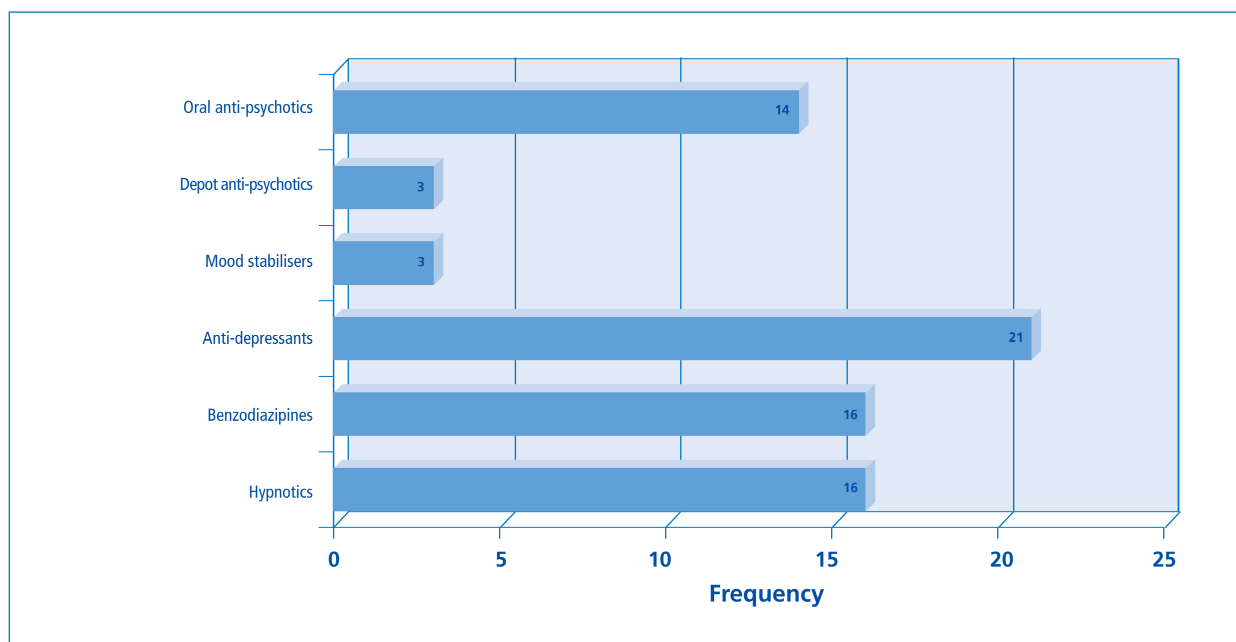
In 33 (21%) cases, an outside agency expressed concern about the prisoner's mental health – outside agencies included probation services (8%), court diversion scheme (5%), police, court officials or escort custody staff (5%) and community mental health services (3%).

Current symptoms Eighty-nine (57%) had symptoms related to mental disorder at reception. The most common were intoxication or withdrawal from drugs or alcohol (27%), anxiety (17%), thoughts of self-harm or suicidal ideas (16%) depression (16%) emotional distress (13%) and hostility (6%). Thirty-five of those with symptoms (39%) had previously been in contact with NHS mental health services, an F20 52SH was opened at reception in 40 (45%) cases and referral at reception to the prison medical officer took place in 64 (72%) cases.

Current treatment Fifty-three (34%) prisoners were taking some medication at the time of reception. Many were taking more than one type of medication. Twenty-one (14%) were receiving an antidepressant, 17 (11%) an oral or depot anti-psychotic, 16 (10%) a hypnotic and 16 (10%) benzodiazepines as anxiolytics (fig. 14). Of those taking benzodiazepines as anxiolytics, at reception, four were considered dependent. Seven of the 16 had their benzodiazepines discontinued, including two of those considered dependent. A further 18 (11%) prisoners were prescribed benzodiazepines as anxiolytics following reception to prison.

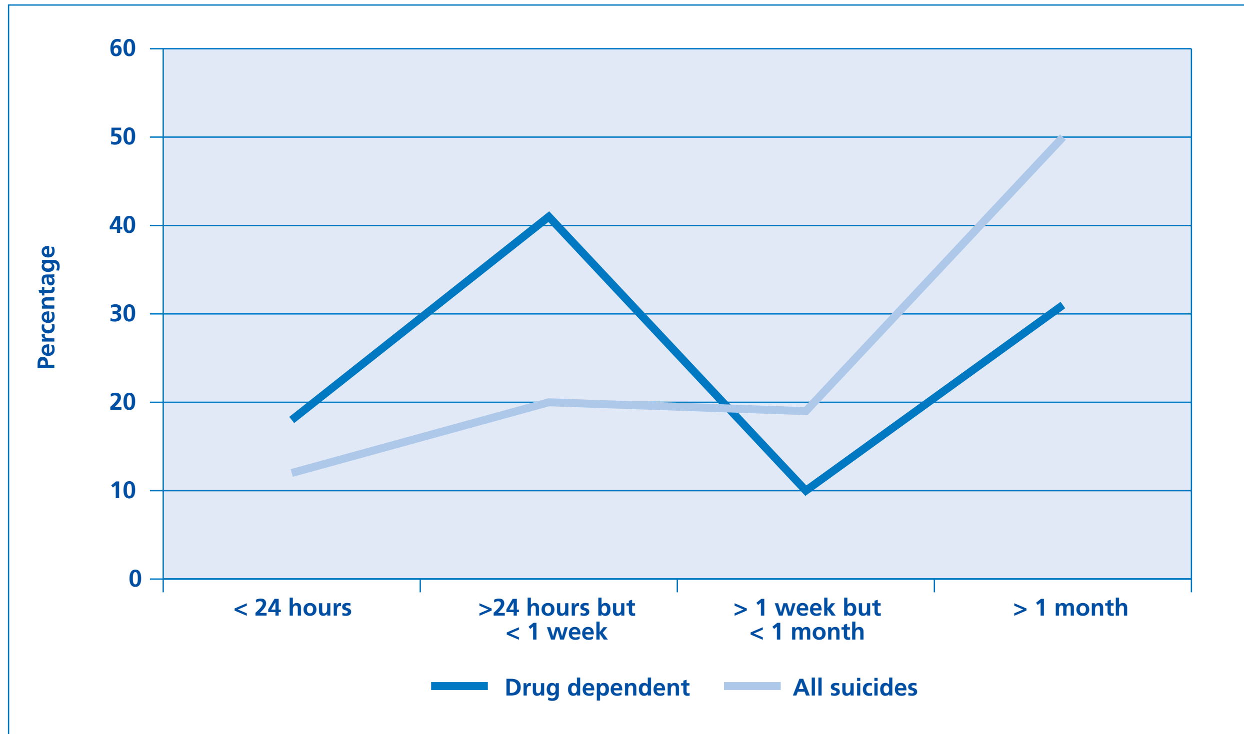
Of those on medication, an F20 52SH was opened at reception in 23 cases; referral to the prison doctor or medical officer took place in 34 cases.

Figure 14: Treatment at reception



Drug misuse Ninety-five (62%) individuals were found to have a history of drug misuse at reception and their main social and clinical characteristics are found in table 5. These individuals were less likely to have a history of violence or to be charged with a violent offence and more likely to be charged with an acquisitive offence. Of those with a history of drug misuse, the most common substances used were heroin (56, 64%), crack/cocaine (23, 27%), amphetamines (23, 27%) and benzodiazepines (16, 19%). Eleven (15%) were known to have had contact with drug services outside the prison and 46 (48%) had a treatment plan for withdrawal on admission to prison. In all cases this included the provision of pharmacological treatment, most commonly dihydrocodeine (DF118), lofexadine, benzodiazepines, an anti-psychotic drug or methadone. Thirty-eight (43%) had some features of drug dependence and a higher proportion than in the whole sample had a secondary diagnosis. An F20 52SH was opened in 27 (28%) cases and referral to the prison doctor or medical officer took place in 43 (46%) cases. Of the 38 considered dependent over half (59%) died within the first week of custody (fig. 15).

Figure 15: Timing of suicide: drug dependent compared with all suicides



Fourteen prisoners (15%) with a history of drug misuse also had ideas of suicide or self-harm at reception. Seven (50%) had previous contact with NHS mental health services, thirteen (93%) had a history of self-harm and nine (64%) also had symptoms of depression. Following reception screening, thirteen were admitted to health care and seven (50%) were health care in-patients at the time of death. Five were referred to a psychiatrist. An F20 52SH was opened in eleven (79%) cases. In 5 cases it was still open at the time of death.

Alcohol misuse Forty-six (31%) individuals were found to have a history of alcohol misuse at reception and their main social and clinical characteristics can be found in table 5. Twenty-six (68%) had some features of alcohol dependence and half had a secondary diagnosis. Five prisoners (15%) were known to have had contact with alcohol services outside prison. Eight (17%) were found to be in withdrawal at reception into prison and all received pharmacological treatment, usually a benzodiazepine and/or thiamine. At reception, an F20 52 SH was opened in 20 (43%) cases and 24 (53%) were referred to the prison doctor or medical officer.

Ten (22%) prisoners with a history of alcohol misuse also had ideas of suicide or self-harm at reception. Six of these had symptoms of depression and anxiety and five had symptoms of emotional distress at reception. All ten had been on an F20 52 SH at some stage, during their prison term, but only three were on an F20 52SH at the time of death. Five had been referred to a psychiatrist and three were inpatients at the time of death.

History of self-harm Seventy-eight (53%) of the total sample of 157 were found at reception to have a history of deliberate self-harm. Of these, 50 (64%) had an F20 52SH opened and 41 (53%) were referred to the prison doctor or medical officer.

Twenty-five (16%) had thoughts of self-harm at reception. Of these, 23 had an F20 52 SH opened and 21 were referred to the prison medical officer. Half had an open F20 52 SH at the time of death. Twenty-two (16%) prisoners had a history of self-harm and had thoughts of suicide or self-harm at reception. Compared with the total sample, they had higher rates of depression, anxiety and emotional distress noted at reception and were more likely to be admitted to health care, referred to the prison medical officer or a psychiatrist, or be placed in a double cell. Nineteen (86%) had an F20 52 SH opened at some point, in 10 cases it was still open at the time of death. Of those, in whom the F20 52SH had been closed, 3 had a primary diagnosis of personality disorder, 1 of schizophrenia, 1 of bipolar disorder/depression and 1 of substance dependence, the other 3 had no psychiatric diagnosis.

Ten of those with a history of self harm and ideas of self harm at reception were health care in-patients at the time of death (7 were located in a single cell in health care) whilst a further 10 had been discharged from in-patient care, 7 of these had a follow up appointment arranged with the prison medical officer but only 1 had an open F20 52SH at the time of death (six were in single cells on the wing at the time of death).

This sub-group of prisoners with a history of self-harm and ideas of self-harm at reception were more likely to be seen as medium or high risk and to have symptoms at final contact.

Table 5: Social and clinical characteristics by individuals with drug or alcohol misuse

	Drug use		Alcohol misuse		Total	
	N=95	% (95% CI)	N=46	% (95% CI)	N=172	% (95% CI)
Demographic Features						
Age: median (range)	26 (17-43)		29.5 (17-56)		28 (17-75)	
Male	84	88% (81-97)	40	87% (77-97)	159	92% (88-96)
Ethnic minority	8	8% (3-19)	4	9% (1-17)	19	11% (6-16)
Not currently married	77	91% (75-95)	36	88% (78-98)	136	86% (79-91)
Living alone	10	30% (15-46)	5	28% (7-48)	19	27% (16-37)
	N=95	%(95% CI)	N=46	% (95% CI)	N=157	% (95% CI)
Clinical Features						
Primary diagnosis						
Schizophrenia & other delusional	4	4% (0-9)	1	2% (0-7)	10	7% (3-11)
Affective disorder (bipolar & dep.)	19	21% (13-30)	12	27% (14-40)	26	18% (12-25)
Alcohol dependence	1	1% (0-3)	5	11% (2-21)	5	4% (0-7)
Drug dependence	38	43% (32-53)	8	18% (7-30)	39	27% (20-35)
Personality disorder	9	10% (4-16)	7	16% (5-27)	15	11% (6-16)
Any secondary diagnosis	39	42% (32-52)	22	51% (36-66)	46	32% (24-39)
Duration of history (under 12 months)	15	16% (9-24)	9	20% (8-31)	25	16% (10-22)
Previous admissions to NHS psychiatric hospital	12	14% (7-21)	5	13% (2-23)	19	14% (8-20)
History of NHS psychiatric contact	29	31% (22-40)	19	41% (27-56)	46	30% (23-37)

	N=95	%(95% CI)	N=46	% (95% CI)	N=157	% (95% CI)
Behavioural Features						
History of self-harm	52	58% (48-69)	26	59% (45-74)	78	53% (45-61)
History of violence	21	25% (16-35)	19	45% (30-60)	47	35% (27-43)
History of alcohol misuse	29	32% (22-41)	46	100%	46	31% (23-38)
History of drug misuse	95	100%	29	63% (49-77)	95	62% (54-70)
Prisoners charged with violent offences	15	16% (8-23)	17	37% (23-51)	41	26% (19-33)
Prison mental health						
Prison hospital in-patients	15	16% (8-23)	7	15% (5-26)	26	17% (11-22)
Mental health symptoms at reception	62	65% (56-75)	27	59% (44-73)	89	57% (50-65)
F20 52SH at time of death	24	25% (17-34)	12	27% (14-40)	38	24% (18-31)
Referred to a psychiatrist in prison	23	24% (16-33)	22	48% (33-62)	50	32% (25-40)
Transferred to NHS hospital while a prisoner	3	3% (0-7)	2	4% (0-10)	4	3% (0-5)
Contact with services						
Last contact within 24 hours of death	58	62% (52-72)	28	64% (49-78)	84	56% (48-64)
Symptoms at last contact	37	40% (30-50)	14	30% (17-44)	55	37% (29-45)
Estimate of immediate risk: low or none	87	92% (86-97)	43	93% (86-100)	141	93% (89-97)
Suicide thought to be preventable	13	15% (7-22)	6	15% (4-25)	22	15% (9-21)

CARE IN PRISON

Referral to prison health services In total, 92 (59%) prisoners were referred to health care from reception, in 42 (27%) cases they were admitted to prison health care as in-patients. Thirty-eight (24%) prisoners were referred to health-care from reception and were also referred again later in their prison term. A further 37 (24%) who were not referred at reception were referred later in their prison term. Fifty (32%) prisoners were referred to a psychiatrist and 4 (3%) were transferred for treatment in an NHS hospital outside prison. A further 7 prisoners had been referred to NHS hospitals and either accepted (3) or were under assessment /discussion (4).

In-patient suicides Twenty-seven (17%) suicides occurred in prison health care in-patient centres. The following findings refer to the 26 on whom we received clinical information. Ten (40%) were admitted to the health care centre following an act of deliberate self-harm or the expression of suicidal ideas, 11 (44%) for other mental health problems and 5 for other problems related to their physical health.

The social and clinical characteristics of the in-patient suicides are shown in table 6. They were more likely to have a diagnosis of schizophrenia, any secondary diagnosis and previous contact including admissions to NHS mental health services. They were more likely to have been charged with violent offences. Nineteen (76%) had symptoms at reception.

They were more likely than the sample as a whole to be taking anti-psychotic medication (44%), benzodiazepines as anxiolytics (28%) and hypnotics (24%). The majority were fully compliant with their drug treatment plan. In-patient suicides were twice as likely to have an open F20 52SH at the time of death and were more likely to be referred to a psychiatrist.

Fifteen (60%) died within 7 days of admission to in-patient care. Eleven (44%) were under medium or high levels of observation at the time of death. In 13 (57%) nursing shortages were reported at the time of death. In five, staff reported problems observing prisoners because of ward or cell design and in 2 because of the needs of other disturbed patients.

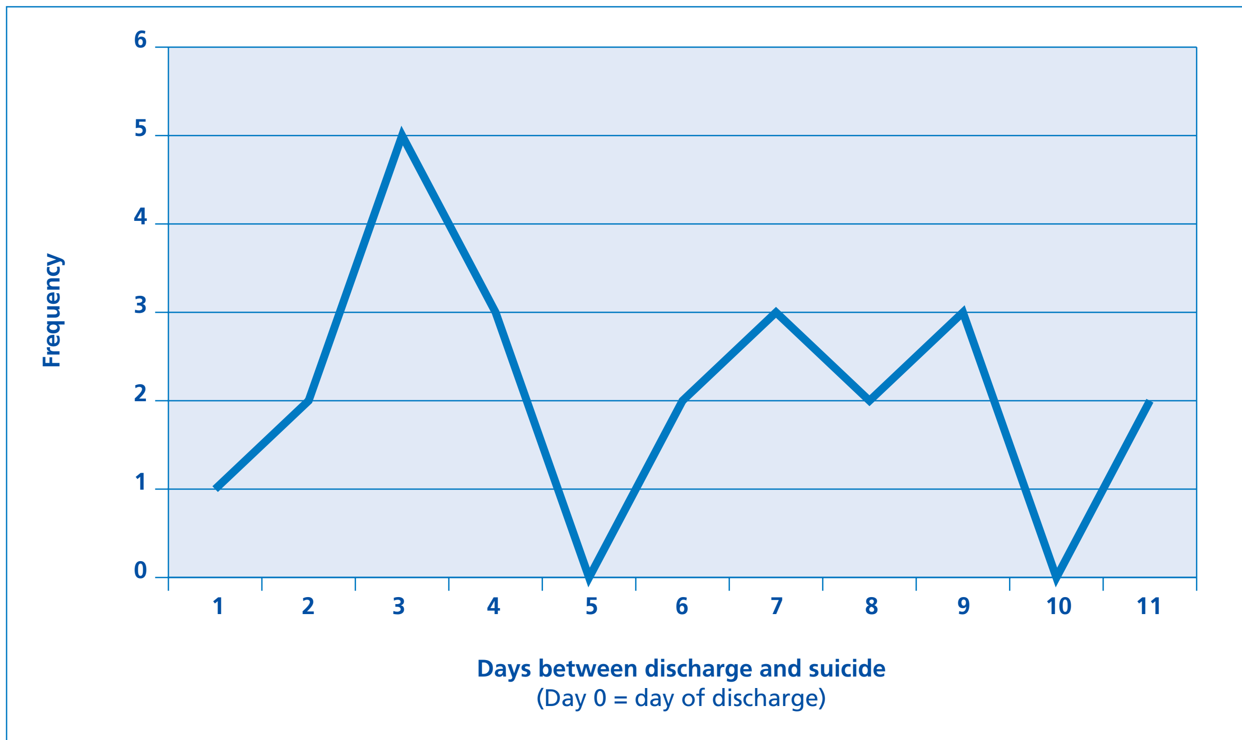
Most in-patient suicides (22, 88%) had been in contact with a member of staff, usually a health care officer, nurse or member of the medical team, within 24 hours of their death. Only seven (28%) had been considered to be at medium or high risk of suicide at last contact although this is higher than in the sample as a whole. Suicides by in-patients were more likely to be seen as preventable and in 81% respondents thought risk would have been reduced by closer supervision, increased staff numbers, better staff training in risk assessment, or improved staff communication. Nine (38%) said that the prisoner would have been less likely to die if they had been placed in a psychiatric hospital rather than prison.

Table 6: Social and clinical characteristics of health-care in-patients

	Inpatients		Total	
	N=27	% (95% CI)	N=172	% (95% CI)
Demographic Features				
Age: median (range)	30 (19-75)		28 (17-75)	
Male	25	93% (83-100)	159	92% (88-96)
Ethnic minority	5	19% (4-33)	19	11% (6-16)
Not currently married	22	88% (75-100)	136	86% (79-91)
Living alone	5	38% (12-65)	19	27% (16-37)
	N=26	% (95% CI)	N=157	% (95% CI)
Clinical Features				
Primary diagnosis				
Schizophrenia & other delusional	6	25% (8-42)	10	7% (3-11)
Affective disorder (bipolar & dep.)	5	21% (5-37)	26	18% (12-25)
Alcohol dependence	1	4% (0-12)	5	4% (0-7)
Drug dependence	5	21% (5-37)	39	27% (20-35)
Personality disorder	3	13% (0-26)	15	11% (6-16)
Any secondary diagnosis	13	62% (41-83)	46	32% (24-39)
Duration of history (under 12 months)	6	24% (7-41)	25	16% (10-22)
Previous admissions to NHS psychiatric hospital	9	43% (22-64)	19	14% (8-20)
History of NHS psychiatric contact	12	48% (28-68)	46	30% (23-37)
Behavioural Features				
History of self-harm	13	52% (32-72)	78	53% (45-61)
History of violence	9	41% (20-61)	47	35% (27-43)
History of alcohol misuse	7	28% (10-46)	46	31% (23-38)
History of drug misuse	15	60% (41-79)	95	62% (54-70)
Prisoners charged with violent offences	8	31% (13-49)	41	26% (19-33)
Prison mental health				
Mental health symptoms at reception	19	76% (59-93)	89	57% (50-65)
Prisoners on F20 52SH at time of death	13	52% (32-72)	38	24% (18-31)
Referred to a psychiatrist in prison	15	60% (41-79)	50	32% (25-40)
Transferred to NHS hospital while a prisoner	1	4% (0-12)	4	3% (0-5)
Contact with services				
Last contact within 24 hours of death	22	88% (75-100)	84	56% (48-64)
Symptoms at last contact	14	58% (39-78)	55	37% (29-45)
Estimate of immediate risk: low or none	18	72% (54-90)	141	93% (89-97)
Suicide thought to be preventable	7	32% (12-51)	22	15% (9-21)

Suicides following discharge from in-patient care Forty-five suicides (29%) occurred amongst prisoners with previous admissions to in-patient care. Nineteen (12%) had had multiple admissions. In 30 of the 45 post discharge cases, the final admission lasted less than 7 days; 26 (58%) were regarded as being greatly improved at the time of discharge. Sixteen (36%) died in the first week after discharge (fig. 16).

Figure 16: Number of suicides per day following discharge from health care



In 14 (33%) cases a health-care officer or key worker had been allocated at discharge to carry out health care outreach work on the wing. In 23 (52%) cases a follow-up appointment was made with the medical officer and in 15 (34%) an appointment was made with a visiting psychiatrist or CPN. In 11 (25%) cases an appointment was made with both the medical officer and psychiatrist. In 10 (23%) cases the suicide occurred before an appointment took place. In 12 (27%) cases no follow-up was arranged with a health care professional. In a further 3, this information was unavailable.

Recognition of risk

F20 52SH forms Information about F20 52SH's was received from prison officers and prison medical officers. In 10 cases, there was disagreement over whether the prisoner had been on an F20 52SH. In 9 of these, it was the prison officer who reported an open F20 52SH. In the next section we included all prisoners said to have been on an F20 52SH, regardless of the source of the information.

Forty (23%) prisoners had an open F20 52SH at the time of death. Their key characteristics compared with those never on an F20 52SH are given in table 7. We received completed clinical information on 38.

Prisoners with an open F20 52SH were more likely to have a history of previous contact including admissions to NHS hospitals and to have a history of previous self-harm compared to the whole sample. They were more likely to have had symptoms at reception, to have had last contact within 24 hours of death and in 16% the risk of self-harm was estimated to be medium or high (compared with 7% of the whole sample). They were more likely to be in-patients and their deaths were more likely to be seen as preventable (22%).

In addition there were 45 individuals (28%) who had an F20 52SH opened during this prison term but which had been closed at the time of death. Four were prison health care in-patients at the time of death. Twenty-six of those prisoners had been in-patients previously and half of this group had spent less than 7 days in prison hospital. All 45 individuals were male, they were more likely to have a diagnosis of personality disorder and more likely to have a history of self-harm.

Prisoners "at risk" Altogether, 141 (90%) of the 157 suicides in this study could have been seen as "at risk" at reception to prison because of a history of previous NHS mental health care (46 cases), a lifetime history of mental disorder (110 cases), current symptoms (89 cases), current treatment (53 cases), a history of drug misuse (95 cases), alcohol misuse (46 cases) or self-harm (78 cases).

At reception 77 (55%) of these individuals were referred for further assessment or treatment by the prison medical officer. A comparison of those who were and those who were not referred is given in table 8. Those referred were more likely; to be women, to have schizophrenia, to have mental health symptoms at reception, and previous contact with NHS mental health services. They were more likely to be in-patients at the time of death, and to have seen a psychiatrist in prison. At last contact, they were more likely to have had symptoms.

Suicides by "at risk" prisoners referred to health care services were more likely to be seen as preventable (24%) compared to those not referred (10%).

Table 7: Social and clinical characteristics of suicides with open F20 52SH forms at the time of death compared to those never on an F20 52SH

	Open F20 52SH at time of death		Never on an F20 52SH		Total	
	N=40	% (95% CI)	N=87	% (95% CI)	N=172	% (95% CI)
Demographic Features						
Age: median (range)	31 (19-75)		28 (17-52)		28 (17-75)	
Male	35	88% (77-98)	80	92% (86-98)	159	92% (88-96)
Ethnic minority	4	10% (1-19)	13	15% (7-22)	19	11% (6-16)
Not currently married	34	89% (80-99)	64	83% (75-91)	136	86% (79-91)
Living alone	6	35% (13-58)	7	21% (7-35)	19	27% (16-37)
	N=38	% (95% CI)	N=77	% (95% CI)	N=157	% (95% CI)
Clinical Features						
Primary diagnosis						
Schizophrenia & other delusional	3	9% (0-18)	5	7% (1-13)	10	7% (3-11)
Affective disorder (bipolar & dep.)	6	17% (5-30)	11	16% (7-24)	26	18% (12-25)
Alcohol dependence	2	6% (0-13)	2	3% (0-7)	5	4% (0-7)
Drug dependence	10	29% (14-44)	22	31% (21-42)	39	27% (20-35)
Personality disorder	2	6% (0-13)	5	7% (1-13)	15	11% (6-16)
Any secondary diagnosis	10	28% (13-42)	26	36% (25-47)	46	32% (24-39)
Duration of history (under 12 months)	6	16% (4-27)	11	15% (7-23)	25	16% (10-22)
Previous admissions to NHS psychiatric hospital	9	26% (11-40)	6	9% (2-16)	19	14% (8-20)
History of NHS psychiatric contact	15	39% (24-55)	14	19% (10-28)	46	30% (23-37)

	N=38	% (95% CI)	N=77	% (95% CI)	N=157	% (95% CI)
Behavioural Features						
History of self-harm	24	67% (51-82)	28	40% (29-51)	78	53% (45-61)
History of violence	13	38% (22-55)	15	24% (14-35)	47	35% (27-43)
History of alcohol misuse	12	33% (18-49)	18	25% (15-35)	46	31% (23-38)
History of drug misuse	24	65% (49-80)	52	69% (59-80)	95	62% (54-70)
Prisoners charged with violent offences	11	29% (15-43)	14	18% (10-27)	41	26% (19-33)
Prison mental health						
Prison hospital in-patients	13	34% (19-49)	10	13% (5-20)	26	17% (11-22)
Mental health symptoms at reception	28	74% (60-88)	34	45% (34-57)	89	57% (50-65)
Referred to a psychiatrist in prison	13	34% (19-49)	15	20% (11-29)	50	32% (25-40)
Transferred to NHS hospital while a prisoner	1	3% (0-8)	1	1% (0-4)	4	3% (0-5)
Contact with services						
Last contact within 24 hours of death	26	68% (54-83)	41	59% (47-70)	84	56% (48-64)
Symptoms at last contact	13	36% (20-52)	30	41% (30-52)	55	37% (29-45)
Estimate of immediate risk: low or none	31	84% (72-96)	71	97% (94-100)	141	93% (89-97)
Suicide thought to be preventable	8	22% (9-36)	7	10% (3-17)	22	15% (9-21)

Table 8: Social and clinical characteristics of prisoners "at risk" referred to health-care from reception compared to those that were not referred (refers to the 141 prisoners "at risk")

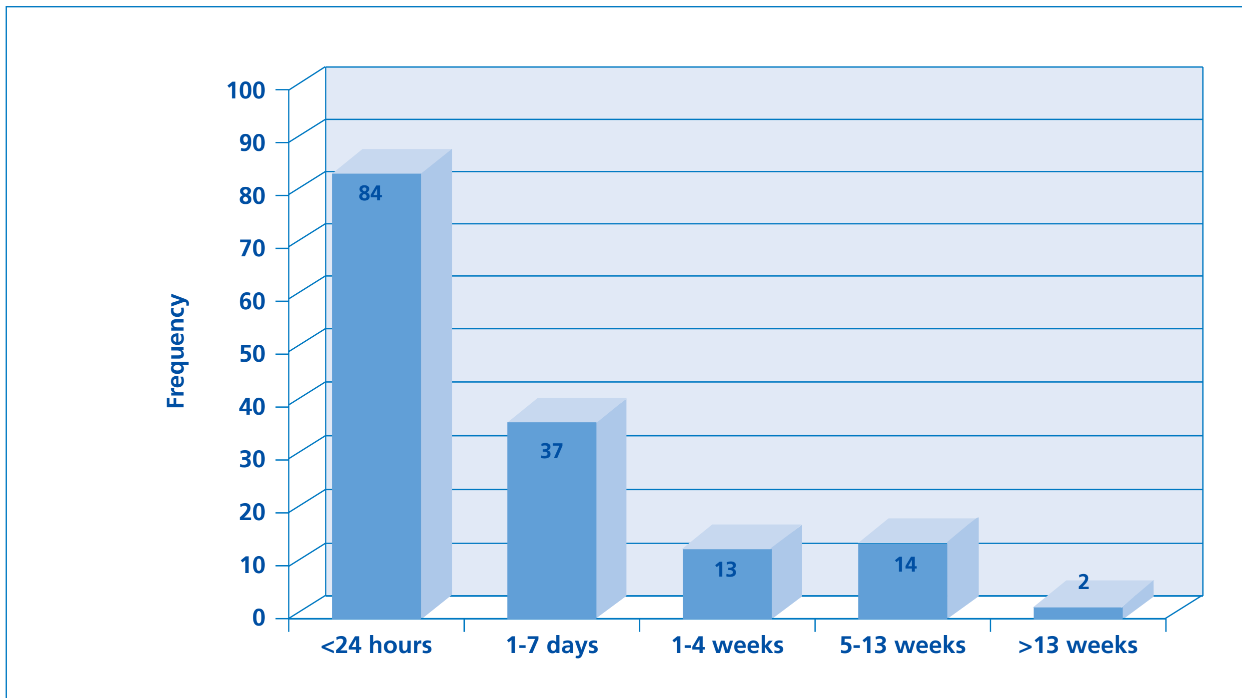
	Referred to healthcare N=77	% (95% CI)	Not referred to healthcare N=64	% (95% CI)
Demographic Features				
Age: median (range)	28 (17-75)		27.5 (17-47)	
Male	67	87% (80-95)	62	97% (93-100)
Ethnic minority	9	12% (5-19)	6	9% (2-17)
Not currently married	61	84% (75-92)	52	90% (82-97)
Living alone	13	35% (20-51)	3	16% (0-32)
Timing of death				
Under 24 hours	9	12% (5-19)	8	13% (4-21)
Between 24 hours and 5 days	18	23% (14-33)	12	19% (9-28)
Over 5 days but within first month	16	21% (12-30)	10	16% (7-25)
	N=77	**% (95% CI)**	**N=64**	**% (95% CI)**
Clinical Features				
Primary diagnosis				
Schizophrenia & other delusional	9	13% (5-20)	10	2% (0-5)
Affective disorder (bipolar & dep.)	14	20% (10-29)	26	20% (10-30)
Alcohol dependence	2	3% (0-7)	5	5% (0-11)
Drug dependence	21	30% (19-40)	39	30% (18-42)
Personality disorder	9	13% (5-20)	15	10% (2-18)
Any secondary diagnosis	30	41% (30-52)	46	26% (15-37)
Duration of history (under 12 months)	10	13% (6-21)	25	24% (13-34)
Previous admissions to NHS psychiatric hospital	13	19% (10-29)	19	10% (2-18)
History of NHS psychiatric contact	31	40% (29-51)	46	24% (13-34)
Behavioural Features				
History of self-harm	46	63% (52-74)	32	52% (40-65)
History of violence	24	34% (23-45)	20	35% (23-47)
History of alcohol misuse	26	34% (24-45)	20	33% (21-45)
History of drug misuse	50	66% (55-76)	45	71% (60-83)
Prisoners charged with violent offences	22	29% (18-39)	15	23% (13-34)
Prison mental health				
Prison hospital in-patients	18	23% (14-33)	6	9% (2-17)
Mental health symptoms at reception	72	94% (88-99)	17	27% (16-37)
Prisoners with closed F20 52SH forms	25	33% (22-43)	13	20% (10-30)
F20 52SH at time of death	24	32% (21-42)	11	17% (8-26)
Referred to a psychiatrist in prison	33	43% (32-54)	16	25% (15-36)
Transferred to NHS hospital while a prisoner	2	3% (0-6)	2	3% (0-8)
Contact with services				
Last contact within 24 hours of death	47	63% (52-74)	33	53% (41-66)
Symptoms at last contact	36	50% (38-62)	17	27% (16-38)
Estimate of immediate risk: low or none	66	87% (79-94)	62	98% (95-100)
Suicide thought to be preventable	16	24% (13-34)	6	10% (2-17)

Last contact with prison healthcare staff

Twenty-four (15%) suicides had no further contact with health care staff after reception. Of these, 4 had mental health symptoms and 4 had a history of mental disorder noted at reception. In 3 of the twenty-four, mental health concerns were noted by prison officers after reception.

Eighty-four (56%) prisoners were in contact with any member of prison health staff in the 24 hours before death, 121 (81%) in the week before death (fig. 17). Contact was most commonly non-urgent and with a nurse or hospital officer (fig. 18).

Figure 17: Timing of last contact with health care professionals



Assessment at final contact revealed an abnormality of mental state or recent behaviour disturbance in 55 (35%) cases (fig. 19). Of those with an abnormality, this was most often difficulty sleeping (33%) recent deliberate self-harm (27%), withdrawal symptoms from drugs (29%) and emotional distress (24%). Nearly a third exhibited more than one symptom.

Figure 18: Health professionals involved in final contact

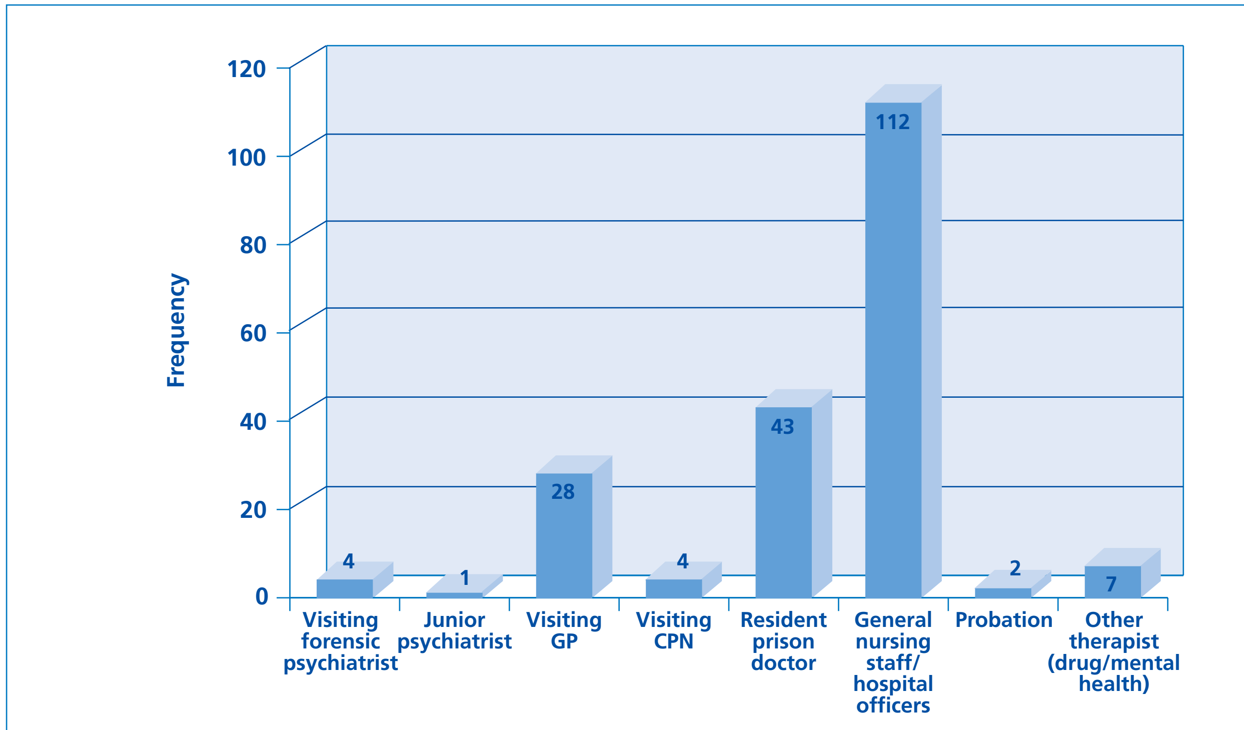
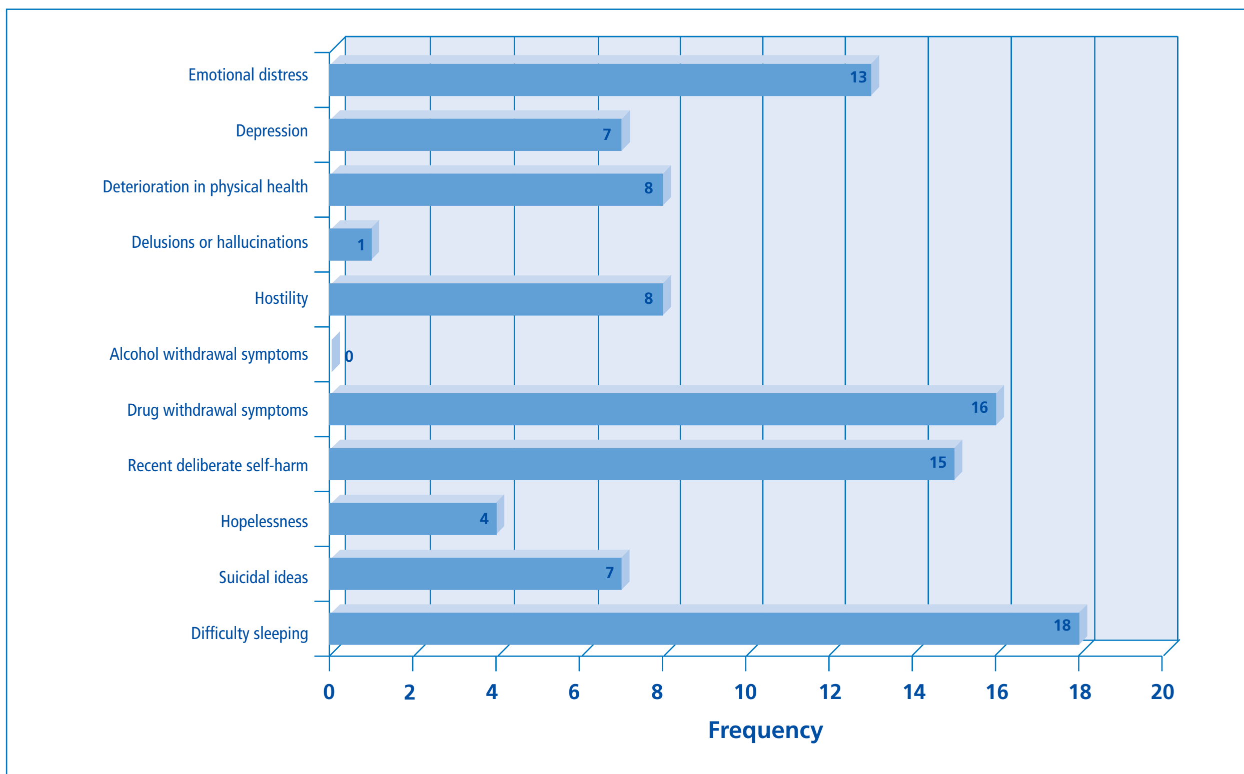


Figure 19: Symptoms at last contact

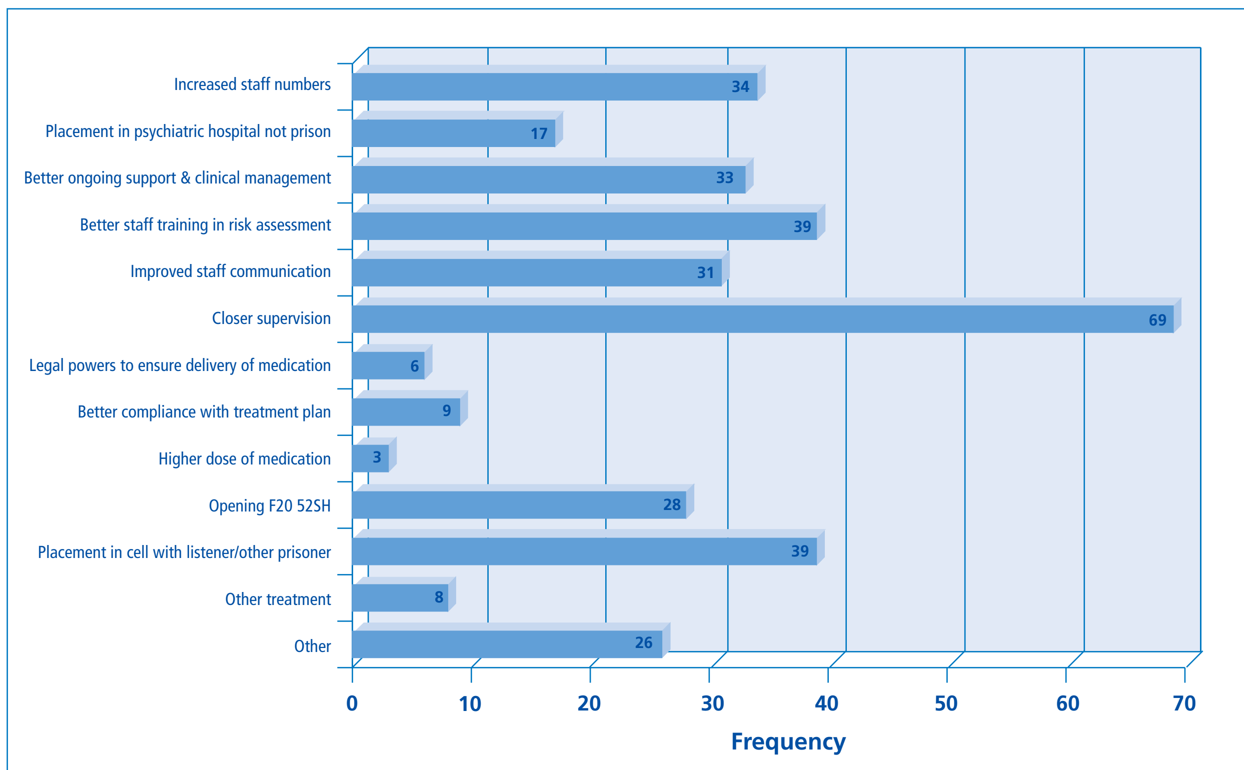


The immediate risk of suicide was estimated to be low or absent in 141 (93%) cases; high immediate risk was identified in only 3 (2%) cases. There was a strong association between timing of last contact before suicide and estimated risk: risk was more likely to be estimated as high when contact was recent. Cases in which risk was estimated to be moderate and high were usually discussed with other members of staff and F20 52SH forms were usually completed. In 1 case the F20 52SH was completed but no discussion took place; and in another 2 a discussion took place but no F20 52SH was opened. In one case neither occurred.

PREVENTION

Twenty-two (15%) suicides were viewed as preventable by prison medical officers. However, respondents indicated that in a higher proportion of cases that there were factors that could have made suicide less likely including: closer supervision (69, 46%), better staff training in risk assessment (39, 26%), placement in a double cell or with a listener (39, 26%), increase in staff numbers (34, 23%), better ongoing support and clinical management (33, 22%) and better communication (31, 21%) (fig. 20).

Figure 20: Factors that could have made suicide less likely



Suicides by “at risk” prisoners in contact with health care services, prisoners with open F2052SH forms, in-patients, convicted prisoners and those under the age of 21 were all seen as more preventable.

ETHNIC MINORITIES

Of the 172 suicides, 19 individuals (11%) were from an ethnic minority, the largest number being black Caribbean (fig. 7). Eight (42%) were known to have had previous contact with mental health services. Nine (53%) had mental state abnormalities at reception, usually hostility, anxiety or hallucinations/delusions. Five (31%) were diagnosed with schizophrenia, 9 (53%) were referred to a psychiatrist in prison but only 3 (16%) were still under a psychiatrist at the time of death. The numbers in this group were too small for more detailed analysis.

YOUNG PEOPLE

There were 31 suicides by people aged 21 or under, 18% of the sample. Seven (23%) were located in adult local prisons or remand centres rather than dedicated young offender institutions, 4 (13%) were in female establishments (housing young offenders and adult prisoners) Of those in adult prisons, 2 were in the segregation unit, 1 was a health care in-patient and 2 were at magistrate's court at the time of death. Twenty-one (68%) were in single cell accommodation.

Their key social and clinical characteristics are shown in table 2. Numbers were small and few clear differences from other age groups were found. However, rates of affective disorder, drug misuse and drug dependence were higher. They had a higher rate of previous self-harm but a lower rate of previous violence. They were less likely to have been under NHS mental health services, and less likely to have committed a violent offence. This suggests that there may be different indicators of risk in this age group.

Within prison, they were less likely to be referred to a psychiatrist, yet their deaths were more likely to be viewed as preventable.

PRISONERS CHARGED WITH VIOLENT OFFENCES

A total of 45 (26%) prisoners had been charged with violent offences. Their key characteristics are shown in table 9. They were less likely to have a history of drug misuse or a diagnosis of drug dependence, but were more likely to have a primary diagnosis of personality disorder and a history of alcohol misuse. A higher proportion had had previous contact with mental health services in the community.

Twenty-three (56%) had mental health symptoms at reception and 20 (44%) were admitted to health care from reception. Twenty-eight (62%) had an F20 52SH opened at some point during their prison spell, but only 11 (27%) were still on an open F20 52SH at the time of death. Twenty-three (56%) prisoners were referred to a psychiatrist but only 10 were still under psychiatric care at the time of death.

Table 9: Social and clinical characteristics of suicides charged with violent offences

	Charged with violent offences		Total	
	N=45	% (95% CI)	N=172	% (95% CI)
Demographic Features				
Age: median (range)	35 (17-75)		28 (17-75)	
Male	44	98% (93-100)	159	92% (88-96)
Ethnic minority	10	22% (10-34)	19	11% (6-16)
Not currently married	36	86% (75-96)	136	86% (79-91)
Living alone	4	18% (2-34)	19	27% (16-37)
	N=41	% (95% CI)	N=157	% (95% CI)
Clinical Features				
Primary diagnosis				
Schizophrenia & other delusional	2	5% (0-13)	10	7% (3-11)
Affective disorder (bipolar & dep.)	8	22% (8-35)	26	18% (12-25)
Alcohol dependence	2	5% (0-13)	5	4% (0-7)
Drug dependence	3	8% (0-17)	39	27% (20-35)
Personality disorder	8	22% (8-35)	15	11% (6-16)
Any secondary diagnosis	13	35% (20-51)	46	32% (24-39)
Duration of history (under 12 months)	6	15% (4-27)	25	16% (10-22)
Previous admissions to NHS psychiatric hospital	7	19% (7-32)	19	14% (8-20)
History of NHS psychiatric contact	19	46% (31-62)	46	30% (23-37)
Behavioural Features				
History of self-harm	21	55% (39-71)	78	53% (45-61)
History of violence	20	56% (39-72)	47	35% (27-43)
History of alcohol misuse	17	41% (26-57)	46	31% (23-38)
History of drug misuse	15	37% (22-51)	95	62% (54-70)
Prison mental health				
Prison hospital in-patients	8	20% (7-32)	26	17% (11-22)
Mental health symptoms at reception	23	56% (41-71)	89	57% (50-65)
Prisoners on F20 52SH at time of death	11	27% (13-40)	38	24% (18-31)
Referred to a psychiatrist in prison	23	56% (41-71)	50	32% (25-40)
Transferred to NHS hospital while a prisoner	3	7% (0-15)	4	3% (0-5)
Contact with services				
Last contact within 24 hours of death	23	58% (42-73)	84	56% (48-64)
Symptoms at last contact	9	25% (11-39)	55	37% (29-45)
Estimate of immediate risk: low or none	36	92% (84-100)	141	93% (89-97)
Suicide thought to be preventable	6	16% (4-27)	22	15% (9-21)

Six (15%) were considered to be in need of NHS hospital care. Three (7%) were transferred for treatment and returned to prison. One was due to be transferred but committed suicide before the transfer took place. In two cases referral was under discussion.

Of the 11 charged with murder or manslaughter, 6 received life sentences. Three were known to have had previous contact with mental health services and 8 had an F20 52SH opened; in 2 cases it was still open at the time of death. All cases had been referred to health care at some point during their prison term and over half had had continuing contact. All ten had been referred to a psychiatrist.

SCHIZOPHRENIA

There were 10 individuals with a primary diagnosis of schizophrenia, i.e. 7% of all cases. Their main social and clinical characteristics are shown in table 10. All suicides in this group were male. Seven were known to have had previous contact with mental health services. In five of these, the service was not contacted for further information, even though all five prisoners had symptoms at reception. Altogether 9 prisoners had symptoms at reception. Six had a secondary diagnosis. Those with schizophrenia were less likely to have a history of drug and alcohol misuse. All but one prisoner received medication within the prison but only half were fully compliant with their treatment.

Five had an F20 52SH opened at some stage during the prison term and in 3 it was still open at the time of death. Six had been referred to a psychiatrist during this prison term and 6 were prison hospital in-patients at the time of death. Three had been discharged from in-patient care within 2 weeks of their death. Three had been recommended for transfer to psychiatric hospital but suicide occurred before the transfer took place in all cases.

Two of the suicides in this group were thought to be preventable. The most commonly reported factors that would have made the death less likely were closer supervision and better clinical management.

Table 10: Social and clinical characteristics of prisoners with schizophrenia

	Number 10	valid %	95% CI
Demographic Features			
Age: median (range)	27.5 (19-43)		
Male	10	100%	
Ethnic minority	5	50%	(19-81)
Not currently married	10	100%	
Living alone	1	25%	(0-67)
Clinical Features			
Any secondary diagnosis	6	75%	(45-100)
Duration of history (under 12 months)	2	20%	(0-45)
Previous admissions to NHS psychiatric hospital	6	60%	(30-90)
History of NHS psychiatric contact	7	70%	(42-98)
Behavioural Features			
History of self-harm	6	60%	(30-90)
History of violence	3	30%	(2-58)
History of alcohol misuse	1	10%	(0-29)
History of drug misuse	4	40%	(10-70)
Prisoners charged with violent offences	2	20%	(0-45)
Prison Mental Health			
Prison hospital in-patients	6	60%	(30-90)
Mental health symptoms at reception	9	90%	(71-100)
F20 52SH forms at the time of death	3	30%	(2-58)
Referred to a psychiatrist in prison	6	60%	(30-90)
Transferred to NHS hospital while a prisoner	0	–	
Contact with services			
Last contact within 24 hours of death	9	90%	(71-100)
Symptoms at last contact	5	50%	(19-81)
Estimate of immediate risk: low or none	8	80%	(55-100)
Suicide thought to be preventable	2	22%	(0-49)

RECENTLY RELEASED PRISONERS

Between April 1996 and March 2000, 354 people died within a year following release from prison at the end of their sentence (fig. 21). Eighty (23%) died in the first month following release (fig. 22), and 40 in the first week (fig. 23). These figures refer to deaths after release from a prison sentence and do not include remand prisoners.

Figure 21: Months between release and death

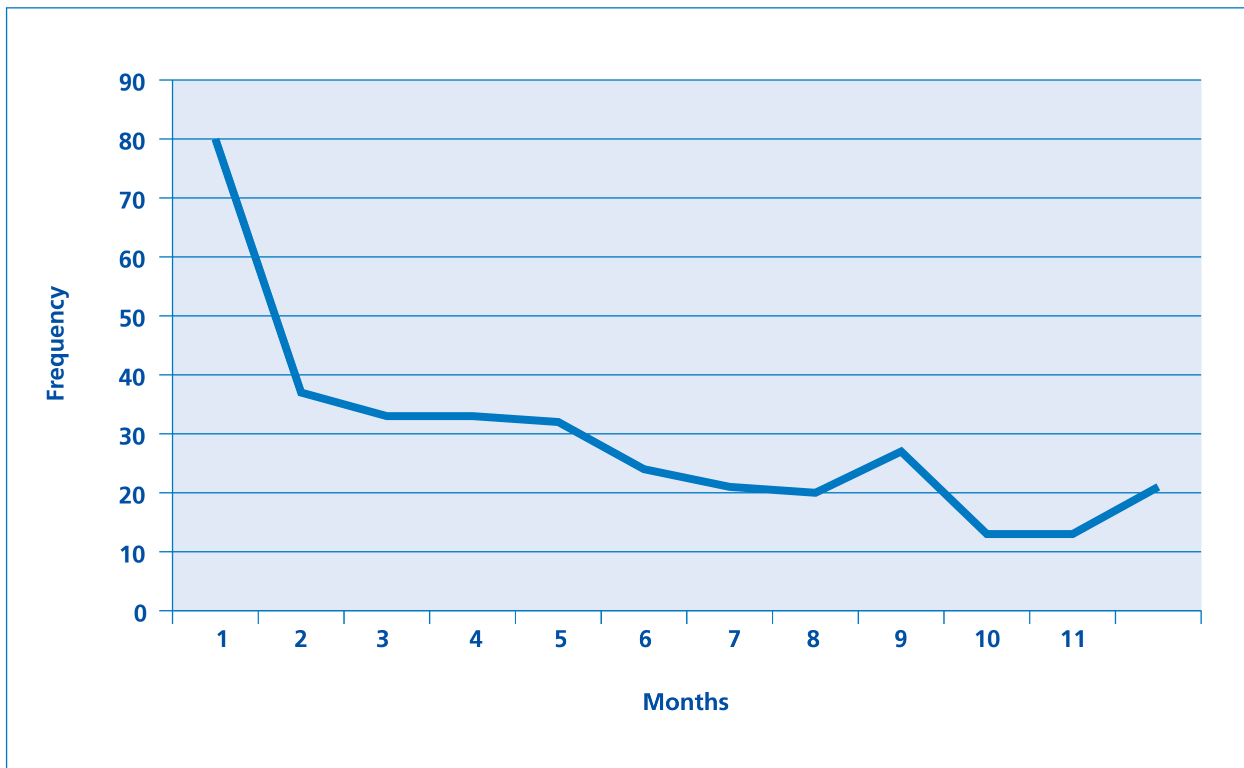


Figure 22: Number of weeks between release and death

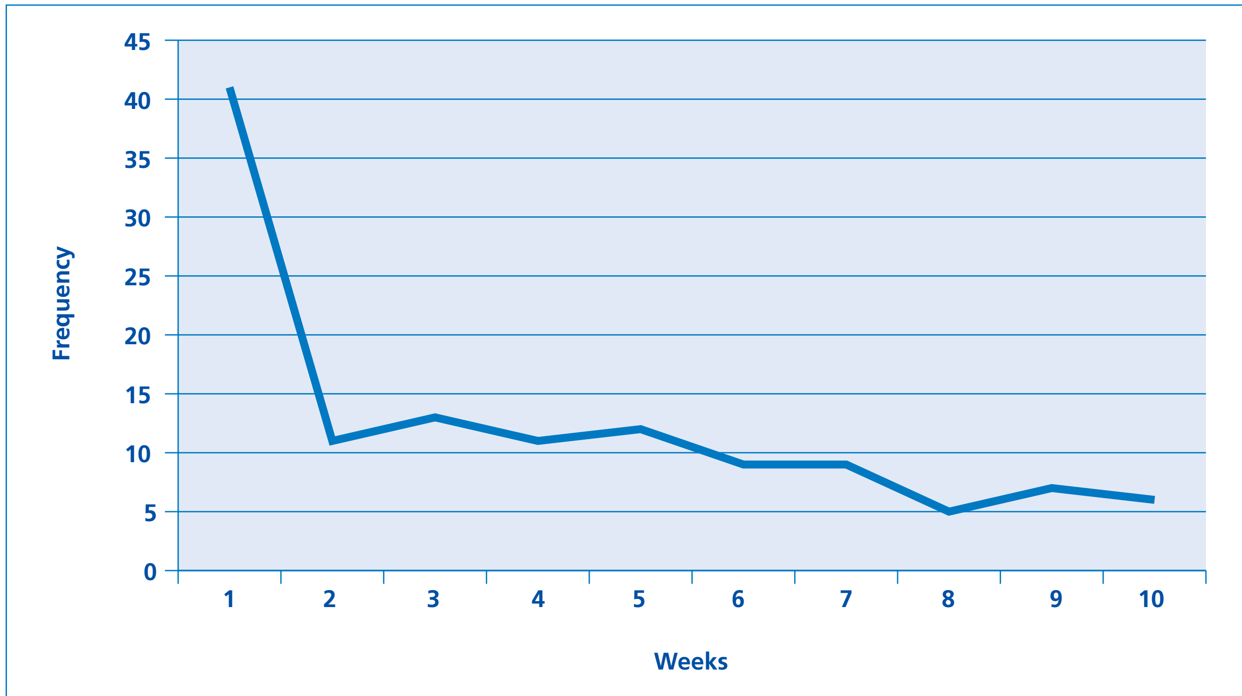
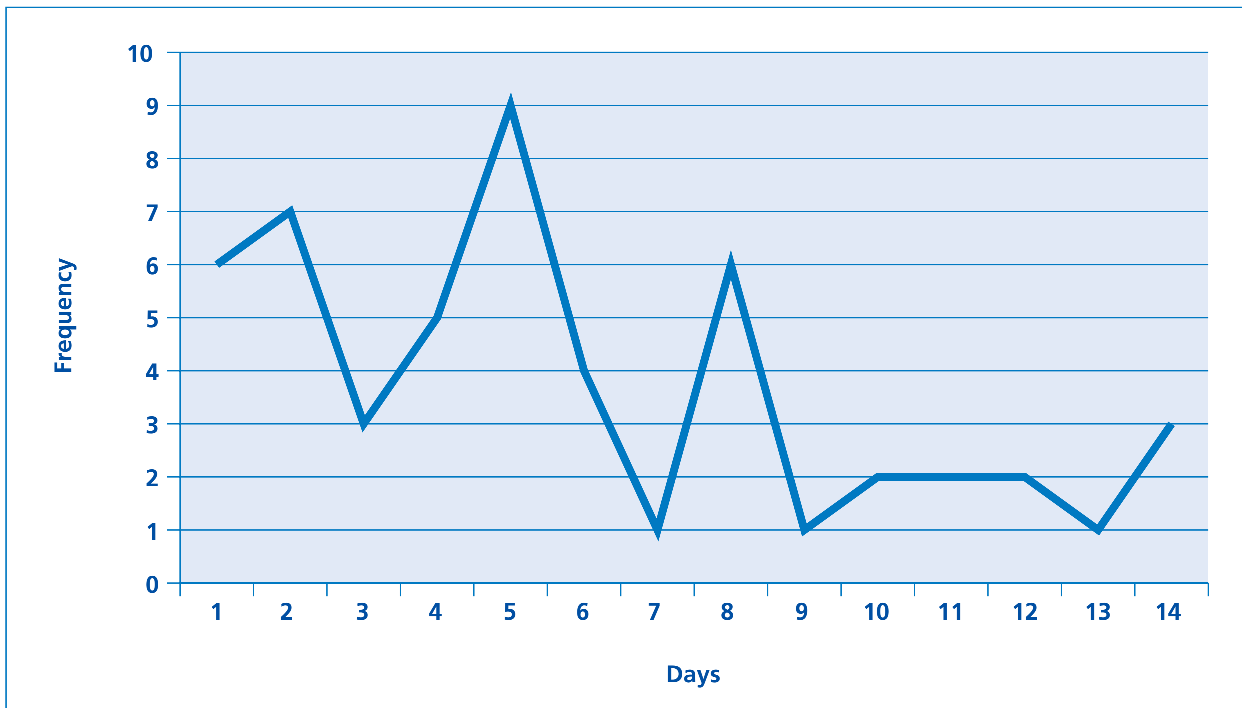


Figure 23: Number of days between release and death



Additional comments

Many of the professionals who completed questionnaires also took the opportunity to comment on the main problems they faced in clinical practice and in the everyday care of prisoners. Although it was not the main purpose of the Inquiry to collect opinions in this way, professionals were encouraged to comment.

Three themes emerged. Firstly, the majority of prison staff reported that prisoners who committed suicide had exhibited an adverse symptomatic reaction to imprisonment. Respondents often reported that they had tried to help prisoners solve these problems, but their ability to do so had been limited.

Secondly, staff complained that there had been a breakdown in service provision. Levels of care and communication were criticised with some staff claiming that better prisoner care may have prevented death. There were a number of criticisms of prisoner transfer procedures and of the way "at risk" prisoners were observed and cared for.

Thirdly, we were frequently told by prison staff that they had been provided with inadequate information about symptoms and risk factors detected at reception.

Conclusions

This report describes all suicides within the prison system in England and Wales over a two-year period. The aims of the project were to examine the care of prisoners who killed themselves and to make recommendations for changes in practice.

It is important to emphasise that a project of this kind is bound to highlight problems in care rather than good practice. That is not to say that good practice does not occur widely. For example, in most cases the detection of symptoms at screening led to follow-up referral; many patients died despite care plans and regular contact with staff. However, this study also suggested several specific areas where improvements could be made, and these are summarised below.

Risk factors for suicide in the prison population

Many of the risk factors for self-harm and suicide identified as antecedents of suicide in this study are common in prisoners in general. Rates of substance misuse/dependence, psychiatric morbidity and self-harm have been examined in the ONS psychiatric morbidity amongst prisoners survey (Singleton 1998), in which a total of 3,142 prisoners were interviewed in 131 prison establishments.

Substance Misuse

The ONS study found that for remand prisoners, 36% of females and 58% of males and for sentenced prisoners 63% of males and 39% of females reported hazardous drinking (Audit Score 8+). For remand prisoners 10% of males and 7% of females reported moderate drug use and a further 40% of males and 47% of females severe drug dependence on a scale designed for the study. For sentenced prisoners 11% of males and 8% of females reported moderate dependence and a further 32% of males and 34% of females severe dependence. Caution must be exercised in comparing data from the ONS study which used standardised questionnaires with data on drug and alcohol misuse/dependence gathered in the current study as the latter were based on clinical judgements made by clinicians. Nevertheless, the ONS figures demonstrate that rates of substance misuse, a risk factor for suicide, are high in the general prison population, not just in those who go on to kill themselves.

Mental Illness

The prevalence of functional psychosis was assessed in the ONS survey using the Schedule for the Clinical Assessment of Neuropsychiatry (SCAN) interview (Wing). The prevalence of any functional psychosis in the past year was 7% for male sentenced, 10% for male remand and 14% for female prisoners. Again, caution must be exercised in comparing ONS data with data from the current study. However, the ONS figures demonstrate that rates of serious mental illness, a risk

factor for suicide, are high in the general prison population, not just in those who go on to kill themselves.

Self-Harm
A secondary analysis of the ONS psychiatric morbidity among prisoners survey (Meltzer 1999) produced data on levels of non-fatal suicidal behaviour in prisoners. This was assessed in a prisoner interview, using a scale designed for the study. A quarter of male remand prisoners and a half of female remand prisoners had a history of attempted suicide. The proportion in sentenced prisoners was less (one twelfth of males and one sixth of females). Furthermore, 12% of male remand and 23% of female remand prisoners had had ideas of committing suicide in the week before assessment. Again there are problems inherent in comparing the ONS study findings with the current study findings but again the ONS findings highlight that previous self-harm and expression of suicidal ideas are common in prisoners in general.

Circumstances of suicide

By far the commonest method of suicide in prison was by hanging. Window bars were the most common ligature points, followed by the bed and other cell fittings. Bedclothes and shoelaces were the most common ligatures used. Therefore, as in NHS mental health in-patient units, attention needs to be given to removing all potential ligature points within areas of the prison where prisoners "at risk" of suicide are placed (**recommendation 1**). This must include in-patient units, where 17% of suicides took place, and should include designated cells on the wings. In areas where there are "at risk" prisoners, consideration needs to be given to the removal of bars from the windows (**recommendation 2**).

Similarly, prisons need to develop policies and practices on the removal of potential ligatures such as shoes with laces from prisoners known to be "at risk" (**recommendation 3**). Prisons must find alternatives to the currently used bed linen (**recommendation 3**). In view of the fact that the commonest ligatures used were bedclothes, there should be a review of the materials used as bedclothes within prisons and alternatives explored. (**recommendation 4**).

Information transfer

There is a need to improve information transfer from the community into prisons, within the prison and from the prison back into the community. We were concerned at how few prisons contacted general practitioners or mental health services with whom prisoners had been in contact in the past. GPs were asked for further information in only 12% of cases, mental health services in less than half. Prisons need to strengthen links with mental health services, GP's and probation and

court diversion services in order to provide the highest standard of care. We are aware that there are problems inherent in the system – for example, prisoners often return from court late in the afternoon or evening to a busy reception area, particularly in some large local prisons. Evening receptions make it difficult to obtain information straight away. Even so, in cases with prior mental health contact, the aim should be to obtain information within 24 hours (**recommendation 5**).

Mental health services and GP surgeries need to be less reluctant to share information with prison health services and should no longer impose financial charges for what is essentially good practice (**recommendation 6**).

Similarly, a common theme emerging from the comments made by those completing the questionnaires was that there was inadequate sharing of information about health and risk issues between reception health care staff and wing staff. Although this recommendation could give rise to concerns regarding confidentiality and privacy, we believe these are outweighed by the need to improve safety for staff and prisoners and to provide them with the means to assess risk accurately (**recommendation 7**). The vehicle by which this information should be passed on is the care plan, to be discussed later.

Guidance and training should be provided by the prison service highlighting appropriate ways of sharing and transferring information regarding high-risk prisoners (**recommendation 7**). Where there are examples of good practice regarding information sharing, this should be shared with all members of prison staff (**recommendation 7**).

Additionally, a 'family hotline' should be established within each prison, to enable family members to obtain and pass on information regarding prisoners that may be relevant to suicide risk reduction (**recommendation 8**).

Reception

The reception environment should offer privacy and confidentiality. At present one fifth of all the prisons included in this study were carrying out screening interviews in a large main reception hall. In one case it was admitted that at busy times screening interviews were carried out in the holding cells. Local prisons have the most problems with privacy; one quarter of prisoners in local prisons received their screening interview in the main reception hall. The reception screening interview provides an important opportunity to engage the prisoner in mental health assessment and treatment. We recommend that prison mental health screening interviews should always be conducted in privacy (**recommendation 9**).

Many prisons reporting suicides indicated that reception screening was conducted by staff with no mental health training. Ideally, staff with comprehensive mental health training should conduct the mental health screening interviews, but as an immediate practical step we recommend that screening is carried out by staff with relevant mental health training, covering the key areas of risk and symptom assessment (**recommendation 10**).

In many cases, suicide occurred within days of a prisoner arriving at a particular establishment – in 11% of cases, within 24 hours. Clearly, the early days of imprisonment are a stressful time, whether the prisoner is on remand or sentenced. We believe that prisons should develop specific areas where prisoners are located for the first few days of their imprisonment, where there are trained staff who monitor reactions to imprisonment. The induction programme could take place within this environment. This approach would be particularly suited to local prisons (**recommendation 11**).

Care plans

Although the majority of prisoners who showed evidence of psychological disturbance at reception into prison received follow-up, more than a quarter did not. We recommend that all prisoners who have had prior contact with mental health services, who have symptoms suggestive of a serious mental illness at reception and/or who have a history of self-harm, should have a multidisciplinary care plan initiated at reception (**recommendation 12**). Similarly, when prisoners have had contact with mental health services outside prison and have a pre-existing care plan, information should be shared promptly under the Care Programme Approach (CPA) (**recommendation 13**). Care plans should include recommendations for the length of time between reviews with named staff to oversee care and with referrals to a psychiatrist, CPN or psychologist where appropriate. All staff concerned with the prisoner should receive a copy of the care plan. The care plans should contain clear arrangements for contacting services in a crisis and for contingency plans should untoward events occur. This recommendation for care planning should be in line with the arrangements for care planning under the Care Programme Approach. The main aim of such a proposal is to reduce risk, but the secondary benefit will be that many needy prisoners will receive a better quality service in line with mental health care outside prison.

Prisoners who have mental disorder but who do not have severe mental illness or major indicators of risk should also have their needs considered at entry into prison. In line with mental health care outside prison, a simple care plan should be devised (**recommendation 14**).

F20 52SH forms

Findings from this project suggest that the F20 52SH procedure is not working effectively. In some cases it was apparent that wing staff thought that prisoners were on open F20 52SH while the health care staff did not. Almost half of the cases had been on an open F20 52SH form at some point during the prison term but more than half of the forms had subsequently been closed. Part of the problem appears to be the "all or nothing" nature of the F20 52SH. The solution may therefore lie in a comprehensive care planning system, of which continual risk assessment is a component. This should be introduced without adding to the bureaucracy of care – a common criticism of the F20 52SH system (**recommendation 15**).

Drug and alcohol misuse

One of the most striking findings is the high rate of substance misuse, in particular drug dependence, in our sample and in prisons as a whole. Sixty per cent had a history of drug misuse and 39% had a history of alcohol misuse. Of the former, around 40% were given a primary diagnosis of drug dependence. Drug dependent prisoners were likely to receive medication to help with withdrawal symptoms. However, few prisoners with substance misuse had an individual treatment plan.

We believe that entry into prison should provide an opportunity to engage prisoners with drug and alcohol problems and that this should be regarded as an essential suicide prevention measure. In order to do this there is a need to develop services comparable to those that are provided outside prison. The first step should be to manage detoxification comprehensively, so that all of those experiencing symptoms of withdrawal receive suitable and adequate treatment. The prison service is recommending the introduction of dedicated detoxification centres within prisons and we would strongly support this proposal (**recommendation 16**). Furthermore, the establishment of detoxification regimes and programmes should be monitored to ensure prison policy is implemented (**recommendation 17**). The prison service also needs to ensure that rehabilitation programmes are fully integrated with the mental health services so that "dual diagnosis" (i.e. co-existing mental health problems and substance misuse) can be identified and treated (**recommendation 18**).

High-risk times and observation

Suicides tend to cluster at quiet times during the day and night when the prisoners are locked up. In prisoners placed within shared cells, many suicides occurred when cellmates were absent. Our findings also highlighted suicides by individuals considered high-risk who were under frequent or continuous observation. Closer supervision and being

placed in shared cells were among the main measures thought to be likely to reduce risk in our sample.

The balance between care, supervision, observation and security is challenging. However, prisons need to expand and develop protocols for the use of double cells and listeners and to have clear supervision arrangements in place for when cellmates are absent. For those requiring more intensive observation, there is a need for the more extensive use of gated cells and constant supervision (**recommendation 19**). Prisons should have clear criteria about the circumstances in which prisoners are moved from high levels of observation to routine levels (**recommendation 20**).

In-patient and post-discharge suicides

One in six prison suicides occurred in the prison health care centre. Risk had often been recognised in these cases. A high proportion had schizophrenia, indeed all suicides by prisoners with schizophrenia occurred during or after an in-patient admission. Prompt treatment, close observation and removal of ligatures and ligature points are vital (**recommendations 21, 2, 3, 4, 5**).

In 7 cases, transfer to an NHS hospital was awaited. Prisons and local NHS in-patient services should jointly monitor delays in transfer to hospital and ensure transfer requests are regularly reviewed and actioned if delays are encountered (**recommendation 21**). This is a key indicator of joint working by prisons and the NHS.

The clustering of suicides in the period immediately after discharge from the healthcare centre indicates the need for better integration between health-care staff and prison officers, in-patient and outreach teams. This should include follow-up within 24 hours, by health care staff for all prisoners with serious mental illness and/or an history of self-harm, discharged from in-patient care (**recommendation 22**).

Training

Prison staff, including escort staff, need to have access to a programme of training by specialist organisations, in the recognition, assessment and management of prisoners “at risk” (**recommendation 23**). Training should cover many of the points highlighted in this report, particularly:

- High-risk times such as the first few days after reception
- Key social and clinical indicators of risk
- Common antecedents and life events, especially prison experiences and events

Training should be regular, with refresher courses at least every 3 years and preferably annually. Flexible methods of training, such as modular training courses would make it easier for busy staff to keep up-to-date with relevant training (**recommendation 24**).

Treatments

Benzodiazepines were used to treat anxiety in around a quarter of our sample. Our concern is that in at least some of these prisoners anxiety may have been an indicator of relapse or onset of major illness, requiring a review of clinical management as a whole rather than symptomatic treatment. In the remainder of cases increased anxiety may have indicated a growing inability to cope with the prison environment. Benzodiazepines suppress anxiety but can lead to dependence and symptoms such as insomnia and agitation. We recommend that benzodiazepines should be used only exceptionally and then only for short periods (**recommendation 25**).

We also have concerns that in nearly half of cases benzodiazepines were stopped on entry into prison. It is important to have benzodiazepine reduction regimes in place, rather than to stop the drugs suddenly.

Aftermath of suicide and contacts with families

Thirty-four per cent of respondents said that there had been no multi-disciplinary review following the prisoner's death. We would recommend that a review is carried out in all cases so that staff can learn from the experience and so that detailed information can be passed to all concerned parties (including the prisoner's family) (**recommendation 26, 27**).

Young suicides

A third of young people who committed suicide were in adult prisons. In three cases young suicides were located in areas where they may have had direct contact with adult offenders. We believe that young offenders should always be separated from adult offenders (**recommendation 28**). Reception and induction procedures should reflect the sensitivity and lack of maturity of this group of offenders, and training for staff should highlight their vulnerability. Similarly the use of shared cells for young prisoners should be increased (**recommendation 29**).

Escorted prisoners

Five suicides occurred in prisoners under the supervision of the Prison Escort Custody Service. This is too small a number for detailed analysis but it does highlight the risk at times of transfer, reception and changing status that is also evident elsewhere in this report. Most of this group had a history of self-harm and/or substance misuse; most were regarded

as low risk. Four died by hanging. These deaths emphasise the importance of the recognition of continuing risk among some prisoners, and the need for close supervision at times of transition. (**recommendation 30**). Prison escort custody staff should receive mental health or suicide awareness training with a refresher course every three years. (**recommendation 31**) .

Recently released prisoners

One of the most important findings in this report is the clustering of suicide on release from prison. Our information about each individual is limited and there is now a need to conduct a more detailed study of the circumstances in which these deaths occur. It is clear, however, that, in prisoners with mental disorder, a review of care is needed prior to release, leading to referral to NHS services where appropriate and early follow-up in the community (**recommendations 32, 33**).

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