Dear Sir / Madam

Below is my (final) revised submission to the Harris Review on child deaths in custody (many apologies but I noted some errors in the previous versions).

The submission is based on a publication and full references for all quotations and data cited below can be found in:

Scott, D. and Codd, H. (2010) Controversial Issues in Prison Buckingham: Open University Press.

Sincerely

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Self inflicted deaths: Formal Submission to Harris Review October 29th 2014

Self inflicted deaths in prison are one of the most disturbing features of the confinement project. It is estimated that around 200 people die in prison each year. Approximately three prisoners kill themselves every two weeks, with a slightly higher number of 'natural' deaths in custody over the same period. The likelihood of a prisoner taking their own life is between four and eleven times higher than the general population. A self inflicted death occurs when somebody takes their own life but only becomes a suicide if the person intended to die. In recent decades such deaths have been reasonably high on the Prison Service agenda but they have not always received major public, political or media interest. As Professor Mick Ryan has pointed out, in the 1940s, 1950s and 1960s few people paid much attention and prisoner deaths were largely unreported. By the early 1980s, however, deaths in prison once again became recognised as a serious cause for concern, largely because of consistent lobbying from prisoners' families and friends, often channelled through the pressure group INQUEST.

The death of Christine Scott, aged 19, who died from a subdural haemorrhage at Holloway in 1982, was one of the first self inflicted deaths to receive major media attention in recent times. In this tragic case Christine died from throwing herself repeatedly around her cell. Whilst isolated deaths continued to create controversy, media and political attention gained serious momentum from the 1980s through focusing on the clustering of deaths in particular penal institutions. In 1984 HMP Brixton recorded ten deaths in a period of just over 12 months whilst the same prison grabbed the headlines again in 1989 when it was revealed that 11 prisoners had died that year, eight being self inflicted. In a period of less than 30 months from 1987-89 11 self inflicted deaths were recorded at Risley Remand Centre, earning it the nickname 'Grisly Risley'. Five young men aged from 17 and 19 died while on remand at HMP Armley between May 1988 and February 1989. A further teenager died at Armley prison in 1990 whilst between August 1991 and March 1992 four young offenders, including a 15 year old, took their lives at Feltham YOI.

Cluster deaths have not been restricted to young male offenders but plague all aspects of the penal estate. Six women hanged themselves in a three-year period from 2002 to 2005 at HMP Durham H wing, whilst from August 2002 and September 2003 six women took their lives at HMP Styal, the latter sad events leading to the commissioning of the Corston report. There have also been cluster deaths among adult male prisoners. In one recent example five prisoners killed themselves at HMP Whitemoor between 19 November 2006 and 10 December 2007.

For some writers, such as Professor Alison Liebling, there exists a continuum of self-destructive behaviour encompassing a range of self injurious acts. It is argued that self harm and 'suicide' arise from psychological pain and operate as a continuum on a 'pathway to despair'. Yet most acts of self harm do not endanger life and it seems more appropriate to understand this action as primarily a means to release pain. A prisoner who self harms is probably trying to find a way of dealing with

negative feelings by turning mental pain into physical pain. Self harm then is a step on the 'pathway to survival' rather than the 'pathway to despair'.

Whether a self inflicted death is defined as a 'suicide' is influenced by the circumstances leading up to the death, the manner in which the person has died, their social background and the location where the act occurred. A self inflicted death in prison is more likely to be defined as a 'suicide' if it is undertaken by a man, occurs during the night and happens at the weekend. Around 90% of prison 'suicides' are accomplished by hanging and historically 'suicide' verdicts are more likely to be reached if the death occurs in the healthcare centre [prison hospital] or segregation unit. Generally there has to be a communication of intent, such as through a suicide note. Under the Suicide Act (1961) it must be proved beyond all reasonable doubt that the act was 'suicide'. If there is ambiguity or the death could be understood as an accident then it cannot be officially defined as suicide.

Deaths in custody have been largely framed through the psycho-medical model resulting in a focus upon individual pathologies rather than penal institutions. The deployment of this interpretive lens informs dividing practices which attempt to identify, classify and profile suicidal risk, often linking self inflicted deaths with 'abnormal' people with serious mental health problems. Yet, the analytical purchase gained from such assumptions is remarkably limited. Even if a person who takes their life has mental health problems this cannot tell us why they took their life at that specific time or provide any insight into the distinct set of interpersonal dynamics leading up to the act.

It has proved exceptionally difficult to identify the manner in which mental health problems actually relate to suicidal attempts or to differentiate the 'suicidal' from the rest of the prison population. One of the key issues here is evidence of the prevalence of suicidal thoughts among prisoners, with a number of recent studies identifying high levels of suicidal ideation. It has been estimated that 46% of male remand prisoners have thought of 'suicide' in their lifetime, and that 40% of male prisoners and 55% of female prisoners experience suicidal thoughts in their lifetime, compared with 14% of men and 4% of women living in the wider community. Whilst many people in prison do have mental health problems, those who commit 'suicide' are less likely to have a psychiatric history than those on the outside who take their own lives.

It seems much more plausible to focus on how self inflicted deaths are a socially negotiated process where the final decision to end life is influenced by the interpretations and expectations of significant others. A suicidal attempt may be a frantic and desperate attempt to 'solve problems of living'. If the response to this situation is hopeless and there is an explicit or implicit expectation that the individual will take their life, this negative communication may erode any sense of hope and facilitate a suicide attempt. Self inflicted deaths then should be conceived as a social problem where those who take their own lives are responding to given temporal, spatial and emotional contexts.

Official discourse has generally privileged explanations where the person who died is understood as being personally culpable for their own death. The individual character and social background of the person who died is identified as pathological: they were 'weak' or 'high risk inadequates' who would have committed 'suicide' whether they were in prison or not. Their death is directly linked to vulnerabilities and risk factors that existed prior to imprisonment such as unemployment, substance misuse, mental health problems, child abuse, and social isolation or through the nature of their offence, such as spouse killers, or sentence length. Alongside this there exists an even cruder notion of individual inadequacy that is closely associated with the traditional prison officer working personality. Prisoners are placed at great psychic distance and successfully 'othered', thus preventing any possible empathy and acknowledgement of prisoner suffering. Negative categorisations justify hostility, neglect and moral indifference, and leads to the blame of prisoners for their own dreadful predicament. Those who harm themselves or attempt to take their own lives

are labelled as childish and pathetic manipulators whose harming act is part of a 'general display of attention-seeking behaviour'.

Self inflicted deaths have also been explained as an inability to cope with degrading prison conditions. From this perspective the prison environment can be healthy and safe for people with vulnerabilities but becomes dangerous when it falls below certain standards. Particular focus has been on prison crowding. It has long been recognised that most self inflicted deaths take place in the most crowded prisons. Prison crowding is seen as exacerbating the structural deprivations of imprisonment, leading to idleness; limited constructive activities; difficulties in carrying out risk assessments; shortages of essential resources; greater unpredictability of daily life; increases in situational induced stress; increased opportunities for violence and intimidation; and increased staff/prisoner ratios. It may also lead to more vulnerable people being imprisoned. In 2014 there has been a resurgence of this argument. The official line in the past has been that prison crowding does not increase self inflicted deaths. In fact it is argued that it does the opposite as it is believed that cell sharing can be used as a preventative strategy. Whilst it is important to consider the situational context, 'surviving the prison place', as Professor Diana Medlicott has argued, is much more complex than just coping with physical conditions.

It has also been asserted by commentators such as Professor Liebling that self inflicted deaths arise from a combination of 'risky prisoners', who may or may not be psychiatrically ill, with an inability to cope with the stress of confinement. The suicidal prisoner is considered to suffer from fear, depression, despondency and hopelessness and a general inability to adapt to prison life. The poorly managed prison is conceived as highly stressful turning already existing emotional disturbances into suicidal ideation. Suicidal prisoners simply do not have the personal resources to cope with the deprivations of an 'unhealthy' and poorly performing prison.

It is argued by Professor Liebling and others that the pains of imprisonment are concentrated at particular points in the prison sentence, with the start of a prison sentence entailing the greatest levels of stress. It should not be forgotten though that the penal environment can undermine constructions of the self for all prisoners. Life in the prison place should be seen as a humiliating and unsafe experience perpetuating fear and loathing on a daily basis. As Professor Medlicott has correctly argued dividing prisoners between 'copers' and 'non-copers' provides only false assumptions about who may be suicide prone. And, as Professor Stan Cohen pointed out some years ago, most prisoners only just cope as the 'prison place' fosters an existential crisis, ultimately leaving some people literally 'shattered'. The real pains of imprisonment are not to be found in the given quality of living conditions, relationships with staff or levels of crowding, but in the denial of personal autonomy, feelings of time consciousness, and the lack of an effective vocabulary to express the hardship of watching life waste away. Deaths in prison should not then be considered as aberrations or malfunctions of the system but rather traced back to the daily processes of imprisonment itself.

It is also clear that custody is experienced differently by young people. Young people are emotionally vulnerable and more likely to find the loss of personal relationships on the outside harder to cope with than adults. Although there are high levels of mental health problems among young people in prison, it seems that the deaths of young people in custody may be more situationally specific to the prison place than those by adults. Young people also have less life experience on which to rely to help to deal with problems associated with prison life, or to manage a suicidal impulse when things are looking bleak. From 1990 - 2007 there were 30 child deaths in custody and 1,695 incidents of self injury or attempted suicide by children from 1998 – 2002. There are also concerns child deaths are more likely to cluster in particular establishments.

As the Prison Service only began to release data on all self inflicted deaths in the mid 1990s any discussion of increases or decreases in death rates must be approached with some caution. There are also a number of common methodological weaknesses with a number of historical studies on deaths in prison. Most of the main reviews include deaths only when a verdict of 'suicide' has been officially established; utilise prison service records only; lack control groups; and are firmly rooted in the assumptions of individual pathologies. Historically, coroners have erred on the side of caution leading to many open verdicts, whilst it also remains possible that some non-suicidal deaths might be deliberately re-designated to avoid an embarrassing scandal. In short, we cannot assume that the recorded data on suicide attempts and self injury bear any valid resemblance to the 'true incidence' of such behaviour.

Given such substantial limitations we should also be careful of what lessons we learn from official data. Official self inflicted death rates are often interpreted as indicating that prisoners are more vulnerable to suicidal ideation at the early stages of custody, and it has long been taken as a given that one of the most vulnerable times is when on remand. Approximately a half of all self-inflicted deaths occur within a month of the prisoner arriving at that establishment, with a third occurring in the first seven days. This data implies that the more time a person spends in prison the lower the likelihood of them taking their own life. Risk of suicidal ideation is expected to be concentrated upon those people who have not yet adapted to incarceration, implying that the prisoner's ability to adapt is central to their survival.

A very different picture emerges, however, when alternative techniques of analysing the data are deployed. A study by Dr David Crighton in 2006 of 525 of the 600 self-inflicted deaths in prisons in England and Wales from 1988 - 1998 found that any changes to the prison place, irrespective of the amount of time spent in custody, gave rise to increased risk of suicidal ideation. Whilst it should be acknowledged that the early period of imprisonment is a time of exceptional risk, transfers to a new prison, or even different parts of the same prison, also give rise to new problems.

Perhaps it is the time spent in any given institution that is important to understanding 'suicides' and self inflicted deaths. The shorter the period of time in a given prison environment, the greater the difficulty a person has in coping with everyday life. Therefore, to focus on remand prisoners at the expense of sentenced prisoners is 'fundamentally misguided' as people on remand are only at a higher degree of risk because they spend relatively short periods of time in a given prison. Uusing death rates based upon the average daily population gives an inflated risk for remand prisoners. In the 2006 Crighton study, for example, 10% of those who took their own lives did so within 24 hours of being transferred from another establishment. Significantly, this figure accounts for just under half of all those who take their own lives within 24 hours of reception into prison.

When looking at average daily populations (ADP), the rate of self inflicted deaths by people on remand appears to be very high. Yet when the figures are calculated via reception into the Prison Service, the rate (39 per 100,000 receptions) is much lower and closely resembles the rate for sentenced prisoners, which stood at 31 per 100,000 receptions for the period 1988-1995.

These findings challenge the idea that prisoners develop coping skills and strategies as custody progresses. Adaptation is not a permanent state of affairs. Coping mechanisms are tenuous and easily eroded. Fear, anxiety of the unknown and the potential harms that imprisonment deliver have profound negative impacts that do not pass with time. Any notion that there exist stages in a person's adaption to 'prison life' is limited as any progress is reversible. The above analysis indicates then that 'coping' and 'non-coping' with prison life are matters of degree that fluctuate over time and all prisoners are vulnerable to suicidal ideation.

In 1973 the first explicit prison suicide policy was introduced by the Prison Department in the guise of Circular Instruction (CI) 39/73. Primarily an exercise in suicide awareness, CI 39/73 established the use of what became known as the 'F' marking system, where prisoners identified as a potential suicidal risk had a large red 'F' placed on their files. Responsibility for perceived suicidal prisoners lay firmly with the medical officer and the primary response was to isolate them in the prison medical centre.

Current policies on self inflicted deaths find their roots in the 1990 HMCIP thematic review of 'suicide and self-harm', widely known as the Tumin Report. The Tumin Report challenged the myths around the connections with mental health problems, stipulating that the suicide prevention should be conceived as social rather than 'medical problem'. In 1991 the Prison Service established the 'Suicide Awareness Support Unit' (SASU) and in the same year the first Listener/Buddy Scheme, where selected prisoners are trained by the Samaritans, was established at HMP Swansea. A guidance pack, 'Caring for the Suicidal in Custody' was also published in 1991 and a revised strategy introduced in 1992 utilising a new form, F2052SH (Self-Harm at Risk). The F2052SH could be activated by any member of staff rather than being the exclusive domain of healthcare staff.

In 1999 HMCIP published the thematic review Suicide is Everyone's Concern which maintained that whilst the current policies were largely well conceived for adult male prisons they had been poorly implemented and neglected the needs of women, young prisoners and those on remand in local prisons. The HMCIP also pointed to management failings, inadequate training of staff and poor communication about prisoners who were suicidal and placed much greater emphasis on environmental factors. This highly influential report wished to facilitate safe and 'healthy prisons' and in response the newly established Safer Custody Group appointed 30 full-time suicide prevention co-ordinators at 30 of the highest risk penal establishments in November 2000 as part of its new Safer Locals Strategy. This initiative was followed up in November 2002 with a new Prison Service Order (PSO 2700) entitled Suicide and Self-Harm Prevention which aimed to provide a 'holistic approach' rooted in risk reduction.

The F2052SH proved to be inflexible, mechanistic, poorly implemented, and under-resourced. Notions of 'shared responsibility' in practice led to 'diminished responsibility'. It focussed on observing rather than actively caring for prisoners and only heightened surveillance and prisoners' sense of shame. Prisoner input was marginalised and constructions of 'suicidal risk' focused on past behaviour rather than present needs. In practice the scheme became swamped by prisoners who saw it as the only way that their needs would be addressed.

In 2002 F2052SH was evaluated by Manchester University Department of Health and as a result in January 2004 the Prison Service introduced its current strategy, the ACCT (Assessment, Care in Custody and Teamwork). Its rationale is to 'work together to create a safe and caring environment, where distress is minimised and those who are distressed are able to ask for help'. The ACCT is based on three levels of risk (low, medium, high) and any member of staff that identifies a prisoner at risk can open an ACCT Plan. An 'Immediate Action Plan' is drawn up within 24 hours which aims to keep the prisoner safe until further assessments are undertaken. A Care and Management Plan (CAREMAP) is then agreed with the prisoner and a case manager appointed. A person at risk is now to be located in a safe environment, which is understood as anywhere the person at risk feels 'safe, comfortable and relaxed' which could be their own cell, a shared cell, a 'safer cell' or in the healthcare centre. Prisons, however, cannot be turned into truly safe environments as practices are shackled by the profoundly punitive nature of confinement.

Under the ACCT responsibility has moved from medical personnel to multi-disciplinary management but this has led to the removal of responsibility from specialist staff. There are also problems around

information breakdown and concerns that the increased emphasis monitoring may result in highly intrusive dividing practices serving institutional, rather than individual, need. The ACCT is underscored by the logic on individual risk and it is assumed that if assessments can be made more accessible and delivered with greater haste, then self inflicted deaths can be effectively managed. It is significant to note that only around a quarter of those who take their own lives have been identified by prison authorities as being at risk of suicide. Following then the insights of Professor Diana Medlicott in her book Surviving The Prison Place, the ACCT fails to acknowledge that the key problem is the potential vulnerability of every prisoner and as such it's practices simply reinforce the labelling of certain prisoners as 'vulnerable', thus implying that 'the rest are invulnerable'. Without question situational preventions and safer cells cannot address psychological pains of imprisonment meaning that it is likely that the ACCT will only address the surface manifestations of the problem.

The number of different policies and procedures over the last forty years indicate just how badly the Prison Service is failing to protect people in prison. The problem is not to do with physical conditions and crowding but derives from the very workings of the prison regime itself. Interventions should be directed at helping people vulnerable to suicidal ideation to develop new meanings and alternative strategies that can help them take their lives forward. Central is the nurturing of hope and the prison is the very last place to try and do this. The most rational solution then seems to be for the adoption of social policies that can provide immediate humanitarian support to people who are suicidal and the diversion away from prison for wrongdoers who are especially vulnerable to the development of suicidal ideation. Given the high numbers of prisoners with suicidal thoughts, and their interconnection with other vulnerabilities, this raises key questions regarding the use of imprisonment at all.

[This submission is a revised and edited version of a chapter I wrote in Scott, D. and Codd, H. (2010) Controversial Issues in Prisons Buckingham: Open University Press. The full references for all quotations in this text and all other data cited in the submission can be found in this chapter and full details of sources in the bibliography of the book.]