Welcome to this edition of Safer Custody News. It is slightly later than usual due to some restructuring within headquarters. In the last edition, Anna Sedenu announced that she was moving on from the newsletter. There have also been other changes within SCOP. The National Safer Custody Managers are now in place and are driving the learning agenda. We have held a couple of action learning workshops at Newbold Revel, with the third taking place in May. We have also issued two Quick Time Learning Bulletins. It is now an opportune time to review the content of Safer Custody News to ensure that it is forming an integral part of our learning strategy. With the help of colleagues in Internal Communications, we will be undertaking a review of Safer Custody News including its content, length and frequency. The review will be completed by the end of May 2010. If you would like to contribute to the review, please send your comments to SCOPlearning@noms.gsi.gov.uk. For now, I would like to thank Anna and all our colleagues around the estate and beyond, for the work that has gone into Safer Custody News over the years. It provides a very solid foundation on which we can build.

For now in this edition, we focus on complex needs including:

- Feedback from the Prison and Probation Ombudsman (PPO) on three stakeholder surveys including the first survey of bereaved families' views
- New insights into fatal incidents following a year-long PPO study
- Update on trials of a new Cell Sharing Risk Assessment form
- Managing complex self harm
- Advances in cell fire-fighting techniques
- A death in custody case study on the good care provided to a prisoner with Tourette Syndrome

We also focus on understanding more about mental health conditions which are often found to be at high levels amongst those in custody. A recent study found that 63% of prisoners had some form of personality disorder whilst between 20-30% had a learning difficulty or disability. Obviously custody presents a unique set of challenges for managing people with these conditions and the associated impact on staff and other prisoners.

We would also like to highlight the forthcoming Complex Needs Learning Day at Newbold Revel on Wednesday 5 May. The event is aimed at front line prison staff and those responsible for residential management as well as health professionals. We will be looking at the unique challenges presented by mental health problems, personality disorders and learning disabilities and how the approach in a custodial setting differs from the management in the community. The day will be a good chance to network and share experiences with other colleagues during the workshop sessions about what works for them.

We hope that you will be able to join us for this important event. Contact details for booking and for further information can be found in the newsletter.

Dr Debra Baldwin
Deputy Head of Safer Custody and Offender Policy

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Reducing distress and promoting the well-being of all who live and work in prisons
SAFETY IN CUSTODY
STATISTICS PUBLISHED

The first official MoJ statistical bulletin on safer custody has been published. The high level report includes data on deaths in custody, self-harm and violence in prison custody, looking at trends across age, gender and time in prison custody. You can access the bulletin from the MoJ website: http://www.justice.gov.uk/publications/safer-custody.htm

PPO STAKEHOLDER FEEDBACK

The Prison and Probation Ombudsman (PPO) has published results of surveys of its three main stakeholder groups - including its first formal survey of bereaved families’ views.

A separate questionnaire gathered views from general stakeholders - included prison governors, safer custody officers and health-related stakeholders, as well as Coroners and IMB chairs. Finally, the PPO carried out a postal survey of those who had made complaints in 2009. You can see results from all three surveys, published in February 2010, on the PPO website: www.ppo.gov.uk

The general stakeholder survey asked for views about a range of issues including PPO publications and communications, complaints investigations, and fatal investigations. Feedback about fatal investigation reports was very positive. Respondents were presented with five statements about the reports, summarised as: reports are easy to understand, and take a reasonable time; recommendations are realistic, based on evidence, and lead to changes in practice. Over 90% of respondents said they ‘agreed’ or ‘tended to agree’ with four out of five of these statements. The least positive ratings (71%) related to the length of time taken for reports to be prepared.

NEW PPO DVD – UNDERSTANDING FATAL INCIDENTS

The Prison and Probation Ombudsman has released a report and awareness DVD on custodial fatal incidents. It provides a review of reports that were published between August 2008-August 2009 focusing on 160 prisoner deaths.

Based on the sample of cases, the report contains insights and statistics on prison fatalities including:

· Nearly half of prisoners who took their own lives were remand prisoners
· 25% of prisoners who took their own lives had been in prison for less than three months
· 94% of self inflicted deaths were by hanging
· 82% used bed sheets as a ligature
· Over half of self inflicted deaths were of those already identified as ‘at risk’ by prison staff

The DVD ‘Investigating fatal incidents’ shows how each incident investigation addresses the concerns of the bereaved family whilst helping authorities to learn the lessons and improve the care they offer. It will increase understanding of the role of the fatal incidents investigation team amongst bereaved family members, coroners, safer custody officers and prison staff.

The report and a link to the YouTube channel can be found at www.ppo.gov.uk
VR REVIEW UPDATE ON KPI, CSRA PILOTS

To keep readers updated with the progress of the ongoing national violence reduction (VR) review, this issue we report on feedback from recent trials of a ‘simplified’ Cell Sharing Risk Assessment (CSRA) form, and of a new measure of prison violence.

‘IMPROVED’ CSRA PILOT

Three prisons in the Eastern region - Bedford, Chelmsford and Highpoint - ran a trial in January to test out a new, briefer CSRA form - shortened to cover only essential and relevant issues. Management’s attitude was summed up by Chelmsford Governor Rob Davis, who said he welcomed the opportunity to be able to have an input at this early stage, instead of having a new system ‘imposed’ later on.

SCOP staff visited pilot sites to talk through the new form with as many staff as possible before the one-week trial started, and stayed in reception to give advice and guidance during day one. We returned for a follow-up visit to gather feedback from reception and healthcare staff who had used the revised CSRA.

Healthcare staff broadly welcomed the simplification. Generally staff found the increased work on establishing evidence was balanced by the more focused approach. They welcomed having two categories of risk – High or Standard instead of the current High, Medium or Low.

The pilot had some problems. Not everyone working the new system had attended the briefing. Some found it difficult to adjust to the reduction in questions, especially if the CSRA had been used for a variety of other purposes e.g. self-harm assessment and/or workshop allocation.

But overall, staff responded with professionalism to the challenge of operating a new system with little preparation. It has shown us that the basic model of the new CSRA is sound. We hope to build and improve on the results, and plan another pilot to incorporate induction staff and to test the review section.

 ALTERNATIVE VIOLENCE MEASURE

Fifteen establishments in the South East Region took part in a six-month trial to measure assaults in prisons on a new basis.

The purpose was to pilot a possible alternative to the existing serious assaults KPI, intended to move the Service away from a concentration on serious assaults and towards a comprehensive analysis of prison violence, and how it can better be tackled. Overall, we hope to improve understanding of violence and provide a mechanism for monitoring performance improvement.

We devised a one-page matrix which uses data already available in prisons (including records of F213 injuries, adjudications, use of force, IEP, referrals to police) but presented in a more meaningful way. The measure also incorporates data on staff and prisoner victims of assaults, to place more emphasis on victims.

SCOP met with Roger Hill, Director of Offender Management for South Eastern, and his performance managers to demonstrate what data had been collected, and its strategic potential for managing violence. The results illustrated the differing approaches, and their results, taken by prisons sharing the same categories of offenders.

Roger and his team showed great interest in this strategy of a one-page summary of violence incidents and prison management, and have invited Deputy Head of SCOP Debra Baldwin to address the South East region’s custody leadership forum. A final meeting with the staff who supported this trial took place on 9 March, to discuss the results.

NEW VR POSTERS

To meet the NOMS commitment to zero tolerance to prison violence, we have developed a series of posters to reinforce the message that we do not tolerate violence in our prisons and action will always be taken. Following Ministerial approval, the posters have been emailed to all establishments.

Contact: Ron Elder, VR Policy lead, SCOP. Email: Ron.Elder@noms.gsi.gov.uk or tel: 0207 217 5551.
“The information is already there to help us reduce violent assaults in prisons.” That was the message to delegates at the recent Learning Day on Violence Reduction.

Over 150 front-line delegates heard how the use of data to assess trends and pre-plan for violent incidents is helping staff address rising violence rates.

Although self inflicted deaths in custody stood at 60 for 2009, compared to the peak of 95 across 2002-2004, and assaults on staff have also fallen, there is still work to be done to reduce violence in prisons.

Debra Baldwin, Deputy Head of Safer Custody and Offender Policy Group, outlined how smart use of information that is already available can help. She commented: “Whilst the figures are encouraging, we need to work hard at reducing violence within the prison. Some of the increase in overall assaults and self harm may be due to greater awareness and reporting but we need to see these figures reduce to make prisons feel safer for everyone who lives and works in them.”

“We have a range of data that can help us. For example, comparing prisoners on different levels of the Incentives and Earned Privileges Scheme with violence data, MQPL and staff survey data can give us an indication of how well we are using these tools. Having over 50% of a prison’s population on enhanced might be good if MQPL and staff survey data shows that most people feel safe in that establishment, but might need reviewing if that is not the case.”

The Learning Day was also a chance for staff to reflect on the business case for reducing violence. London Director of Offender Management Digby Griffith highlighted the cost to the organisation in both human and financial terms if violence continues to increase and stressed how important the role of front line staff will continue to be in tackling the problem.

Police support was also discussed as Assistant Chief Constable Bob Evans, Police Advisor to NOMS and DC Dominic Murphy of the Metropolitan Police Counter Terrorism Command outlined how they ensure that violent assaults are fully investigated and followed up. ACC Evans explained the process of investigating the most serious assaults and passing them to the Crown Prosecution Service. DC Murphy focussed on how prison staff can help with the investigations by preserving evidence and balancing this against health and safety issues.

Ron Elder, NOMS Violence Reduction Policy Lead said: “This presentation gave a very important message and if prisons act on it, they can help the police to build a solid case for the CPS to prosecute individuals and thereby deal effectively with the most serious assaults in prison.”

DELEGATE FEEDBACK

Delegates attending the Learning Day commented that the information they had gained would be helpful in their day to day roles, and almost 60% felt that they had learned something new. Feedback comments included: “I hope there can be more days like this one, where there is a forum to share ideas and learn from other people’s good practice.” One delegate said: “Thank you for providing some excellent thinking points and the speakers were outstanding.”
MANAGING COMPLEX SELF-HARM

Managing complex self-harming behaviour, such as repeatedly attacking wound sites, inserting articles into the body, biting, head-banging or repeated ligaturing, is extremely difficult. Because individual circumstances vary considerably, it’s problematic to devise a management strategy to fit every case.

PSO 2700 gives advice on managing challenging self-harming behaviour, and PSO 1600 on the use of force to prevent such behaviour. But as a starting point, remember that self-harm is a symptom of underlying emotional distress, and often it is a method of coping.

Self-injury has an immediate effect, creating instant – though temporary – relief. But the underlying emotional issues remain. In time, self-injury can become an automatic response to the ordinary strains of everyday life, and both frequency and severity of self-injury may increase. Asking someone who self-injures to just stop is in effect removing what may well be their only coping mechanism. Instead, encourage the person to find healthier ways of dealing with their distress.

Here are some principles to help formulate a management strategy for someone whose self harm is persistent, or likely to cause life threatening injury or permanent disability. The information covers both legal and procedural compliance.

MENTAL CAPACITY ACT 2005

The Mental Capacity Act 2005 protects people who cannot make decisions for themselves e.g. due to a learning disability or a mental health condition. It provides clear guidelines for carers and professionals about who can take decisions in which situations. The Act (which came into force in October 2007) makes it a criminal offence to neglect or ill-treat a person who lacks capacity. The Act is relevant to the management of people engaged in life-threatening or persistent self-harm in custody, through regular mental health assessments and involving Mental Health In-Reach Teams (MHITS) in enhanced case reviews.

DUTY OF CARE

The overriding duty of care for prison staff is to preserve life. Legal advice confirms that staff are able to take reasonable steps to exercise their duty of care. Use of force can be appropriate where staff are properly trained and where it is reasonable, in the circumstances, to use force to prevent further injury. This may include cases of persistent self harm, where there is a risk of life threatening injury or permanent disability. All decisions taken must be defensible and justified in the circumstances.

PSO 1600 governs use of force. It allows force to be used to prevent risk to life and risk to limb, and also covers use of ‘measures of last resort’ (special accommodation and mechanical restraints). These measures must stop as soon as the original justification has ceased. They cannot constitute a long-term solution to behaviour management.

The difficulty with use of force and mechanical restraints is they can often interfere with injury sites. For similar reasons, using pain compliance techniques may be both difficult and undesirable, particularly where an individual lacks mental capacity.

MULTI DISCIPLINARY WORKING

The enhanced case review process must direct the management of prisoners displaying extreme levels of self harm. This process must include an operational manager F or above. Actively involving a range of departments (such as education, therapy, PE, Workshops, CARATs, psychology) will help provide diversion and support to both individuals and to the staff managing them.

It’s essential that health and mental health assessment establish any underlying physical or mental health triggers for the behaviour. Assessments must be regularly revisited, to ensure that changes in health and mental healthcare needs are promptly identified and any changes to mental capacity are noted and acted upon. Whether or not a diagnosis of mental illness is made, the PCT can provide advice and guidance on clinical managing option.

Repeated self-harming behaviour is very difficult to manage in a prison environment, so it is important that the PCT is fully engaged as well as the Offender Health Regional Lead to provide support and advice on management plans.

RECORD KEEPING

Good note-taking is a vital communication tool, and staff have a professional and legal duty to keep records. All management decisions must be fully recorded to evidence why decisions have been taken, at what level, options considered and the outcome. These records provide the grounds for the use of force, measures of last resort and allow anyone looking after the individual to understand why decisions have been taken.

In deaths involving prisoners with complex needs, the PPO is often critical of failures to record information effectively. This is a key area where improvements are needed. The PPO, Coroner and Courts take the view that if something is not recorded, it did not happen. Good record keeping should provide:

- A full account of staff assessments and care planned/provided;
- Relevant information about the prisoner’s condition at any point;
- Measures staff have taken in response to the prisoner’s needs;
· Evidence that staff have understood and honoured the duty of care, have taken all reasonable steps to care for the prisoner, and that prisoner/staff safety hasn’t been compromised;
· A record of any arrangements made for continuous care.

**SUPPORT MECHANISMS**

Managing complex behaviours can be extremely stressful for staff and other prisoners exposed to it. Don’t overlook the importance of support mechanisms for staff dealing with prisoners with complex needs, and others affected by their behaviour.

Arrangements must be in place to provide additional support during periods of acute self-harming crises. For staff, regular debriefs, group discussions, access to occupational health or counselling services and general support will ensure that adverse reactions are picked up early and targeted support offered. Also see PSO 8150 on Post Incident Care.

It’s equally important to consider support mechanisms for any prisoners affected by the behaviour. Using peer support schemes e.g. Listeners can be useful. For more intensive support, refer to healthcare and MHITs.

**FAMILY INVOLVEMENT**

Depending on the circumstances, involving family members may prove beneficial, if carefully managed. Families could provide vital insights into a prisoner’s behaviour or motivations. Consider involving family members through telephone contact with the case manager; telephone/visit access to the prisoner; or invite families to attend case reviews.

**SEGREGATION**

Wherever possible, avoid managing prisoners who are engaged in persistent or extreme self harm in segregated conditions. Segregation limits the scope for personal choice, and the lack of distractions and loss of trust – alongside any mental health problems and high emotional states - is likely to cause prisoners to challenge staff authority. Over-reliance on force or disciplinary responses can also lead to a downward spiral of behaviour. The prisoner may ‘act out’ more to gain some kind of control over their situation, or use the ‘force’ as a means to harm themselves further.

Decisions to locate a self-harming prisoner in segregated conditions must be fully compliant with PSO 1700 and the ACCT management arrangements set out in PSO 2700.

By Samantha Hughes, Suicide Prevention & Self-harm Management policy lead, SCOP.

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**SCOP COMPLEX NEEDS LEARNING DAY**

It’s known that a high number of prisoners have mental health problems (one study found personality disorder was present in about 63% of the prison population), and an estimated 20-30% have learning difficulties or disabilities, according to a Prison Reform Trust report. The challenge this presents for front line prison staff will be the theme for the next safer custody learning workshop.

The “Complex Needs” learning workshop, taking place at Newbold Revel on Wednesday 5 May, is aimed at all front line prison staff plus those responsible for residential management. Mental health, personality disorders and learning disabilities present unique challenges in the prison environment, differing from those arising when conditions are managed in the community.

Topics to be covered on the day will include:

· General information and statistics on mental health, personality disorder and learning disability
· What does mental illness, personality disorder and learning disability mean?
· What do these conditions mean if you are working in prison?
· What issues do you have in your prison? What works and what doesn’t?

Potential speakers for the event include Director General Phil Wheatley, mental health professional and trainer, Dr Mike Smith, and a Prison Reform Trust representative.

The workshop will be a combination of speakers, workshops and plenary sessions. Registration will open at 8.30am, with the event running from 9.15am to around 2.45pm. Invites have been mailed to Governing Governors shortly, asking them to nominate suitable delegate(s) to attend. For more information, please contact National Safer Custody Managers Cassie Robinson (tel: 020 7217 8226 or email: Cassie.Robinson@noms.gsi.gov.uk) or Jon Vellacott (tel: 0207 217 0773 or email: Jon.Vellacott@noms.gsi.gov.uk).
HARNESSING THE POWER OF IN-REACH TEAMS

Holloway’s in-reach mental health team provides services to up to a quarter of the prison’s population at any one time and offers support to staff managing prisoners with complex mental health issues.

The team, run by the Camden and Islington Foundation Trust, was set in 2001 and commissioned by Islington Primary Care Trust. It is staffed by psychiatric nurses, social workers, forensic and general adult psychiatrists and a counselling psychologist.

The team works in partnership with the primary mental health care services, inpatient psychiatric assessment unit and detox unit. Together, they provide a comprehensive range of services to meet prisoners’ needs. Community support is also available through the in-reach team’s links with St Mungo’s, Shelter, Women in Prison and Southside Partnership to ensure continued support once the prisoner is released into the community. These services are all integrated into one cohesive system rather than displaced amongst different departments. This is done by joint clinical governance structures and joint referral and assessment pathways.

The in-reach team is viewed very much as an integral part of the prison rather than a separate entity and is integrated into the prison’s systems. They attend the daily SO meeting as well as the ACCT and CRSU reviews and safer custody and violence reduction meetings.

Mark Landy, in-reach team manager, explains how the service works: “We provide an in-reach service to prisoners with complex needs which often involves a combination of mental illness and/or disorder, substance misuse and a range of social problems. Women with very high risk of suicide/self harm are assessed and a management plan is developed in conjunction with the discipline staff. The emphasis is on maintaining these prisoners on the ordinary levels by responding quickly to a crisis, having a range of services and interventions which can be implemented immediately, and working closely with the unit staff that provide the majority of the care. Our ability to act instantly and effectively with our partners has reduced the number of deaths in custody through suicide and significantly reduced those on constant supervision. Women on ACCT and in an acute crisis who need to be supervised continuously or those awaiting transfer to hospital can be located on the psychiatric assessment unit for more intensive input.”

The approach appears to have addressed many of the concerns of the Prisons Inspectorate. The March 2008 follow up inspection report states:

“Unlike at our last inspection, few women were held on constant watch in the healthcare centre and there was more emphasis on active engagement.”

“There was a good range of counselling services coordinated through healthcare at one weekly referral meeting.”

The service also extends to supporting prison staff that face the demanding task of supervising prisoners with complex needs. Mark Landy explains: “It’s important for staff to have an outlet to talk about their feelings and experiences, for example how they are coping when dealing with a prisoner who presents a high risk. We can facilitate meetings for prison staff when they are dealing with an individual with complex needs and offer support and training.”
MANAGING DISRUPTIVE BEHAVIOUR: HMP WORMWOOD SCRUBS’ CASE MANAGEMENT PROTOCOL

Research in 2006 by the Psychology department at HMP Wormwood Scrubs found that less than ten individuals were responsible for 50% of incidents of difficult or disruptive behaviour.

The following year, a Case Management Protocol team was put in place to address this issue. Since this time, the CMP has been recognised by the Butler Trust in its award scheme, and by inspectors during the 2008 inspection of Wormwood Scrubs. Their report commented: “The prison used an innovative case management protocol approach to manage and support a small number of difficult prisoners to settle on normal location.”

The 2006 research was a scoping study into the nature and extent of “difficult to manage prisoners” within HMP Wormwood Scrubs and was a response to PSO 1810 that required Governors to develop strategies to deal with such prisoners.

The study found that the ten individuals causing most disruption made up less than 0.85% of the prison population. Less than 0.3% (four individuals) were responsible for 23% of the incidents. Research drawing on a number of sources indicated that prisoners in this group were inclined to have multiple problems and a number of different negative behaviours including violence, threatening and abusive behaviour, bullying other prisoners and damaging property.

In response to these findings, Wormwood Scrubs introduced its Case Management Protocol (CMP) in 2007. This is an individualised approach to supporting those prisoners with the highest need and identified as being most able to benefit from its input.

The CMP is a multi-disciplinary team comprising of discipline staff, mental health nurses and a psychologist. They support prison wing staff in managing the behaviour of the most difficult prisoners, with referrals being made from the residential units, healthcare centre, mental health professionals and the segregation unit.

Once it has been agreed that a prisoner fits the CMP criteria, the team will develop a plan for each offender that enables them to be managed on the wing, only resorting to the use of segregation when absolutely necessary. Before the CMP, there was no co-ordinated way of managing these prisoners and they were quite often moved between wings, segregation and health care according to their behaviour. There was also inadequate continuity with regards to information-sharing, making it difficult for staff to adopt a consistent approach to breaking the negative cycles of violence and behaviour.

Over the past three years, the CMP has received over 150 referrals and 110 prisoners have been managed through the protocol. Each prisoner has a plan with an individualised programme of support to help them change their behaviour. The plan is based on their response to a problem checklist examining three areas where the prisoner is likely to have problems – practical, psychological and interpersonal – as well as clinical assessments. As a minimum, the prisoner will have regular meetings with their personal officer and targets are set jointly. If required, prisoners will also receive therapeutic input from a psychiatric nurse or psychologist where appropriate. The plan is shared with other professionals involved in managing the prisoner.

It is acknowledged that there will always be a need for targeted multi-disciplinary support for the small percentage of prisoners responsible for a disproportionate amount of challenging behaviour. It is for this reason that the work of the team is expected to continue.
RELOCATING PROLIFIC SELF-HARMERS

Here’s the scenario: a Cat B prisoner, who is a prolific self-harmer and has recognised mental health problems, is downgraded to Cat C. His Cat B prison has a healthcare centre offering 24-hour care, and this is where he is located. Your establishment - a Cat C prison, with a history of managing ‘challenging’ prisoners with suicide/self-harm risks - is chosen to look after him. You only provide part-time healthcare, Monday-Friday till 5pm. You need to consider:

· How to ensure the prisoner’s safety, should he self-harm at night or during the weekend.
· How to manage the relocation without unsettling him and triggering a self-harm incident.
· How would staff manage someone with such a serious self-harm history.
· What protocols would be needed to manage his self-harm.

This ‘scenario’ summarises an actual situation which arose at HMP Erlestoke – and is a good illustration of the difficult issues that can arise with the transfer of prisoners with complex needs.

As a first step, a series of meetings were held with all interested parties (including residential Governors and safer custody coordinators from both the Cat B and C prisons, the forensic in-reach practitioner, and healthcare staff) with the aim of agreeing a management plan. Meetings considered why the prisoner self-harmed, suitable coping strategies, and how staff should react if he self-harmed.

A key player was Erlestoke’s Tony Grant - he would be the prisoner’s Offender Supervisor. Tony works in the Erlestoke’s Offender Management Unit (OMU), and is also the Unit’s Safer Custody Representative. He wrote a detailed study of this case, to count towards a First Line Management qualification. After analysing the problem, Tony came up with three possible solutions:

- ‘Do nothing’ option – he should remain in the Healthcare Centre in the B Category prison.
- Relocate to Cat C prison Erlestoke, and reside on normal location, in the Induction Unit.
- Re-locate to Erlestoke, but reside on the Care and Separation Unit as their Unit Orderly.

To weigh up these different relocation options, Tony carried out a ‘SWOT’ analysis - identifying the strengths, weaknesses, opportunities and threats of each. He concluded that the best option was number three, above.

Tony then put together a detailed action plan, describing what actions needed to take place both before and after transfer. ‘Before’ actions included nominating and briefing a Personal Officer, drawing up an action plan for night staff, including protocols on what to do if he self-harmed, and holding a wing meeting for all staff who would encounter the prisoner. ‘After’ actions included: arranging for the prisoner to have a tour of Erlestoke; finding him a job to help him feel valued; setting clear boundaries about what would happen if he self-harmed; and providing suitable distractions, such as art material and a library card.

Tony said: “This was a difficult case, and everyone involved learnt a lot from it. We hoped to eventually relocate this prisoner to normal location, which initially we did. However, in due course, despite excellent multi-agency collaboration within Erlestoke, the prisoner’s mental health deteriorated. He was eventually re-located to the local prison where 24-hour observations could be maintained to ensure his safety.”

This case study demonstrates the good work that Erlestoke staff carried out to ensure prisoner safety and respond to changing situations. There will be periods of respite and relapse in managing prisoners with complex needs. Plans need to be constantly reviewed and evaluated to take account of the prisoner’s changing circumstances and needs.
A recent Prisons and Probation Ombudsman (PPO) fatal incident investigation report has praised an establishment for ensuring that a prisoner with complex needs was dealt with sensitively. All staff and fellow prisoners were made aware of the individual’s condition and how this could affect his daily life.

The report found that Mr H had a long history of complex mental health problems. He had been diagnosed with Tourette Syndrome (TS), an inherited neurological condition, as well as Obsessive Compulsive Disorder (OCD).

Mr H disclosed his mental health problems at reception. Staff arranged for him to be properly assessed in the healthcare centre by a doctor. He remained there for several months. He was also assessed by an outside mental health hospital, under the Mental Health Act. After sentencing, he was returned to prison where medical staff regularly reviewed his treatment.

For long periods, Mr H’s tics were particularly bad, leading him to self-injure by hitting himself around the head and banging his head against walls. As a result he was placed on an ACCT on a number of occasions.

Over time, he was considered well enough to be moved to a residential wing. Staff were made fully aware of his condition and how it would affect his behaviour. This information was also shared with other prisoners on the wing. He was kept under review and regularly moved back to healthcare for periods of assessment and additional support.

The prison consulted a Tourette charity to gain information on the condition and its symptoms. They were also open to advice offered by Mr H’s partner and ensured that this was shared with staff on the residential wing. The information was laminated and displayed on the wing so that both staff and prisoners would know what to be aware of.

Mr H was admitted to healthcare as a result of staff concerns about his appearance. Tests revealed he had taken non-prescribed Subutex. He was closely monitored, but two days later he was found unconscious on his cell floor by staff; resuscitation was attempted but was unsuccessful. The post mortem determined that his death has been caused by a cerebral abscess.

Clearly Mr H had disabilities that were potentially very difficult to manage within a custodial setting. Providing staff who would be managing him and prisoners who would be living with him information about how his disabilities may affect his behaviour is a good way of preventing misunderstanding, encouraging others to be supportive and tolerant.

ABOUT TOURETTE SYNDROME

Tourette Syndrome (TS) is an inherited neurological condition, affecting 300,000 adults and children in the UK. The key feature is tics – repeated, uncontrollable movements and sounds. These are chronic (long-term) and involuntary. The different symptoms can be simple, such as blinking, or complex, like touching or jumping. As well as uttering words or making sounds, vocal tics can include throat clearing, sniffing and/or coughing. Tics can be made worse by stress and anxiety, whilst relaxation or concentration can help.

Over 85% of people with TS have additional conditions, most commonly Obsessive Compulsive Disorder and Attention Deficit Disorder, as well as sleeping problem rage attacks, anxiety and depression. For more information, contact the charity Tourettes Action: www.tourettes-action.org.uk

ABOUT OCD

Obsessive Compulsive Disorder (OCD) is a common form of anxiety disorder that involves distressing, repetitive thoughts. The thoughts come into the mind automatically, however irrational they seem, and the sufferer is powerless to ignore them. Sufferers describe feeling like a “stuck record”.

Compulsions are the actions that people feel they must repeat to reduce the anxiety. For example, some people can’t stop thinking about the germs and diseases they could catch. To cope with this they wash their hands repeatedly. Other compulsive rituals may have no connection to the nature of the obsessive thoughts. Carrying out the ritual usually gives people temporary relief from the anxiety but at other times they can be so full of doubt that they repeat the ritual for hours.

It’s thought that OCD is caused by previous experiences, Stress does not cause OCD but a distressing event such as giving birth or a bereavement may act as a trigger. Treatment is usually through counselling, psychotherapy, cognitive behaviour therapy and medication.

By Cassie Robinson, National Safer Custody Manager.
Background information courtesy of: www.mentalhealth.org.uk
GOOD PRACTICE: MANAGING FOOD REFUSAL

Reasons for food refusal in prisons are varied, but are usually to attract attention to a particular cause or to protest about a personal situation. In Immigration Removal Centres, food refusal is often a protest against detention, the handling of the person’s immigration case, or the threat of removal/repatriation.

Whatever the reason, these cases can be immensely difficult and emotionally challenging for staff to manage. It can also be very distressing for staff and other prisoners to witness the physical effects of starvation over time. But there is much that can be done to handle such cases sensitively and appropriately. This article uses a case study to demonstrate positive practice in managing food refusal incidents in custody. It also highlights newly-revised clinical guidelines on the management of food refusal amongst prisoners/detainees.

CASE STUDY

A prisoner, Mr D, died at outside hospital. The post mortem found the cause of death to be inanition (starvation). The case was investigated by the Prisons and Probation Ombudsman, who said that a hugely difficult situation was handled professionally and compassionately. In particular, staff showed commitment and dedication, kept clear and concise records of their actions and sought legal and medical advice at every opportunity. Mr D’s brother, and Mr D himself, when he was alive, praised prison staff for his treatment. The IMB had also been impressed by the actions of staff, who they felt had shown dedication and professionalism in this difficult situation.

The management strategy adopted in the case of Mr D included:

- His mental capacity was assessed and recorded daily, and a senior manager attended all case conferences.
- Staff were made aware of the Mental Capacity Act and its consequences, and were reminded of the need for detailed and rigorous record keeping.

PERSONALISED CARE

The establishment took steps to reduce Mr D’s distress as much as possible. When Mr D could no longer attend work due to his failing health, arrangements were made for him to access the prison library as he still enjoyed reading. If he wanted to attend the library by himself, he was able to use a wheelchair.

Mr D was also offered exercise and showers on the wing whenever he wanted them. When he became too weak to shower by himself, a male member of healthcare staff assisted him. He was offered activities such as attending education or quiz books, to try to keep him active. Staff also issued him with a personal alarm, in case he needed to call for help when he was in his cell.

Mr D told staff that he was becoming distressed during the night, as he was being woken by the number of observations on him. It was agreed to reduce the level of night observations from five per hour to hourly, provided he allowed increased medical checks to allow his condition to be better monitored.

CLINICAL GUIDELINES ON FOOD REFUSAL REVISED

Offender Health, Department of Health, has issued updated clinical guidelines on how to manage food refusal in prisons and immigration removal centres.

The detailed guidance, covers the physical effects of food refusal (including the risks of refeeding syndrome), the most effective practical and clinical management of individuals refusing to eat and drink, as well as relevant legal aspects. It highlights that individuals must not be given treatment against their wishes in the UK, and that the Mental Capacity Act 2005 makes clear that decisions made by people who are mentally capable must be respected at all times. Also included are useful flow diagrams and an advice sheet for prisoners/detainees. You can access this guidance from the DH website: www.dh.gov.uk (search using the product number: 288691).

Although aimed at health professionals, this guidance contains relevant and useful information that all staff dealing with a food refusal would benefit from reading. Deputy Head of SCP, Debra Baldwin, emailed all Governing Governors/Directors of Contracted Prisons on 3 February 2010, to alert them about this new guidance.

Note that the guidance does not apply to the management of young people under the age of 18 years of age, as they fall outside the remit of the Mental Capacity Act 2005.

REFEEDING SYNDROME

Giving too much food or fluid to a malnourished person can cause problems such as cardiac failure, acute circulatory fluid overload and liver dysfunction. This is known as ‘refeeding syndrome’ and can be fatal.

Someone who decides to start eating again after refusing food for more than a few days is at potential risk of refeeding syndrome, especially if they were malnourished at the outset. Initiation of feeding must be cautious, providing generous quantities of minerals and vitamins, and should be based on clinical guidelines on refeeding (see insert box).
In response to a number of serious fire incidents, including two that resulted in the deaths of prisoners and two serious self harms, Safer Custody & Offender Policy (SCOP) has carried out a detailed analysis of fire incident data, alongside the NOMS Fire Safety Advisor. Results have highlighted some important trends, including overlaps between those who set fires and those who are identified as at risk of self-harm. Almost one-third of fire perpetrators have also self-harmed, records show.

SAFER CUSTODY TRENDS: FIRE INCIDENTS

Most fire incidents in prisons can be classified as non-life-threatening (46% since 1999 involved no damage). However some (7% since 1999) are either serious or extensive. In a few cases (19 since 1978 – including five since 2000), the incident was fatal. In about 9% of fire incidents, a prisoner or member of staff is injured (injuries include smoke inhalation but actual burns are relatively rare) and 3% require hospitalisation. Most cases are treated internally by the prison health services.

In the five years ending 2008, there averaged 1,068 fire incidents per year (costing an estimated £140,000 p.a.) in prisons in England and Wales. Many arose from the malicious ignition of paper (46%) and bedding (31%).

Between 1999-2008, approximately 49% of fire incidents occurred in local prisons (37% in male cat B locals) and 12% in female establishments (more than twice what might be expected). The proportion of female incidents classified as either serious or extensive was 4% compared with 8% in the male estate.

As with national data on assaults and self-harm in prisons,
younger prisoners are more likely to be involved in fire incidents than older prisoners (see graph). The YOI estate (including YO wings in adult prisons) accounted for 35% of all fire incidents. 64% of fire incidents occurred in cells, and another 2% in each of segregation/CSU and healthcare centres.

What procedures do you have in place for the removal of excess bedding, newspapers and rubbish to prevent the stockpiling or build-up of potential fuels? Do you pay particular attention to stairwells and flat roofs overlooked by cell windows?

Do you have effective systems in place to accurately record and share information about prisoners who have previously set fires in your prison, other prisons or on previous sentences?

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<tr>
<th>Table 1. Fire perpetrators involvement in other selected incidents</th>
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<td>Incident Type</td>
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<td>ASSAULT (as assailant)</td>
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<th>Table 2. Fire perpetrators also involved in other types of incidents</th>
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<td>Incident Type</td>
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Tables 1 & 2 demonstrate that fire setters have complex needs and therefore the incident should not be dismissed as an act in isolation. Consider whether there was intended self harm, suicide or indiscipline. Ensure you monitor the prisoner closely until any investigations are carried out.

CASE STUDY

Mr G, a 19 year old prisoner, died after barricading the door to his cell and setting a fire. He was a serial offender and a persistent self-harmer with complex needs, who had attempted to take his life on numerous occasions. He had been sexually abused as a teenager. Mr G’s history of alcohol and drug abuse worsened his emotional instability. Although staff knew about his distress and an ACCT assessor had referred him to the mental health team, there was no evidence that Mr G had been seen and so the complexity of his suffering had been left undiagnosed and very little intervention had taken place.

Staff stated that Mr G was a much improved and happier person after the anniversary of the sexual abuse had passed and so, two days before his death, his ACCT was closed. His death was 10 days after the anniversary of the date he was sexually abused and in a letter, he stated that he could not live with “burdens passed”.

LEARNING POINTS

1. Consider making early referrals to mental health or other partner services when prisoners with complex needs arrive in custody. If referrals are made, ensure that they are followed up in a timely manner.

2. If a prisoner has a high risk trigger factor (such as traumatic event anniversary dates) this should be taken into account when considering closing ACCT documents and post closure phases.

3. People who are in crisis who decide to end their life can often seem much happier and more relaxed in the period leading up to the event as the weight of their problems is lifted. Be aware of at-risk prisoners who undergo a transformation of mood and appear much brighter and happier.

By Tom Wilson, National Safer Custody Manager, SCOP.

BRONZEFIELD SAYS ‘YES’ TO BEARS

An important element of the ACCT care-planning process for at-risk prisoners is to help people find non-harmful ways of coping. The process of drawing up an ACCT caremap should include finding out what has helped the person to cope in the past, and whether they could use or adapt that coping strategy again.

One women’s prison has recently given the go-ahead for women to be allowed a soft toy, as part of their coping strategy. This came about when a woman, with a history of prolific self-harm by ligaturing whilst in prison, returned to custody. Her ligaturing was becoming more frequent and life-threatening. Staff discovered that whilst at home, she had a teddy bear to help her cope.

HMP/YOI Bronzefield’s Safer Custody Coordinator, Xenia Maeson, said: “We authorised a teddy bear for this woman, as a one-off. Her ligaturing immediately reduced and has remained low. Although she has some learning difficulties, she is now engaging with staff both on her residential unit and in her place of work.”

As a result of this success, Bronzefield then consulted relevant HQ groups, as well as other female prisons, to find out if they allowed soft toys in possession; and if so, how they managed it, including security aspects.

Huw Sullivan from NOMS Women’s Team said: “I advised that I had come across this before, although it is rare. It has been managed effectively with no real security issues. The toy should be thoroughly searched, recorded on her property card, and her ACCT review - including the reasons for having it, and the expected benefits.”

After advice from Bronzefield’s Head of Safety Wendy Bayley, approval was given for a teddy bear/soft toy (maximum size 35cm, and not to be filled with beads or beans) to be added to the facilities list. Toys can be sent in by family/friends to any woman at Bronzefield, and will be treated as any incoming item. Xenia added: “The bears are for in-cell use only. They cannot be taken elsewhere, unless part of an ACCT careplan. We will be monitoring how this works out. So far the response by the women has been very positive.”

SCOP’s Suicide Prevention and Self-Harm Management policy lead Samantha Hughes said: “This is not about promoting a national teddy bear strategy, but it’s a good example of a prison taking an individualised and creative approach to a prisoner’s needs. It’s pleasing to see support actions that go beyond what we might normally see in care plans. Allowing family or friends to send in appropriate soft toys is also one way of including them in caring for an at-risk prisoner.”

Has your establishment identified any unusual items, or coping methods, that have been successful in supporting an at-risk prisoner? If so, we’d be interested to hear from you. You can email: SCOPLearning@noms.gsi.gov.uk
Dozens of fires take place in prison cells every year, started either accidentally or deliberately by the occupants. Safeguarding staff and preventing harm to the prisoner are priorities but unlike in normal building fires, the need to contain prisoners whilst bringing the emergency under control is of equal importance.

The Regulatory Reform (Fire Safety Order) 2005 requires compliance by prisons. The first stage of a strategy to address this has involved looking at alternatives to the current fire fighting procedures and equipment. Les James, Head of Safety and Fire, led the project to improve fire fighting techniques in prison. He explains: “Currently, there is no automatic fire detection system installed in a cell. There are automatic detectors close to the cells but this leads to a delay before the alarm is raised unless prisoners or staff notice the fire first. Until now, staff fought fires by putting a standard fire hose reel through a point in the cell door but this is only effective if the fire is in line with the door. If it’s anywhere else, then little or no water comes into contact with the flames.

“Conventional hoses use a lot of water so there is often a lot of water damage to the cell and often, damage to the cells below.”

In looking to improve fire fighting procedures, Les was seeking solutions to two separate challenges:

- A replacement breathing apparatus system that would protect staff from smoke inhalation whilst safely removing the prisoner
- An alternative to the current fire-fighting equipment that would reduce water damage and be more effective in tackling blazes

The research to find alternatives was exhaustive and Les sought co-operation from the Health and Safety Laboratory, German prisons and a testing facility also based in Germany.

His conclusions have led to the roll out of newly designed Cell Snatch Rescue Equipment (CSRE) to prisons in England and Wales. The Irish Prison Service is following suit and is being awarded a Taoiseach’s Public sector excellence award at a ceremony in Dublin later this month.

The CSRE is a chemical oxygen set (smoke hood) which is easy to don and one-size-fits-all. It gives prison staff 15 minutes of breathing protection including a five minute safety margin. It is a simple means of protecting staff from smoke inhalation. The product is easier to use than the current Short Duration Breathing Apparatus (SDBA) which was in service for 15 years but presented some operational difficulties. The CSRE can be stored for up to six years with only simple visual maintenance required and training is simpler than the SDBA.

The CSRE has already been used at HMP Peterborough. Two staff were able to use the system to successfully rescue a prisoner who had started a cell fire.

The second stage of investigations, supported by a 2008 report by BRE Fire and Security, has identified a less damaging fire-fighting solution – water mist. NOMS has now bought a number of manual water mist systems and these have been deployed to prisons based on risk and need but will be phased in across the whole establishment. Under tests, the water mist systems have proved effective against shielded fires as opposed to the former hose system that could only tackle fires within unobstructed range. The mist systems used just over six litres of water per minute to suppress a fire – almost a tenth of that used by the hose system – just as effective but less damaging.

Les James says: “The new fire-fighting equipment will help in the smooth running of the prison regime. We know that some prisoners start fires deliberately just to enjoy disrupting the prison regime and to cause damage to cells. More effective equipment with less water damage means that cells can be quickly returned to use or at least, are out of action for less time than previously. It has taken the “fun” element away from them.”
DISTRACTION MATERIAL – SURVEY RESULTS

SCN recently surveyed establishments to find out whether they promoted distraction boxes. We explained a distraction box as: “something that contains things that can distract you from self-injuring. You can put anything in there that you like, and can decorate the box however much you want to.” We asked Suicide Prevention Coordinators to provide brief details, including: what the boxes contain; estimated spend; details of any protocols in place around their use.

A total of 91 establishments (about three-quarters) responded. Of these, nineteen said that they offered distraction boxes, whilst another eight said they had plans to introduce them. Twenty-nine said they offered activity packs or kept stocks of diversionary material, usually stored in individual wings. Thirty-five did not offer distraction boxes, but several said they were interested in finding out more.

WHAT’S IN A NAME

Responses showed that establishments use different terms to describe their diversionary material, reflecting how they are utilised. HMP Leeds offers ‘happy boxes’, HMP Foston Hall has ‘boredom busters’, whilst HMP Send stocks ‘crisis intervention boxes’.

At HMP Bronzefield, women on the SAFE programme create ‘safe boxes’. (SAFE is a three-day psycho-educational, problem-therapy based programme of structured group exercises and discussion. It focuses on awareness and coping skills, and is targeted at women who have self-harmed in custody or in the community).

Women are encouraged to put things in the box that make them feel safe, such as photos of loved ones and friends, letters from loved ones, lockets and positive affirmations and thoughts they have written. Safe boxes are made from art materials provided by the Programmes staff. The women keep the boxes in their cells. Residential officers are aware of the boxes, and in the event of a cell search, they are treated with respect.

WHAT’S IN THE BOX?

We asked SPCs to describe what type of material and activities they provided. Items commonly mentioned included: stress balls; puzzles, especially jigsaw puzzles and sudoku; playing cards; games; art/drawing materials and colouring-in books/sheets. Also listed were word searches, books and relaxation CDs. Some establishments offer electronic items, such as hand-held games. One prison had offered games stations, but had withdrawn them following misuse.

HMP Downview stocks a variety of basic in-cell activities, but also has an on-site card shop, where women can purchase card-making kits. Women can also buy craft materials (matchsticks and glue) through the canteen.

AT HMP Edmunds Hill, each unit has an activity box with basic items such as puzzles and painting by numbers, and dot-to-dot colouring books. SPC Andy McGowan said: “Some of these items may seem childish, but have proved useful in managing prisoners with learning difficulties or low levels of literacy and numeracy.”

Many prisons clearly put a lot of thought into the contents of boxes. HMP Low Newton’s Safer Custody Manager Nikki Stephenson said: “We have also recently toyed with idea of adding other items to the boxes with the Security Department and Safer Custody Team Leaders’ agreement. We are considering various items, including coloured tissue paper and a small guidance book, showing how to create flowers and other items with it.”

One respondent had purchased ready-made distraction boxes from the National Self-Harm Network, at £12 each, and commented: “They were very useful and did what they said on the box - distracted from self-harm.”

LOCATION

Several prisons, such as HMPs Lewes and Gloucester, place boxes on each residential wing. Elsewhere, HMP Parc has distraction material in ‘high risk’ areas, including the Care & Separation Unit (CSU) and in healthcare. Similarly, at Gren-don, Rye Hill and Guys Marsh, boxes are issued in segregation/CSU. At HMP/YOI Cookham Wood, a box of activities is kept in the safeguarding office, whilst Aylesbury keeps a store of material in the safer custody office, which all staff can access.

PROBLEMS

We asked establishments to highlight any difficulties they had come across regarding distraction material. Problems mentioned included contents of boxes “going missing”. (This was not an issue however at HMP/YOI Moorland, where use of activity boxes is managed by the residential staff. Usage is logged and reported at the monthly safer prisons meeting.)

Some spoke of difficulties and restrictions in purchasing material, such as: “It is sometimes difficult to get someone locally to go out and purchase contents with the credit card, and can take weeks.” For others, re-stocking boxes/supplies was problematic. Comments included: “...after we had set up a box for each wing, some did not replenish the stock as required.”

Two female prisons which issue activity boxes to women on ACCT said that there had been some evidence of links between a rise in number of women on open ACCTs, and the contents of activity boxes being viewed as ‘desirable’. Both subsequently revised the material provided, e.g. replacing art
materials with basic colouring pencils. One explained: “We now maintain items that are good for distraction for prisoners in crisis, but not so attractive that they feel there is benefit in being on ACCT to obtain the items.”

At other end of the spectrum, some reported negative reactions from prisoners to more basic material offered. Ranby’s Safer Custody Manager David Cape said that take-up of distraction kits was low: “The offer often invokes a derogatory response from the offender in crisis, although they have been used.”

BUDGET

Few respondees detailed how much they spent on diversion material. Of those that did, HMP Leeds said: “Our Happy Boxes have items such as painting by numbers, jigsaws, games, puzzle books and card-making sets. They cost about £100 per year to set up and keep replenished. We check on a weekly basis to ensure they are always stocked with diversionary items.” A handful of prisons said costs for providing packs were small.

LINKS TO ACCT

Some establishments offer distraction material to prisoners as part of the ACCT process. At Castington prison, distraction boxes are offered to all those on an ACCT document at every case review. At Edmunds Hill, activity boxes are offered to prisoners when an ACCT is opened, as part of the caremap. Unit staff also have discretion to issue items to prisoners not on ACCT, where they feel it appropriate.

HMP/YOI Northallerton does not use distraction boxes, but instead each case is considered separately, with the case conference used to determine what suitable materials are available and will be useful to the offender.

SUMMARY

Current NOMS policy on suicide prevention and self-harm management advocates providing distraction material. PSO 2700 states: “Leaving prisoners for long periods bored with nothing but their immediate troubles to think of may add to their distress and risk of harm.” It encourages access to in-cell and out-of-cell appropriate activities (like art, exercise and relaxation tapes) that can provide distraction, and alternatives to help prisoners manage their distress. Diversionary material is listed as a core element of care to be addressed in the ACCT caremap.

Our survey suggests that establishments recognise that keeping at risk prisoners occupied is an important part of their safer custody strategies. It has also highlighted the need to ensure that items are tailored to the needs of the particular population in terms of gender, age and ability. Boxes need to be monitored and maintained to ensure they remain complete and up to date. Where distraction boxes are being considered, why not ask at-risk prisoners for ideas about what they should contain?