Independent Review into Self-Inflicted Deaths in NOMS Custody of 18-24 year olds
Call for Submissions

Foreword by Lord Toby Harris

When I accepted the invitation from the Minister for Prisons to lead this Independent Review into Self-inflicted Deaths of 18-24 year olds in National Offender Management Service (NOMS) Custody, I was very conscious that this would be a once in a generation opportunity to improve the management of some of the most vulnerable people in custody.

All self-inflicted deaths are a tragedy and those that occur whilst individuals are under the protection of the state must be subject to the most thorough scrutiny. These tragic deaths have raised concerns not only from their bereaved families, but have generated criticism of processes from interested organisations and individuals.

I am determined that this review will pull together the key learning from these deaths so that we can help ensure that 18-24 year olds, and indeed vulnerable people in all age groups, including children, do not continue to die when they are under the protection of the state. I am pleased that all members of the Independent Advisory Panel on Deaths in Custody have accepted my invitation to join this review which will be enriched by the experience and expertise they will provide.

I want to develop a coherent set of recommendations that, once implemented, will help NOMS manage all offenders in a manner more conducive to their safety and well-being.

I invite you to share with us your expertise, experience, interest, and reflections so that we can take them into account in this important piece of work.

Lord Toby Harris

Introduction

On 6th February 2014 the Justice Secretary announced an independent review into self-inflicted deaths in National Offender Management Service custody of 18-24 year olds and invited Lord Toby Harris, Chair of the Independent Advisory Panel on Deaths in Custody to conduct it.

The purpose of the review is to make recommendations to reduce the risk of future self-inflicted deaths in custody. The review will focus on issues including vulnerability, information sharing, safety, staff prisoner relationships, family contact, and staff training and will seek these through this call for submissions alongside

existing and commissioned research and meetings with stakeholders and people affected and interested more broadly.

This review is examining cases since the roll out of Assessment, Care in Custody and Teamwork (ACCT) – the care planning system for prisoners identified as at risk of suicide or self-harm. ACCT roll out was completed on 1st April 2007. From 1st April 2007 until 31st December 2013 there were 84 recorded self-inflicted deaths among 18-24 year olds in custody; this represents 19% of all recorded self-inflicted deaths in this period.

We would strongly welcome your contribution to the review and would like to invite you to make a submission to support the review process. Your submission can be based on your personal or professional experience, your organisation's experience, or knowledge from research or other means and need not conform to any specific format.

To give us the best chance of considering them, submissions should be received by midnight on 18th July 2014.

We have set out below a number of questions, which are potentially relevant to the Review and which we may want to examine during the course of our work. While we will be very interested in receiving submissions that cover these questions, at the same time, you are not limited by them. If there is something else that you would like to say, you should feel free to do so. Similarly, you should not feel obliged to respond to every question - please select questions that are most relevant to your experience and skills.

Please let us have any examples, case studies, research or other types of evidence to support your views.

All submissions to the review may be made available in the public domain unless you make it clear, at the time of submission, that you do not agree to this. Any information released will be protected under the Data Protection Act.

Identification of Vulnerability

1. How would you define 'vulnerability' in terms of a young person (under 24 years) who is in NOMS custody? What factors in their previous experiences are most likely to increase their vulnerability?

2. At what points in their journey through custody are young people most vulnerable?

3. How can systems and processes be improved in terms of identifying which young people in custody are most vulnerable and at risk of self-inflicted death?

4. How can vulnerability be better identified in custody in terms of:

    i. Mental health needs
    ii. Age
    iii. Maturity
    iv. Drug use
    v. Alcohol use
    vi. Gender
    vii. Location/distance from home
    viii. Bereavement
    ix. Learning difficulties
    x. Communication disorders
    xi. Educational needs
    xii. Physical limitations
    xiii. Other

5. Are there any bespoke tools that would assist in identifying particular types of vulnerability?

6. Do attitudes and behaviour contribute to vulnerability; staff/staff, staff/prisoner and prisoner/prisoner?

Information sharing

7. (a) What are the biggest barriers to effective information sharing about potential vulnerabilities within the criminal justice system?

   (b) How these might be overcome, particularly in the context of existing resource constraints?

8. How can information sharing be improved and better utilised to identify vulnerable young people and what information should be provided from:

   i. Within the criminal justice system?
   ii. Within an institution?
   iii. From external agencies?

9. How can mental healthcare provision be improved to meet the needs of young people more effectively, in terms of:

   i. Information sharing pre-custody
   ii. Information sharing in custody
   iii. Information sharing post-custody.

10. In the context of self-inflicted deaths in custody, how can any learning and best practice from the youth secure estate be best applied to the adult secure estate?

Management of ACCT

11. Have the aims of Assessment, Care in Custody and Teamwork (ACCT), which is intended to reduce risk for those identified as at risk of suicide or self-harm, been achieved?

12. Has the identification and management of individuals at risk of self-harming improved since ACCT replaced F2052SH (the previous system used to manage those in custody believed to be at risk of suicide or self-harm)?

13. Are ACCT documents being appropriately opened and closed?

   i. Should an ACCT be opened more frequently for this age group?
   ii. Is the document adequate for managing the risk in this age group?

14. Are the right people contributing to the ACCT document?

15. How can the ACCT management process be improved to better ensure the needs of those identified as at risk are more effectively met?

16. Are relevant mental health needs sufficiently covered in current ACCT processes?

Management of Vulnerability in Custody

17. How might we most effectively take into account the needs and particular vulnerabilities of specific groups, including ethnic minorities?

18. When a young person is remanded or sentenced to custody, what issues should be taken into account in terms of initial allocation into an institution, and any subsequent transfers to minimise risk of self-harm and self-inflicted death?

19. (a) Do you think the recent changes to the Incentives and Earned Privileges scheme, which means those sentenced to custody will have to work towards their own rehabilitation to earn privileges - they will not receive them through good behaviour alone - have an effect on vulnerable young people in custody?

    (b) If your answer is yes, please set out why you think this is the case, noting in your answer any evidence, case studies or research that show why this is particularly the case for this age group.

20. How do you think that processes to support young adults who are transferring from the youth estate to the young adult estate can be improved to help mitigate risk of self-inflicted death?

21. (a) Are 'safer cells' effective or not, and why? (Safer cells are cells that can assist staff in the task of managing those at risk from suicide by ligaturing. Safer cells are designed not only to minimise ligature points, but also to create a more normalising environment.)

    (b) Does more need to be done to reduce the number of ligature points in cells?

    (c) What could be done further to improve the design of safer cells?

22. In the context of self-inflicted deaths, how can safety, including violence reduction and bullying, be improved in custody in terms of:

    i. Effectiveness of systems to report violence and bullying (both by inmates and by staff).
    ii. Effectiveness of systems to tackle violence and bullying (both by inmates and by staff).
    iii. Reducing access to dangerous items or materials.
    iv. Availability of safer cells.
    v. Prescription drug sharing.
    vi. Illegal drug use.
    vii. Effectiveness of emergency response systems
    viii. Role of external agencies.
    ix. Observation of those identified as at risk including timed observations and CCTV.

23. Are emergency procedures sufficiently well-developed both within prisons but also in respect of other agencies to deal with self-inflicted injuries as swiftly and effectively as possible? How could they be improved?

Procedures following a self-inflicted death in custody

24. How can investigations into self-inflicted deaths in custody be improved, in terms of:

    i. Prison and Probation Ombudsman (PPO) processes.
    ii. Inquest procedures
    iii. Opportunities for family input into investigations.
    iv. Ability of the Inquest and PPO to consider the context of a particular death.

25. How might arrangements around Legal Aid better take into account the needs of bereaved families?

26. How might processes be improved immediately following a self-inflicted death so that valuable information at the scene of the incident is better preserved and recorded?

27. How might the learning from deaths be better disseminated?

Staff Training

28. Are staff trained and prepared effectively for working with vulnerable young people?

29. What specific skills do you think staff working with young people should be supported to develop so they can better identify and manage vulnerability?

30. Should volunteers be used to identify and manage individuals at risk, and if so how?

31. Are 'listeners' being used to best effect?

32. How should staff be sufficiently trained so that vulnerability is effectively reported and acted upon?

Family, support network

33. How might the arrangements around family and support network contact be improved to:

    i. Support vulnerable young people?
    ii. Better ensure families and friends can alert establishments to concerns?