Back in summer 2008, plans were put in place to start a review of the ACCT care-planning system for identifying and supporting at-risk prisoners. Various consultations events took place during 2008/09, and then began the painstaking task of analysing the feedback and suggestions for improvement. This task is now complete, and our report (inside) summarises the main findings from the ACCT review.

The bottom line is that all groups consulted – that means safer custody teams and generalist staff, healthcare staff, stakeholders and prisoners themselves – broadly agreed about what areas are working well and what needs strengthening. Key improvements areas include: revisiting and updating ACCT staff training, doing more to ensure that policy requirements are clearly understood, and that prisoners see ACCT in a more positive light. A main piece of work will be making the overall policy on suicide prevention and self-harm management (PSO 2700) less complex and more user-friendly. What we suspected (that many of you find it difficult to get computer access; and when you do, you find the electronic version of PSO 2700, with its myriad of hyperlinks, difficult to navigate around) we now know for certain. So although the consultation part of the review is complete, the real work now starts to implement the key recommendations.

There were sixty self-inflicted deaths in custody during 2009, the same number as the year before, and the rate of deaths fell slightly on 2008 (see trends box, right). A big thank-you on behalf of Safer Custody and Offender Policy to everyone who worked so hard to care for at-risk prisoners throughout the year. DG Phil Wheatley said he was pleased that there was no rise in self-inflicted deaths, despite the increased population pressures, and confirmed that preventing prisoner suicides would remain important core business for NOMS in 2010.

Also this issue, we have a progress update on the ongoing NOMS violence reduction review; further feedback from the families and learning workshop held in the Autumn; and some important learning from recent inquest verdicts into deaths in custody. We also look at ways to tackle the issue of shouting out of cell windows, which has been a factor in a small number of self-inflicted prisoner deaths.

Finally, having worked on this newsletter since spring 2003 (doesn’t time fly…), this is the last issue I’ll be editing. So it’s farewell from me, and a big thank-you to everyone who has contributed material and ideas over the years.

Anna Sedenu
SCN Editor
The National Self Harm Network (NSHN) is encouraging nominations for its fledging award scheme, first launched in 2009 to recognise individuals and departments for ‘excellence’ in supporting people who self harm.

The NSHN is a national charity that supports people who self-harm as a means of coping. There are three award categories: Mental Health Professional of the Year; Medical Practitioner of the Year; and A&E Department of the Year. Details of how to make a nomination for the 2010 awards will be posted on the NSHN website shortly.

These awards are open to all – and one of last year’s winners was a prison officer from HMP Nottingham. Senior Officer Paul Searson, Nottingham’s Suicide Prevention Coordinator, scooped one of two ‘highly commended’ awards in the mental health professional category.

Reflecting on his award, Paul said that he had been delighted to achieve recognition on behalf of all the hard-working staff at HMP Nottingham. He said: “Prisoners who self harm or attempt suicide are a part of the self-harm community that is often forgotten.”

Nottingham’s Suicide Prevention Team Leader, Nik Foster, said: “Managing people who self harm is hard work and often goes unrecognised. Paul has done some excellent work over the past year in safely managing this group of offenders and helping them move on to other establishments or to homes in the community. Whilst it has been a team performance from everyone at Nottingham, Paul has taken real ownership and fully deserved this recognition.”

Paul outlined Nottingham’s care approach: “Whilst we don’t do anything different to other establishments, we adopt a structured approach to managing vulnerable prisoners. We strongly believe in managing prisoners on regular residential units. As far as possible, we avoid healthcare unless a prisoner needs medical supervision.”

Unusually for a local prison, Nottingham doesn’t have a dedicated healthcare in-patients facility. Paul added: “We are fully aware of the extra pressure this can put on wing staff. But when balanced with the successful management of some of our more prolific self-harmers, it’s a system that works well and we will continue to push.”

Nottingham also takes family support and access to friends very seriously. Prison staff work hard to ensure that vulnerable prisoners have access to contact family, public protection permitting. He explained: “This can be as simple as finding telephone numbers, to arranging special visits for those that have seriously self harmed.” Staff also encourage prisoners to focus on the positive aspects of their lives and to work towards short and long term goals.

Good working relationships with partner agencies, both inside and outside the prison, have also helped. Paul said: “Our primary and secondary mental health provision is excellent. Our local PCT part-fund my post, so I am actually part of the healthcare team.” One difficult case last year involved a remand prisoner who was assessed as a serious suicide risk. Intense media interest complicated the situation further. Discipline staff worked closely with healthcare, mental health teams and psychology to ensure that the prisoner received vital support. They also encouraged the prisoner to maintain family contact, and on several occasions contacted the family direct to discuss support plans.

The National Self Harm Network offers support through downloadable leaflets, discussion forums and stories from self harmers everywhere. For more information, see: www.nshn.co.uk

Safer Custody and Offender Policy (SCOP) is to merge with Operational Policy Unit (OPU) with effect from April 2010. The merger is part of a Directorate strategy to meet the challenges of the NOMS HQ review by organising work within fewer, larger groups.

At the time that OPU was set up in April 2005, there was a clear separation between pure policy and casework. OPU enabled policy groups to access operational views, and worked closely with policy leads to ensure that the operational consequences of policy development were properly considered. However, with the setting up of NOMS Agency, this distinction no longer exists. OPU has also been involved in issues which have close ties to SCOP’s work, such as satellite TV, stored property, and prisoner finance.

Head of SCOP, Pat Baskerville, said: “There is a clear logic to this merger, given the close policy overlaps. It will also help ensure that, with a smaller headquarters, we maintain current good levels of service.” Some internal restructuring within the newly merged team is likely to follow. As a first step, Head of OPU Tony Watson will join SCOP’s SMT.
NOTTINGHAM SAMARITANS ‘PIONEER’ HONOURED

A long-serving Samaritans volunteer has been awarded an MBE in the 2010 New Years Honours list, in recognition of her support to HMP Nottingham.

Dedicated Marjorie Kirk, a 75-year old retired teacher from Woodthorpe (pictured above), has volunteered with the Samaritans branch in Nottingham since 1990. Nottingham prison staff nominated Marjorie for the award, describing her as “committed, supportive, and caring”.

Marjorie was a key player in establishing the relationship with Nottingham prison and in first developing a Samaritan-supported Listener peer support scheme there 18 years ago. Prisoner Listeners offer confidential, emotional support to other prisoners in distress.

Since joining Samaritans in 1990, Marjorie has undertaken various roles including Nottingham branch Director, Regional Prison Support Officer and Prison Coordinator.

Marjorie said: “I feel honoured to have received this award and truly humbled that people from Nottingham prison nominated me. It is a privilege to have met so many amazing people at the prison through my volunteering with Samaritans and it has been a real pleasure to be involved.”

Samaritans Chair Sophie Andrews congratulated Marjorie, commenting that the award was a much deserved public acknowledgement of her committed volunteering over 20 years. She said: “This is a wonderful example of the dedication our 17,000 volunteers put into providing the vital 24/7 Samaritans service.”

NATIONAL SAFER CUSTODY MANAGERS APPOINTED

A new team of National Safer Custody Managers (NSCMs) has been appointed to work closely with Directors of Offender Management (DOMs) to support the delivery of safer custody across the regions.

The NSCMs, who are all based in London and part of Safer Custody & Offender Policy (SCOP), will each support specific DOM regions on the full range of safer custody-related issues.

Kate Eves - who is also overall Team Leader - will cover the East of England. Kate was formerly SCOP’s violence reduction policy lead. She re-joined SCOP in October 2009, following a short secondment to the London Serious Youth Violence Board.

John Gaynor will cover London, North East and Wales. John comes to the team from the Work Force Modernisation programme. He has also worked in the Directorate of High Security prisons and at HMYOI Feltham.

Cassie Robinson will be responsible for the West Midlands and North West regions. Cassie has worked in SCOP for four years, leading the PPO Liaison and Learning team.

Tom Wilson will support the South East and South West. Tom joins the team from HMP Wormwood Scrubs, where he worked in a range of operational roles, most recently as Deputy Head of Safer Custody.

Finally, Jon Vellacott takes the lead for the East Midlands and Yorkshire & Humberside. Most recently, Jon spent two years working in Operational Policy Unit on a range of operational issues, including End of Custody Licence and Release and Recall performance.

Please note that the NSCM is different to the former role of the Area Safer Custody Advisers (ASCAs). Prior to regional restructuring, ASCAs were based in and funded by Area Offices, and liaised directly with establishment safer custody teams within their area. In contrast, NSCMs will work directly with DOMs offices and will not have a direct link with establishments. If you are based in an establishment and need help with any safer custody related query, your first step should be to contact your Safer Custody Team Leader, Deputy Governor or Governor for assistance.

Jon Vellacott, John Gaynor, Cassie Robinson, Kate Eves and Tom Wilson
We recently featured brief details of a learning workshop we hosted at the Prison Service College in September, themed around ‘Working with Families’ (see SCN Sept/Oct 2009). This issue, we follow up that report with more detailed coverage of issues raised during workshop sessions. As our earlier report outlined what keynote speakers said, we haven’t repeated those details here.

This workshop and a series of others, with different learning themes, have replaced the annual Safer Custody Conference. Overall, they aim to present policy guidance and learning on key strategic issues to frontline staff, thereby improving delivery of safer custodial services.

**ATTENDANCE**

The day was aimed at establishment Family Liaison Officers (FLOs) and Safer Custody Team Leaders. 111 prison staff attended, including 54 trained FLOs. Nearly 100 establishments were represented. Of those who completed evaluation forms, 68% said it was their first time at a safer custody organised event.

Stakeholders from various policy groups and outside organisations were invited to the learning event, and took part in the workshops. Samaritans, INQUEST, the Prison and Probation Ombudsman and PACT were all represented.

**WORKSHOPS**

Workshops covered three themes: engaging families in end-of-life care; families and ACCT; and Family Liaison Officers. Delegates were allocated to groups according to their establishment’s function and remained in these groups for all three workshops. Workshops were facilitated by a mix of individuals with operational and/or policy experience.

**ENGAGING FAMILIES IN END OF LIFE CARE**

An issue all groups raised was inconsistency in information-sharing between healthcare and discipline staff. They felt that some members of staff were happy to pass on information if it affected a prisoner’s care on the wing, but others would hide behind ‘medical confidentiality’. However, one group thought that this was a general communication issue, and wanted to see more consistency across the country.

Staff from Immigration Removal Centres (IRCs) and those that hold foreign national prisoners reported that language difficulties made it hard for them to engage with prisoners who have a terminal illness.

IRC staff also revealed that Immigration Rules require the site director to deliver the death message to a bereaved family, rather than a trained FLO.

Who is deployed to inform families following a death in custody at your establishment? Most establishments have at least one trained FLO. He/she should always be accompanied by a colleague on the first visit to a family. It is suggested practice for this colleague to be the Governor or in the case of an IRC the Director.

Another issue raised was selecting the most appropriate members of staff to conduct bedwatches. Managers should consider the personal circumstances of staff when they ask them to carry out these duties, to ensure that they have not recently suffered a family bereavement or other kind of loss or serious illness. The staff member should also be adequately informed about the prisoner and how their illness may affect their behaviour.

Groups seemed to like the idea of sharing information with families and hospital staff about the need for restraints. This would both structure expectations and make families aware of what decisions staff on bedwatches can and cannot take. Training and support for staff who are involved in caring for the terminally ill was thought to be lacking.

Does your establish give adequate support to staff who carry out bedwatch duties? Caring for a very ill person can be emotionally draining and distressing. It is important that all staff involved in an individual’s care in these circumstances are offered support and involved in any debriefs following a subsequent death.

Remember that staff can contact Employee Support or their Care Team if they have any concerns about caring for terminally ill prisoners. Managers also have the facility to refer staff for counselling using the National Framework Agreement.

The Young People’s estate raised specific issues about the methods of information sharing when prisoners were moved into the over 18s estate. Attendees felt that there was no natural point to hand over information to.

**FAMILIES AND ACCT**

How we care for vulnerable prisoners is a vital issue. We know that approximately 30% of prisoners who take their own lives had no family contact prior to their deaths. We also know that families can be a significant source of information about prisoners as well as providing important support to prisoners.
Most groups felt that they engaged with families in some way, but family contact was limited during the ACCT process, because most prisoners did not want it. Contact was difficult to achieve when high numbers of prisoners were on an ACCT, and people felt that families could cause conflict. IRCs identified particular problems. Staff from the Young Adult estate indicated that they had experience of disappointment from families, caseworkers and prisoners who had moved from the Young People’s estate to the over-18s estate, around reduced availability of contact.

There was a general feeling that FLOs should only be deployed following a death in custody. This would maintain the focus and prevent any conflict of interest. There was confusion about the roles of FLO and Family Contact Officers (FCOs). The latter’s role is to encourage the involvement of supportive family members in the care of at-risk prisoners, and to encourage/help prisoners involve those family members who can help them. However, few prisons seemed to have introduced FCOs into their Safer Custody Team.

One group said that there was a process in place for families to inform a prison that their relative might be at risk, but no means of informing the family of any outcome or offering them support. Groups also highlighted the need for ACCT staff training to cover how to deal with prisoners’ families.

As FLOs may not be deployed for some time following the initial training course, it was felt that there was a need for refresher training and mentoring for the newly trained.

If you don’t already, consider organising regular meetings for FLOs or inviting them to your Safer Custody meetings, so they feel less isolated and become part of a supportive team.

Again, the issue of contacting the families of foreign national prisoners was raised, as was the need for national guidance on how to manage ‘out of area’ deployments.

WHAT HAPPENS NOW

The learning day raised a number of issues to which there are no immediate or simple solutions and which have crossovers with other policy areas. But overall, it was an extremely useful exercise in highlighting what the current problem areas are and setting in motion joint work to find solutions.

PSOs 2710 and 2700 are being reviewed as part of the specification process, and the issues raised during this learning day will be considered as part of this process, and will also feed into the review of the whole suite of safer custody training.

National Safer Custody Managers will work closely with DOMs to ensure they are aware of the importance of the FLO role and the positive difference it has made to the relationships with bereaved families following a death in custody.

By Cassie Robinson, National Safer Custody Manager, SCOP.

CASE STUDY: ACCT & FAMILIES

Karen Chapman, who recently took over as Safer Custody Coordinat- or at HMP Stocken, is a strong supporter of engaging with families. Karen said: “Families can be the most powerful source of help we can have, when dealing with prisoners who are genuinely distressed for one reason or another.”

Karen explained that she always gets involved with some of the more complex cases, to support wing staff. It is soon apparent from talking through with the prisoner what his issues are, and if contacting the family will be beneficial.

She said: “When we have contacted family, it has been very successful. I try and get out to the visits centre to meet them if they come to visit, which gives them a chance to air any concerns they have. I always give them my direct line telephone number and have found that they will let me know if they have concerns.”

Asked if she had any tips for other establishments, Karen said: “The main thing is that the contact has to be appropriate in the circumstances and that really is a judgement call by staff.”
ACCT REVIEW - RESULTS & NEXT STEPS

ACCT (short for ‘Assessment, Care in Custody and Teamwork’) is the care-planning system for identifying and managing prisoners at risk of suicide or self-harm. It was introduced across the prison estate in partnership with Offender Health during 2005-2007.

From the outset, NOMS committed to review ACCT, once there had been an opportunity to observe the system in operation across the entire prison estate. The last prison to introduce ACCT did so on 16 April 2007, and plans were put in place to start a review from summer 2008.

The ACCT review is now complete, and has resulted in a total of 34 recommendations. The key work streams arising from the review are:

- A rewrite of PSO 2700 and its associated guidance, alongside ‘specifying’ the ACCT process itself.
- A review of the suite of ACCT training. A mapping exercise is already underway with Learning & Development Group and Training Services, to capture the current ACCT training commitment and identify where content needs updating to keep pace with operational need. We are also identifying opportunities for smarter delivery methods which will reduce the burden on establishments.
- Re-formatting the ACCT document in line with requests for additional forms, guidance and space to record additional information.

The recommendations and key work streams will lead to wide-reaching changes to policy presentation, curriculum development and operational delivery. We are very grateful to everyone who took part in the review, whether in person through workshops or focus groups, or by contributing written comments.

THE REVIEW PROCESS

As well as consulting specialist staff, policy and operational managers, prisoners and interested organisations, Safer Custody and Offender Policy (SCOP) invited all staff to contribute suggestions for improving ACCT via a dedicated e-mailbox, advertised on the NOMS intranet (the ‘e-consultation’). This approach was designed to optimise the potential for learning and provide the basis for further development work during 2009.

SCOP also hosted a Safer Custody staff event in September 2008, to identify practitioners’ concerns. Held at Newbold Revel, this was aimed at Area Safer Custody Advisers and establishment-based safer custody staff. Similar events targeting healthcare professionals took place in North West and East & West Midlands Areas. Finally, a fourth consultation phase involved prisoners in four establishments in Yorkshire & Humber Area.

MAIN FEEDBACK THEMES

Despite the wide-ranging scope and range of approaches taken, feedback was fairly similar across all groups, as demonstrated by the consistent nature of many of the recommendations in the final report.

A significant number of comments reflect high levels of apparent misunderstanding about current policy requirements, and indicate a need to revisit how information is effectively communicated between SCOP and establishments. This supports the Specification, Benchmarking & Costings agenda, requirements to modernise, as well as the new approach to audit, assurance and compliance that has been introduced to reduce the number of avoidable deaths and self harm amongst prisoners.

Safer Custody staff in establishments and the e-consultation reported high levels of dissatisfaction with the complexity of PSO 2700, as well as difficulties in accessing information in the online version, due to complicated hyperlinks embedded in the PSO. Concerns over accessing policy were also voiced in the healthcare event, where lack of access to prison IT was identified as a key barrier to effective delivery of local policies. Healthcare staff also reported a misalignment between policy requirements as set by PSO 2700, and healthcare delivery as set by the Partnership Board.

“Too detailed and no realistic chance of meeting every requirement every time”

“PSO 2700 is too unwieldy. On top of that establishments had to write their own local policies - surely this is an example of excessive bureaucracy that has limited impact in the field.”

“Needs to be user friendly and simpler”

“No access to Quantum and no time to read PSO”

The majority of e-consultation comments related to ACCT training, with requests for additional guidance, for example interview techniques, conducting case reviews and care planning and identifying risk. Healthcare staff requested greater integration between healthcare and prison training. There was a consistent view from healthcare staff that their training needs were not being met. Comments included: “Expand training for new recruits”, “Foundation Refresher needed” and “More focus on Care Map training”.

There were many comments about the ACCT document itself, including detailed suggestions for improvements. For example, “Care map should be printed on the flip side of the case review sheet and a new care map should be completed every time a case review takes place” and: “Section to record alternatives to self harm - so staff don’t remove them during searches”. Many people also asked for additional forms, such as a Post-Closure Review form; night sheets; and an observation sheet inside the front cover, instead of an observation box. There were also requests for more robust documentation for long-term use.
PRISONER VIEWS

Findings from the prisoner consultations indicated that prisoners generally understood the purpose of ACCT. They made a number of positive comments, indicating that certain aspects of the process are working well. These included:

“its like a safety net”
“If there wasn’t ACCT, there would be more suicides, it works”
“staff check on you and treat you well”

However, for many prisoners, staff actions in response to ACCT felt more like surveillance rather than interaction, with comments about the levels of observations, particularly for those in shared accommodation. Negative comments about ACCT included:

“people [on ACCT] are vulnerable and get terrorised”
“why should we be put in with them, they might kill themselves and we would see it”
“officers get complacent”
“officers don’t take it [ACCT] seriously”

Areas for improvement include: reducing the stigma associated with being on an ACCT; promoting positive staff/prisoner relationships - especially the case manager role; and involving others in the support of prisoners during the process, such as their family and other prisoners.

Prisoners seemed to think well of peer support work, as illustrated by comments like: “Need peer supporters that can give advice” and:

“Prisoners need to talk to other prisoners”. The main limitation was linked to mistrust of other prisoners. Here, comments included: “the stereotype on the wing is that you are soft if you use them [Listeners]”; and: “I don’t trust them [Listeners]”.

SCOP will look at how to reduce levels of suspicion between prisoners. With SBC proposals seeking to extend the use of peer support, and the review of Samaritan Services in the U18 estate due to report, there is a clear need to take account of prisoner attitudes to peer support.

NEXT STEPS

Recommendations from the review will now be taken forward under the governance of the Safer Custody & Throughcare Board, chaired by Ian Poree (Director of Commissioning & Operational Policy), and its sub-committees. The Safer Custody and Offender Health Sub-Committee will progress recommendations relating to healthcare and mental health.

Finally, SCOP will take forward recommendations around the commissioning of research alongside Jo Bailey (Lead Psychologist, Operations Directorate) with the intention of using in-house psychologists to complete elements of research as part of their professional development.

For more information, you can contact Samantha Hughes, Suicide Prevention and Self Harm Policy Lead, SCOP: Samantha.Hughes@noms.gsi.gov.uk

TIMETABLE FOR CORONERS’ REFORM SET

The Government has announced a timetable for implementing major reforms to the coroners’ system, including appointing a new Chief Coroner, and developing national standards of service for bereaved families.

A new Chief Coroner for England and Wales will be appointed in the spring. This new post is intended to introduce national leadership and ensure greater consistency of approach between areas. In March, the Ministry of Justice and Department of Health will issue consultation papers asking for views on the policy details of the new system. This will be followed in the autumn by the appointments of a National Medical Adviser to the Chief Coroner, and a National Medical Examiner. The new system is expected to go live in April 2012.

These changes were introduced in the Coroners and Justice Act 2009, which received Royal Assent on 12 November 2009. Other key reforms included in the Act are:

- Changes to improve the experience of bereaved people who come into contact with the system, including giving families and others with a central interest in the investigation, appeal rights against particular decisions taken by coroners, and a new Charter for bereaved people, setting out expected standards of service.
- Measures to reduce delays and improve the quality/outcomes of investigations and inquests.
- A new system of medical examiners for deaths not investigated by the coroner, to provide independent scrutiny and confirmation of the medical cause of death given by a doctor in a way that is proportionate, consistent and transparent.

A number of changes were made to the draft legislation during the House of Lords consideration, including that legal aid for investigations where the person died on active service or in state detention has been brought within the formal scope of the civil legal aid scheme. It will still be means tested and will need to meet specified criteria, but it will enable the Legal Services Commission to make decisions on these cases without reference to Ministers.

The Government also agreed that arrangements should be put in place so that the reasons for investigations lasting over 12 months are recorded. Coroners must therefore report to the Chief Coroner any investigation that has not been completed within 12 months, but also when that investigation is completed. The number of these investigations will be collated and included in the Chief Coroner’s annual report.

For more information, see the MoJ website: www.justice.gov.uk
The review of PSO 2750, Violence Reduction, was announced in February 2009. It has three main work streams: the Cell Sharing Risk Assessment (CSRA); an alternative Key Performance Indicator (KPI) for serious assaults; and the violence reduction processes operated by prisons. Here’s an update on our progress so far.

**CELL SHARE RISK ASSESSMENTS**

Although the CSRA process was originally introduced as a response to in-cell homicides, prevention of murders is not recorded in the PSO as an explicit reason for the process, and many staff view the CSRA as a tool to reduce non-lethal violence in cells. There is also an (incorrect) belief among some people that the CSRA covers self-harm issues. It does not. It is about preventing homicides and reducing in-cell violence.

The number of homicides in prison has thankfully remained very low over the last ten years. For non-lethal assaults, we know that around 17% of assaults between prisoners take place in a cell (2,195 out of a total of 12,800 prisoner-on-prisoner assaults occurred in cell locations in 2008). Some of these are between cell mates, but many are opportunistic assaults in an ‘out of sight’ location. Analysis of the time when cell assaults took place shows peaks at morning unlock and evening lock up, with just 1.8% of assaults occurring between 8pm and 7am. On this basis, the locked cell can be seen as a relatively safe location.

**‘IMPROVED’ CSRA PILOT**

The current CSRA process is lengthy and includes questions which are not relevant for the purpose. We have devised a new form which covers only essential and relevant issues. This has been agreed with colleagues in Offender Health and the healthcare assessment has been amended to cover only salient medical issues. We consulted London Reception officers, and ran a short trial in a few prisons in the Eastern region. We will report the results shortly.

**ALTERNATIVE KPI FOR SERIOUS ASSAULTS**

A trial in the South East Region involving 15 prisons over six months has just finished. The purpose was to pilot an alternative to the serious assaults KPI which used data already available in prisons but which was presented in a more meaningful way for Governors. This should allow a greater understanding of violence in prisons and provide a mechanism for monitoring performance improvement, especially since it includes some diagnostic measures. For example, the number of times force is used in a prison can be a useful diagnostic for the appropriate management of violent incidents and thus result in staff and prisoners feeling safer. A full analysis of the results of the pilot is underway.

**VR PROCESSES**

The review is also examining the processes developed locally by prisons to manage violence, including well known approaches such as the Tackling Anti-social Behaviour (TAB) process. We intend to determine if there’s a need to mandate a national policy or publish suggested practice guidance.

**FUTURE WORK**

We will be analysing the results of both the short CSRA pilot which took place in January, and the alternative KPI pilot, and preparing further recommendations on future measures. We are also developing an additional workstrand around arrangements with the Police and CPS concerning investigation and prosecution of the most serious assault cases. We will report separately on this when agreement has been reached. Most of the revised policy flowing from this work will be turned into specifications of minimum standards. This means the revised PSO 2750 should be much smaller – and much clearer.

To meet the NOMS commitment to zero tolerance to violence in prisons, we will be running a poster campaign over the next few months to reinforce the message that we do not tolerate violence in our prisons and action will always be taken.

Finally, we are holding a Violence Reduction Learning Day at Newbold Revel on 3 February 2010, to help prisons use information already available to target and address violence.

**NEW RECRUIT TO VR TEAM**

Some of you may recall that Lucy Freeman left us on promotion in July. After a marathon recruitment exercise, I’m delighted to announce that Petra White joined us in January, on promotion, to fill the post of violence reduction policy manager. Petra previously worked in the Director General’s Briefing and Casework Unit and will be bringing fresh new ideas to challenge our thinking. I know she is looking forward to building up her network of contacts with you.

By Ron Elder, Violence Reduction Policy Lead, SCOP. Email: ron.elder@noms.gsi.gov.uk or tel: 020 7217 5551.
PRISONERS JOIN ‘SAFER RISLEY’ BANDWAGON

Prisoners have made an important contribution towards improving safety at Cat C male training prison, HMP Risley, by participating in a full-day workshop to establish perceptions of safety, identify any gaps in current strategies, and come up with ideas for improvements.

Thirteen offenders from all areas of the prison took part in the violence reduction (VR) workshop in early December. The format was based around template questionnaires and pro-formas on the violence reduction toolkit, on the Prison Service intranet.

This prisoner consultation followed on from a similar event attended by around 50 staff in April 2009, at Haydock Park Race Course. Actions agreed at this prisoner workshop have since been incorporated into HMP Risley’s Continuous Improvement Plan, so that the plan now places more emphasis on offender involvement. This is in line with PSO 2750 on Violence Reduction, which states as a mandatory action that “….Prisoners and staff must be given opportunity and guidance to participate in and benefit from the strategy.”

The prisoner workshop was facilitated by Safer Custody Manager Mick Lathwood, Safer Custody Officer Lee Cunningham and lifer John Taft, with administrative support from Jenny Bowen.

Governing Governor Bob McColm opened and closed the workshop, and pledged his commitment to support and address whatever actions came out of the workshop at the end of the day. He also invited some of the offenders involved to present their findings to the Senior Management Team.

Mick told SCN: “Offenders really involved themselves in the task, and I was struck by their enthusiasm. The day was a great success. Although the general consensus was that safety at Risley has improved significantly in the last two years, it’s important that we keep the momentum going.”

He added that he felt confident that getting offenders to give feedback to SMT would increase managers’ awareness of the issues as seen by prisoners, and help establish common ground.

PRISONER SUGGESTIONS

Prisoners raised a number of concerns about safety. These included supervision in shower areas on the wings and in gym areas, and during movement to work activities. Risley operates a free-flow system, and whilst incidents are rare, the group felt that ‘one breach was a breach too many’. There were also concerns around the layout and supervision of the healthcare waiting room, and the potential for prisoners having their medication taken off them as well as possible assaults.

The list of things which prisoners said that they would like to see included:

- IEP sanctions for prisoners who get into debt by borrowing from other prisoners, and then need protection, to be added to Risley’s VR strategy.
- Greater involvement for prisoners in promoting safety in their own areas, by setting up their own VR committee.
- Prisoner representatives to promote VR in Risley’s local induction programme.
- Pro-social modelling training for prisoners to improve staff/offender relationships.
- More structured activity for prisoners on part-time working, to make better use of their time.
- Noise reduction policies.
- More ownership in wing cleaning materials, especially in shower areas (linked to decency agenda and sense of well-being).
- Religious artefacts publicity materials, to help prisoners understand the importance of these items to different cultures, to promote respect, and to dispel the notion that some ethnic groups are being treated more favourably than others.

NEXT STEPS

Risley is now drafting an action plan, which will give the prisoners ownership in addressing the action points highlighted on the day. Each of those involved will receive a copy. Mick said: “In effect, they are now part of the joint working party charged with conducting further improvements to the Safer Risley agenda.”

Contact: Mick Lathwood, Safer Custody Manager, HMP Risley. Tel: 01925 733000 or email: Mick.Lathwood@hmps.gsi.gov.uk
In one of the case studies detailed in this issue’s learning feature (see case three on page 12), the inquest verdict identified shouting out of the window as a contributing factor in the actions that led to the death of a vulnerable young person.

Although there is no national policy on shouting out of windows, the NOMS definition of violence makes it clear that violence is wider than physical harm, and takes account of the impact that fear (as a result of threats and intimidation) can have on well-being.

A small number of PPO investigations into self-inflicted deaths in custody have also identified shouting out of cell windows as a contributory factor. In one recent case, the deceased had complained to staff that other prisoners were targeting abusive shouting at him out of their windows.

Although some action was taken (an ACCT document was opened and the prisoner was moved to a quieter landing), the alleged anti-social behaviour was not reported, and no security incident report was made. The Governor in question accepted a PPO recommendation that he should audit the reporting of intimidation through windows, and satisfy himself that it was being dealt with appropriately.

WARREN HILL ‘SHOUTING’ SURVEY

For establishments looking for ways to investigate and tackle this issue, a good example has been set by HMYOI Warren Hill. Psychological Assistant Emma Orchard conducted a survey to gain a clearer understanding of young people’s views about shouting out of windows, with the aim of helping to reduce/prevent this behaviour.

All young people were invited to complete the survey, and 145 questionnaires were returned (a 65% response rate). The survey asked participants various questions, including whether they ever shouted out of their windows, and how often; and had anyone shouted anything offensive to them? It also asked for views about how to stop shouting out of windows, and why they thought this would help.

Results indicate a clear distinction between the majority (24 or 16.8%) who saw shouting as a continuation of social activity and not a problem, and 26 young men who did not like what was being shouted at them - though this was a recurring problem for only five. Of those that stated ‘there’s no need to stop it’, reasons given included: ‘everyone needs to talk to someone’, ‘because it’s natural to talk to people’.

A number of respondents (11 or 7.7%) suggested basic warnings as a remedy. Others proposed less punitive measures, including distraction (11) and other social interaction (15). Some suggested that showing DVDs at night would help prevent shouting out of windows, since ‘people would be more interested in the film’ or ‘people would watch film and wouldn’t bother getting out of bed to shout’.

Warren Hill has a central TV system, which allows one film to be played to all young people on in-cell TVs. However, since a small number of respondents said they shouted out of the windows to talk about what was on the TV, this would need to be taken into consideration.

Warren Hill’s Safeguarding Policy Lead Alisa Purton told SCN: “This was an impressive piece of work by Emma, and we are taking this issue very seriously. We have excellent safeguarding reps [young people] who would love to make a film to be played on induction of the possible effects of this behaviour. We are just trying to sort out the logistics and funding.”

To follow up the survey, Warren Hill put together a leaflet for young people, highlighting what the survey found - including what people said being shouted at made them feel - and urging them to: “Think before you shout”.

Kay Nooney from SCOP’s VR team said: “This report represents the very good idea of finding out about shouting from windows by asking those most affected. It is very valuable to us, as it supplies some rare factual underpinning on an issue which has attracted a lot of attention.”

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LEARNING FROM INQUEST VERDICTS

This issue, we draw some important learning points from three recent narrative inquest verdicts into deaths in custody, and subsequent Rule 43 Coroners reports. Rule 43 of the Coroner's Rules gives Coroners the power to make reports to a person or organisation where he/she believes that actions should be taken to prevent future deaths. The third case study mainly applies to establishments holding young people. For more advice about any of the ACCT procedures mentioned in this article, see PSO 2700 - Annex 8G.

Don’t forget that Safer Custody & Offender Policy (SCOP) is responsible for responding to all Rule 43 correspondence. This is to ensure that responses reflect national and local policy, and that SCOP is kept aware of issues raised by Coroners, and can share learning across the prison estate.

Coroners sometimes send Rule 43 letters directly to the relevant prison Governor. If this happens, please send copies to us immediately at: jenny.rees@noms.gsi.gov.uk and: amy.harbin@noms.gsi.gov.uk. Rule 43 correspondence must be responded to within 56 days from the date on which the letter is sent.

CASE STUDY ONE

Mr W, an adult life-sentence prisoner, had been on an ACCT continuously for two years prior to his death. He frequently spoke to prison staff about his intention to take his own life, although he had never harmed himself. A decision was taken to close his ACCT the day before his death, although he was not present at the case review.

Mr W was regularly prescribed medication, including diltiazem and the antiepileptic drug gabapentin, for various health-related ailments. He held these medicines in his own possession, as no risks had been recognised. He was accidentally prescribed a double dose of gabapentin a week before his death.

The inquest verdict stated that Mr W took his own life accidentally, not intending to die. The cause of death given was diltiazem and gabapentin toxicity with ischaemic heart disease, with paracetamol toxicity. Issues highlighted at the inquest were:

· Mr W consumed a fatal (for him due to a heart defect) quantity of drugs comprising diltiazem and gabapentin at some time during the night of 12 July and the morning of 13 July 2007.

· Side effects of gabapentin include depression, emotional problems and anxiety.

· In the two/three months prior to his death, prison doctors prescribed a significant amount of medication for Mr W without awareness that he was on an ACCT. The Coroner made a Rule 43 recommendation that there should be an alert on the healthcare system to advise staff of any prisoners on ACCT.

RESPONSE: There is no mandatory requirement to have such an alert system. However establishments must have local suicide prevention and self-harm management strategies that take account of risk. Prisons should also have local protocols covering management of information about at-risk prisoners - including information available to healthcare staff.

Mr W's ACCT plan was closed at a Case Review by a Case Manager acting alone. The Coroner made a Rule 43 recommendation that all ACCT case reviews must comprise a multi-disciplinary team.

RESPONSE: When considering whom to invite to the case review, the Unit or Case Manager should think not only of staff who have met the prisoner, but also consider who else could positively contribute. A member of staff who knows the prisoner well should attend the review (such as personal officer or the person who raised the initial concern). Where there are mental health or drugs/alcohol issues, an appropriate member of healthcare staff must be invited to contribute to the first review - in writing or by telephone if they cannot attend at short notice. A member of the Chaplaincy Team must also be invited to attend.

Each case must be treated individually and attended by staff involved in the care of the prisoner. Where a provider of any specialist service (e.g. healthcare, mental health services, substance misuse, probation, psychology, family advice, bereavement counselling) is referred to or involved in caring for an at-risk prisoner, he/she must be invited to contribute to ACCT case reviews.

The Coroner also recommended that if closure is considered at a case review, it must include the prisoner.
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Mr W was not specifically observed and monitored following the closure of the ACCT. The Coroner recommended that after the ACCT is closed, observations and monitoring should be continued until the post closure review, seven days later.

RESPONSE: There is no mandatory requirement for formal set observations after the ACCT is closed, but it would be reasonable to expect informal staff interaction with the prisoner between closure and the post-closure interview.

The ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so, i.e. the problems that caused the ACCT Plan to be opened have been resolved or reduced; the prisoner can cope with any remaining difficulties; has access to/is making use of some positives e.g. friends, family, counsellor, member of chaplaincy team, hobbies, education/employment; and knows who to contact (and how) should he/she need further support.

CASE STUDY TWO

Mr X suffered from significant mental health problems and long-term drug dependency. He had been receiving methadone maintenance treatment in the community. This treatment continued when he was remanded into custody, and he remained stable. Following a routine court appearance, he was kept overnight in a police station under Operation Safeguard (a policy introduced in 2006 to manage the shortage of prison places). The following day, he was not returned to the sending prison. Instead he was sent to the nearest local prison with available space. This prison did not prescribe methadone. Four days later, Mr X hanged himself.

The jury returned a narrative verdict which stated: "Mr X suspended himself. On the balance of probabilities we do not believe he intended to die." The jury outlined factors which it believed had contributed to his death:

- Inadequate information provided on the PER (Prisoner Escort Record) form on Mr X’s transfer to Magistrate’s Court - the statement of no known medical risk, and the fact that he was on methadone maintenance not stated prominently (as a prisoner on methadone maintenance he should have been excluded from Operation Safeguard)

- Having been locked out under Operation Safeguard and sent to a Police Station, Mr X should have been returned to a prison with methadone maintenance in place.

- Does your establishment have measures in place to ensure that all relevant information about risk - including methadone maintenance - is clearly marked on PER forms, to ensure that at-risk prisoners are returned from court to the sending establishment?

- PSO 1025 titled ‘Communicating Information About Risks on Escort or Transfer – The Prisoner Escort Record’ states that all medical holds, included those on drug maintenance programmes, should be highlighted ‘return to the discharging establishment’ (see PSO 1025, page 21, paragraph headed ‘Health Medical’).

CASE STUDY THREE

A young person (M) aged 15 was recalled to custody for breaching the terms of his licence. He had only 23 days left to serve before release, when he was found hanging in his cell. The jury returned a narrative verdict which highlighted many deficiencies in the care and support given to M.

Key issues included that the establishment where M was placed was selected on the understanding that a range of protective factors would be in place. However due to sickness, absence and confusion among staff, nobody from outside the prison visited M during his 22 days in custody - including no family or Youth Offending Team (YOT) workers.

A Detention and Training Order (DTO) planning meeting did not take place within ten working days of M’s reception into custody, as it should have. Had such a meeting taken place, those who knew M well would have been able to share their knowledge of him. In turn, this would have helped prison staff to support M more appropriately.

- How does your establishment ensure that contact is made with a young person’s next of kin within the 48 hours laid down in PSO 4950, and that DTO planning meetings take place within the required 10 day period?

M’s late arrival, hurried reception and admission onto a wing to meet an 8.30pm ‘lockdown’ deadline resulted in his risk level and confusion among staff, nobody from outside the prison visited M during his 22 days in custody - including no family or Youth Offending Team (YOT) workers. These documents were kept in the casework office which was completely separate from the wing.

- Do you have effective measures in place in your establishment to ensure that full attention is paid to Asset forms on reception and later e.g. by Personal Officers, first night and wing officers?
THIRD SECTOR LAUNCHES MENTORING CAMPAIGN

A coalition of third sector organisations has launched a campaign to provide all young adults who leave prison with mentors, to meet them at the gate and help them settle back into the community.

The ‘GateMate’ campaign is founded by The Prince’s Trust, Clinks, the Mentoring & Befriending Foundation, St Giles Trust and Catch 22. It is backed by an interactive website www.gatemate.org which allows mentoring providers to add their project details.

An online search facility means users can locate a mentoring project by region/type of service. People who have positive experiences of being mentored can add their stories to the site. It also allows providers to begin to share best practice, and enables potential mentors – including ex-offenders - to search for, and approach, an organisation that they would like to work with.

Speaking at the campaign launch in London on 21 January, GateMate campaign manager Hassan Modjiri explained that from various consultations, including a roundtable event and questionnaires sent to several prisons, it had become clear that being met at the gate by a mentor would make a real difference. He said that the next step was to get organisations to upload their details onto the website, and to encourage young offenders to use the tool, including contributing their own experiences.

To complement the GateMate campaign, Clinks has launched a set of volunteering and mentoring guides, with Ministry of Justice backing. The four guides cover: Managing Volunteers; Demonstrating Effectiveness; Setting up a Project; and External Quality Standards. They aim to deliver the best possible support, advice, and guidance to prisons, probation and the third sector involving volunteers and mentors in working with offenders and ex-offenders. You can download all four guides from the Clinks website: www.clinks.org/volunteeringguides.aspx

The jury concluded that words and phrases such as these were intimidating and were likely to have affected M’s frame of mind and contributed to the actions that led to his death.

The day before his death, M had been transferred to a wing during a full staff training day, meaning that prisoners spent most of the day in their cells. Reduced staff levels meant that prisoners on M’s new wing had had no association and were restless. This led to heightened shouting through the windows on the night of his death, ranging from a general ‘shout out’ asking where new prisoners were from, to vicious and nasty abuse including invitations to “string up”.

The jury concluded that words and phrases such as these were intimidating and were likely to have affected M’s frame of mind and contributed to the actions that led to his death.

The jury also identified an ineffective interpretation of the Personal Officer Policy and prison officers with incomplete and inconsistent Juvenile Awareness Staff Training. An induction process with sessions where trainers failed to attend, and where modules were inappropriate for the length of M’s sentence and his age, meant that an accurate picture of M and his needs was never established.

By Martine Tranter, PPO Liaison & Casework Team, SCOP.
TV NIGHT-TIME WARNING

We recently (SCN Sept/Oct 2009, pg 15) reported on options to avoid disturbing at-risk prisoners or their cell mate during night-time observations. The term ‘observations’ refers to checks made on the prisoner whilst he/she is asleep, in contrast to supportive daytime ‘interactions’, when staff talk with the prisoner.

One option we mentioned was leaving in-cell TVs on (but muted) overnight. However Estate Capacity Directorate, Technical Services, has since advised that establishments should not leave cell TVs on overnight for observation purposes, as this presents a potential fire hazard.

Please ensure that local instructions about staff conversations with/observations of at-risk prisoners (see PSO 2700, para 8.7.2) do not recommend leaving in-cell TVs on overnight as a way of reducing sleep disturbance.

IAP WEBSITE GOES LIVE

The Independent Advisory Panel (IAP), a key part of the ‘Ministerial Council on Deaths in Custody’, has launched a new independent website for practitioners and other interested parties.

The IAP’s role is to provide independent advice and expertise to ministers on deaths in all forms of state custody – prisons, police, approved premises, immigration and those detained under the Mental Health Act in hospitals.

The website (http://iapdeathsincustody.independent.gov.uk/ ) includes details about the Panel members, minutes of IAP meetings, news, learning from deaths and near deaths in custody, relevant research and good practice documents from across the custody sectors, guidance on policy and best practice produced by the IAP, consultation exercises, e-bulletins and links to relevant external websites.

Announcing the website launch, IAP Chair Lord Toby Harris said: ‘The IAP is committed to consulting and engaging with a wide range of stakeholders in order to collect, analyse and disseminate relevant information about deaths in custody and the lessons that can be learned from them. The aim is that as the website develops, it will be used as a resource for those working within the different custodial sectors to share good practice and learning on preventing and reducing the number of deaths in custody.”

For further information about the IAP website or the work of the Ministerial Council, you can contact the Ministerial Council’s Deputy Head of Secretariat, Matt Leng. Email: matthew.leng@noms.gsi.gov.uk or phone: 020 7217 8547.