SAFER CELLS EVALUATION

FULL REPORT

Tamara Burrows, Andrew P. Brock, Susie Hulley,
Chloe Smith and Lucía Summers

The Jill Dando Institute of Crime Science
University College London
Third Floor, 1 Old Street
London EC1V 9HL
Tel 020 7324 3000 Fax 020 7324 3003
Email: jdi@ucl.ac.uk
www.jdi.ucl.ac.uk

ABOUT THIS REPORT

1. In response to a spate of suicides by hanging, the Prison Service of England and Wales developed a 'safer cells' programme. This report assesses the extent to which this programme has affected rates of self-harm and suicide in 6 of the establishments in which it has been introduced. It also attempts to answer the following 5 research questions set by the Prison Service:

   - How are safer cells being used? Which prisoners are placed in safer cells? For what reasons?
   - How do other methods compare with safer cells?
   - How do prisoners and staff feel about safer cells? Are there any unintended negative consequences of using safer cells?
   - Is there any evidence that prisoners benefit from being placed in a safer cell?
   - Are safer cells more useful for certain groups of prisoners than others, for example taking account of gender/age differences in methods of self-harm?

2. The following methods were used in the evaluation (for more detailed information on methods, see Appendix A):

   - Interviews with around 10 prisoners from each prison,
   - 1 staff focus group at each prison,
   - Questionnaires to around 100 prison staff, across the 6 prisons
   - Discussions with SPCs from each prison,
   - Individual record analysis of 10 self-harming women prisoners, and
   - Analysis of suicide and self-harm data in each prison.

3. There are a number of caveats to the results. It is difficult to draw firm conclusions, first because of the low basic rate of suicide in most establishments and secondly because safer cells do not share a common design and have not been used for the purpose for which they were intended in all establishments. This clearly makes evaluation of the effect on suicide difficult. The work was also carried out in a short time frame with a limited budget. Nevertheless, we feel that we can provide some advice to the Prison Service on how this policy might be developed in a useful but cost-effective manner.

The remainder of the report falls into 8 chapters:

CHAPTER 1: SUICIDE AND SELF-HARM IN PRISON

Defining and Measuring Suicide and Self-Harm in Prisons

4. Research into suicide is problematic. It is clearly impossible to ask those who have killed themselves why they did so. Researchers are forced to draw on secondary sources such as interviews with staff, relatives and friends. Such studies involve retrospective analysis and thus suffer from a number of methodological weaknesses (Towl, Snow & McHugh, 2000). In an attempt to overcome this, many researchers have focused on individuals who have either attempted suicide or intentionally injured themselves. This approach is based on the notion that suicide represents an extreme end of a continuum of self-injurious behaviours, a view that has received some empirical support (Towl, Snow & McHugh, 2000) but still remains in dispute (Kreitman, 1977).

5. Although the notion of a continuum may be relevant for some individuals, it is not necessarily so for all. McHugh and Towl (1997) note how terms such as 'self-injury' and 'attempted suicide' present problems of definition. Specifically, individuals may self-injure either with or without any intention to end their lives. Kreitman, Phillip, Greer et al (1969) proposed the term 'parasuicide' to describe behaviours displayed by an individual to parody suicide where there was no intention to end life. Kreitman (1977) argues that these two forms of behaviour are distinct in terms of epidemiology and phenomenology. He suggests that they represent separate but overlapping phenomena since many people who do commit suicide have a history of self-harming behaviours. If this position is accepted, then studies of individuals who engage in self-injurious behaviours, whilst being very valuable in their own terms, will not necessarily provide useful information about suicide. However, due to the increasing support for the first perspective (Liebling & Krarup, 1993), in this report, we have chosen to adopt the notion that suicide represents an extreme end of a continuum of self-injurious behaviour and therefore include research examining self-harm.

6. Ireland (2000) discusses the perceived lethality of injurious behaviour. Researchers have argued that, if the methods by which individuals choose to harm themselves are not highly lethal, then this act can be described as 'deliberate self-injury' in contrast to 'attempted suicide'. However, Livingston (1997) indicates that the concept of 'deliberate self-injury' cannot be applied in a prison context, as it is common for prisoners to select a highly lethal method of self-injury (such as hanging) and yet have a low level of suicidal intent. Livingston instead chooses to group a wide range of self-injurious behaviours under a single term, 'self-injurious behaviour'.

7. A further problem confronting research into suicide relates to the process of reporting. Some authors (e.g. Hassan, 1995) have argued that suicide is always under-reported because of the legal criteria for determining suicide. According to a Safer Custody Group report (2002a), a coroner holds an inquest into all deaths in custody and a 'suicide' verdict is only returned if there is clear evidence that an individual intended to end their life. If there is any doubt regarding the individual's intent to die, an open verdict or a verdict of death by accident or misadventure will be recorded. Dooley (1990) points out that up to 35% of deaths considered 'open' or 'misadventures' in prison were probably suicides. Further, there are

considerable differences between individual coroners in making judgements (Atkinson, 1978; Towl & Crighton, 1998).

8. Since 1991, the Prison Service has adopted the term 'self-inflicted death' to refer to all apparent suicides in custody. This all-embracing description covers all deaths arising from non-natural causes that appeared to be directly caused by the actions of the individual concerned.

9. There is also some uncertainty as to the best measure of suicide rate in the prison context. Studies have calculated suicide rates by measuring these against the average daily population or total receptions ('throughput'). Towl and Crighton (1998) suggest that self-inflicted death rates as a proportion of average daily population are likely to produce an over-estimate of the true rate because more individuals will have been received in establishments throughout a given period, and therefore more will be at risk of suicide. In contrast, calculations based on total receptions are likely to produce an under-estimate of suicide, partly due to double counting of individuals coming and going to court, etc.

10. The Royal College of Psychiatrists (2002) response to the Thematic Review on Suicide in Prisons produced by Her Majesty's Chief Inspector of Prisons for England and Wales (1999) questioned whether suicide rates should be used to measure the effectiveness of suicide prevention strategies. Suicide rates, even in prisons, are too low to be taken as a measure of effectiveness, except over several years. The report suggests that more routine measures of related phenomenon such as lesser forms of destructive behaviour would be preferable.

11. There are, then, a number of problems associated with the definition and measurement of suicide and self-harm in general and in the prison context in particular. In this report we have chosen to adopt the Prison Service's definition of 'self-inflicted deaths'. Where the term 'suicide' is used in this report, it should be viewed as referring to self-inflicted deaths.

The extent of the problem

Self-Inflicted Deaths

12. Since the early 1980s, great concern has been expressed in the UK regarding rising prison suicide rates (Camilleri, McArthur & Webb, 1999). There has been a marked increase in both the number and rate of self-inflicted deaths over the past two decades. The rate of self-inflicted deaths amongst prisoners increased 40% during the 1990s. The Safer Custody Group (2002a) does note, however, that the rate of self-inflicted deaths for 2001 was 22% lower than the highest recorded rate in 1999. Nevertheless, despite the recent reductions, the overall trend is upward (see Figure 1). The figures for 2002 show a rise of 29% on 2001 levels to 94 incidents, representing the highest ever annual figure (The Howard League, 2003, unpublished). Based on the average population figure of 70,860, the self-inflicted death rate for 2002 is 132.7 per 100,000 inmates.

13. In 1979, Topp (1979) calculated the suicide rate to be 42 per 100,000 (using daily average population) in what is widely cited as the first empirical study into suicides. In 1989 it was estimated that the suicide rate in prison was four times that of the

general population and by 1993, despite implementing a number of recommendations of the Chief Inspector of Prisons, the rate was estimated to be 56 per 100,000 and rising (Liebling & Krarup, 1993).

14. It is important to note, however, that the report produced by the Royal College of Psychiatrists (2002) suggests that, although suicide rates in prison are high, they are not necessarily higher than can be expected given the vulnerable nature of the individuals who are sent to prison.

Self-Harm

15. The high rates of self-harm in UK prisons is also concerning. The data have not been very reliable until recently. The most recent and reliable figures indicate that there were 3,667 incidents of self-harm recorded across the prison estate in the first quarter of 2003 (Safer Custody Group, 2003, unpublished report). The number of incidents of self-harm by women is disproportionate to their representation within the prison population as is the number of self-harm incidents by male juveniles. Women were 9 times more likely to injure themselves than adult males in Category B Locals or young offenders. Juvenile males are 1.5 times more likely to injure themselves than young offenders.

16. Historically, only a limited number of studies have been conducted into self-harm in prison (Wool & Dooley, 1987; Camilleri et al, 1999) and data on the extent of self-harm in prisons in the UK are not easily available. Further, self-harm is more difficult than suicide to measure. Records rely on staff making a subjective judgement about an individual's intention to kill themselves. This is one factor leading to the inconsistent reporting of self-harm incidents.

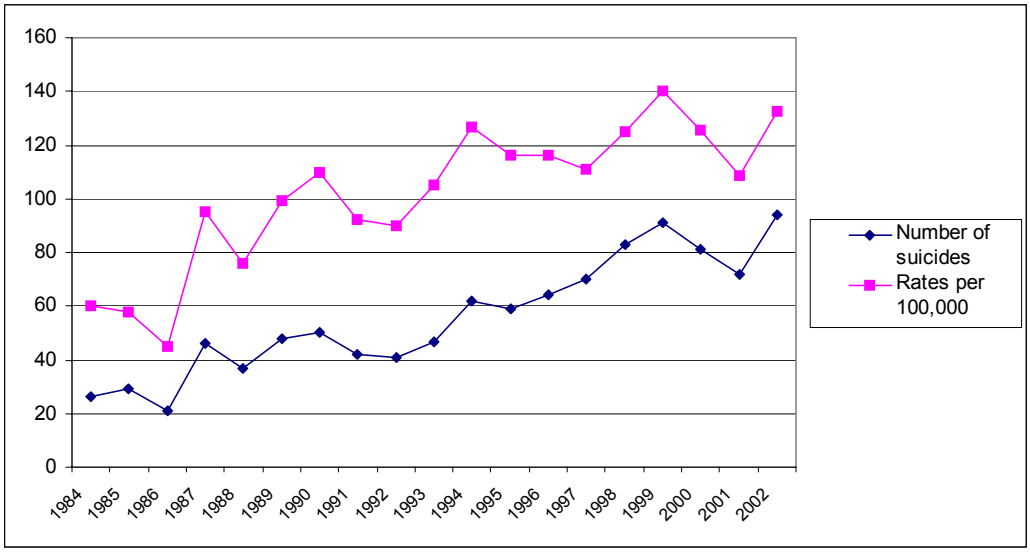

Fig. 1. Number of prison suicides and suicide rate per 100,000 average daily population in England and Wales, 1983-2002. (Source: Home Office, cited in Royal College of Psychiatrists, 2002).

17. There have been more criticisms of recording and monitoring practices (Howard League of Penal Reform, 1999). In recent years, there have been two primary sources for recording self-harm: the Health Information System for Prisons (HISP) and the Inmate Reporting System (IRS) (HM Prison Service, 2000). Neither system discriminates between attempted suicide and self-harm and research has found clear discrepancies in the number of incidents reported between the two systems. In December 2002, a revised F213SH form was rolled out across the entire estate and corresponding changes were made to the IRS system. These changes improved the consistency of information provided about self-harm incidents and improve the quality of information provided (Safer Custody Group, 2003, unpublished report).

Risk Factors Associated with Self-Inflicted Deaths in Prison

18. The roles of gender, age, offence type, etc. have all been examined extensively in the research literature. As they are not directly relevant to this research, a summary of this literature is provided in Appendix B.

Methods of Self-inflicted Death in Prison

19. The overwhelming majority of self-inflicted deaths in prison occur as a result of asphyxiation, also known as 'hanging' (Dooley, 1990). The usual method of hanging is to place a ligature or noose around the neck and tie it to a fixed point, which will bear a degree of weight. The person leans forward, producing impaired blood flow to the brain with a loss of consciousness. The leaning body produces further dead weight on the trachea, which is closed causing asphyxiation. It is important to note that many individuals die like this in a sitting position (Royal College of Psychiatrists, 2002). 92% of the deaths occurring between 1999 and 2001 involved this method (Safer Custody Group, 2002a).

20. Hanging produces relatively instantaneous death when compared with other methods available to prisoners, such as self-strangulation, which involves tying a ligature tightly around one's neck until death occurs. The chances of intervening and stopping the death is much more likely in other methods, including self-strangulation. Hanging is therefore considered to be more lethal than other methods available to prisoners.

21. Table 1 displays information on methods of self-inflicted deaths by hanging in UK prisons. The most common ligature points were cell windows, which were used in 47% of cases, while the bed was also used in 18% of cases. The most common ligature type was bedding (in 73% of hanging cases) followed by shoelaces (12%).

Ligature	%	Ligature point	%
Door	7	Belt	1
Toilet/recess	9	Clothing	7
Bed	18	Shoelaces	12
Windows	47	Bedding	73
Other	19	Other	7

Table 1. Self-inflicted deaths by hanging in 2002, by ligature point and ligature employed. (NB: Adapted from Safer Custody Group, 2003, unpublished report).

CHAPTER 2. COMMUNITY APPROACHES TO SUICIDE AND SELF-HARM PREVENTION

22. Over the last century, the two major methods for preventing suicide in the general community have been (Leenaars, Cantor, Connolly, EchoHank, Xiong, Kokorina et al, 2000; Lester 1998):

    (1) The establishment of suicide prevention centres based on the crisis intervention model, and

    (2) Psychiatric/psychological treatment of depressed and psychiatrically disturbed patients with effective medications and psychotherapy.

23. In recent years, a third major method for preventing suicide based on the notion of situational prevention has emerged in the literature. Specifically, *preventing access to lethal methods* of suicide. International research has been conducted on the availability of a number of methods for committing suicide, including firearms, car exhaust, domestic gas, medication and poisons, drowning and jumping (Lester, 1998).

Domestic gas

24. In the 1960s, Stengal (1964) formally proposed controlling the environment as a means of decreasing the incidence of suicide, noting the role that the detoxification of domestic gas played in changing national suicide rates.

25. The most well-known demonstration of the potential effectiveness of this strategy was the reduction in both gas suicides and the overall suicide rate following the detoxification of domestic gas in the United Kingdom (Kreitman 1976; Brown, 1979). The percentage of carbon monoxide in coal gas declined from 13% in 1955 to 0% in 1975. The suicide rate declined in all age groups and for both sexes for suicide by carbon monoxide poisoning. In contrast, other methods rose over the same period, but not sufficiently to prevent a significant decline in the overall suicide rate. This indicates that although some *displacement*[1] did occur (the term 'displacement' refers to the substitution of one method of suicide for another whose availability has been reduced) there was still a reduction in overall rates.

26. However, some researchers argue that full 'substitution' or 'displacement' of lethal method occurs when access to another method is prevented. For example, Burvill (1980) found that although the introduction of non-toxic gas in Australia led to a dramatic drop in suicide rates by this method, it was also associated with an increase in suicide by motor vehicle exhaust gas.

27. In addressing this issue directly, Clarke and Mayhew (1988) improved on Kreitman's (1976) data analysis and precisely documented the gradual detoxification of domestic gas in England and Wales and the declining suicide rate using domestic gas and other means. Clarke and Mayhew concluded that blocking opportunities, even for deeply motivated acts, does not inevitably result in

[1] The term is borrowed from criminological literature (Clarke and Lester, 1989)

displacement, a finding that strengthens the case for opportunity-reducing or 'situational' crime prevention.

Firearm control legislation

28. Lester and Murrel (1980) examined the effect of gun control laws on suicide rates. The US study found that the states with the strictest handgun control laws had the lowest suicide rates with handguns and the lowest overall suicide rates. The study also concluded that switching to an alternative method for suicide did not occur to any great extent in those states in which the gun control laws were stricter. This finding has been replicated in a number of other studies (Lester, 1998). Loftin, McDowall and Wiersema (1991) concluded that the legal restriction of access to guns in Washington D.C. prevented both suicides and homicides estimating an average of 47 deaths annually being prevented between 1968 and 1987. Lester and Leenaars (1993,1994) concluded that Canada's Criminal Amendment Act of 1977 had a preventative effect on suicide with no evidence of switching to an alternative method.

29. In contrast, Takahashi, Hirasawa and Kovamam (1998) argue that a minority of studies suggest that the reduction of suicide rate by legal restriction of firearms is temporary and that the effects can be offset by other methods, although it may take some time. For example, Rich, Young, Fowler, Wagner and Black (1990) lent support to this 'substitution' hypothesis in their evaluation of the effects of Canadian gun control legislation by suggesting that a decrease in firearm-related suicides was eventually offset by an increase in suicide by other means.

Car exhausts

30. Clarke and Lester (1987; Lester and Clarke 1988) found that suicides from car exhausts in the United States levelled off and perhaps declined following the introduction of emission controls in the late 1960s. In contrast, in the United Kingdom, where emission controls had not been imposed, the use of car exhaust for suicide rose dramatically. This finding was replicated in Japan (Lester & Abe, 1990).

Medications

31. Oliver and Hertzel (1972) reported that when sedatives were restricted in Australia in the 1960s, their use for suicide declined, without there being and increase in the use of other methods. The relationship between decreasing barbiturate availability and declining suicides by this drug has also been reported in Britain and Japan.

Summary

32. In summary, international research indicates that the decline in the availability of a lethal agent leads not only to a fall in the use of that method, but possibly also a decrease in the overall rate of suicide (Clarke & Lester, 1988). Lester (1998) suggests that, although there is evidence for substitution, reducing the availability of a method of suicide may also reduce the overall suicide rate if the method restricted is commonly used as a lethal method.

33. It is frequently argued that opportunity-blocking methods are pointless if the only result is that in a few years some other method takes its place. Clarke and Lester (1989) however make the point that many people, if prevented from suicide at a particular time, find other solutions to their difficulties and may never kill themselves. Thus, even if in the longer term a new method begins to replace one that has been removed, many lives will have been saved in the interim.

34. That suicidal behaviour is influenced by the availability of lethal agents suggests that the act of taking one's life is, in large measure, also a product of situational factors (Clarke and Lester, 1989). This research has implications for a theory of suicide. It is typical to think of suicide as a desperate act, chosen by seriously dysfunctional people at their wits' end. It seems unlikely that such people would be deterred by the effort needed to overcome the restrictions placed upon obtaining a lethal amount of their preferred method of suicide. Specifically, it is assumed that a genuinely suicidal person will always find a way to die. However, the present viewpoint suggests suicide may be a logical decision made by people based upon rational issues such as the availability of different methods for suicide (Clarke & Lester, 1989). On this basis, Clarke and Lester formed a 'decision' theory of suicide.

35. Clarke and Lester (1989) view suicide as the combined result of deep but possibly temporary despair (consistent with the *crisis model* of suicide intervention), the weakening of moral restraints, and the availability of a method that is not too difficult or aversive to use. Physical *availability* and *acceptability* are highlighted as important determinants in the choice of method (Lester, 1998). *Availability* refers to the extent to which a particular agent of suicide is available to the individual. While *acceptability* refers to the extent to which a person's choice of method is shaped by the norms, traditions and moral attitudes of their culture. The combination of *availability* and *acceptability* determine the choice of suicide method (Lester, 1998). The existence of one without the other is unlikely to result in the potential method being selected.

36. Lester (1998) suggests that, when asked, many people state that they would consider only one method of suicide. If access to this method were restricted, then suicide may well be averted in these people.

Implications for prison setting

37. The majority of research in this field focuses on identifying risk factors for suicide and self-harm. However, little evidence exists concerning the importance of these risk factors in the aetiology of suicide and self-harm and how these factors interact (Livingston, 1997). Early studies were based on psychiatric models and, as such, were largely concerned with identifying and describing correlates of suicide. Indeed, these studies arguably overemphasised the role of mental disorder and individual characteristics at the expense of other factors, such as the role of the immediate environment.

38. There is also a particular difficulty in the prison context in taking this 'medical model' approach to the control of suicide and self-harm, which is predicated on the assumption that those at risk can be reliably identified and appropriate treatment offered. Even though suicide rates in prison are criticised as being too high,

completed suicides in custody (and the community) have a statistically low baseline (Towl & Hudson, 1997). Therefore, while many individuals enter prison with the identified risk factors for both suicide and self-harm, relatively few actually carry out these acts. As a result, screening the prison population would generate a large number of 'false positives' – prisoners identified as having the propensities associated with a higher risk but would not then go on to kill themselves.

39. Clearly 'false positives' can be reduced by classifying fewer people as potentially at risk – setting the criteria for inclusion in that group at a higher level. This would raise the potential problem of 'false negatives', i.e. prisoners that were not screened as being a high risk but who subsequently commit suicide or self-harm.

40. The potential for 'false positives' and 'false negatives' during the risk assessment process lends further support to the case for exploring situational approaches to suicide prevention and self-harm. Specifically, environmental techniques to reduce opportunities for suicide and self-harm impact on all individuals whether or not they are judged 'at risk'. Situational approaches therefore do not seek to discriminate between individuals on the basis of pre-disposing risk factors. Indeed, Wortley (2002) argues that it is safer to assume that all prisoners are at risk and focus on generic environmental contributors to self-harm.

41. If Clarke and Lester's (1989) decision theory of suicide in the general community is applied to suicide in the prison context, then we would expect situational changes to the prison environment, such as the introduction of safer cells, to reduce the number of suicides. Indeed, Gunnell and Frankel (1994) suggest that the greatest potential for suicide prevention seems to arise from limiting the availability of methods. In addition, due to the pre-existing limited access to other lethal agents within the prison environment, we would expect even less displacement of method than in the general community. On the basis of both decision theory and the two-stage situational model of suicide prevention in prisons proposed by Wortley (2002), we can hypothesise that the introduction of safer cells in the six pilot prisons will significantly reduce rates of self-harm and suicide among inmates.

CHAPTER 3. SAFER CELLS POLICY

42. In the UK, traditionally, prisoners at serious risk of suicide were often placed in isolation in cells known as strip cells (unfurnished rooms). These cells are typically low stimulus, ligature-free and have minimal furniture (typically only a low built-in bed). Researchers have universally condemned the use of such cells for suicidal prisoners. Liebling (1993, 1997), Lloyd (1990), Power, McElroy and Swanson (1997), Hayes and Rowan (1988) and Rowan (1994) have argued that the use of isolation cells for suicidal and at risk prisoners is problematic as it potentially increases an at risk prisoner's sense of social isolation. These researchers argue a cell that is Spartan and clinical in appearance is more likely to reinforce the prisoner's sense of isolation and depression. Liebling (1991) argues that many prisoners find these cells very distressing and that it may act as a disincentive to prisoners to let prison officers know that they experiencing difficulties. In 2000, the use of strip cells in the management of prisoners identified as at risk of suicide or self-harm was officially eliminated by the Prison Service.

43. The fact that the majority of self-harm and suicide occurs when a prisoner is alone and unsupervised in the cell suggests the design of cells can play a critical role in suicide prevention (Wortley, 2002). Atlas (1989) highlighted the importance of architectural considerations in prison designs. He argued that it is theoretically possible to remove all possible means of suicide from within a cell and subsequently generated a list of 27 design features to create a safer cell environment. Atlas provided design features for both retrofitting existing cells and recommendations for new cells. His suggestions included structural changes to eliminate ligature points such as: modifying existing light fixtures, ventilation covers and all protrusions in cells; replacing metal bar doors with scratch resistant polycarbonate glazing on the inside panel of the door; and eliminating exposed pipes, hooks, hinges and catches from the cells. To address alternate methods of suicide, Atlas suggested removing any electrical outlets from the cell and promoted the use of fire-retardant materials. In addition, to reduce the process of institutionalisation, Atlas suggested that cells should have the recommended amount of natural and artificial lighting and cells should be painted in pastel colours rather than institutional green or stark white.

44. Reser (1992) also formulated a number of recommendations relating to changes in the cell's physical environment. However, Reser focused primarily on the need to deinstitutionalise the environment. Similar to Atlas, he recommended the use of natural colours and improved lighting. However, he also promoted the provision of radios, access to drinking water, washing and toilet facilities and the use of soft furnishings. These recommendations were designed to reduce the prisoner's sense of confinement and create more normalised living conditions. Reser was critical of the notion that a cell could be made 'suicide proof' by simply eliminating opportunities for self-harm. Rather he contends that preventative design must 'alleviate stress as well as reduce opportunity' (p.174). Reser stated that the preventative design (1992, p.174) 'must take into account the detainee's experience of the situation and the immediate cell environment, and the cumulative and stressful lack of control that has already taken place'.

45. On the basis of these studies, Wortley (2002) proposed a two-stage situational prevention model. Specifically, cell design must incorporate conditions that both reduce suicidal feelings and restrict the ability of the prisoner to act on suicidal

feelings. Wortley discusses the possible tension that his model creates between *precipitation control* and *opportunity reduction*. He cites the example that strip and padded cells 'might eliminate opportunities for self-harm but they also produce sensory deprivation, increase distress, exacerbate feelings of isolation and may elicit a defiance reaction that leads to a self-fulfilling prophecy'.

46. Wortley (2002) concludes that controlling self-harm requires a combination of strategies that both make prison a less dehumanising experience and provide an adequate level of care. He argues that prisoners do not need to be isolated in order to receive specialised care and they do not need to be kept in strip cells in order to restrict their access to means of self-harm. He suggests that a balance can be found between controlling precipitators and controlling regulators of self-harm. Indeed, the psychology of space and the prison environment are as important as the physical safety of the cells (Camilleri et al, 1999).

47. To create a 'safer' environment, interventions are required that address the building fabric and the supporting regime in prison (Safer Custody Group, 2002b). On the basis of this and reflecting the research outlined above, the Prison Service has piloted 'safer cells' which involve the reduction of ligature points whilst maintaining a normalised physical environment (Safer Custody Group, 2002b). Safer cells are designed to:

    - Significantly reduce the risk of a prisoner committing suicide, or self-harming, using the fabric of the cell.
    - Create a more normalising environment, which is as light and open as possible promoting a supportive and calming quality.

48. Safer cells are designed to make the act of suicide or self-harm as difficult as possible. This is achieved primarily by reducing ligature points as far as possible. Specialist 'anti-ligature' furniture and fittings are installed as an integral part of the cell fabric. The design also takes into account the physical needs of the prisoner and the necessary level of robustness required in the construction of fixtures and fittings (HM Prison Service, 2000).

49. A safer cell cannot be considered safe in its own right; it complements a regime providing care of at risk prisoners. As a result, the layout, colour and style of furniture within the Safer Cells are designed to create a normalising, light, airy environment which serves to reduce the stress levels of those placed in them.

50. Safer Cell design features include:

    - A high security window grill with 6mm fixed polycarbonate sheeting
    - Moving plate safe ventilator with perforated metal plate protection on the cell side
    - Rectangular, floor-mounted safe skirting heater pipes
    - RCD protected TV co-axial twin power socket
    - Cornice light fitting and protective metal casing
    - Open storage shelf
    - Fixed resin clad storage unit
    - Fixed resin clad privacy screen
    - Polycarbonate wall mirror with edge framing
    - WC pan with acrylic resin shrouding and seat and button flush
    - Shelf and splash-back

- Secure duct
- Standard cell door
- Cast synthetic resin washbasin with button water controls and outlet nozzles
- Garment hanging space
- Single piece of thermoplastic safer chair
- Fixed bed-base with open storage under
- Audible cell call systems

51. The cell furniture and sanitary ware must make it difficult to attach or support a ligature or to use the corners to self-harm. All corners must be rounded and have sufficient radii to minimise injury or accident. Any projection, such as shelving, must be tapered and the sides angled inwards. Materials must be strong, so that broken parts cannot be readily used to self-harm (Safer Custody Group, 2002b)[2].

52. Due to budgets not always being available at each prison for the implementation of the safer cells meeting the full safer cell specification, 'reduced risk' specifications are also available to prisons. These aim to produce a 'reduced risk' environment but to a lesser extent to that of a full specification safer cell (Safer Custody Group, 2002b).

53. There are many prisoners identified as high risk, perhaps for only a limited time, such as during induction into custody or whilst undergoing detoxification. According to the Safer Custody Group (2002b) lesser measures, such as the 'reduced risk' cells or just safer windows and beds may prevent a significant number of impulsive self-inflicted deaths. These improvements are achieved at a reduced cost to that of a full safer cell installation.

54. Whilst policy exists for the inclusion of safer cells in new accommodation, problems with overcrowding and resource constraints mean that the introduction of safer facilities is being phased in gradually in existing prisons.

55. Safer cells necessarily complement a more general suicide and self-harm reduction policy which includes such things as the promotion of trusting staff-prisoner relationships, support for self-harmers, Listener Schemes, and other kinds of accommodation including Care Suites and gated observation cells.

[2] Exact Specifications can be found in 'Safer Cell Furniture and Fittings Guide' and the 'Safer Prison Building Requirements Guide', available via the Safer Prisons Unit in the Safer Custody Group.

CHAPTER 4. SUMMARY OF FINDINGS

56. This chapter summarises answers to the 5 research questions based on our research in the 6 prison establishments. Table 2 summarises findings from each prison. For a full discussion of research findings for each prison, see Chapters 5 to 10.

Question 1: How are safer cells being used? Which prisoners are placed in safer cells? For what reasons?

57. Across the 6 prisons studied, safer cells were used in a variety of ways, many of them not related to suicide or self-harm prevention. They were used in the following ways:
    1. As normal accommodation for at risk prisoner groups (e.g., induction unit, HCC, segregation units) in prisons where entire wings were safer cells
    2. As normal accommodation for non at risk prisoner groups (e.g., enhanced prisoners, lifers, sex offenders) in prisons where entire wings were safer cells
    3. For those judged at reception to be at risk of committing suicide and placed in safer cells (e.g., the induction unit at Feltham and Hull)
    4. For those on mainstream units who start ligaturing and staff feel are at serious risk of suicide (either placed on residential safer cells or moved to safer cell on another unit)
    5. For other reasons, including using them as punishment, to control violent and refractory prisoners, and to give staff 'respite' (e.g., Eastwood Park)

58. In prisons where entire wings were safer cells, they were not often used for the most at risk groups of prisoners. For example, at Lindholme, enhanced prisoners are placed on their only safer cell wing, whilst at Swaleside until recently one of their safer cell wing housed lifers. At Hull, sex offenders were housed on a safer cell wing but the induction unit only had a small number of safer cells.

59. In prisons where smaller numbers of safer cells were distributed throughout the prison, safer cells were again not always used in the intended manner. This was most notably the case at Eastwood Park, where safer cells were often actively discounted as a management strategy for at risk women on the basis that they were not liked by women and were unhomely. At Eastwood Park, safer cells were used variously as punishment, for violent and refractory prisoners, at the prisoners request and for demanding prisoners to give staff 'respite'.

60. In those prisons (Hull and Feltham) where safer cells were used as part of a management programme for at risk prisoners, there often were not enough of these cells. At Hull and Feltham, faced with less safer cells than at risk prisoners in need of safer cells, staff had difficulties knowing how to prioritise their most at risk newcomers. Also, there were occasions when at risk prisoners had to be transferred away from their residential unit to another unit which had safer cells. There are concerns with this practice to do with the psychological effects of being

moved from one's normal location, which would be rectified if there were sufficient safer cells on all units where they are needed.

Question 2: How do other methods compare with safer cells?

61. Safer cells and other accommodation methods tend to complement more general strategies such as staff-prisoner relationship building, Listener Schemes, Samaritans, Outreach workers, risk assessments, ongoing monitoring and support, etc. Other accommodation methods include gated observation cells, care suites, double cells, and unfurnished ('strip') cells. Thus, safer cells play only a small role in prisons' overall suicide and self-harm prevention strategies and are only one of a number of accommodation strategies. Nevertheless, the role played by safer cells in preventing suicide and self-harm is unique.

62. Often, staff tended to prefer not to isolate at risk prisoners into single safer cells. For this reason, in many prisons (e.g. Feltham, Eastwood Park), safer cells were used usually as a last resort. However, they were considered to be very helpful in this regard, for prisoners for whom all other methods had been exhausted or for other reasons did not respond to other types of intervention.

Question 3: How do prisoners and staff feel about safer cells? Are there any unintended negative consequences of using safer cells?

63. There is no evidence from our research to suggest prisoners or staff dislike safer cells per se. Most prisoners and staff expressed mixed feelings about safer cells. All acknowledged their important role in reducing hangings via removal of ligature points. Many, particularly in the newer generation safer cells, liked the layout and felt the cells were homely. However, some of the older generation safer cells (such as those at Eastwood Park) were thought to be unhomely and dirty. The SPC at Eastwood Park told us that the women prisoners liked the newer safer cells at that establishment.

64. Prisoners and staff identified some important problems with safer cells, the most serious of which will require attention if safer cells are to ultimately be effective.

Ventilation

65. Ventilation is perhaps the most serious design concern regarding safer cells. A large majority (perhaps 90% or more) of prisoners interviewed spontaneously identified poor ventilation as a serious problem in safer cells. According to prisoners, the lack of ventilation caused physical problems due to the heat and stuffiness (and coldness in winter) and were also distressing psychologically because they were not able to open their own windows. Ventilation was complained about even at Dovegate where the entire prison was made up of safer cells.

Stigma

66. Stigma was identified as a concern only at Feltham, where those on safer cells were actively bullied sometimes violently. This led to some prisoners refusing to go into a safer cell. Some prisoners threatened to commit suicide if they were sent to a safer cell or they threatened to vandalise the safer cell. Stigma was a problem at Feltham due to the population being young male offenders, and due to the safer cell layout in that prison. At Feltham, safer cells were scattered throughout the prison and non at risk prisoners were mixed in wings with at risk prisoners, identifiable by the fact that they were in a safer cell.

67. Stigma may be less of an issue in women's prisons. At Eastwood Park many women self-harm so that this is not stigmatised. In the other male prisons it was thought that the absence of stigma was due to the fact that whole wings were safer cells. Where some cells on induction were safer (such as at Hull which also included young male offenders) stigma was minimised because prisoners did not yet realise they were in a safer cell, and also because there had not been enough time to develop bullying relationships amongst prisoners.

68. One potential way of reducing stigma could be to ensure non at risk prisoners are also randomly placed in safer cells (as occurs at Brinsford). However, this would require there being enough safer cells to accommodate all those at risk plus others. This policy would also need to be in place from the outset. At Feltham, non at risk prisoners are refusing to go into safer cells for fear of being bullied.

69. Of course, if entire wings or prisons were safer cell designed, stigma would also not be a problem. This is one advantage of building all prisons as safer cells and for large-scale refurbishments at existing prisons.

Ligature points in safer cells

70. It is clearly very important to remove as many ligature points as possible from safer cells. Our research suggests that safer cells are often not ligature point free. It is also important to minimise 'copycat' suicides by removing improvised ligatures once they become known to staff and prisoners.

71. Most suicides occurring in safer cells in the prisons we investigated were the result of prisoners improvising ligature points. This was most notable in Dovegate, where three suicides close in time all used the safer cell door upper hinge as ligature points. Clearly, it will never be possible to remove all ligature points, but it is important to take action once a suicide has occurred to remove these ligatures from other safer cells in the prison. One problem seemed to be that contractors were not building safer cells to specification. Some kind of quality control needs to be in place to ensure that contractors are building safer cells in line with Safer Custody Group specifications.

Question 4: Is there any evidence that prisoners benefit from being placed in a safer cell?

72. Despite not being able to conduct rigorous analyses of the data (as explained in Appendix A), we have two lines of evidence to suggest that safer cells are preventing suicides and that they may do so in the future. The first line of evidence is that some prisoners told us that being in a safer cell had prevented them from committing suicide. The second line of evidence is that the data suggests prisoners may be substituting hanging for less lethal methods (such as cutting or self-strangulating) in safer cells.

Suicides prevented due to safer cells

73. Of the 54 prisoner interviews we conducted across the 6 prisons, 3 prisoners (2 from Feltham, 1 from Hull) told us they would have committed suicide had they not been in a safer cell at the time. Of the 54 prisoners we interviewed, 27 said they had a history of self-harm and suicide. This means that around 11% of those who had a self-harm history had not killed themselves as a direct result of being in a safer cell. One prisoner from Feltham said:

    *'When I am in the [safer] cell I sometimes think, 'F**k it! I want to end it'. Then I sit around for an hour or so and try to work out a way. But there is no way when it comes down to it. I just think about it and feel better. They are effective in that way. They change people's minds. Because when you can't do something, you just stop trying.'*

74. Another prisoner from Feltham said he had tried to commit suicide in a safer cell but had not been able to. He said that by the time he left the cell he was no longer suicidal. A prisoner from Hull also said that he had wanted to commit suicide but was not longer motivated to do so once he had left the safer cell. The inmate from Hull said:

    'There have been times when I would have hung myself [while in a safer cell]. But I couldn't. I got over it eventually.'

75. There were 539 hangings by 428 inmates resulting in 35 deaths across the prison estate in four months from December 2002 (when the new F213SH form was introduced) to March 2003. Six of the 504 attempted hangings happened in safer cells (1.2% of all self-harm incidents by hanging). It is difficult to draw firm conclusions from these data because we do not know whether safer cells were available in the establishments in which the incidents took place, and staff had failed to allocate the at risk inmates to them, or whether there were no such cells available. Nevertheless, we can conclude that *at least three, but perhaps many more prisoners have been prevented from committing suicide as a result of this programme.*

Substitution of hanging by less lethal means

76. Our research suggests that, instead of hanging, less lethal methods may be being used in safer cells. Death occurs very quickly by hanging compared to other methods available to prisoners. Less lethal methods such as self-strangulation or cutting can potentially be interrupted before death occurs. One prisoner from

Swaleside told us he had tried to suicide by self-strangulating using a pillow case five times since being in a safer cell, but he was unable to do so.

77. An analysis of the self-harm data in some of the prisons also suggests prisoners may be udsing less lethal methods of self-harm (in particular cutting) instead of more lethal methods (such as hanging). At Feltham where reliable self-harm data were available for a 14-month period, 65% of self-harm in safer cells was by cutting, but cutting accounted for only 45% of self-harm incidents in non safer cells. Hanging was more common in non safer cells. In safer cells only 5% of self-harm incidents were by hanging, whereas in other cells 18% were by hanging.

78. In addition, examining the method of completed suicides provides interesting findings. At Eastwood Park, the most recent suicide was by self-strangulation, in contrast to the previous 5 suicides which were by hanging. Although in this situation self-strangulation resulted in suicide, it is more difficult to kill oneself using this method. Also, again at Swaleside, the only suicide to have occurred in a safer cell was by self-strangulation using an electrical flex from the television. This is an interesting case because it is likely that the prisoner was very motivated to kill himself. It would have taken some time to organise this suicide, and it would have taken some time for the prisoner to die. Although the safer cell did not stop this presumably motivated prisoner from committing suicide, the evidence suggests that other more spontaneous suicides may be prevented.

Question 5: Are safer cells more useful for certain groups of prisoners than others, for example taking account of gender/age differences in methods of self-harm?

Safer Cells and Gender

79. It has been suggested that safer cells are not as useful in women's prisons as in men's due to the small population of women prisoners, the small numbers of suicides by women, and the tendency for women to self-strangulate more than men. If we look in detail at more recent findings from the Safer Custody Group and elsewhere, there is in fact evidence to suggest that safer cells should be useful in the women's estate.

80. The first issue has to do with the small numbers of women prisoners and the debate over whether women in prison commit suicide at comparable rates to men. The suggestion that on the whole women in prison do not suicide as much as male prisoners has led to some neglect of issues of suicide and self-harm amongst women prisoners (Liebling, 1994) and to the question of the usefulness of anti-ligature safer cells for women prisoners. There is however emerging evidence that women do suicide to at least the same degree as men (Liebling, 1994) and that this rate is rising. Therefore, although absolute numbers are small, suicide is an important problem in women's prisons.

81. Secondly, there are other important issues to explore with respect to safer cell suitability and gender since women and men are known to use different methods to self-harm. In particular, the notion that women self-strangulate proportionately more than men (and therefore use ligature points proportionally less than men) requires a closer look since it has implications for the usefulness of anti-ligature cells in women's prisons. In fact, it is clear that when it comes to suicide, that men and

women use very similar methods – around 92% of both men and women use ligature points to hang themselves. This points to the equally important role played by ligature points for women as it does for men.

82. Where women and men's methods differ is with respect to self-harm. Since December 2002 we now have more reliable self-harm data. It is evident that when it comes to self-harm, women do use hanging proportionally less than men. Instead, they self-strangulate (without a ligature point) more than men relative to other methods of self-harm. However, it is an important point that women have much higher rates of self-harm than men. Although women make up only 5-7% of the prison population, 82 self-harm hanging incidents were by women in the 4 months examined since December 2002, and 278 incidents by men. Thus, a third of self-harm incidents involving ligature points occurred in the women's estate.

83. This provides an argument for the use of anti-ligature safer cells in women's prisons. Women suicide overwhelmingly using hanging, and many of their high rates of self-harm are the result of hanging. However, our research did suggest that when considering the use of safer cells at women's prisons, some gender differences need to be taken into account. The women we interviewed all preferred shared accommodation. It is important there is enough double cell provision in women's prisons.

Safer cells and male young offenders

84. Young offenders are generally believed to be a particularly impulsive group of prisoners, prone to impetuous suicides. As safer cells aim at the prevention of impulsive suicides, safer cell provision needs to be adequate with these groups. For these reasons, safer cell provision in young offender institutions could presumably play an important role.

Summary of Findings by Prison

Table 2. Summary of findings by prison.

	Eastwood Park	*Hull*	*Swaleside*	*Feltham*	*Dovegate*	*Lindholme*
Safer cells	▪ female closed local, adult & YOI ▪ high levels of suicide & self-harm risk ▪ 8 single safer/reduced risk cells in juvenile wing and 4 in HCC	▪ cat B local, adult & YOI ▪ under 24s, sex offender wings, seg unit & HCC: all safer cells (double/single) ▪ 5 single safer cells on induction, 6 on care & separation unit	▪cat B training, adult ▪1 wing all single safer cells ▪1 gated safer cell on HCC ▪lifers on safer cell wing but during research safer cell wing changed to induction ▪low incidence of self-harm and suicide	▪ YOI and juveniles, remand centre ▪ 33 safer cells (double and single) in HCC, induction and residential units	▪private, cat B, adult ▪includes Therapeutic Community (TC) for 200 ▪suicide & self-harm rates high (no suicides in TC) ▪cell door design problem (now fixed); new prison; inexperienced staff	▪ category C training, adult ▪ 30 of 120 cells on enhanced wing are single safer cells
How are safer cells used? Which prisoners are placed in safer cells and for what reason?	▪ not often used to manage self-harm and suicide, except for **new arrivals aged <21** ▪ seen as contra-indicative for suicidal inmates ▪ used as **punishment**, for violent/refractory inmates, at **prisoners' request**, for **demanding** inmates (respite for staff)	▪ all in units listed above: under 24s, sex offenders, seg unit, HCC ▪ in **induction**, only used as **last resort** ▪ if suicidal, might move wings to get to safer cell	▪**induction** in safer cell wing now ▪other at risk inmates usually remain on normal location ▪if serious attempt made, **moved to HCC** (last resort)	▪ **risk assessment** to decide who allocated ▪ **not** normally for **new arrivals** (to reduce stigma) ▪ **double cells** mostly used for **only one** at risk inmate ▪ **inmates reluctant** to use them, because of stigma ▪ **not enough**: problems prioritising, inmates having to move	▪ all cells are safer cells (2 double cells per wing) ▪ **double** cells **not used** for at risk inmates	▪**not** used for **suicide** and **self-harm** prevention (used for enhanced prisoners) ▪staff thought it best to have 1-2 spare safer cells in each wing
How do other methods compare with safer cells?	▪ **double** ordinary cells best management strategy (no double safer cells at time) ▪ need **safer clothing & bedding** or ability to **remove** these in crisis	▪ best approach: **relationship** building, good **assessment** & **support**, Listeners, Samaritans ▪ safer cells good when relationship not yet built or in crisis ▪ **double** cells best, but not liked by prisoners ▪ **CCTV** good if monitored constantly	▪best approach: **shared** accommodation (short-term) and **relationship** building (long-term) ▪safer cells **useful** in comparison, esp. for **impulsive** acts ▪Listeners scheme viewed positively ▪inmates requested care suite	▪ best approach: good risk **assessment**, staff-inmate **relationships**, ongoing **support**, **normalised** environment ▪ **Outreach** very positive	▪ best approach: positive staff-inmate **relationships** (inmates said did not always exist) ▪ **over-reliance** on **CCTV** and design ▪ **more staff**, esp. psychologists, needed ▪ Listeners scheme positive ▪ need care suite and gated observation cell	▪best approach: **Listeners**, esp. if with care suite ▪good staff-inmate **relationships**

	Eastwood Park	*Hull*	*Swaleside*	*Feltham*	*Dovegate*	*Lindholme*
How do staff and prisoners feel about safer cells?	▪ **not liked**, esp. by prisoners, but value in crisis acknowledged ▪ problems with **ventilation** and **maintenance** (old, dirty, unhomely) ▪ **need for double** safer/reduced risk cells	▪ **positive** (spacious, comfortable, clean, **normalised**), but **ventilation** problems ▪ more effective for suicide than self-harm	▪more effective for suicide than self-harm ▪should **not** be used **in isolation**	▪ **mixed feelings** (thought prevented likelihood of impulsive hanging, but **stigma**) ▪ more effective for suicide than self-harm ▪ **positive effect** on prison	▪ **mixed feelings** (**value** in reducing ligature points **acknowledged**, but design problems, esp. **ventilation)** ▪ inmates do not like double cells ▪ little effect on self-harm	▪**mixed feelings** ▪inmates regard them as too clinical and basic
Are there any unintended negative consequences ?	▪ **negative emotional effects**, inc. frustration, depression ▪ stigma not a problem ▪ 2 out of 8 inmates had **vandalised** a safer cell ▪ 1 out of 8 had **waited** to leave safer cell to self-harm	▪ **ventilation** ▪ stigma not a problem ▪ vandalism has occurred, but not major problem ▪ **substitution of method** and **waiting** to leave safer cell to self-harm reported	▪**ventilation** problems, leading to **worsened physical and emotional health**, inc. increased self-harm ▪social **isolation** ▪no stigma or vandalism reported	▪ **stigma** ▪ increased feelings of **isolation** ▪ lack of **ventilation**	▪ lack of **ventilation**, leading to **anger** and **worsened mental and physical health** ▪ most **acute** in **double** cells	▪neither stigma, vandalism or lack of ventilation were identified as problems
Is there any evidence that prisoners benefit from being placed in safer cells in terms of reduced rates?	▪ **minimal** evidence ▪ most recent suicide by **self-strangulation in safer cell**; previous by hanging in non safer cells	▪ **time frame too small** to say ▪ one inmate **said no longer suicidal** when left safer cell ▪ **2 out of 41 self-harm** incidents occurred in **safer cells**	▪cannot say (mainly used for lifers) ▪2 suicides since safer cells introduced did not require ligature points ▪one prisoner attempted suicide by **self-strangulation** 5 times while in a **safer cell**	▪ **hanging substituted by cutting** in safer cells to some extent (less lethal) ▪ **inmates felt hanging not possible**; one tried and failed to hang himself in a safer cell	▪ **suicides** and **self-harm** in **safer cells still** occurred ▪ likely that some reduction, taking into account 'teething' problems ▪ '**copycat**' suicides, once a method is successful	▪cannot say, because not used to address these ▪**not** thought to be **key strategy** by either staff or inmates (current approach regarded as effective)

CHAPTER 5: RECOMMENDATIONS

85. Recommendations are listed below and draw on the executive summary as well as the findings in the rest of the report.

86. There is strong evidence that good design can reduce suicide. Given that suicide by hanging is quick, easy, and has been the method of choice for those inmates wishing to kill themselves, the safer cells programme has much to commend it. **We recommend, therefore, that the programme continues** bearing in mind the following points:

- The issue of cell ventilation needs to be addressed.

- If inmates find a ligature point in the safer cells, which had not been anticipated by the designers, then remedial action needs to be taken as quickly as possible, before the method spreads within and between establishments. The rapidity with which the weakness of the sink design was dealt with is an example of good practice.

- Those inmates at greatest risk are young and early in their sentence. Young men are at high risk of impulsive suicides. If safer cells are to be rolled out across the prison estate, it makes sense to give priority to those establishments. Category C and D training prisons are less of a priority. Female prisons should also not be forgotten as they suicide to the same extent as men, hanging is also their favoured method, and they have very high self-harm hanging rates.

- If cells in existing establishments are to be adapted to the safer cell standard, then the issue is which cells and how many. Assuming that choices have to be made, and that not all cells could be converted in a cost effective manner, we suggest that safer cells should be available in induction wings and that a proportion of remaining cells might be converted. The number should be sufficient to guarantee that a substantial number of inmates not judged to be at risk would be located in safer cells, thus reducing any stigma. It would also mean that staff would not have to make fine judgements about which inmates were or were not at risk.

- The context of the whole prison needs to be taken into account in converting cells within existing establishments. If the safer cells are ‘better’ than other cells, then there is a risk that either they will encourage acts of self-harm in order to secure a transfer into a safer cell, or that staff will use them as a reward rather than for the purpose for which they were intended. If they are ‘worse’ than other cells, then they may be used, or perceived to be being used, for punishment.

- Ideally the population of the establishment should be taken into account in designing the cells and their number and location. Women and young offenders, for example, have particular issues in relation to the frequency of suicide and self-harm and the design and use of these cells. Unfortunately paying attention to the characteristics of the inmate population may restrict the flexibility of the use of the accommodation in the future. There are, however, some points that may be relevant to any future use. For example,

locating safer cells on frequently used routes, say at the top of a flight of stairs, so that a large number of inmates pass the door routinely, leaves the occupant open to potential bullying and abuse.

- Assuming that the issue of ventilation can be addressed, then safer cells could become standard in all new establishments. For the marginal cost at that stage, this would give greater flexibility of use over the lifetime of the establishment. It would also reduce the issue of stigma if all cells were built to that standard and lessen the importance of risk assessment since all inmates would be located in safer cells.

Ongoing monitoring of the safer cells scheme

87. It is important that the Safer Custody Group continue to monitor the use of safer cells and their effects. It was not possible for us to determine the effect of the safer cells programme on self-inflicted deaths because the programme was relatively new and the death rate is low. We were also concerned at the poor quality of some of the data – it was not possible, for example, to determine in which specific cell an inmate had self-harmed. The new data collection methods have overcome most of these problems but care needs to be taken to ensure that the data are collected as intended and that staff understand the reasons for the collect of the information. The existence of suicide prevention co-ordinators in establishments is extremely helpful in this regard.

88. It should not be forgotten that if safer cells are working in reducing suicides, the self-harm data may begin to show increased levels of self-harm within safer cells due to prisoners trying and failing using other methods. For example, one prisoner tried to self-strangulate 5 times using bedding but was unable to kill himself. The self-harm data should be monitored carefully to tease out the differences between rises in self-harm rates due to these incidents, and rises in self-harm rates due to other causes.

89. Currently designed safer cells appear to make it very difficult for inmates to use a ligature point to commit suicide. Nevertheless, prisoners can be very inventive, and have time to consider options. If there is a death by hanging in any safer cell, then a rapid assessment needs to be made to determine whether the method used calls for a redesign of the cell, or whether the method was so specific to the skills of the inmate as to make further modification of the cell unnecessary.

CHAPTER 6: HMP AND YOI HULL

Summary

- Large Category B local, adult and YOI, CNA=816
- Half of total cells in prison are safer
- Safer cells entirely comprise under 24 wings, sex offender wings, segregation unit and HCC; 2/3 of these are double
- 5 single safer cells on induction and 6 on care and separation unit
- 20 suicides in past 15 years (all hanging), 10 self-harm incidents per month since Dec 02 – rates are below average for Category B locals and YOIs

Use of Safer Cells at Hull

- Used for all under 24s, all sex offenders, all on HCC, all on segregation
- HCC safer cells also have CCTV for surveillance
- Not used for some at risk groups – vulnerable prisoner and induction units not safer cells
- 5 induction safer cells only used if other methods exhausted or ruled out because staff prefer new prisoners to be with others
- Sometimes allocation difficulties occur on induction and care and separation unit due to small number cells – who is most at risk?
- Occasionally prisoners moved from non safer to safer cell wing if there is concern they will try to ligature
- CCTV safer cells thought good but only if screen monitored constantly

Comparing Other Strategies with Safer Cells

- Staff and prisoners thought relationship building, good assessment and support structures, Listeners and Samaritans most effective
- Safer cells effective when (a) relationship not yet built, and (b) in a crisis situation.
- Staff thought double cells best accommodation for those at risk but not all prisoners like double cells
- Strip cells not used with at risk prisoners; no gated observation cell at Hull

Staff and Prisoners' Feelings about Safer Cells

- Overall, prisoners were very positive about safer cells at Hull
- Liked layout, spaciousness, cleanliness – staff and prisoners felt they were normalised
- But ventilation was thought a serious problem
- All prisoners acknowledged benefits of safer cells in reducing suicide but thought less effective in preventing self-harm

Unintended Consequences of Safer Cells

- Ventilation one of few negatives
- Stigma, vandalism and dehumanisation not problems
- Some displacement - one prisoner wanted to hang himself but used a razor instead in safer cell; another waited until he left safer cell and jumped off landing

Do Safer Cells Work in Reducing Suicide and Self-harm?

- Safer cells only operational from 3 months ago, too soon for effectiveness to be known
- 1 suicide since safer cells installed; occurring in ordinary cell on induction
- 1 prisoner said he was suicidal but by time he left safer cell was no longer suicidal
- Only 2 of 41 self-harms in past 4 months occurred in safer cell – significantly less than expected (likely to be due to lower vulnerability of those on safer cell wings)
- Staff thought normalising atmosphere of safer cells may be more important than design in reducing self-harm and suicide
- May be benefits in Hull rearranging accommodation to house those most at risk in safer cells – e.g. induction and vulnerable prisoners units

The Prison

90. Hull is a category B local prison holding sentenced and unsentenced adult and young male prisoners. The prison is a large one – after a recent major expansion it has a CNA of 816 and an operational capacity of 1,021. This added 358 CNA places in five new wings and a new HCC, all of which became operational in January 2003, and all of which are safer cell designed. The prison is Victorian in design, but has a mixture of buildings from different architectural eras, including two original Victorian wings.

Safer cells at Hull

91. With the recent expansion, around half the prison cells are now safer cells (full specification) and of these, around two thirds are double (the double cells are of the bunked bed style). In total, there are 131 single safer and 256 double safer cells capable of housing 643 prisoners, over half the operational capacity. The large majority of safer cells are located in the five new wings and HCC, which are made up of entirely safer cells. These house the under 24s, the sex offenders, and those in the HCC and those on segregation. In all these wings there are a mixture of double and single cells, and the HCC's 20 cells all have CCTV cameras installed for surveillance. A small number of single safer cells were also fitted to the induction unit (five) and the care and separation unit (six). Table 3 summarises Hull's safer cell provision by wing.

92. Some practical problems with safer cells noted by staff included: (a) no safer cell televisions were boxed (the SPC told us that one prisoner had tried to self-strangulate in a safer cell using the television cable), (b) two safer chairs have been broken recently producing plastic shards useable as weapons, (c) sinks are breakable and take a longer time for replacement than non safe cell sinks, and (d) it was suggested that safer chairs could create a ligature point by being wedged into the edge of the bed.

Suicide and self-harm at Hull

93. On average, there have been around one to two suicides each year at Hull over the past 15 years, a rate of 343 self-inflicted deaths per 100,000 prisoners. Although this ranks Hull at number 15th highest out of all prisons in England and Wales, Category B prisons with vulnerable populations and high turnover are commonly ranked highly. The 20 suicides that have occurred since 1988 have all been hanging, many using bedding and a window as a ligature point. Most suicides preceded the introduction of the safer cells apart from the most recent suicide in April 2003 which occurred in a non safer cell on the induction wing.

94. Self-harm rates are not overly high at Hull, with 41 self-harm incidents occurring between December 2002 and March 2003. The rate of self-harm is 49 per 1000 prisoners, which is low compared to the average Category B local rate of 57 per 1000 prisoners, and 53 per 1000 prisoners for young offenders.

Wing	Safer cells	Non safer cells	Description
A	5 Single	Most	Induction wing and first night centre for adult and YOI remands (Victorian design)
B	0	All	Voluntary drug testing wing for enhanced adult sentenced and remand prisoners (Rebuilt after WW2)
C	0	All	Holding adult sentenced and remand prisoners, mostly on standard and with quick turnaround (Victorian design)
Care and Separation Unit	6 Single	18	This is actually the ground floor of C-Wing and is for prisoners under general cellular confinement after adjudications etc.
D	0	All	Adult remand and convicted
E	0	All	Built early 1960s, electronic locking with night sanitation facilities, houses vulnerable prisoners
HCC	All (around 20 single) + CCTV	0	HCC
G	All	0	Young persons up to 21 years – remanded and convicted
H	All	0	Offenders between 21 and 24 years – remanded and convicted
I	All	0	Adult sex offenders not on treatment programmes
J	All	0	Sex offenders on treatment programmes
K	All	0	Segregation unit for prisoners under GOAD (i.e., for disruptive prisoners under Rule 45)

Table 3. Description of residential units at HMP Hull.

95. The most common method was cutting and there were 4 hanging self-harm incidents and 2 self-strangulation self-harm incidents (one of which needed A&E treatment) over the past four months. None of these were recorded as occurring in safer cells.

96. Recent inspectorate reports have praised Hull's suicide and self-harm prevention policies. There is a pre-reception and reception programme, a Listeners Scheme (with 17 Listeners) though no peer support scheme. There are twelve cordless Samaritan phones, one in each wing, and an additional three direct line mobile phones for the whole prison. Although there is no separate detoxification unit, this treatment is available to all prisoners and there are six CARAT workers on site. The Suicide Prevention Team meets quarterly. On average, there are about 35 prisoners throughout the prison on an open F2052SH form at any one time.

How are safer cells used at Hull? Which prisoners are placed in safer cells at Hull? For what reasons?

97. Safer cells are used in two distinct ways at Hull. First, they are used as normal location for around half the wings at Hull, and secondly, prisoners are allocated to safer cells on occasion on the basis of risk assessments, generally as a last resort.

As normal location

98. Safer cells are used to house all those prisoners under 24 years of age (Wings G and H), all sex offenders (Wings I and J), those in the HCC and segregation wing (K Wing) since these wings are made up entirely of safer cells. There may be some argument as to whether these are the most appropriate groups to be allocated to full specification safer cell wings. The vulnerable adult prisoners wing is made up of non safer cells, and it is arguable that these are in fact a more at risk group than the young or sex offenders at Hull (this is discussed further below).

99. The decision to place at risk prisoners in a double cell is made on a case-by-case basis. At risk prisoners are never housed together in the same cell. Only suitable prisoners (in terms of temperament) are placed with an at risk prisoner.

As the result of a risk assessment

100. Secondly, as part of the wider self-harm and suicide prevention strategy, safer cells at Hull are used as a 'last resort' for at risk prisoners on induction and for some in the care and separation unit. Other prisoners who are at risk throughout the non safer cell wings in the prison may be relocated to a safer cell wing if it is deemed necessary.

101. Regarding prisoners on induction, focus group staff indicated that they prefer not to allocate at risk prisoners to one of the five single safer cells on the induction unit because they prefer new prisoners to be with other prisoners at this early stage (safer cells are single and other cells are double on the induction unit). Staff only use a safer cell at this stage if there is a clear reason for doing so, such as when other methods have been exhausted or ruled out. As one staff member commented, 'all safer cells [in the reception unit] are single cells. People coming into prison on their first night usually need someone to talk to. Therefore the safer cell is a last resort because you don't want them to be alone.'

102. Sometimes there were too many at risk prisoners on induction and difficulties arose with respect to determining which prisoners are most 'at risk'. There had been situations when staff were unsure about whether at risk prisoners should be removed from a safer cell simply because a 'more' at risk prisoner arrived. These problems were compounded by difficulties with obtaining timely and accurate prisoner background information at the initial risk assessment process on reception. Similar difficulties have been experienced while allocating cells in the care and separation unit.

103. Occasionally, those who are housed outside the safer cell wings may be moved to a safer cell wing if they are suicidal even if they would not normally fit into the population housed there. For example, the SPC told us of a persistent self-harmer who had recently begun self-strangulating and ligaturing on a wing with single

safer cells, but no double safer cells. Although the prisoner was not a sex offender, with the prisoner's permission, he was moved to double safer cell with a suitable prisoner on one of the sex offenders' wings.

104. Another issue which staff found difficult was whether to allocate safer cells to prisoners who officers felt were threatening suicide and self-harm in order to obtain something they wanted (such as moving cell locations). In this situation, it is difficult to know whether to allocate prisoners to a safer cell. In cases where staff are unsure whether the threat is manipulative, they typically err on the side of caution in managing the prisoner.

How do other methods used at Hull compare with safer cells?

Long-term methods

105. Staff in the focus group believed that the most effective way to deal with a self-harming or suicidal person was to take a long-term view involving the development of trusting prisoner-staff relationships, good assessment and support structures, staff training, identification of the root causes of the behaviour, and the effective use of resources such as the Listeners Scheme and the Samaritans. Prisoners and staff both praised the Listeners Scheme. It was also felt that linking prisoners at risk with other agencies, such as drug and alcohol support services were very useful, although there were difficulties with availability of these services at all times they were needed.

106. Staff did note that relationship building was often difficult with Hull prisoners due to the high throughput, so it was suggested that safer cells could be important in situations where relationships were not yet built or were not able to be established.

Short-term methods

107. In terms of handling actively suicidal and self-harming prisoners in the short term, the placement of prisoners in a double cell with an appropriate prisoner as a cellmate was thought by staff to be the most effective strategy due to its minimisation of social isolation and the increased observation levels. These were thought to be more effective short-term strategies than putting prisoners on single safer cells. Though it should be noted that a number of the prisoners interviewed indicated that they preferred being in a single cell. As one commented, 'sometimes the other person has their own problems. The last thing you need when you are like that [at risk] is to hear someone else's problems'. Therefore, selecting the appropriate prisoner (such as a Listener) is vital.

108. There is no gated observation cell at Hull but there is one unfurnished or 'strip' cell located in the care and separation unit but this is not used with at risk prisoners. Rather they are used sparingly with those who are violent to staff or other prisoners as a last resort.

CCTV versus non-CCTV cells

109. CCTV cameras are present in the safer cells in the recently built care and separation unit. Early impressions by staff of the CCTV system were positive. Staff felt this gave them a tool for extra monitoring of at risk prisoners although it was

noted that the use of such technology should not be at the expense of interactions with the prisoner. In addition, the SPC pointed out that CCTV cells are good as long as there is someone watching the monitors at all times. This was perhaps one factor in the recent hanging self-harm incident in a CCTV safer cell at Hull.

110. Prisoners' views on the presence of CCTV in the safer cells were mixed. One prisoner complained about the lack of privacy, while another repetitive self-harmer stated, '... I like it [CCTV] because they can keep an eye on me'.

How do prisoners and staff at Hull feel about safer cells?

Prisoners

111. Nine prisoners were interviewed. All had had experience of being held in safer cells, were from A, E, G, H, I, and K Wings, were a mixture of remand and sentenced prisoners, and four had a history of suicide and self-harm.

112. Overall, prisoners at Hull were very positive about safer cells. Seven out of nine believed they were superior to the normal cells for reasons including 'the layout is better', they are more 'spacious', 'brighter', and 'cleaner' than the other cells, in particular those in the old Victorian wings.

113. Despite this overall positivity, the majority of prisoners thought that ventilation was a serious problem. One prisoner stated that this affected his health and another said 'the ventilation is terrible. I am literally ready to run out of the cell when the door is opened to get fresh air. The heat and stuffiness do my head in'.

114. All prisoners interviewed acknowledged the benefits of safer cells in reducing suicide, but the majority indicated they felt the cells did little to prevent self-harm, particularly cutting.

Staff

115. Staff pointed out that the new safer cells are much more normalised in design compared to the rest of the prison, particularly compared to the Victorian wings. The safer cells according to staff are more functional, comfortable, and lighter. Staff felt that if there was to be a reduction in self-harm and suicide at Hull then this normalised design would be largely responsible.

Views on double versus single safer cells

116. It is difficult to know which is viewed more positively by staff and prisoners. Staff seem to like the idea of not socially isolating prisoners. Prisoners, on the other hand, may prefer to be on their own, but also tended to think at risk prisoners may be helped by being placed in double cells. However, we only interviewed 9 prisoners so conclusions are difficult to draw. Six of 9 prisoners said they preferred to be in a single cell. The reasons given included the need for privacy and also potential problems with other prisoners. Two of 9 said they did not mind where they were placed. Six of 9 said they would like an at risk friend to be placed in a safer cell and three of six thought this should either be in a double safer cell or combined with a Listener.

Are there any unintended negative consequences of using safer cells at Hull?

Dehumanising effects

117. Safer cells were not thought to be dehumanising at Hull. Compared to the Victorian cells, the safer cells are light and comfortable apart from the problem of ventilation.

Stigma

118. Stigma did not seem to be a problem for those at Hull, probably because every cell in the new wings were safer cells, and because those prisoners placed on a safer cell and the others in the induction unit were not yet aware of the purpose of the safer cells. Also, the fact that prisoners were only in there for a short period of time means there was no time to develop a peer group capable of stigmatising an at risk prisoner. Nevertheless, one prisoner interviewed was placed in a safer cell on induction when he was withdrawing from drugs. He said he was very resentful that he was not placed on normal location.

Vandalism

119. Staff did give examples of vandalism to safer cells. However, they were not sure this was related specifically due to being placed in a safer cell, or whether it was related to other factors. For example, one prisoner who was withdrawing from drugs had smashed a safer cell plastic chair, which left sharp pieces. Only one prisoner interviewed said he had ever felt like vandalising a safer cell (this was because of the heat) but he said that the furniture was built-in and too strong to break.

Alternative or displaced suicidal or self-harming behaviour

120. Many prisoners said they believed the safer cells got individuals through a crisis situation, but they also suggested that a determined prisoner would not be stopped. Staff consensus was that some prisoners will simply wait for the opportunity to attempt self-harm or suicide or will use another method. This was supported by prisoner interviews. One prisoner said he had wanted to kill himself whilst in a safer cell. He said that he would have hanged himself but that as it was not possible in a safer cell he instead used a razor to attempt suicide by cutting his wrists. Another prisoner said he had waited until he was released from his cell and immediately threw himself off his second floor landing.

121. On the other hand, there was a sense that sometimes suicidal behaviour could be prevented altogether. For example, one prisoner said that he would have hung himself in a safer cell except that it was impossible to do. He said that by the time he had an opportunity, he was no longer suicidal: ‘There have been times when I would have hung myself [whilst in a safer cell] but I couldn’t. I got over it eventually’.

Is there any evidence that prisoners at Hull benefit from being placed in safer cells?

122. The available data do not allow us to determine whether or not safer cells are beneficial in terms of reducing self-harm and suicide at Hull. The main problem is that it is still too early to determine the effectiveness of the safer cells in reducing self-harm and suicide.

123. Due to the low numbers of suicides, we were not able to conduct before and after analyses (before and after safer cells were introduced), or to compare suicides in safer and non safer cells. However, some analyses comparing rates of self-harm across locations were able to be conducted and are reported below.

Suicides

124. To date, there are no obvious reductions in suicides since the introduction of safer cells. This is to be expected since safer cells were introduced a matter of months ago, and there are such small suicide rates. Nevertheless, by examining suicide patterns in Hull we can begin to develop ideas about the possible effectiveness of safer cells.

125. Since 1988 there have been 20 suicides in Hull, on average between one and two per year, although there were four in 2002. All 20 of these were by hanging and all occurred prior to safer cells being introduced, apart from the most recent suicide in April 2003 which occurred in the induction wing, in a non safer cell.

126. Suicide patterns at Hull over the past 15 years reflect the average pattern of suicides across the whole of the prison estate. They involved a range of ages - 19 to 56 years. Over half were unsentenced (60%) at the time of the suicide. Bedding was the most common ligature used (9 out of 20) and the most common ligature point was a window (11 out of 20). Ten occurred in normal location, 5 on the HCC, 1 on each of segregation and vulnerable prisoner unit, and two occurred in the hospital.

127. The most recent suicide occurred in April 2003 and involved a 23-year old remanded male who hung himself in his first few days using bedding as a ligature and the bed as the ligature point. This occurred in the induction unit in a normal single non safer cell. He was not on an open F2052SH.

Self-harm

128. The self-harm records prior to Dec 2002 are unreliable. However, we can gain some insight into self-harm patterns in Hull if we look at the four months from December 2002 to March 2003 from the point at which the new self-harm forms were introduced. During this four-month period there were 41 self-harm incidents at Hull, around 10 per month. Most were cutting although four were hanging and two were self-strangulations.

129. Since safer cells are designed to reduce ligature points it is also worthwhile exploring those self-harms involving ligatures. Table 4 provides details of these four incidents. There has also been one self-harm using self-strangulation since the safer cells have been in place. This occurred in an ordinary cell in the induction unit. It was a self-strangulation involving A&E by a 29-year old.

130. Only one of these incidents occurred in a safer cell, although, for this, ligature point details are unknown. The rest occurred in ordinary cells. The fact that a hanging incident in the CCTV cell occurred highlights the point that installing CCTV cameras in the cells is not in itself enough to prevent self-harm from occurring. Monitoring is as important as it is in other non CCTV cells.

Other self-harm incidents occurring in safer cells

131. Only one other of the 41 total self-harm incidents at Hull in the four months from 1st December 2002 incidents were recorded as occurring in a safer cell. The database records this as a segregation safer cell and involved an prisoner cutting himself with a razor. The prisoner was not on an open F2052SH form.

132. As there were 387 safer cells and 431 non safer cells, statistically it would be expected that by chance 19.4 of the 41 self-harm incidents should have occurred in safer cells. It does appear that safer cells are less likely to have had a self-harm incident occurring in them over the past four months compared with non safer cells.

133. The fact that only 2 self-harm incidents were recorded as occurring in safer cells even though around half the cells in the prison are safer is worth exploring. Perhaps the most likely explanation, and one felt to be the case by the SPC, has to do with the lack of vulnerability of the populations in the safer cells wings.

134. The SPC felt that the sex offenders and young offenders were both quite settled groups and he thought there had never been high rates of self-harm amongst young offenders at Hull. According to the SPC, problems with self-harm seemed to

	Hanging self-harms
Incident 1	The first hanging self-harm incident occurred in the HCC in a safer cell. This involved a 36 year old in a single CCTV Cell hanging using a shoelace but the ligature point is unknown. It is uncertain whether the CCTV was monitored at the time. The prisoner was not suspended – neither of his feet were lifted. No treatment was required.
Incident 2	The second self-harm case this year involving hanging occurred in the vulnerable prisoners unit in an ordinary cell and involved a 38 year old who used the window as a ligature point and bedding as the ligature. His feet were suspended but no treatment was required.
Incident 3	The third one occurred in the care and separation unit in a non safer cell and involved a 25 year old who hung himself from his light fitting using bedding. This required A&E treatment.
Incident 4	The fourth occurred soon after and involved a 21 year old who again hung himself from the light fitting using bedding on an ordinary cell in the induction unit but required no treatment.

Table 4. Hanging self-harm incidents at Hull from December 2002 to March 2003 (inclusive; four months in total).

be common on the vulnerable prisoner unit and the induction unit. In fact, around half of the 41 incidents over the past four months did occur on either the vulnerable prisoner unit (12 incidents) or the induction unit (9 incidents).

135. These results point to the possible benefit of rearranging Hull's accommodation units to house those most at risk. For example, there may be questions about why the induction unit and the vulnerable prisoners units are not located on safer cells wings.

CHAPTER 7: HMYOI FELTHAM

Summary

- YOI and Remand Centre for male juveniles and young offenders.
- 33 safer cells across the HCC, induction and residential units, all introduced in the last two years
- Since 1988 there have been nine suicides, none taking place in a safer cell
- There were on average 5 incidents of self-harm in 4 months since December 2002
- An at risk population with a high proportion of prisoners on remand and/or juveniles from a wide geographical area

Use of Safer Cells at Feltham

- Risk assessments at reception determine safer cell placement; on normal location a multi-disciplinary team assesses need
- Staff reluctant to allocate new prisoner to safer cell, unless seriously at risk, because of importance of normalising them and stigma
- Double cells mostly used for one prisoner only as two at risk prisoners cannot be held together, and other, non at risk prisoners do not often agree with being placed with an at risk prisoner
- Sometimes allocation difficulties occur on induction units – who is most at risk?
- Sometimes allocation difficulties when a prisoner threatens to suicide if he is placed on a safer cell (due to stigma)
- Staff would like more safer cells on residential units – sometimes at risk prisoners must be moved to induction units due to lack of safer cell spaces on residential units

Comparing Other Strategies with Safer Cells

- Staff thought good risk assessments, good staff-prisoner relationships, ongoing support for prisoners, normalised environment most effective
- Safer cells viewed as one tool as part of an overall strategy
- The Outreach Team well regarded by prisoners
- The Listeners Scheme was well regarded by prisoners although Listeners were thought to be too young in some cases

Staff and Prisoners' Feelings about Safer Cells

- In general, prisoners had mixed feelings about safer cells mainly due to the stigma attached to them, but many did believe they prevented the likelihood of hanging
- Staff felt safer cells were helpful in preventing impulsive suicides but not in stopping a determined prisoner as not all ligature points had been removed
- Staff did not think safer cells were particularly effective in reducing self-harm
- Most staff thought safer cells had had a positive effect on the prison as a whole and that Feltham could benefit from the installation of more safer cells

Unintended Consequences of Safer Cells

- Stigma was the main problem associated with the use of safer cells
- Other problems included increased feelings of isolation and the lack of ventilation

Do Safer Cells Work in Reducing Suicide and Self-harm?

- Findings suggested possible method displacement from more lethal (hanging) to less lethal (cutting) self-harm methods
- Most prisoners did believe that safer cells prevented the likelihood of hanging
- One prisoner had attempted suicide and failed because of the cell design
- Another prisoner had wanted to suicide but did not try because he did not think he could due to the design of the safer cell

The Prison

136. Feltham was formed by the amalgamation of Ashford Remand Centre and Feltham Youth Custody Centre in 1991. It holds those awaiting court hearings for London and the Home Counties, those sentenced who are awaiting transfer and those serving sentences. Feltham is divided into two main units, one of which holds juvenile prisoners (up to 17 years old; Feltham A), the other 18- to 21-year-olds (Feltham B). The prison has an operational capacity of 922 and a CNA of 886.

Juveniles (Feltham A)

137. The juvenile section (Feltham A) consists of 8 units, each holding 30 prisoners with 1 double and 28 single cells. Of these, 1 is an induction unit, and the remaining 7 are residential units, 4 for prisoners on remand and 3 for sentenced prisoners. Table 5 shows details of accommodation and safer cells.

Young offenders (Feltham B)

138. Feltham B has 13 units - a HCC with 20 places, a newly refurbished induction unit (30 places), and 9 residential units. These include 2 closed, 2 for prisoners on remand, 2 for convicted prisoners, 1 mixed (both unsentenced and convicted prisoners), 1 mixed for vulnerable prisoners, and 1 for enhanced convicted prisoners. Each of the residential units has around 56 places. What used to be the old induction unit at Feltham B is now being converted into a HCC. There is also a segregation unit in Feltham B (see Table 5).

139. Recent inspections have highlighted serious problems across many areas, including suicide and self-harm prevention. However, in the most recent inspection in 2002 some improvements were noted. A remaining significant problem in Feltham relates to staff shortages, which means that prisoners usually get less than the recommended 25 hours a week of purposeful activity and the ten hours out of their cell each day.

Safer cells at Feltham

140. There are 33 safer cells at Feltham, 6 located in the HCC, 6 in the juvenile induction unit, 1 in each of the 7 juvenile residential units, and 14 in the young offender induction unit (of which 11 are double and 3 are single). It is not clear exactly when the safer cells were introduced, since conflicting information was provided by the Safer Custody Group and the prison itself. It seems, however, that at least some were introduced sometime before the end of 2001.

141. A total of 15 new safer cells, some of them double, are to be introduced in a new HCC to be located in the young offenders section but available to all prisoners. In addition, all cells in the detoxification unit to be opened in September 2003 will be safer cells (CNA of approximately 20).

142. Safer cell design problems identified by staff included: (a) sinks are potential ligature points; (b) it is possible to use a fork to jam above the cell door to create a ligature point; and (c) televisions in safer cells are not boxed-in providing an opportunity for self-injury.

	Unit	CNA	No. SCs	Description
FELTHAM A	Bittern	30	6	Induction / FNC
	Curlew	30	1	Unconvicted
	Dunlin	30	1	Sentenced (Section 91 and DTOs)
	Eagle	30	1	Sentenced (Section 91 and DTOs)
	Falcon	30	1	Unconvicted
	Grebe	30	1	Sentenced
	Heron	30	1	Unconvicted
	Jay	30	1	Unconvicted
	HCC	20	6	
FELTHAM B	Kingfisher	30	14	Induction / FNC
	Lapwing	56		Being converted into new HCC at present
	Mallard	56		Remand and convicted
	Nightingale	56		Convicted
	Osprey	56		Remand
	Partridge	56		Closed
	Quail	56		Remand
	Raven	56		Remand and convicted vulnerable prisoners
	Swallow	56		Convicted
	Teal	44		Convicted enhanced prisoners
	Waite	56		Convicted
	Segregation Unit			

Table 5. Description of Feltham residential units, including CNA and number of safer cells.

Suicide and self-harm

143. Feltham holds a relatively at risk population, a high proportion being on remand and/or juveniles, from a wide geographical area. Since 1988, there have been 9 suicides in Feltham (2 in 1991, 2 in 1992, 1 in 1996, 2 in 1997, 1 in 2000 and 1 in 2001), none occurring in a safer cell. All suicides were by hanging, with windows as ligatures points and bedding as the ligatures being most common. There has been an average of around 5 self-harm incidents at Feltham per month since December 2002. On average, there may be 35 open F2052SH forms at any one time.

144. Although Feltham was criticised in recent inspectorate reports for some aspects of its self-harm and suicide prevention strategy, as one of the prisons in the Safer Locals Programme, a number of initiatives to prevent suicide and self-harm have been introduced in the last eighteen months. These include a peer support scheme, an Outreach Team, monthly Suicide Prevention Committee meetings, and there are now 18 Listeners and 22 Samaritan cordless phones in residential units and on reception. Those on open F2052SH forms are regularly reviewed by the Suicide Prevention and the Outreach Teams.

How are safer cells used at Feltham? Which prisoners are placed in safer cells? For what reasons?

Safer cells on the induction units

145. A suicide and self-harm risk assessment is conducted at reception where a multidisciplinary team decides the best method for handling those who may be suicidal or at risk of self-harm. As there are safer cells on both juvenile and young offender section induction units, decisions are made at this point about safer cell placement.

146. It is more often more difficult to determine how at risk young offenders are, as compared to juveniles. Staff indicated that when juveniles arrive at the prison they come with a lot of information about their personal history. With young offenders, the prison officers have much less information available and important details are often found out late.

147. Regardless of their at risk status, prison officers and Outreach Workers said that they were reluctant to recommend that a new prisoner go into a safer cell. They felt that it was important to normalise the prisoner into prison life from the outset, so they will 'fit in' and make friends. Although social isolation can be reduced through the use of the double safer cells on the induction units, there are serious problems with stigma at Feltham. Staff felt that beginning prison life in a safer cell marks the prisoner out as at risk and may jeopardise how well they adapt to prison life.

148. Nevertheless, those who are seriously at risk are often placed in safer cells. A problem with this process, staff said, was that too many new arrivals can be considered to be at risk, but the number of safer cells is limited, so that staff are sometimes faced with the problem of prioritising the most at risk. Situations potentially exist when an at risk prisoner has to be removed from a safer cell to allow a more at risk individual to use it. Questions arise over how to decide which individual is more at risk.

149. A further difficulty in reaching a decision arises when a prisoner is thought to be at risk, but threatens to kill himself if placed in a safer cell in order to avoid being stigmatised. Staff were concerned that if a decision was made to move or keep the prisoner in normal location but under supervision and he was still successful in harming himself, prison staff would be accountable for not holding the prisoner in a safer cell.

Normal location and HCC

150. Once on normal location, staff are able to build relationships with prisoners. If a change in mood or behaviour is noticed, this is reported to the Outreach Workers, a team of social workers who provide counselling and advice. As part of this process, a decision is made about whether to allocate the prisoner to a safer cell.

151. There are some problems with availability of safer cells in the residential units. In the young offender section, all 14 safer cells are located on the induction wing, and there are no safer cells on the residential units meaning prisoners have to be relocated to the induction unit if placed on a safer cell. Even on the juvenile section, where there are one safer cell per wing, sometimes at risk prisoners had

to be moved to the induction unit due to there being not enough safer cells available.

Single vs. double safer cells

152. There are 11 double cells, all on the young offender induction unit. Staff told us that most double safer cells are used for one prisoner only. This is because it is not appropriate to put two at risk prisoners together, and not many low risk prisoners at Feltham agree to be placed in a double cell with an at risk prisoner. This is likely to be due to the stigma attached to safer cells. Staff also pointed out that it may be inappropriate to expect young prisoners to undertake the emotional task of being a cell mate of a self-harming or suicidal prisoner.

How do other methods used at Feltham compare with safer cells?

153. Staff at Feltham widely viewed safer cells as only one part of an overall programme of care for at risk prisoners. Staff believed that the most important suicide prevention approach was a good risk assessment process, followed by the development of a solid relationship with prisoners and ongoing support. They also emphasised the need for a 'normalised' environment, particularly when the prisoners first arrive.

154. An important source of support for suicidal and self-harming individuals at Feltham came from the Outreach Workers. The majority of the 10 at risk prisoners interviewed had found the Outreach Workers very helpful. One prisoner said: 'Outreach is excellent. They don't judge or criticise you for why you are in there and they are there to help you (...) After I talk to them I feel better'.

155. Some of those interviewed had utilised the Listeners and indicated that they were useful. However, one criticism of the Listeners scheme was that the Listeners were too young, therefore, prisoners felt it was less effective than at other prisons.

156. However, safer cells were still viewed as playing an important and unique role in reducing suicide and self-harm at Feltham. In questionnaires, staff rated safer cells as effective in comparison to both normal location and alternative forms of management accommodation, including gated observation cells (see Table 6). In addition, staff indicated they would like more safer cells on residential units since there are often not enough.

How useful are safer cells to manage at risk prisoners compared with...	...normal location?		...alternative management accommodation?	
Very useful	36	(57.1%)	26	(41.3%)
Somewhat useful	25	(39.7%)	28	(44.4%)
About the same	2	(3.2%)	9	(14.3%)
TOTAL	63	(100%)	63	(100%)

Table 6. Staff perceptions of usefulness of safer cells compared with alternative accommodation (from the questionnaire data, N=63).

How do prisoners and staff at Feltham feel about safer cells?

Prisoners

157. Ten prisoners were interviewed at Feltham. Overall, prisoners interviewed were mixed or indifferent in their feelings about the layout of safer cells. Phrases such as 'they are alright, I guess' were commonly used to describe their layout. However, the majority acknowledged that safer cells did prevent the likelihood of hanging. Two of the prisoners also indicated that the safer cells gave them time to think when they felt suicidal.

158. Prisoners were also mixed in their attitudes towards being in safer cells and eight admitted to stigmatisation and bullying as a result of being in a safer cell (stigma is discussed in more detail in the section 'unintended consequences' below). Five of those interviewed suggested that they would like to see a friend at risk of suicide placed in a safer cell. Two indicated they would not like to see a friend placed in the safer cell, suggesting that being in the cell creates a 'lack of control' that can result in anger. A further two suggested that they would like to see an at risk friend placed in the safer cell in conjunction with, or following an alternative intervention, such as talking to Outreach Workers or family. A further two suggested an alternative management strategy all together, such as talking with staff and Outreach Workers. Further, two of the prisoners indicated that they became angry because they were not consulted when placed in a safer cell.

Staff

159. Overall, staff believed that the safer cells were useful in reducing the opportunities for hanging where suicide was an impulsive act. For those determined to commit suicide, the general sentiment was that the prisoner would find a way. Staff participating in the focus group stressed that although safer cells have effectively removed some ligature points, it was still possible to commit suicide in safer cells due to design problems to do with the sinks, televisions, and doors.

160. Staff did not think the safer cells were particularly effective in reducing self-harm, since the majority of self-harm involves cutting.

161. Forty-nine of the 63 prison officers who completed the questionnaire (78%) thought safer cells had made an overall effect on the prison as a whole and almost all of these thought the effect was either very positive or somewhat positive. One of the staff stated that the introduction of safer cells had increased awareness of the issues of suicide and self-harm prevention.

Are there any unintended consequences of using safer cells at Feltham?

162. The main problem associated with the use of safer cells was the stigmatisation attached to these, which made at risk prisoners to be more easily identified and then targeted for different forms of abuse. This led many prisoners to refuse to be placed in safer cells, some even threatening to vandalise them. Other problems reported include the lack of ventilation and its consequent effects on the mood and health of the prisoners placed in the safer cells, the lack of privacy, and staff concerns about over-reliance on safer cells.

Stigma

163. Staff indicated that stigma is a key problem with safer cells. Prisoners in safer cells may be labelled 'fraggles' as a form of ridicule. Some prisoners stated that they would rather remain in segregation than be placed in a safer cell. There appeared to be a genuine fear among prisoners of being seen to be different or weak through being in a safer cell. Safer cell prisoners are sometimes subject to violence, almost always subject to verbal threats or taunts, and victimised in other ways, such as having their food stolen at lunch. One staff member indicated that the stigma can be so great that the bullying received has caused suicide attempts among some at risk prisoners.

164. Conversely, if being bullied already, a prisoner will sometimes request being placed in a safer cell. Safer cells allow these individuals to more easily avoid interacting with other prisoners or being involved in shout outs while in the cells, since the windows do not open. However, it was noted that some of the safer cells (it is not clear which ones) were geographically in a position whereby other prisoners are able to constantly walk past the cells providing the opportunity to threaten those in safer cells.

165. In line with the staff focus group findings, eight out of the ten prisoners interviewed identified stigma and bullying as a consequence of being placed in the safer cell, and reported experiencing many of the forms of abuse described above. One of the two prisoners who indicated no stigma or bullying as a result of being placed in the safer cell said that this was due to him being placed in there at the induction stage along with others. He said that, because of this, he was not identified as at risk.

Lack of ventilation

166. Both staff and prisoners identified the lack of ventilation as a limitation in the design of the safer cells. This causes the temperatures to be too hot in the summer but too cold during the winter, and can lead to prisoners feeling claustrophobic and uncomfortable, which can, in turn, make them angry, and can lead to worsened depression, panic attacks and related health problems.

Other cell design issues

167. One prisoner complained about the lack of privacy while being placed in a safer cell, which he said was disruptive, especially during the night when he was trying to sleep. Furthermore, two of the prisoners complained that there was a lack of storage space in the cells. In contrast, a further two prisoners indicated that the cells were more spacious, modern and generally more aesthetically pleasing than normal cells.

Vandalism

168. Two prisoners suggested that being in the cell creates a lack of control that can result in anger. Prisoners also indicated that they were very frustrated and angry when placed in the safer cell without being consulted. One member of staff pointed out that threats of vandalism were often made when an prisoner was told he was to be moved to a safer cell, due to the stigma attached to them. Three prisoners

said they had wanted or tried to 'smash-up' the safer cell, but they all said that they could not do it, due to the cell design and the strength of the furniture.

Over-reliance on safer cells

169. Staff suggested there is a danger associated with viewing safer cells as the only way to solve problems of suicide and self-harm. They felt there could be a danger of over-reliance on their use at the expense of more effective approaches to suicide prevention.

Is there any evidence that prisoners at Feltham benefit from being placed in a safer cell?

170. No firm conclusions can be made from the suicide and self-harm data in terms of changes in rates of self-harm and suicide. Complicating matters, no reliable information could be obtained regarding the exact date the safer cells were introduced at Feltham. Nevertheless, an examination of descriptive elements of the data can throw some light on their usefulness. We can gain some insight into potential locations we may expect safer cells to have an impact by examining the suicide and self-harm data, particularly those involving ligature points.

Suicides

171. No suicides have occurred at Feltham since 2002, which was around the time the safer cells and the other initiatives in the Safer Locals Programme were introduced. However, from 1988 to 2001 (inclusive), there were 9 suicides (all hanging) in Feltham, at a rate of around 1 or 2 every couple of years. Windows as ligatures points and bedding as ligatures were most common. Prisoners were from a range of age groups, most were on normal location, and all but two were unsentenced. There was no data available on whether prisoners were on an open F2052SH form at the time.

Self-harm

172. There is a longer time frame of reliable self-harm data available for Feltham because the new self-harm monitoring system was piloted there. Examination of this shows that between November 2001 to August 2002, and from December 2002 to March 2003 (inclusive; fourteen months altogether)[3], there were 217 self-harm incidents at Feltham, of which 80 took place in safer cells.

173. Of those occurring in safer cells, only four were by hanging. (In all four self-harm hanging cases in safer cells, bedding was used as a ligature. The ligature was attached to a different ligature point in each case, namely a door, a window, a toilet area, and railings.) If we compare the methods used to self-harm in safer cells with those used to self-harm in other locations during this time period, it seems that some degree of method substitution took place. Specifically, the results suggest that hanging is less common in safer cells but that cutting is more common in safer cells compared with other cells (see Table 7).

[3] Extra detailed data are available for HMYOI Feltham, which was part of the Safer Locals Programme. Unfortunately, the database is incomplete and lacks information from September 2002 to November 2002 (inclusive).

174. As can be seen from Table 7, cutting was more prevalent in safer cells (65% of self-harm in safer cells was by cutting but cutting accounted for 45% in other cells), while hanging was more common in other types of cells (5% of self-harms in safer cells were hanging but accounted for around 18% of self-harm incidents in other cells).

175. Although numbers are small, it does not appear that self-strangulation is more common in safer cells at Feltham than on ordinary location, suggesting that it is possible that prisoners are not exchanging hanging for self-strangulation, but rather they are exchanging hanging for cutting.

176. This very tentative finding will be useful to follow up because, whilst it does suggest some method displacement is occurring, less lethal methods such as cutting may be being used instead of more lethal methods such as hanging.

177. The possibility that more lethal methods are being at least in part exchanged for less lethal methods such as cutting suggests the possibility that, over a long time frame, there may be fewer suicides in total, particularly if safer cells can be made truly ligature free.

178. The possibility that safer cells may reduce suicides in the long-term at Feltham is supported by information obtained from prisoner interviews. For example, two prisoners felt it was not possible to hang oneself in a safer cell, one of them having tried and failed. This particular prisoner stated that he had attempted suicide by hanging in a safer cell but was not successful due to the design of the cell, i.e. lack of ligature points. He indicated that he would have successfully killed himself had he been in a normal cell. He also pointed out that, by the time he was moved back to normal location, he no longer felt like harming himself. A second prisoner said he had wanted to commit suicide but had not tried to since he knew he would not be able to. He said:

> *'When I am in the [safer] cell I sometimes think "F**k it! I want to end it". Then I sit around for an hour or so and try to work out a way. But there is no way when it comes down to it. I just think about it and feel better. They are effective in that way. They change people's minds. Because when you can't do something, you just stop trying*.'

179. A further two prisoners agreed that it was not possible to hang oneself in a safer cell. As one of them put it, 'you can hang yourself in a normal cell - it's easy. But in the safer cell you can't do that. There is nothing in there that you can hang yourself with. It's not possible.' Only one prisoner stated that he had heard there was a way of hanging yourself in the safer cells, but he himself did not know how. Some prisoners interviewed, however, believed a safer cell would not stop a determined individual who would simply wait for the opportunity.

	Safer cells		Other cells	
Method	**N**	**(%)**	**N**	**(%)**
Cutting	52	(65.0)	62	(45.3)
Hanging	4	(5.0)	24	(17.5)
Self-strangulation	9	(11.3)	13	(9.5)
Burning	1	(1.3)	3	(2.2)
Poisoning / swallowing objects	6	(7.5)	12	(8.8)
Head banging / wall punching	3	(3.8)	14	(10.2)
Wound aggravation	3	(3.8)	3	(2.2)
Suffocation	1	(1.3)	2	(1.5)
Other	1	(1.3)	4	(2.9)
TOTAL	**80**	**(100.0)**	**137**	**(100.0)**

Table 7. Method employed in self-harm incidents taking place in safer cells as compared to other types of cells in Feltham, from November 2001 to August 2002 and from December 2002 to March 2003 (inclusive; fourteen months in total).

CHAPTER 8: HMYOI EASTWOOD PARK

Summary

- Eastwood Park, a female closed local prison with high levels of self-harm and suicide risk
- There are 12 single safer and reduced risk cells and more reduced risk cells are being phased into its detoxification and induction unit. Eight of the existing cells are on the young offender wing, and the other 4 are in the HCC. Adults may only be placed in young offender wing safer cells overnight, so the safer cells are currently most often used with under 21s

Use of Safer Cells at Eastwood Park

- The existing safer cells at Eastwood Park are not often used as a method of managing suicide or self-harm, except in the case of under 21s who often spend their first night in a safer cell
- Suicide and self-harm risk are at times viewed by staff as contra-indicative for safer cells – often staff will actually rule out the use of a safe cell for a suicidal/ self-harm prisoner on the basis that the safer cell is likely to be more emotionally harmful to the prisoner compared with keeping her on normal location
- Safer cells are used as punishment, for violent and refractory prisoners, at the prisoners request and for demanding prisoners to give staff respite

Comparing Other Strategies with Safer Cells

- Shared accommodation was thought by staff to be the most effective method of managing at risk prisoners. There are no double safer cells
- Special accommodation (strip cells) are not used
- Safer cells are useful but staff felt that both safer clothing and bedding are needed or that clothing can be removed during a crisis

Staff and Prisoners' Feelings about Safer Cells

- Prisoners do not like safer cells
- Staff were more neutral but urgent need for more double cells on adult wings
- All prisoners interviewed were concerned about windows and ventilation
- Other criticisms included dirtiness, oldness, unhomely and uncomfortable
- Staff and prisoners thought safer cells were a good measure in a crisis period

Unintended Consequences of Safer Cells

- There appeared to be some negative emotional effects of existing safer cells including frustration, depression and tearfulness
- Some prisoners said it made them want to self-harm more
- Stigma was not a problem
- 2 out of 8 prisoners had vandalised a safer cell
- 1 of the 8 prisoners said she had once waited until she left the safer cell to self-harm

Do Safer Cells Work in Reducing Suicide and Self-harm?

- Minimal evidence that prisoners benefit from the existing safer cells – too few of them, disliked by prisoners, not used as intended
- Few self-harms recorded in safer cells but this is because least at risk prisoners placed in them
- In depth case studies of 10 self-harming prisoners across time suggests self-harm stayed the same or increased in safer cells
- Most recent suicide was in safer cell, by self-strangulation; this was different to previous 5 suicides which all involved ligature points; suggesting method displacement to less lethal method
- Safer bedding and clothing may have prevented this suicide but long-term problems with these must be considered
- Examination of literature and data suggests safer cells should be used in women's prisons – women suicide overwhelmingly by hanging (at similar rates to men), have very high self-harm rates and absolute numbers of self-harm hangings are high – around 1/3 of the total self-harm hangings across the estate

The Prison

180. Eastwood Park is a female closed local prison, which opened in its current form in 1996, with a population at the time of this research of 259 (operational capacity of 325; CNA of 295) including 46 under 21s, 9 of whom are under 18. There are six residential units, one of which (D Wing) holds young offenders and juveniles, and it is here that most of the safer and reduced risk cells are located. D Wing has 36 cells in total, 14 of which are double, 8 are single, and the other 8 are single safer cells.

Suicide and self-harm at Eastwood Park

181. Eastwood Park has high levels of prisoner self-harm and suicide risk (HM Inspectorate of Prisons, 2001). Since opening, there have been 6 suicides, 3 occurring in 2000, and 1 in both 2001 and 2002. There has also been 1 suicide so far in 2003 occurring in January. The self-harm rate is also high with around 36 incidents per month occurring since December 2002.

182. These high rates are in part due to the high proportion of women who have serious mental health problems and personality disturbances. Recent inspection reports (e.g., HM Inspectorate of Prisons, 2001) raise concerns about the inability of staff at Eastwood Park to provide a safe and secure environment for prisoners due to overcrowding, staff shortages, and lack of staff training and specialist staff. This is despite the very good work done by many staff. According to the SPC, crowding is no longer such a big problem but there are still dramatic staff shortages and only 44% of staff have received suicide prevention training. Risk assessments on reception are still carried out by non-specialist agency nurses.

183. As a pilot in the Safer Locals Programme, Eastwood Park has had a SPC for the past 3 years. It has a Suicide Prevention Team which meet monthly, and multidisciplinary teams meet weekly to discuss those on open F2052SH forms. Very recently, improvements to reception procedures, first night induction procedures, and the development of a detoxification centre have occurred, some of which involve the construction of reduced risk cells.

Safer and reduced risk cells at Eastwood Park

184. At this time, Eastwood Park has only a small number of operational safer and reduced risk cells – only 12 of a total of 156 cells, all of which are single occupancy. Eight of these are on D Wing, introduced in 1998. The other 4 safer cells are in the HCC. The HCC is made up of these 4 safer cells and 2 double gated cells. Two reduced risk cells were introduced in 2002, and the other 2 in 2003.

185. Strictly, 4 of the 8 safer cells in D Wing are actually reduced risk cells, in that they have a number of ligature points remaining (e.g., have standard light fittings rather than corniced lighting) and have privacy screens. The HCC safer cells are also more accurately called reduced risk cells for the same reasons.

186. A number of new reduced risk cells are being phased in at Eastwood Park. A double reduced risk cell has very recently been constructed on the induction unit and is now operational but was not at the time this research was carried out. This was converted from two existing single cells into one double safer cell. A new

detoxification unit is also being built fitted out with entirely reduced risk, and mostly double cells.

How are safer cells used at Eastwood Park? Which prisoners are placed in safer cells? For what reasons?

187. The SCP told us that there is no official policy specifying how safer cells should be used or who should be placed in them. Our research suggested that there appears to be an informal policy of *not* using the existing safer and reduced risk cells for those at risk of suicide or self-harm. Only rarely do the safer cells appear to be used to increase the safety of women at direct risk of self-harm or suicide. Instead, they are used for a variety of other reasons, including as normal accommodation for under 21's, at the request of a prisoner herself, as a method of punishment for those on basic levels of the incentives and earned privileges system, and as a method of controlling violent and refractory prisoners. The HCC safer cells are often used to 'give staff a break' from disruptive patients. Each of these are described in more detail below.

188. It is worth noting that focus group staff told us they were concerned about being blamed if a prisoner was to commit suicide without having been placed in a safer cell. They stated that these considerations affect their decisions about who goes in a safer cell.

For those at risk of suicide or self-harm

189. Focus group staff told us that current safer and reduced risk cells are not seen as a priority tool for prisoners at risk, aside from new under 21s who are often placed there on their first nights. It seemed that there was an informal policy of *not* using safer cells for those on open F2052SH forms. For example, one officer wrote on a questionnaire: 'we don't use them [safer cells]. We cannot punish the suicidal by placing them in safer cells'. We also noted that the SPC could identify only 10 prisoners who had both been in a safer cell at some point in time and who had also been on an F2052SH form at some point, suggesting those at risk were not routinely placed in safer cells. Further, our inspection of 10 individual case records suggested that, on occasion, when an F2052SH form was opened, the multi-disciplinary team actively decided not to move the at risk woman to a safer cell because of the possible negative emotional impact of the safer cell environment.

190. Staff told us that if they ever do believe an at risk prisoner may benefit from being in a safer cell, they then usually must convince or persuade the prisoner since prisoners do not on the whole like safer cells. For this reason, most focus group staff felt that the best way to use safer cells was at the request of the prisoner herself. Nevertheless, it seemed that some staff felt that it was unfortunate that safer cells were not more liked by the prisoners, since some of them could benefit from their 'safe' attributes.

191. It was, however, evident that, at least occasionally, prisoners at Eastwood Park are placed in safer cells whilst they are at risk to minimise their opportunities to self-harming or committing suicide. For example, the woman who suicided by self-strangulation in a safer cell January this year was placed in a safer cell because it she had started ligaturing and staff were concerned for her safety. Also, two of eight women interviewed by us thought they had been placed in a safer cell as a

safety measure because they were self-harming or suicidal. It appears that woman are placed in safer cells for their own safety only occasionally as a last resort.

192. One problem is that because the ordinary location safer cells are all located on D Wing, adults who are at risk may only be placed there overnight. Aside from the problem of the limited time an adult can spend in a safer cell, all adults must be removed from their normal location to a safer cell, which can be isolating for the prisoner.

At the prisoner's request

193. Staff in the focus group told us that it was common for women to be placed in a safer cell as the result of a request by a prisoner herself. The reasons women request to be moved to a safer cell, however, are usually unrelated or only indirectly related to self-harm or suicide risk. Staff told us that these commonly include: (a) to be released from the 'pressure on the wing', (b) need for a 'change', (c) to cope with a 'crisis', and (d) because they enjoy the increased observation of the safer cells. For example, one prisoner from the 10 case studies requested a move to a safer cell because she normally shared a call and she needed some time on her own.

As punishment

194. Some of the prisoners interviewed told us that safer cells were sometimes used as punishment for women on the basic level of the incentives and earned privileges scheme. In fact, 2 of 10 prisoners interviewed stated their reason for being placed in a safer cell was for punishment. The SPC stated that because the women do not like the safer cells, the staff tend to use them as a method of punishment.

For violent and refractory prisoners

195. Staff also explained that prisoners may be placed in safer cells to manage their violent or refractory behaviour. This can be a an attractive alternative to other control methods (such as special accommodation on C Wing) as there is less paperwork involved in removal to safer cells.

To give staff respite from disruptive prisoners'

196. There were also suggestions that the four cells in the HCC were often used to give staff some respite from disruptive and demanding prisoners. The last Inspectorate report described the HCC as 'bleak' and stated that the nursing staff were often overworked in looking after these disruptive patients. According to this report, there were many seriously disruptive and mentally ill women in the HCC at any one time, making it a very difficult unit to work on.

How do other methods used at Eastwood Park compare with safer cells?

197. Self-harm and suicidal behaviour were usually managed through other methods and accommodation at Eastwood Park. The importance of not isolating at risk women, and the role of relationship building were emphasised by both staff and prisoners. Staff focus groups and prisoner interviews suggested that women who

were at risk of self-harming or suiciding were best usually in double cells. Double cells, and other accommodation and methods are described below.

Double cells

198. In addition to the 8 safer and reduced risk cells, D Wing has 14 double cells (as well as 8 single cells). The women interviewed all viewed the use of double cells favourably for women who were at risk. Wing staff told us that there are many requests for double cells, which are far more popular than the single cells in D Wing. The SPC also told us that he believed there was an urgent need for reduced risk double cells in the main adult ward.

Gated observation cells

199. There are two gated (double) cells in the HCC. The SPC told us that these are used for the most needy health care prisoners. The safer cells, according to our research, are used for those who are not at such high risk, or those who are causing a disturbance to prison staff.

'Special accommodation' cells

200. On C Wing, the vulnerable adult women's wing, there are two 'special accommodation' cells, previously known as 'strip cells'. Women who are violent or refractory may be placed in these cells, whereas at risk women may not be. Clothes and bedding are allowed to be removed from prisoners in these cells but this is not the case in safer cells where clothes, etc. are not allowed to be removed.

201. Focus group staff expressed the wish to be able to use these 'special accommodation' cells for suicidal prisoners who were using clothing and bedding as ligatures. These staff suggested humane but 'safer' clothes or anti-tear bedding would be helpful in these situations. Another possibility they suggested was that someone senior should have the authority to recommend temporary stripping. They argued that whilst there is always a need to maintain a prisoner's dignity and self-worth, at times at times of extreme crisis in order to save someone's life, there should be the provision to use stripping until the period of crisis is over.

Other methods

202. Eastwood Park has a very new Listeners Scheme (there are six available), and has Samaritans but at the time the research was conducted none of the six phones were working. The Care Suite was also very new and had not been used many times when this research was carried out.

How do prisoners and staff at Eastwood Park feel about safer cells?

Prisoners

203. We interviewed eight prisoners, and their average age was 19 years. All of them were from D Wing. All except 2 had histories of self-harm and/ or suicide attempts and had had experience in the safer cells. The prisoners interviewed unanimously

expressed negative attitudes towards the existing safer and reduced risk cells at Eastwood Park. The only thing positive stated was by one who said safer cells gave her time to think due to the absence of distractions. The SPC agreed that the prisoners preferred ordinary location cells to the safer cells.

204. The biggest complaint, and one expressed by each of the eight prisoners, concerned the windows and lack of ventilation. Women felt the cells were too hot in the summer, too cold in the winter, and generally stuffy. They were also described as difficult to keep clean and dirty (3 prisoners described them as 'filthy'), and the sinks were thought to be unsatisfactory as they were often not working properly. Four prisoners complained that the toilets had no seats. The prisoners' comments collectively give the impression that they viewed the cells as unhomely, badly ventilated, and not conducive to creating an environment that could comfort a suicidal individual.

205. Two prisoners conceded that a single safer cell could be a good measure to get an at risk prisoner through a short crisis period, however 6 prisoners were sceptical about the value of this and 3 commented that they would never want an at risk friend to go into one unless it was double and she could go in with a friend.

206. Although it may be too early to tell, it is likely the prisoners will find the newer cells being built much more acceptable. The SPC commented that prisoners like the double cell on induction. According to the SPC this cell is more aesthetically pleasing than those on D Wing and the HCC and the women like them partly due to this and partly due to the fact that they are double.

Staff

207. Focus group were fairly neutral in their attitudes about the helpfulness of the safer cells on D Wing and the HCC. Most acknowledged safer cells could be helpful in times of crisis but thought it was a pity that the current safer cells were not liked by prisoners. However, the SPC was much more positive about the newer safer cells and said that he felt there was a strong need for more reduced risk double cells, particularly on E Wing, the large adult wing. He said 3-4 would be good, but if money were no object ideally all of them should be fitted with this newer furniture.

208. In terms of the benefits of safer cells in terms of reducing suicide and self-harm, staff focus group participants suggested they did not think safer cells reduced suicide but felt it may make it easier for prisoners in some ways (by providing time out, etc.) as well as making it easier for staff by giving them a break. Staff also felt that safer cells do not stop ligaturing because of the rules preventing clothing from being taken from a suicidal prisoner. All staff felt that 'safer clothing' should be used and acknowledged the need for them to be more appealing.

Are there any unintended negative consequences of using safer cells at Eastwood Park?

Dehumanising effects

209. Our research suggests that the negative aspects of the safer cells did lead to some negative emotional states for the women who were placed in them. In fact, as

described above, sometimes safer cells were ruled out in F2052SH management meetings due to the possible negative emotional impact.

210. Because some of the women we interviewed were placed in the safer cells as punishment (and other reasons aside from vulnerability), it is difficult to tell the extent to which their negative responses to the safer cells were based on the safer cell itself or the circumstances surrounding their entry into the safer cell. Nevertheless, there is some suggestion from the interviews that the safer cells themselves had a negative impact on their emotions and behaviour, separately from the circumstances surrounding it.

211. Five prisoners said they felt angry because they were in the cell against their wishes, but they indicated this was exacerbated by the heat and lack of ventilation in the safer cell. Another prisoner said she felt 'frustrated' because there was nothing to do or look at. Another prisoner said she felt dizzy and faint due to the heat. Three prisoners said the cells had made them feel depressed and tearful. One woman said the safer cell had made her want to self-harm more. She had once made a ligature in her safer cell by putting her chair in the sink plughole and using her shoelaces as a ligature. One prisoner said it made her feel she wanted to 'curl up and die'.

212. There is a possibility that some women self-harm in safer cells as a way of alerting staff to their distress. One prisoner who was moved to the safer cell as punishment, self-harmed whilst in there using a razor. She explained that she self-harmed as a way of coping when she is depressed and that staff 'take notice of you when you self-harm'. The increased observations in safer cells may make this more likely.

Stigma

213. Stigma did not seem to be a problem for those at Eastwood Park, probably because they were not used for those who are likely to be stigmatised and because so many women self-harm anyway. Self-harm is not stigmatised as much amongst women prisoners as with men.

Vandalism

214. Six of the eight prisoners interviewed believed it was impossible to 'smash up' safer cells, but one said she had broken the television and radio in her safer cell although it is not clear why she did this. Another reported that she never feels the need to vandalise normal cells, but in a safer cell she punches the wall. It is difficult to determine if this is because of the safer cell environment itself or due to the circumstances surrounding her entry into the safer cell.

Alternative or displaced suicidal or self-harming behaviour

215. Prisoners at Eastwood Park do not tend to be kept in the safer cells for very long periods of time. Perhaps for this reason, one prisoner said she had waited until she left the safer cell to self-harm if she wanted to.

Is there any evidence that prisoners at Eastwood Park benefit from being placed in a safer cell in terms of reduced self-harm and suicide rates?

216. From the quantitative and qualitative research conducted there appears to be minimal evidence to suggest that prisoners benefit from being placed in safer cells as they currently exist at Eastwood Park. These findings seemed to be supported by responses to Eastwood Park staff surveys. Around half the 19 staff who participated said they thought safer cells were 'somewhat' beneficial, but almost a half were not sure or said they were not beneficial.

217. As with most of the prisons investigated in this report, rigorous statistical analyses were not possible due to small suicide numbers and due to unreliable self-harm data before December 2002. It is worth bearing in mind that, broadly speaking, even if data were more reliable and we had higher base rates, a clear reduction in overall numbers of suicides or self-harm incidents at Eastwood Park could not be expected due to the small numbers of safer cells installed in the prison, and because the cells have not been used in their intended way. Nevertheless, it is helpful to look in more detail at the suicide and self-harm data that is available. Statistically, there has been no immediate or apparent reduction in suicides or self-harm since the introduction of safer cells at Eastwood Park.

Suicides

218. There are no obvious reductions in suicides since safer cells have been introduced. In fact, the most recent suicide occurred in a safer cell. Safer cells were introduced to D Wing in 1998, and to the HCC in 2002 and 2003. There were six suicides throughout this period, three of which occurred in 2000 and one each year after that. They occurred in various locations throughout the establishment including a safer cell on D Wing in the most recent suicide by self-strangulation in January 2003. (Of the others, 1 occurred in segregation, 1 in the HCC prior to the installation of the safer cells there and 3 on ordinary location.) Three were under 21s and the other three were between 21 and 24.

219. Regarding this safer cell suicide, the SIO report was not available at the time this research was conducted however some details are known. The prisoner was described by the SPC as a prolific self-harmer whose method was usually cutting. In the weeks leading up to her death, she had started ligaturing, prompting staff to move her to a safer cell. The woman was on an open F2052SH form. She was on intermittent supervision but this was reduced to 3 in 1 at the time of her suicide. She was found with a torn towel tightly wrapped around her neck. From the information available, there seems to be nothing to suggest that the safer cell had worsened her emotional state. Nor is there anything to suggest this prisoner would not have suicided in an ordinary cell using the same method or an alternative method.

220. The suicide method used by this woman, self-strangulation, was different from that used by the previous five suicides at Eastwood Park in that it did not involve a ligature point. It is possible she may have hung herself instead had there been a ligature point available. Although it is never possible to prevent all suicides, there is always the possibility that if there was provision to replace her towel with a safer one, she may have been prevented from committing suicide.

Self-harm

221. If we examine self-harm rates in D Wing compared with the ordinary cells in D Wing over the first four months since the introduction of the new self-harm monitoring form, we can see that of the 21 self-harm incidents during the four month period on D-wing, only one occurred in a safer cell. Although this may appear to suggest that self-harm is occurring less often in safer cells on D Wing than in ordinary cells, this finding in fact tells us little firstly because the numbers are too small to be reliable, and secondly, since often at Eastwood Park those who are most at risk are actively kept out of safer cells. In other words, those most likely to self-harm are probably not being placed in safer cells, resulting in fewer records of self-harm in safer cells.

222. If we examine the 10 case studies of individual women who have self-harmed in Eastwood Park who have spent time in safer cells, we can see that self-harming women who are placed on safer cells do not show reduced self-harming behaviour. In most cases the women reported just as much, if not more in some cases, self-harming behaviour using bed linen as ligatures, head banging, cutting, etc.

223. In sum, our research suggests that even when we look closely at the experiences of those in safer cells as they currently exist, there is little evidence to suggest they are beneficial in their current form for prisoners in terms of reductions in self-harm behaviour, suicidal feelings and behaviour.

CHAPTER 9: HMP DOVEGATE

Summary

- New, private Category B prison for adult males serving four years or over
- Opened 2001; includes a Therapeutic Community for 200
- Suicide rate is high - 4 suicides in 2002; 3 were by hanging from the cell door upper hinge very close in time
- Door design problems now fixed; staff failure to implement observations also played role
- No suicides in Therapeutic Community
- Self-harm rate very high – over 4 times higher than average Cat. B rate
- Dovegate has serious problems with high staff turnover (30% left in 2002), staff shortages, and recruitment of very inexperienced staff
- These may be 'teething' problems to do with young age of prison
- High suicide and self-harm rates should be considered in this context

Use of Safer Cells at Dovegate
- All cells are safer cells; 2 double cells per wing
- Double (safer) cells are not used for at risk prisoners

Comparing Other Strategies with Safer Cells
- Staff thought positive staff-prisoner relationships important, but prisoners thought good relationships did not always exist
- Possible over-reliance on CCTV in corridors to monitor prisoners at expense of prisoner-staff relationships
- Listener Scheme highly spoken of by staff and prisoners
- No gated observation cell or care suite; staff would like these
- Prisoners want more staff, especially psychologists

Staff and Prisoners' Feelings about Safer Cells
- Staff and prisoners had mixed feelings about safer cells
- They acknowledge their value in removing ligature points
- But both staff and inmates pointed out the lack of ventilation as a major design problem
- Other design problems: insects breed in vents; heating problems; trickle vent system resulted in unpleasant odours from nearby farms
- Prisoners do not like double cells, due to small size and ventilation problems
- Thought by staff to have little effect on self-harm due to availability of razors

Unintended Consequences of Safer Cells
- Lack of ventilation, leading to anger and worsened mental and physical health
- These problems most acute in double cells

Do Safer Cells Work in Reducing Suicide and Self-harm?
- High suicide rate show that safer cells are not themselves enough to prevent suicide and self-harm from occurring.
- Safer cells were not enough to mitigate 'teething problems' of staff shortages, high turnover, staff inexperience
- It is likely that if prison was not safer cell designed there would have been more suicides and self-harm incidents
- That ligatures were improvised shows safer cells cannot be completely safe but points to importance of minimising ligature points where possible
- That 3 possible 'copycat' suicides occurred using door hinges shows importance of rectifying design problems immediately

The Prison

224. Dovegate is a privately operated, purpose built, Category B training prison for adult males (over 21 years of age) serving four years and over. It is a new prison – opening in 2001 and including a Therapeutic Community accommodating 200. It has an operational capacity of 860 (CNA is 800) including up to 90 prisoners serving life sentences.

225. Since opening, Dovegate has had an extremely high turnover of staff (almost 30% of staff left during 2001), and has been criticised along with other private prisons for recruiting generally very inexperienced staff (National Audit Office, 2003). These may be 'teething problems' since it has been operational for only a short period of time. The high number of suicides occurring at Dovegate in 2002 should also be viewed in this context.

Safer cells at Dovegate

226. All cells were constructed as safer cells, of which 720 are single and 84 double. There are also six dorms, each holding 12 prisoners. Most double cells were converted from single cells and are either bunked or twin rooms.

227. Safer cell features include: a moulded light, screened-off toilet facilities, vent windows, moulded beds, fixed desks, one shelf and one cupboard (with rounded edges). The double cells, which have been converted from singles by installing an extra moulded bed above the original, have shower curtains to section off the toilet facilities completely. There are approximately two double safer cells per wing.

228. Overall, Dovegate has a radial design, with an observation point in middle, which allows easier observation. CCTV cameras are also installed in the corridors and association areas. This design, however, is less conducive to direct staff-prisoner interaction.

Suicide and self-harm

229. The suicide and self-harm rate at Dovegate is very high. Four suicides occurred in 2002 and the self-harm rate of 94 per 1000 prisoners is over 4 times higher than the average Category B prison rate.

230. Dovegate appears to have suicide and self-harm policies in place and overall offers a full and varied regime. On average, there may be about five open F2052SH risk assessment forms at any one time, and these are regularly reviewed. The Suicide Prevention Committee meets monthly and receives external advice. All reception staff are trained in suicide awareness. Agency staff are not employed on a regular basis, and, when they are, they are not based in the reception unit. A reception programme has been in place since 2002, and a Listeners scheme also exists, with twelve Listeners. There are, however, no peer support schemes, Samaritan cordless phones and there is no Detoxification Unit.

231. Prisoners have association for about three hours Monday to Friday and 11 hours at the weekends. Dovegate also provides a wide range of vocational and educational opportunities for prisoners compared to other prisons. Thus, prisoners are typically quite active in the use of their time out of the cells.

232. These large numbers of suicides and self-harm incidents needs to be considered in the context of the prison's young age, and problems with staff inexperience, staff shortages, and the very high staff turnover rates.

How do other methods used at Dovegate compare with safer cells?

Staff-prisoner relationships

233. Prison staff highlighted the value of good staff-prisoner relationships and the provision of a supportive approach in the management of at risk individuals. They also pointed out that the fact that staff came from a wide range of ethnic and cultural backgrounds facilitated the development of positive relationships.

234. This finding was not completely supported by the formal prisoner interviews. Many prisoners interviewed felt that there were too few staff and that interaction levels were low relative to other prisons. In addition, they stated that levels of observation, particularly at night, were lower than in other establishments. For example, one prisoner stated '...the staff almost never come around to check your cell at night. So there is plenty of time to try to commit suicide or to self-harm'.

235. There was also a concern relating to over-reliance on technology such as CCTV to monitor prisoners, and as a result reducing opportunities for staff-prisoner interaction. Finally, some prisoners also felt that staff took a long time to respond to the prisoner alarms (e.g. '...the alarms in the cells aren't answered immediately. It defeats the purpose of having them there if no on answers them. By the time someone does it will probably be too late').

Special cells

236. No care suite exists at Dovegate and staff felt that this would be helpful for managing at risk prisoners. Some prisoners agreed with this idea.

237. A request had been made by the Senior Psychologist to convert one of the cells in Health Care into a gated observation cell. Currently, Dovegate does not have such a cell, which makes it more difficult to observe at risk prisoners who require constant observation.

Single vs. double safer cells

238. A small number of double safer cells exist at Dovegate on various wings. However, staff told us that these are not used to house at risk prisoners. The majority of prisoners interviewed said they preferred being in a single cell. Prisoners stated that the double cells were simply single cells, which had been modified to become double cells. The ventilation problems (see section below) and the size of the cell made them, one prisoner argued, 'unbearable'. One prisoner also suggested that the curtain in these double cells create the opportunity for a further ligature point.

Psychology services

239. Some of the prisoners indicated that resources would better be spent on having more staff, particularly psychologists to deal with at risk prisoners. As one prisoner

put it, ‘I don’t think suicide goes down by changing something that is material. Most people like that have some serious mental problems. If money is going to be spent, it should be on more psychologists’.

Other support services

240. Both staff and prisoners spoke highly of the Listeners scheme.

How do prisoners and staff at Dovegate feel about safer cells?

Prisoners

241. Overall, prisoners at Dovegate had mixed feelings towards safer cells. Four prisoners were positive, describing the cells as ‘modern’, ‘spacious’, ‘newer’, ‘cleaner’, ‘cosy’, ‘more comfortable’ and ‘less prison-like’, whilst three others held negative opinions. One resented being placed in a safer cell, saying: ‘...I’ve never in my life had a suicidal thought or decided to cut myself’, which indicates that, even in a prison where all are safer cells, there is still some stigma attached to them. The remaining three prisoners were indifferent in their views.

242. Two of the prisoners said they suffered from depression and anxiety and suggested that the cell did not help these problems.

243. Nine of the 10 prisoners interviewed complained about the cell windows and the lack of ventilation. Some prisoners explained how insects breed inside the vents and dust circulates continually through the cell. The term ‘inhumane’ was used in more than one interview when describing the windows.

244. Other design-related complaints included the heating, which was not identified as an issue at other establishments. At Dovegate, the heating panel is located in the ceiling of the cells, therefore, for prisoners in ground floor cells, the effect is minimal, particularly as hot air rises, but, for people on the second floor, the effect is like ‘being in a toaster’ because of the combined heat from the floor heating (from the ceiling of the cells below) and their own heated ceiling. According to prisoners, this creates an extremely hot climate. Some of the prisoners also mentioned the lack of storage space and desk size as issues.

245. Despite the numerous complaints relating to design aspects of the cells, a number of prisoners did concede that the anti-ligature aspect of the safer cells was effective in preventing suicide. However, they were quick to highlight that a determined individual would find a way. The prisoners at Dovegate, as is the case in other establishments, also universally suggested that safer cells did not prevent self-harm, particularly in relation to the availability of razors.

Staff

246. The main problem with the safer cells, according to the prison staff, was ventilation (see above).

247. Staff did acknowledge the value of the safer cells in reducing the opportunity to commit suicide for those prisoners experiencing a short-term crisis. However, they indicated that safer cells had a limited impact on reducing self-harm. The fact that a

number of suicides and self-harm incidents have taken place in Dovegate's safer cells, they pointed out, highlighted the creativity of a prisoner determined to commit suicide.

Are there any unintended consequences of using safer cells at Dovegate?

Ventilation

248. The main problem, again, according to both staff and prisoners, was ventilation, cells being very hot in summer and cold in winter. Staff and prisoners thought this led to a number of physical and psychological conditions, including respiratory problems, head aches, frustration, lethargy and claustrophobia, which were more acute for those held in double cells.

249. The trickle vent system, which cannot be closed, was also problematic in that both a nearby turkey farm and factory produced extremely unpleasant odours. To prevent these odours coming into the cells, prisoners often jam wet bread into the vent, which hardens when it dries, and effectively blocks the vent. Staff indicated that the bread is then almost impossible to remove.

Stigma

250. On the whole, stigma was not identified as a major problem at Dovegate, since all cells were safer cells.

Vandalism

251. Although none of the respondents had 'smashed-up' their cell, two prisoners indicated they contemplated vandalism on numerous occasions due to frustrations caused by inadequate ventilation. As one prisoner put it, '...[safer cells] are so obviously designed by someone who has never spent time in a cell. When you have nothing else in your life, the ability to open and close your own window takes on huge significance. Taking that away, especially if someone is depressed already, is adding insult to injury'.

252. Another prisoner commented, however, that because of the many vocational, educational and recreational programs offered at Dovegate, only a minimal amount of time is spent in the cells, which reduces the impact of the negative aspects of the cell.

Is there any evidence that prisoners at Dovegate benefit from being placed in a safer cell?

253. The high rates of suicide and self-harm at Dovegate demonstrate safer cells are not in themselves enough to prevent suicide and self-harm from occurring. Safer cells do not appear to have been enough to mitigate the effect of other teething problems in the prison. It is possible that, had the prison not been safer cell designed, there would have been more early suicide and self-harm problems.

254. On the other hand, that ligatures were able to be improvised to door hinges in three hanging suicides demonstrates the importance of ensuring ligature points are

minimised and of ensuring cells are built to specification. It is likely that the modifications made to the cell door to reduce ligature points as a result of these suicides will prevent suicides at Dovegate in the long term.

255. It is possible that staff have overly relied on safer cells to 'do the work'. We noted problems with staff observation levels, and high reliance by staff of indirect supervision measures such as CCTV. Prisoners did not always feel that good relationships had been developed between staff and prisoners. These problems are all the more likely where there is high levels of staff inexperience, high staff turnover, and staff shortages.

256. The remainder of this section examines suicide and self-harm at Dovegate in more detail.

Suicides at Dovegate

257. Four suicides occurred in 2002, all taking place in the main part of the prison (not the Therapeutic Community). Three were by hanging, by attaching a ligature to the door upper hinge, and took place between January to June 2002. The other death occurred after a prisoner refused essential medical treatment in July 2002.

258. In only one of the hanging cases a F2052SH form was open at the time of the incident. Inspection of the SIO reports suggests failure to implement systematic observations of the prisoners played a role in all three hangings. In one case where the prisoner was on 15-minute watches, no checks were made for an hour before he was found dead. In another case, an observation entry was made stating that the prisoner was fine at 06:00h, while the medical officer estimated the time of death to have been at approximately 04:00h.

259. The Safer Custody Group has since modified the door design by reducing the gap between the door and the frame in order to prevent prisoners from looping a ligature around the door hinge to use as a ligature point.

260. It appears that, as soon as a prisoner successfully commits or attempts suicide, other prisoners both at that location and in some cases other prisons, become aware of this, hence the 'copycat' suicides occurring so close to each other in time.

Self-harm at Dovegate

261. The average self-harm rate from December 2002 to March 2003 was 15 incidents per month (average monthly rate per 1000 prisoners is 94). The most common method for self-harming in safer cells was cutting (45 incidents; 75% of all incidents). Of the remaining 15 incidents, 9 took place by wound aggravation (15%), the remainder being fairly evenly distributed across other methods (see Table 8). Self-harm by hanging was rare at Dovegate, with only 2 instances representing 3.3% of all self-harm incidents.

262. In the first incident, the prisoner used the door as a ligature point and a tracksuit cord as a ligature. It is not known from the data available whether the actual ligature point was the door upper hinge. In the second case, a strip of bedding was attached to a light fitting. This was done by burning a hole at each end of the light screen, then threading the ligature through these. In this case, the prisoner activated the alarm immediately before the incident, so that staff were able to intervene in time to

prevent the suicide. They indicated that they were not sure if the fixture would have held his weight or not. Neither of these prisoners required medical treatment.

263. It is not possible to determine whether any of these incidents took place in the Therapeutic Community, although staff during the focus group indicated that problems relating to self-harm and suicide were almost non-existent in this wing of the prison. This is due to the fact that prisoners that attempt suicide or self-harm while in the Therapeutic Community are removed from the program. Also living in the Therapeutic Community is voluntary. Therefore, individuals entering the community are proactively trying to improve themselves and are less likely to be predisposed to suicide and self-harm.

	All cases		**One case removed**	
Method	**N**	**(%)**	**N**	**(%)**
Burning	1	(1.7)	1	(3.8)
Cutting	45	(75.0)	20	(77.7)
Hanging	2	(3.3)	2	(7.7)
Poisoning	1	(1.7)	1	(3.8)
Self-strangulation	0	(0.0)	0	(0.0)
Head banging / wall punching	2	(3.3)	2	(7.7)
Wound aggravation	9	(15.0)	0	(0.0)
TOTAL	60	(100.0)	26	(100.0)

Table 8. Number of self-harm incidents (and percentages) taking place in safer cells, according to method employed, for Dovegate (from December 2002 to March 2003, inclusive). The rates and percentages are reported for all cases of self-harm and also for the remaining incidents after the case of a prisoner who self-harm 34 times was removed.

CHAPTER 10: HMP SWALESIDE

Summary

- Category B training prison for adult males. Opened in 1988
- F Wing was added in 1999 and is made up entirely of safer cells (120)
- During the research F Wing changed from the lifer wing to the induction wing
- Swaleside houses lifers and long-term prisoners at 'low risk' of suicide and self-harming
- Suicide rates are lower than average for Category B prisons - since 1992 there have been four suicides in Swaleside, 1 in 1992, 1 in 1994 and 2 in 2001. One of the suicides in 2001 took place in a safer cell, by means of self-strangulation
- Levels of self-harm are also low – self-harm rate is 5 per 1000 (compared to an average of 23 per 1000 for most Category B prisoners); staff said they only have between 2 and 9 prisoners who self-harm at any one time
- The prison catchment area has a strongly masculine culture which tends to view self-harming/ suicidal behaviour as weak

Use of Safer Cells
- F wing originally housed lifers but during the research F Wing became the Induction Wing, housing new arrivals for up to 2 weeks
- There is also a gated safer cell on the HCC

Comparing Other Strategies with Safer Cells
- Shared accommodation was thought by staff to be the most effective method of managing at risk prisoners
- Safer cells were thought useful in comparison to alternatives, mainly for deterring impulsive suicide attempts
- The Listener Scheme was praised as effective in terms of suicide prevention and prisoners wanted a care suite

Staff and Prisoners Feelings about Safer Cells
- Some prisoners thought safer cells may prevent suicide but none believed that they would impact self-harm
- Staff were positive about safer cells, seeing them as an effective tool, particularly for suicide prevention, but not in isolation

Unintended Consequences of Safer Cells
- Stigma and vandalism were not identified as problems but ventilation problems and social isolation were
- One prisoner's self-harming increased due to these problems

Do Safer Cells Work in Reducing Suicide and Self-harm
- Until recently, safer cells used for lifers, not a high risk group
- Now used for induction unit so may have more benefits
- 2 suicides since safer cells introduced were by methods not requiring ligature points
- According to staff, one prisoner attempted suicide 5 times in a safer cell by self-strangulating using pillow case but could not kill himself
- prisoners and staff do not think safer cells help reduce self-harm because razors and ligatures are easy to obtain

The Prison

264. Swaleside opened in 1988 as a Category B training prison for adult males serving four years or more and who have at least 24 months left to serve. On opening there were four residential units - Wings A, B, C and D, each with 126 single cells. Recently some of these cells have been converted to double cells to address the increasing prison population. In 1998 and 1999 two further Units were built, each housing approximately 120 prisoners. The first unit was built as a drug treatment unit (E Wing) and the other as a lifer first stage centre (F Wing), the latter of which was entirely single safer cells. However during this research the lifers on F Wing were moved to D Wing, previously the induction unit, so that F Wing became the new induction unit. Swaleside now has an operational capacity of 775 (CNA 752).

Suicides and self-harm at Swaleside

265. Swaleside has a relatively low incidence of suicide and self-harm. There have been four suicides at Swaleside since 1992, 1 in 1992, 1 in 1994 and 2 in 2001, with one of the suicides in 2001 taking place in a safer cell by means of self-strangulation. Between January 1998 and June 1999 there were 31 incidents of self-harm.

266. At the time of the 2002 inspectorate report, staff believed the low rates were partly due to the positive staff/prisoner relationships where problems were discussed and resolved before becoming serious (Inspectorate Report, 2002). Staff focus groups during our research suggested that low rates of self-harm could also perhaps be related to the strong masculine culture at Swaleside, imported from the South London areas from which the majority of prisoners originate. Here self-harming is seen as a significant weakness. The therapeutic community is also likely to have an impact on rates.

267. The process regarding an at risk prisoner at Swaleside is as follows: Once identified as at risk a F2052SH is opened for the prisoner, of which there are about four to six opened per month. A care plan is then developed involving all available agencies within the prison. Staff deemed this process as particularly important. On the basis of this risk assessment process a decision is made as to whether the prisoner should be referred to the Health Care Unit or remain on the wing.

268. Open F2052SH forms are reviewed regularly, then quality checked by the Suicide Prevention Team and audited by liaison officers. The procedures regarding these forms are reviewed annually. The Suicide Prevention Team at Swaleside meets quarterly and there is also an Anti-bullying Committee in which prisoners are involved.

269. No training on suicide awareness and/or prevention is currently provided at the prison, nor has it taken place during the last few years. This was a point highlighted by the Inspectorate Report (2002) which recommended that staff suicide awareness training needed updating. Many agency staff are employed, especially in the HCC, but also in reception.

Safer cells at Swaleside

270. F wing at Swaleside is made up entirely of single occupancy safer cells, 120 in total. Sixty were introduced in July 1999 and sixty in August 1999. As they were built four years ago the safer cells at Swaleside predate a number of improvements in the

design specification of safer cells. At present the gated cell in Health Care is built to safer cell specification and there are plans to install more in Health Care and in the Segregation unit.

How are safer cells used at Swaleside? Which prisoners are placed in safer cells? For what reasons?

271. As Swaleside's safer cells occupy an entire wing the policy relating to their use is broad and does not specifically target individuals who are deemed to be at risk. Until the middle of June 2003 F wing housed lifers- a population generally believed to be at low risk of suicidal and self-harming behaviour- then in June the lifers were moved onto D wing and F wing became the Induction Unit for new prisoners. This was done for a number of reasons. It allowed resources for lifer prisoners to be concentrated as they were already kept in C Wing and D Wing is adjacent to it. Also, moving the induction unit to F wing where the safer cells are seemed sensible as new prisoners represent a high risk in terms of suicidal and self-harming behaviour. For this reason the safer cells may prove more effective here than before, particularly as the induction process lasts up to 2 weeks depending on the needs of the prisoner.

272. Prisoners who are on F2052SHs generally remain on their wing under the watchful eye of staff, however those who make a serious attempt on their life are put onto Health Care where the safer designed gated cell is available if necessary.

How are other methods used at Swaleside compare with Safer Cells?

273. Staff seemed positive about the use of safer cells. When asked specifically how safer cells compared with alternative management accommodation staff indicated that they saw them as relatively helpful. Only 7% of staff saw safer cells as not very useful or not at all useful in comparison. In particular safer cells were seen as equally or more humane than the alternatives and as easy, if not easier to search by all but two member of staff; all but one member of staff thought that prisoners were equally or more easy to observe in safer cells.

Shared accommodation

274. Shared accommodation was the preferred short-term strategy to prevent suicide and self-harm amongst all staff as they believed that social isolation has potential adverse effects on at risk prisoners. No double safer cells at present are available at Swaleside. As one member of staff summarised: '...Shared accommodation is the first and most effective response to an at risk prisoner, then safe cells, and as a final resort, the Gated Cell in the health care wing where the prisoner is under constant supervision'. Nevertheless, prisoners did not always like to share a cell.

275. A gated cell in the health care wing, which was safer cell designed, is used for prisoners at a high risk of harming themselves. However it is extremely staff intensive and so not always thought to be a cost-effective choice.

276. Staff use 'unfurnished/special cells' (i.e., strip cells) as a last resort for violent prisoners who are a danger to themselves or others. Staff felt that strip cells should

not be used for suicidal prisoners due to their tendencies to increase a prisoner's sense of isolation and hopelessness.

277. A safer cell on the segregation unit would be helpful according to the staff at Swaleside as prisoners put in segregation can be vulnerable to suicidal and self-harming behaviour. Plans are currently under development to install some safer cells in the segregation unit in the future.

278. The Listeners Scheme was seen as an extremely effective approach to suicide prevention at Swaleside, where there are approximately 15 Listeners. Prisoners suggested though that a Care Suite should be created and thought that the Listeners needed more training. Staff indicated that they take an inclusive policy with the Listeners with, for example, the Listener's chairman attending internal suicide awareness/prevention meetings held by staff. The idea is to actively involve prisoners in their own healthcare. In addition, during the induction process, a Listener will come to talk to new prisoners about the services available, such as Listeners.

How do prisoners and staff feel about Safer Cells?

Prisoners

279. Ten prisoners interviewed at Swaleside. Eight of these were lifers, two of whom were interviewed whilst still living in the safer cells, *before* they moved to D wing, and six who were interviewed *after* the move to D Wing but who had been living in safer cells up until that point. The remaining two prisoners were from the induction unit, who were interviewed after the safer cells on F wing had become the induction unit, so that these prisoners were, at the time, in safer cells.

280. The prisoner feelings about safer cells varied. All prisoners complained about the windows and the lack of ventilation, which some claimed caused asthma, colds and flu like symptoms. The air was described as 'stale' and 'dusty'. Some prisoners indicated that not being able to open their window increased their feelings of aggression and frustration. This led three prisoners to comment that they had wanted to smash the cell up, although did not because the design of the cell does not enable them to. One prisoner reported that being placed in a safer cell *increased his self-harming behaviour.* If he had been in a normal cell the prisoner explained that he could have taken his anger out by slamming a cupboard door or calmed down by getting some fresh air.

281. The majority of prisoners reported that they prefer to be alone in a cell although there were mixed views in regards to whether they would like an at risk friend to be placed in a safer cell with them.

282. In terms of the design of the safer cells there were often conflicting opinions. What one prisoner liked another prisoner disliked, for example one prisoner was very positive about the cell layout, explaining that the safer cells are easier to keep clean and have more storage space than ordinary cells. However two other prisoners said there was a lack of storage space which meant that belongings had to be kept on the sideboard in full view of other prisoners, which led to bullying and cell theft. Prisoners commented that the cells were badly laid out, claustrophobic, unhomely, dehumanising and clinical. One interviewee said that they were no better than a strip cell and increased depression, increasing the likelihood of self-harm or suicide.

283. One prisoner complained that the alarm bells in the safer cells were too loud. He said that they would wake other prisoners on the wing, which, due to the stigma and bullying that could result, would discourage him asking for help in this way. This prisoner believed that staff should be alerted through a silent alarm system.

284. Some prisoners thought that safer cells were good because 'they make suicide just that bit more difficult', with another typical response being 'I believe safer cells are a good deterrent, the longer you have to think about it the less you want to kill yourself'.

285. In terms of self-harm no prisoners believed safer cells reduced self-harm or made it more difficult, with stories of razors being passed under the door. The prisoners who had self-harmed and/or had attempted suicide did not feel that being in a safer cell changed their intentions/behaviour in any way.

286. A final remark, reflecting the feelings of many prisoners: 'If you are going to use safer cells for prisoners who are suicidal then they should be used properly' – regular staff checks and prisoners not stripped down and thrown in against their will (as was reported by one prisoner).

Staff

287. 64% of the staff thought that safer cells *were effective* in reducing self-harm and 61% in reducing suicide.

288. Although staff believe that shared accommodation is the most effective short-term strategy for preventing self-harm and suicide (as discussed above), safer cells were deemed a particularly effective tool for suicide management in crisis situations. One staff member explained 'Safer cells can be effective in dealing with impulsive suicides. A prisoner's time in the safer cell may be just enough to get that prisoner through the crisis stage'. However staff did acknowledge that often at risk prisoners were determined to commit suicide and that for those prisoners safer cells may be less effective - 'You cannot make a completely safe cell. A suicidal prisoner has a lot of time on his hands to think of a way...'.

289. Staff also identified cases of prisoners self-harming whilst in a safer cell. The majority of self-harming at Swaleside takes the form of 'cutting' and so safer cells cannot be expected to have a particularly big impact. The Suicide Prevention Co-ordinator explained that preventing self-harm in this way was a control issue for staff, like prisoners' access to razors. However as prisoners can also make effective weapons for cutting from easily accessible objects such as biros it is difficult to control this type of self-harm completely, and safer cells will have little impact.

290. Overall, staff supported the use of safer cells but were aware that they should not be used in isolation. They thought that improving relations between staff and prisoners was key to the long-term management of at risk prisoners so that staff know the prisoners and can recognise significant behaviours. In fact one member of staff acknowledged that 'the use of safer cell's may even lower the alertness of staff and this must be addressed in procedures', being wholly reliant on safer cells could lead to staff apathy regarding the needs of at risk prisoners.

291. In terms of the design of safer cells, staff were less critical of design faults than prisoners. This is despite the fact that at Swaleside safer cells were installed in 1998, since which there have been a number of improvements in the design specification of them. However, given that at the time of the focus group the safer cells had been used primarily for long-term prisoners (low risk), perhaps the potential design faults have not been brought to the staff's attention through the actions of the prisoners. However, ventilation issues were identified by both staff and prisoners.

Are there any unintended negative consequences of using safer cells at Swaleside?

Ventilation problems

292. Every staff member and every prisoner who took part in our research at Swaleside criticised the ventilation system in safer cells. Some prisoners blamed it for colds and flu like symptoms and complained that it exacerbated asthma. The lack of ventilation was also said to increase prisoners' aggression and frustration and in turn lead to increased self-harming behaviour.

Dehumanising effects

293. One prisoner commented that being in a safer cell was a further reminder that he was institutionalised and others explained that they found the cells dehumanising, unhomely and clinical. One prisoner compared it to the strip cell and suggested that it could increase depression and again the likelihood of self-harm or suicide, which was verified by other prisoners.

Social isolation

294. Staff thought safer cells may socially isolate prisoners and this could prove problematic with an at risk individual. This is why they advocate shared accommodation as the most effective prevention technique for suicidal and self-harming behaviour. However, prisoners generally reported that they prefer being alone in a cell although they had mixed views on sharing their safer cell with an at risk friend.

Stigma

295. Neither the staff nor the prisoners reported any stigma attached to being placed in a safer cell at Swaleside. There was some suggestion of stigma attached to F2052SH's, however. Not all prisoners agreed but one prisoner explained that he would not tell a member of staff if he was feeling depressed because he did not want to be identified as at risk by the other prisoners. In this way then it could be inferred that the same would apply to safer cells if it was individuals specifically identified as at risk prisoners who were allocated to them, although this is not currently the case at Swaleside.

Bullying and theft

296. Although there was disagreement over whether the safer cells provide sufficient storage space, two prisoners believed that they did not. In turn they thought that this led to increased bullying, intimidation and cell theft as belongings had to be left out, where other prisoners could see them. The Suicide Prevention Co-ordinator said that the possibility of lockers in safer cells is being investigated but providing lockers without a ligature point is problematic.

Is there any evidence that prisoners at Swaleside benefit from being placed in a Safer Cell?

Suicides

297. There have been four suicides at Swaleside since 1988, a low rate, even for a Category B prison which generally have relatively low rates. This low rate may be due to the nature of the prisoner population at Swaleside and the masculine culture from which many originate. There are hints that prisoners at Swaleside are beginning to use less lethal methods than hanging, but suicide methods require careful monitoring over a number of years.

298. Two suicides have occurred since the safer cell wing was built, but neither of these were by hanging, although one did occur in the safer cell wing. This was a self-strangulation using an electrical flex from the television by a lifer. (The other was recorded as cutting and occurred at the HCC in a non safer cell). The two suicides occurring prior to the prison having safer cells were both by hanging, one occurring on segregation, and one occurring in the HCC.

299. The safer cell suicide was by a lifer who was waiting to be transferred to another prison. The prisoner had had an open F2052SH in the past but there were no concerns at the time of his death. The prisoner was found dead having self-strangulated with an electrical flex in his safer cell. Throughout the night staff had visually checked on him but had not attempted to gain a response. The staff reported the difficulty in observing cells at night, when prisoners were allowed to hang material at their windows, making the interior of the cells extremely dark. They also pointed out that if the light were switched on at this stage friction with prisoners would develop.

300. Electrical flexes being used for self-strangulation is avoidable if cells are built to full specification but preventing self-strangulation *entirely* in safer cells is likely to be impossible as prisoners may access some aid for self-strangulation– clothes, bedding etc.

301. Nevertheless, the fact that neither of the two suicides since the safer cells have been introduced were by hanging tentatively supports the possibility that prisoners are finding it more difficult to suicide at Swaleside. Hanging is a more lethal method than self-strangulation. Although one prisoner killed himself by self-strangulation, another prisoner at Swaleside had attempted suicide 5 times in a safer cell by tying a pillowcase around his neck but was not able to kill himself. Indeed, staff and prisoners agree that safer cells make committing suicide more difficult, one prisoner said that they deter prisoners by providing time out without the usual lethal means.

Self-harm

302. We did not compare self-harm rates before and after safer cells were introduced for two reasons. First, the self-harm data was unreliable at this time, and, secondly, a large number of more at risk prisoners were moved to Swaleside at the time the safer cells were introduced meaning that any differences in self-harm rates could be attributable to the population increase and change.

303. The more reliable data, collected during the four months after December 2002, record only four incidents of self-harm, which is a very low rate. The SPC thought there were only ever between about 2 and 9 prisoners actively self- harming at any one time. Two incidents occurred in the segregation unit, and one occurred in a safer cell when it was a lifer wing. The other occurred in ordinary location, but it is not possible to tell where exactly. Two of these were cutting including the incident in the safer cell. The others were poisoning and head banging. None were on an open F2052SH form.

304. The safer cell incident involved a prisoner cutting himself using a razor. During the interviews a number of prisoners reported that razors are easily passed to prisoners through the gap between the door and the floor of the safer cell. Again the ability of prisoners to gain possession of razors under the door seems problematic.

305. The prisoners, without exception, thought that safer cells did not reduce self-harm or make it more difficult. This is unsurprising when we consider evidence that ligatures can be improvised from bedding and the relatively easy access to razors. One prisoner reported that being in a safer cell increased his self-harm behaviour because he found the environment generally depressing and the lack of ventilation problematic.

CHAPTER 11: HMP LINDHOLME

Summary

- Category C training
- 30 safer cells on G Wing (1/4 of G wings total) installed in 2002
- G Wing is for enhanced prisoners
- Low rates of suicide and self-harm (2 suicides: 1 in 1988, and 1 in 1996)
- 4 self-harms in 4 months since 1st December 2002
- Rates are low even for Category C prisons

Use of Safer Cells
- Not used as part of prison suicide and self-harm prevention strategy
- Used with enhanced prisoners – not an at risk group
- Enhanced prisoners randomly allocated to 30 safer cells
- Listeners thought safer cells should be used as transition to normal location after time in care suite
- The SPC wants to remove enhanced prisoners from safer cells to make them available for at risk prisoners
- Staff thought may be best to have 1-2 spare safer cells on each wing kept vacant

How other methods compare
- Listeners Scheme thought by prisoners and staff to be the most important especially in conjunction with care suite
- Strong staff-prisoner relationships were also thought important
- Other factors influencing low rates may be: open design of prison; availability of leisure and vocational activities; normalised environment

How Prisoners and Staff feel about Safer Cells
- Overall, prisoners and staff had mixed feelings in relation to the safer cells on G Wing
- Enhanced prisoners often resist being placed in safer cells, as they are thought too 'clinical' and 'basic'

Unintended negative consequences
- Stigma and vandalism not identified as problems
- Ventilation not identified as major problem

Do Safer Cells Work in Reducing Suicide and Self-harm?
- Because not used to manage at risk prisoners and due to low suicide and self-harm levels, it is difficult to draw conclusions
- Prisoners and staff did not think safer cells would ever be a key prevention strategy because their current approach is thought very effective

The Prison

306. Lindholme opened in 1986 as a Category C training prison for adults. Lindholme houses prisoners with a variety of offence categories (most commonly burglary and drug-related but also minor offences such as vehicle offences and serious offences such as murder) and a variety of sentence lengths (the majority between 2 and 4 years, but including a number of 'lifers').

307. Lindholme was originally a Royal Air Force airfield built in 1940. In 1986, its accommodation was converted from dormitories to single and multi-occupancy cells on lockable spurs. Many of the original buildings remain in use. This prison also has an Immigration Removal Centre, making it a split site. Its operational capacity is 761 and its CNA also 761.

Safer cells at Lindholme

308. There are 30 full specification single safer cells at Lindholme, all of which were introduced in February 2002. At present, these safer cells are only available in G Wing, which also has 90 additional normal cells. Enhanced prisoners occupy G Wing exclusively and a random selection process takes place to allocate prisoners to the safer cells. This wing is a relatively new wing (the only wing not divided into spurs[4]).

Suicide and self-harm

309. Lindholme has a low suicide and self-harm rate. From 1988, there have been only 2 suicides in Lindholme (1 in 1988, and 1 in 1996). In terms of self-harm, between December 2002 and March 2003 only four incidents occurred, none of which took place in a safer cell. It's self-harm rate is 1.4 per 1,000 (the average for Category C training prisons is 14 per 1,000).

310. The reasons for the low rates of suicide and self-harm at Lindholme relate to a degree, to the prison type. Remand prisoners are at a much higher risk of suicide and self-harm (Bogue & Power, 1995) than Category C training prisons. Nevertheless, its rate is even lower than that of Category C training prisons in general.

311. There is a reception programme and a peer support scheme for those who have never been to prison before. There is also a Listeners Scheme and a care suite. There were no Samaritans cordless phones. Despite not having a separate detoxification unit, arrangements can be made for prisoners with drug problems to receive rehabilitation, advice, education and treatment. One of the wings operates a 28-place rehabilitation unit. On average, there may be one to two open F2052SH forms at any one time, which are reviewed regularly. The Suicide Prevention Team meets every two months.

312. Suicide prevention training is available on all training shutdown days, although this has only been done recently, since there were no tutors available before then. In an unannounced follow-up inspection of Lindholme conducted from the 29th February to

[4] At Lindholme no prisoner (unless on segregation) is ever locked in their own cell. During the night and meal times, each spur of 8-12 cells is locked, meaning that prisoners are never enforced to be on their own- they can lock their own doors if they want.

2nd March 2000 it was noted that, in relation to a recommendation made in a 1996 inspection, the majority of reception staff were now trained in suicide awareness.

How are the safer cells used at Lindholme? Which prisoners are placed in safer cells at Lindholme? For what reasons?

313. When G Wing was built it was decided by the Governor at that time that it would be used to house enhanced prisoners[5]. There are a total of 120 enhanced prisoners in G Wing with approximately 15 additional enhanced prisoners on the waiting list in other wings. Ninety occupy the normal cells whilst 30 are randomly allocated to the safer cells.

314. As the prisoners are enhanced, they are allowed to modify their cells to make them more comfortable. During this process ligature points are often introduced. In effect this means that the prison has its least at risk prisoners in the safer cells and allows them to introduce additional (unsafe) furniture[6] into the rooms. Therefore, the safer cells are in no way used as any part of the prison's suicide or self-harm prevention strategy.

315. The majority of respondents to the staff questionnaire recognised that safer cells were not being used for at risk prisoners. Interestingly, despite this management policy of the previous governor, the overwhelming majority of respondents to the staff questionnaire indicated that they believe that a prisoner at risk of suicide or self-harm should definitely be placed in a safer cell (85% and 60% respectively). Further, the majority of participants (70%) believed that safer cells were effective.

316. In fact the suicide prevention co-ordinator has recently put forward a proposal to the Governor to remove Enhanced prisoners from G Wing and thus the safer cells. This is to allow more at risk prisoners to be placed in the safer cells.

How do other methods used at Lindholme compare with the safer cells?

317. The staff focus group highlighted the Listener Scheme, good staff-prisoner relationships, and the layout of the prison into 'spurs' as each playing an important role in the prison's success in minimising self-harm.

318. The Listeners Scheme is very good at Lindholme. In fact, Listeners sat in on staff focus groups. Staff felt Listeners were the strongest tool available in regards to suicide and self-harm prevention, taking on high levels of responsibility.

Listener Scheme

319. The prison currently has 13 Listeners. All new prisoners are given a talk by one of the Listeners during their induction and posters are in place around the prison to advertise the service beyond their induction. In addition, if a prisoner has an F2052SH opened, a Listener will automatically visit them.

---

[5] Prisoners on the highest level of the IEP (Incentives and Earned Privileges) Scheme.
[6] This typically involves replacing the moulded plastic 'safer chairs', with soft cushioned chairs.

320. When a prisoner asks for a Listener, the meeting will often take place in the care suite. This consists of 3 rooms - 1 bedroom with twin beds, 1 TV room/lounge, and 1 dining room with limited catering facilities. If an extended period is needed in the suite, the Listeners will take it in turns to be with the at risk person 24 hours a day until they are happy that the prisoner is fit to return to normal location. (NB: An active self-harmer, with open wounds, would not be put in the care suite.) Staff, Listeners and many of the prisoners interviewed felt that the normalised environment created by the care suite coupled with the continual presence of a Listener constituted an extremely effective combination in the management of suicidal prisoners.

321. Listeners comment that a safer cell would perhaps be a useful safe guard and provide a 'stepping stone' to use for some prisoners after they have spent time in the care suite, and before going back on normal location. Prison staff shared this sentiment.

322. At present, if the Listeners feel that someone is still at risk and needs to build up their confidence the Listeners will ask a senior officer if the prisoner can come onto their spur for as long as is necessary. If possible, this request is granted. In this situation B wing is used as a number of Listeners happen to reside in the same spur on that wing. The at risk prisoner will be moved into a room on their spur.

323. At Lindholme, many of the Listeners are 'lifers' and therefore have accumulated extensive experience in prison. They therefore have first hand knowledge of most problems prisoners face. They know prison routine very well, and can empathise with at risk prisoners. A mutual respect and partnership has built up between Listeners and staff.

324. Listeners who had been in other prisons frequently brought up the novel atmosphere at Lindholme, the respect Listeners are given, and the extremely low incidences of self-harm and suicide.

Staff-prisoner relationships

325. We noted that staff-prisoner relationships at Lindholme appeared on the whole to be very good. First names were used, and a high degree of interaction occurred between staff and prisoners. Listeners commented that the atmosphere created by staff at Lindholme was unique with high interaction levels compared to other prisons and were extremely complimentary about POs.

326. Staff commented that they get to know the prisoners on their wing very well and can therefore note mood changes. Staff can ask a Listener to visit a particular prisoner they have concerns about.

Spurs, environment, and additional factors

327. At Lindholme, prisoners are never locked in their own cell (unless on segregation). Instead, each wing is divided into spurs of 8-12 cells. It is the doors to these spurs that are locked. Prisoners can lock their own cell door but prison officers cannot. The spur doors are only locked during the night and mealtimes. This means that prisoner-prisoner interaction is high and prisoners are given a high degree of freedom.

328. The geography of Lindholme means that there is a lot of space, the buildings are in good condition and sports facilities are widely available. In addition to this, 95% of prisoners are employed for meaningful work and/or go to education.

329. All of these more normalised characteristics of Lindholme may also contribute to the low levels of suicide and self-harm at his location.

Active self-harmers

330. Active self-harmers are put on watch within their normal cell (the level is decided depending on each case). The prison is however in the process of getting a gated observation cell and sees this as a possible way to manage an active self-harmer during a short-term crisis.

How do prisoners and staff at Lindholme feel about safer cells?

Prisoners

331. Overall, prisoners at Lindholme were mixed in their feelings towards safer cells. Some felt that the safer cells were more spacious and modern than normal cells. However, the ventilation was still mentioned as a problem.

332. Some prisoners pointed out that they do not think safer cells solve the problem. For example, one of them stated: 'If you put them in a safer cell, they still have the problem. I see them as a form of strip cell'. As such, prisoners thought that safer cells should only be used for short periods as a form of crisis intervention.

333. A few Listeners were interviewed at Lindholme. They tended to agree that one of the roles of Listeners within the Prison Service should be to keep prisoners out of safer cells. Staff and Listeners should be spending time talking to the person, getting to the root cause of the problem and helping to find a solution. Safer cells were described by one Listener as 'too basic to be of help to a suicidal prisoner'. Mirroring this scepticism, only two of the prisoners interviewed would want an at risk friend to be put in a safer cell. The remainder felt that a double cell with a Listener or the care suite with a Listener would be more appropriate.

334. The suicide prevention co-ordinator commented that, especially when G Wing was first opened, the enhanced prisoners did not wish to be placed in the safer cells. Prisoners described the cells as 'clinical' and many preferred normal location.

Staff

335. Overall, staff members at Lindholme had mixed feelings regarding the safer cells. As they are not used to manage at risk prisoners and due to the low level of suicide and self-harm at Lindholme, it was difficult for staff to draw conclusions regarding the value of safer cells.

336. A member of staff commented that the freedom offered to prisoners at Lindholme means that all prisoners are exposed to ligature points all day during work, association and education. To make use of a safer cell would mean locking up at risk prisoners for longer to avoid exposing them to these risks. They questioned the logic of this.

337. Another staff member added that if useful at all, it would be most beneficial to have perhaps 1-2 spare safer cells on each wing which are kept vacant and used as and when necessary.

338. Both staff and Listeners are sceptical as to whether safer cells would ever become a key part of their self-harm and suicide prevention strategy - mainly as current practice seems to be very effective and self-harm is simply not a problem at the prison.

Are there any unintended negative consequences of using the safer cells at Lindholme?

Stigma

339. The general consensus regarding stigmatisation was that it was not particularly an issue at Lindholme. Prisoners singled out as engaging in self-harming behaviour may be teased but 'nothing serious'. Comments were along the lines of 'stress head' or 'go hang yourself'. However, because the prisoner in the safer cell is enhanced and therefore typically not at risk, there is not a stigma problem specifically with safer cells.

Vandalism

340. Vandalism was not identified as an issue at Lindholme. None of the prisoners interviewed had ever wanted to smash it up and, with the exception of the heat, could see no reason why someone might be driven to smash it up: '…its just like a kitchen and you don't get annoyed that you can't move that around do you'.

341. However, some of the Listeners present at the focus group did not believe that the sinks or the toilets in safer cells are unbreakable. They said that the sink could be wrenched off the wall and an inventive prisoner could use the toilet as a ligature. However, there was no evidence of such vandalism occurring.

Psychological consequences

342. Though overall the prisoners interviewed reported no adverse consequences in terms of the psychological effects of safer cells on prisoners, one prisoner did say that the cell made him feel 'mentally claustrophobic' and felt that they could have detrimental psychological effects on prisoners.

Is there any evidence that prisoners at Lindholme benefit from being placed in a safer cell?

343. The 30 safer cells at Lindholme are used with enhanced prisoners and are not used as part of the suicide and self-harm prevention strategy. Enhanced prisoners are randomly allocated to the safer cells. Since they are not being used in the intended way and there are few of them, it is unlikely they are having an impact on suicide and self-harm levels, which are very low in this prison anyway.

344. Since 1988, there have only been 2 suicides at Lindholme (1 in 1988, and one in 1996). Both of these incidents occurred prior to the installation of the safer cells. Both involved hanging, both using bedding as ligatures, one using the bed as a ligature point and the other the window.

345. Only four incidents of self-harm occurred during the period of December 2002 and March 2003, none of which took place in a safer cell. Three were by cutting, and all these occurred in the segregation unit. The other was by poisoning on an ordinary location.

REFERENCES

Atkinson, J. (1978). *Discovering Suicide*. London: Macmillan.

Atlas, R. (1989). Reducing the opportunity for inmate suicide: A design guide. *Psychiatric Quarterly*, 60, 161-71.

Bogue, J. & Power, K. (1995). Suicide in Scottish Prisons, 1977-93. *Journal of Forensic Psychiatry*, 6(3), 527-540.

Brown, J. (1979). Suicides in Britain. *Archives of General Psychiatry*, 36, 1119-1124.

Burvill, P. (1980). Changing patterns of suicide in Australia, 1910-1977. *Acta Psychiatrica Scandanavica*, 90, 91-96.

Camilleri, P.; McArthur, M. & Webb, H. (1999). *Suicidal Behaviour in Prisons: A Literature Review*. School of Social Work, Canberra: Australian Catholic University.

Clarke, R.V. & Lester, D. (1987). Toxicity of car exhausts and opportunity for suicide: Comparison between Britain and the United States. *Journal of Epidemiology and Community Health*, 41, 114-120.

Clarke, R.V. & Lester, D. (1989). *Suicide: Closing the Exits*. New York: Springer-Verlag.

Clarke, R.V. & Mayhew, P. (1988). The British gas suicide story and its criminological implications. *Crime & Justice*, 10, 79-116.

Dooley, E. (1990). Prison Suicide in England and Wales, 1972-87. *British Journal of Psychiatry*, 156, 40-45.

Gunnell, D. & Frankel, S. (1994). Prevention of suicide: aspirations and evidence. *British Medical Journal*, 308, 1227-1233.

Hassan, R. (1995). *Suicide Explained*. Melbourne: Melbourne University Press.

Hayes, L. & Rowan, R. (1988). *National Study of Jail Suicides: Seven Years Later.* Alexandria, VA. National Centre of Institutions and Alternatives. National Institute of Corrections, U.S. Department of Justice.

Her Majesty's Chief Inspector of Prisons for England and Wales (1999). *Suicide is Everyone's Concern: A Thematic Review*. London: Her Majesty's Inspectorate of Prisons for England and Wales, Home Office.

Her Majesty's Prison Service (2000). *Prevention of Suicide and Self-Harm in the Prison Service*. London: Stationery Office.

Howard League for Penal Reform (1999). *Scratching the Surface: the hidden problem of self-harm in prisons*. The Howard League: London.

Ireland, J. (2000). A descriptive analysis of self-harm reports among a sample of incarcerated adolescent males. *Journal of Adolescence*, 23, 605-613.

Kreitman, N. (1976). The coal gas story. *British Journal of Preventative and Social Medicine*, 30, 86-93.

Kreitman, N. (1977). *Parasuicide*. London: Wiley and Sons.

Kreitman, N.; Phillip, A.E.; Greer, S. et al. (1969). Parasuicide. *British Journal of Psychiatry*, 115, 746-7.

Leenaars, A.; Cantor, C.; Connolly, J.; EchoHawk, M.; Xiong He Z.; Kokorina, N.; Lester, D.; Lopatin, A.; Rodriguez, M.; Schlebusch, L.; Takahashi, Y.; Vijayakumar, L. & Wenckstern, S. (2000). Controlling the environment to prevent suicides: International perspectives. *Canadian Journal of Psychiatry*, 45(7), 639-644.

Lester, D. (1998). Preventing suicide by restricting access to methods of suicide. *Archives of Suicide Research*, 4, 7-24.

Lester D. & Abe K. (1989). Car availability, exhaust toxicity and suicide. *Annals of Clinical Psychiatry*. 1: 247-250.

Lester, D. & Clarke, R. (1988). Effects of reduced toxicity of car exhaust. *American Journal of Public Health*, 78, 594

Lester, D. & Leenaars, A. (1993). Suicide rates in Canada before and after tightening firearm control laws. *Psychological Reports*, 72, 787-790.

Lester, D. & Leenaars, A. (1994). Gun control and rates of firearm violence in Canada and the United States. *Canadian Journal of Criminology, 36, 463-464*.

Lester, D. & Murrell, M. (1980). The influence of gun control laws on suicidal behaviour. *American Journal of Psychiatry*, 137, 121-122.

Liebling, A. (1991). *Suicide and Self-Injury Amongst Young Offenders in Custody*. Unpublished PhD Dissertation, Cambridge University. Cited in...

Liebling, A. (1993). Seclusion in prison strip cells: a practice to be ashamed of. *Bristish Medical Journal*, 307, 399-340.

Liebling, A. (1997). Risk and Prison Suicide. In H. Kemshall, & J. Pritchard (Eds.), *Good Practice in Risk Assessment and Risk Management*. London: Jessica Kingsley.

Liebing, A. & Krarup, H. (1993). *Suicide Attempts and Self-Injury in Male Prisons*. London: Home Office.

Livingston, M. (1997). A review of the literature on self-injurious behaviour amongst prisoners. In G.J. Towl (ed.) Suicide and Self-Injury in Prisons*, Issues in Criminal and Legal Psychology*, 28. Leicester: British Psychological Society.

Lloyd, C. (1990). *Suicide and Self-Injury in Prison: A Literature Review*. London: Home Office.

Loftin C.; McDowall, D.; Wiersema, B. & Cottey, T. (1991). Effects of restrictive licensing of Handguns on homicide and suicide in the district of Columbia. *The New England Journal of Medicine*. 325(23), 1615-1620.

McHugh, M.J. & Towl, G.J. (1997). Organizational reactions and reflections on suicide and self-injury. In G. J. Towl. (ed.) Suicide and Self-Injury in Prisons, *Issues in Criminal and Legal Psychology*, 28. Leicester: British Psychological Society.

Oliver, R. & Hetzel, B. (1972). Rise and fall of suicide rates in Australia. *Medical Journal of Australia*, 2, 919-923.

Power, K.; McElroy, J. & Swanson, V. (1997). Coping Abilities and Prisoners Perception of Suicidal Risk Management. *The Howard Journal*, 36(4), 378-392.

Reser, J. (1992). The design of safe and humane police cells: a discussion of some issues relating to Aboriginal people in police custody. In D. Biles and D. McDonald (eds.), *Deaths in Custody Australia, 1980-1989.* Canberra, Australia Institute of Criminology.

Rich, C.; Young, J.; Fowler, R.; Wagner, J. & Black, N. (1990). Guns and Suicide. *American Journal of Psychiatry*, 147, 342-346.

Rowan, J. (1994). Suicide Prevention. *American Jails*, November/December, 23-28.

Royal College of Psychiatrists (2002). *Suicide in Prisons*. Council Report CR86. London: Royal College of Psychiatrists.

Safer Custody Group (2002a). *Safer Custody Report for 2001: Self-inflicted deaths in Prison Service custody*. London: HM Prison Service.

Safer Custody Group (2002b). *Suicide Prevention Strategies: guidance on preventing prisoner suicides and reducing self-harm; the role of the Samaritans; and safer custody cell protocols*. London: HM Prison Service.

Safer Custody Group (2003). *Suicide Prevention Co-ordinators Conference May 2003 Unpublished Report*. London: HM Prison Service.

Stengel, E. (1964). *Suicide and Attempted Suicide*. Baltimore: Penguin.

Takahashi, Y., Hirasawa, H. & Koyamam, K. (1998). Restriction of suicide methods: A Japanese perspective. *Archives of Suicide Research*, 4, 101-107.

Topp, D. (1979). Suicide in Prison, *Journal of British Psychiatry*, 134: 24-27.

Towl, G.J. & Crighton, D.A. (1998). Suicide in prisons in England and Wales from 1988-1995, *Criminal Behaviour and Mental Health*, 8, 184-192.

Towl, G & Hudson, D. (1997). Risk assessment and management of the suicidal. *Issues in Criminological and Legal Psychology,* 28, 60-64.

Towl, G.; Snow, L. & McHugh, M. (Eds.)(2000). *Suicide in Prisons*. Leicester: British Psychological Society.

Wool, R. & Dooley, E. (1987). A study of attempted suicides in prisons. *Medical Science and the Law*, 27(4), 297-301.

Wortley, R. (2002). *Situational Prison Control: Crime Prevention in Correctional Institutions*. Cambridge: Cambridge University Press.

ACKNOWLEDGEMENTS

During the course of this project we have been greatly supported by the Safer Custody Group. In particular, we would like to thank Brent Greenaway, Rebecca Teers, Richard Lane and Barry Gilbraith for their continuous help and advice, without which the project would not have run so smoothly.

We would also like to express our appreciation and gratitude to our contacts at each of the prisons visited. Without exception, and despite their time being at a premium, we have been welcomed into each of the prisons and aided in our research above and beyond the call of duty: John Rafferty at Dovegate; Huw Sullivan at Eastwood Park; Tom Murray at Feltham; John Hyde at Hull; Alistair Leitch at Lindholme; and Martin Glaze at Swaleside.

Finally, we are indebted to the staff and prisoners at each of the prisons who so kindly gave up their time to take part in this research. Without their help and honesty the research would not have been possible.

Tamara Burrows
Andrew P. Brock
Susie Hulley
Chloe Smith
Lucía Summers

APPENDIX A: DETAILS OF METHODS USED

Quantitative Data Sources

Data recorded in the self-inflicted deaths and self-harm databases, which are designed and maintained by the Safer Custody Group, were used to calculate rates. The self-inflicted deaths database contains detailed information on the prisoner's demographic and offence-related characteristics, as well as information on the method and instruments used. It is based on information facilitated by the Prison Service National Operations Unit, which is put together with any data available in the Incident Reporting System (IRS).

Information contained in the F213SH form, which is locally completed every time a self-harm incident takes place, was used to establish rates of self-harm. The improved F213SH form and reporting procedures were implemented in December 2002. Since then, data have continued to be recorded on the prisoner's demographic and offence-related characteristics and methods and instruments used, but have also included other more detailed information, such as the precise location of the incident, i.e. type of cell. This means that, since December 2002, the database is more reliable and comprehensive.

Prison population and reception figures were obtained from the Research Development and Statistics Directorate in the Home Office. Senior Investigative Officer reports for suicides taking place in safer cells were also examined, together with a sample of individual prisoner records obtained locally from HMYOI Eastwood Park.

Before and after comparisons

We had originally planned to examine rates of suicide and self-harm before and after the safer cells were introduced in 5 of the 6 prison establishments[7]. Data were to be separately analysed for each establishment because they differed in the number and style of safer cells, the time when they were introduced and the extent to which other interventions also aimed at reducing self-harm and/or suicide were in place. For these reasons, it was not possible to aggregate data across prisons.

A number of data limitations prevented us from carrying out these analyses. The first problem was the low base rate of suicides, which meant that there were not large enough numbers to enable comparisons to be made before and after the safer cells were introduced. The second problem was that the self-harm data were not reliable prior to December 2002, again meaning that we could not make valid comparisons before this time.

More self-harm data should have been available from November 2001 for HMYOI Eastwood Park and HMYOI Feltham, which were part of the safer locals programme, where the form was piloted. The data sets were, however, incomplete.

[7] The exception was HMP Dovegate, for which before and after and across locations comparisons were not possible because all cells were constructed as safer cells when the prison was first built.

Across Location Comparisons

Ideally, a comparison of suicide and self-harm rates of those in safer cells and those non safer cells would have been helpful. There were three problems, which meant these analyses were difficult to conduct. The first two related to the unreliability of the self-harm data and the low suicide base. Also, data on precise location were not available prior to December 2002, when the new F213SH form was introduced. In the case of the 2 prisons where we could conduct these analyses, there were difficulties interpreting the data because those in safer cells were generally a very different population to those in non safer cells. It was impossible to find a matched control group with which to compare safer cell self-harm rates.

Suicides and Self-harm in Safer Cells

Rather than conducting before and after and across location analyses, we instead examined in detail the suicides and self-harm incidents occurring in the safer cells of each of the study prisons. Incidents of suicide and self-harm which had actually taken place in safer cells in the six project establishments were examined, in order to determine the circumstances surrounding each event. Where possible we looked at differences in methods and other factors between those occurring in safer and non safer cells.

Individual Records Analysis

A detailed analysis of 10 individual records from HMYOI Eastwood Park was carried out, in order to examine self-harming behaviour over time. The criteria for inclusion in this part of the study where that prisoners had been held in a safer cell at some stage, and had an open F2052SH currently or in the past, which is an indication of risk of self-harming and/or suicidal behaviour.

Staff: Questionnaires and Focus Groups

Questionnaires and focus groups were used to obtain views from prison officers on the perceived effectiveness of safer cells in reducing suicide and self-harm, and how these compared with alternative management forms of accommodation. Prison staff were also asked to give their opinions on which prisoners should be placed in safer cells and which subgroups, if any, would benefit the most, e.g. males versus females. Other practical issues, such as how easy safer cells are to search, were also addressed in the questionnaire.

Staff focus groups consisted of between 6 and 12 participants (depending on the establishment and staff availability) and lasted between one and two hours. Staff held a variety of roles but had direct experience managing inmates and were familiar with the safer cells. This included suicide prevention co-ordinators, prison officers, psychiatric nurses, health care staff, psychologists and other staff involved in the risk assessment process and management of at risk inmates. Two JDI researchers facilitated the focus groups (see Appendix C for the focus group schedule).

Prisoner Interviews

Individual interviews were carried out with prisoners, seeking their views on the effectiveness of safer cells in reducing suicide and self-harm, and on whether safer cells had an effect on the whole prison and/or on prisoners who were placed there, including unintended negative effects. Other issues, such as whether prisoners might wait to be removed from a safer cell to harm themselves, were also discussed in the interviews.

A total of 56 interviews were held with prisoners across the six establishments. Again, the number of interviews varied between prisons from seven to ten participants depending on prisoner availability. Inmates came from a variety of offending backgrounds in addition to having varying degrees of previous self-harming and suicidal behaviour. The interviews were semi-structured in nature and ranged between fifteen minutes to one hour in duration. Inmates were selected on the basis of having experience in safer cells. They received participant information sheets prior to the interview, outlining the nature of the research and the responsibilities of both the participant and the researcher. Prior to the commencement of each individual interview, the researcher clarified the inmates understanding of the research and a consent sheet was signed (see Appendix D for the interview schedule).

APPENDIX B: FACTORS ASSOCIATED WITH SUICIDE AND SELF-HARM IN PRISON

Numerous studies into suicide and self-harm among prisoners have been conducted over the past three decades. The majority of research has been descriptive, examining the characteristics and risk factors of those who have died (Safer Custody Group, 2002a). The characteristics examined include 'demographic' (gender, age), 'individual' (psychiatric history), 'experiential' (bullying), 'crime-related' (offence-type, legal status and sentence length) and 'situational' (prison type, location).

Gender

The issue of gender in prison suicide remains controversial. The general assumption is that, as in the community, women tend to have substantially lower rates of suicide than men, though rates of self-harm appeared to be much greater (Camilleri et al, 1999). Despite this general assumption, a number of studies have concluded that males are no more likely to commit suicide in prisons than females, when numbers are viewed as a proportion of the inmate population (Liebling, 1992; Morrison, 1996).

Women constitute a relatively small proportion of the total prison population, typically reported between 3-7% (see Liebling, 1994). Therefore the actual numbers of suicides is extremely small and determining rates is therefore problematic. Liebling (1994) makes the point that, while women make up a relatively small number of the prison population, this should not justify the present lack of research examining the specific needs of female prisoners. Females are at considerable risk of suicidal behaviour. Among other things, for example, Liebling explains that dependent children and other equivalent family ties and responsibilities play an important role in the dynamics of female prison suicide.

Table 9 suggests that the rate of self-inflicted deaths among men has remained relatively stable over the seven-year period. By contrast, the rate of self-inflicted deaths among women appears to have increased. The extremely low overall numbers of suicides and the variable population of female inmates means the figures must be treated with considerable caution.

	men		women	
year	number	rate	number	rate
1995	57	116	2	101
1996	62	117	2	88
1997	65	111	3	112
1998	79	127	3	97
1999	86	140	5	154
2000	73	119	8	239
2001	66	106	6	160

Table 9. Number and rate per 100,000 (average daily population) of self-inflicted deaths by gender, from 1995 to 2001. (NB: Adapted from Safer Custody Group, 2002).

An interesting observation, highlighted in the report produced by the Royal College of Psychiatrists (2002), is that the rate of 'self-asphyxiation' or 'hanging' in the general community has doubled among men and trebled among women during the past decade or so. Research has yet to explore whether this 'fashion' in suicidal behaviour in the general community has impacted on prisoner behaviour.

Female inmates are over represented in the statistics in terms of self-harm (Camilleri et al, 1999). Indeed in the UK, self-harm is seen as a predominantly female activity. Explanations for this include the high incidence of serious psychiatric disturbance in prison as well as the notion of women being 'more manipulative'; acts of self-harm are intended to exploit the system. Wilkins and Coid (1991), however, argue that acts of self-mutilation are an indication of serious psychiatric disturbance and should not be interpreted as merely a reaction to the situational stress associated with being in prison.

Age

The impact of age upon suicidal behaviour is also problematic. Both Lloyd (1990) and Livingston (1997) note that research provides contradictory findings. Lloyd argues strongly for the importance of providing a control group for comparative purposes. Part of the methodological difficulties of examining age as a variable, is that the age structure of prisons is skewed towards the younger population (Camilleri et al, 1999).

Research indicates that over the past thirty years the group most at risk of suicide in the general community is young men. Those at greatest risk have experienced poor socio-economic circumstances, unemployment, involved in delinquent behaviour, poor educational achievement, have abused drugs and/or alcohol, been violent and experienced violence, been impulsive, have low self-esteem, separated from parents, have few close friends, experienced mental illness such as depression and have previous episodes of suicidal behaviour (Camilleri et al, 1999). Most of these factors are typical of young offenders.

This is relevant to the discussion of two contrasting theories of suicidal behaviour. One, the 'importation' theory, suggests that the prison population is an at risk group as they share many of the characteristics of those who commit suicide in the general population. They 'import' those characteristics into the prison system with them, and therefore it should not be surprising that there is a high rate of suicides in prisons. An alternative view is that the prison situation itself, possibly combined with the traumatic events associated with getting there, provokes suicidal behaviour in otherwise relatively stable individuals.

The evidence relating to age and self-harm, as with suicides, indicates prisoners most at risk are slightly younger. Eyland, Corben & Barton (1997) found a significantly greater proportion of unsentenced inmates under 22 years of age in the self-harm population, compared to the overall unsentenced inmate population.

Liebling and Krarup (1993) also argue that there is a relationship between age and self-harming behaviour, with those inmates aged under 21 years being most at risk. In their study of 305 incidents of self-harm there were 248 prisoners whose age at that date could be determined. Those under 21 accounted for 43% of the acts of self-harm, whereas they made up only 17% of the average daily population and 31% of the annual receptions.

In contrast to the above mentioned studies, in Lloyd's (1990) review of British studies he concluded that older inmates are slightly more at risk than younger inmates. However, he

notes that the studies reviewed do not provide evidence to suggest a strong relationship between age and suicide, sufficient to be used for the prediction of suicides effectively.

Livingston's (1997) review of the literature found that the research produces contradictory findings in relation to age and self-injurious behaviour in prisons. However, despite these contradictions, evidence gathered suggests there is some association between younger prisoners and suicidal behaviour.

Figure 2 shows the number of self-inflicted deaths by age as a percent for 2001. The number of prisoners in each age group, within the overall prison population is also shown. The figure indicates that the highest number of self-inflicted deaths occur in those aged 21-29 and 30-39. However, these groups also form the majority of the prison population (Safer Custody Group 2002). Self-inflicted deaths in the 15-20 and 40-49 age groups were higher than expected when examined in relation to the proportions of these age groupings within the overall prison population.

Offence type

Although results are mixed, studies have found evidence that those charged with or convicted of violent or sexual offences compared with the general sentenced prison population were significantly over-represented (Dooley, 1990; Bogue & Power, 1995). Lloyd (1990) also indicates that sex offenders are subjected to considerable violence from other prisoners, which may make them more vulnerable to suicidal behaviour. Figures produced by the Safer Custody Group (2002), however, are inconsistent with this, indicating that self-inflicted deaths among those convicted or charged with sexual offences equalled the proportion in the overall prison population. Figure 3 shows that those charged with violent crimes and theft and handling crimes tend to be over-represented.

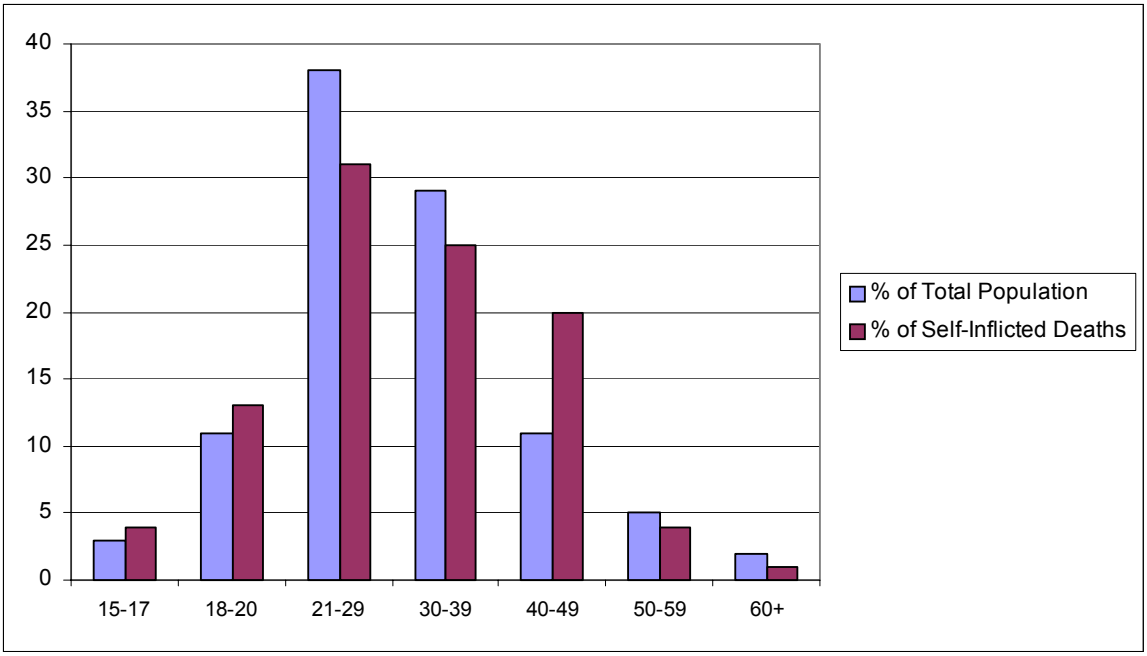

Fig. 2. Number of deaths and average prison population by age for 2001. (NB: Reproduced from Safer Custody group, 2002).

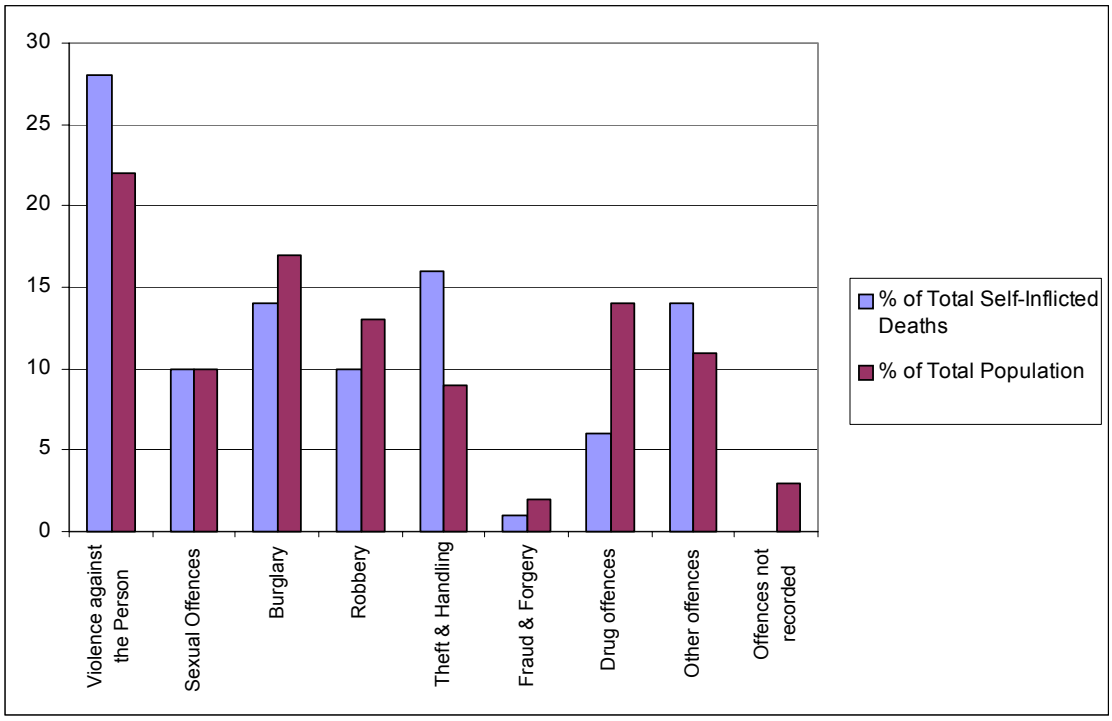

Fig. 3. Self-inflicted deaths by offence-type from 1996 to 2001. (NB: Reproduced from Safer Custody Group, 2002)

Legal status

International research consistently indicates that unsentenced or remand prisoners are at a disproportionately higher risk of suicide and self-harm. Dooley (1990) found that an average of 11% of people in custody were on remand, though they accounted for 47% of all suicides in prison. Similarly, Wool and Dooley (1987) also found remand prisoners to be over-represented in self-harm figures.

History of self-harming behaviours

According to Livingston's (1997) literature review, a history of self-harm or attempted suicide has been linked with an increased risk of future self-harm or suicide, regardless of gender in both young offenders and adult prisoners. Liebling (1994, p.6) has argued repeatedly that self-harming behaviour and suicide are closely related, stating, *'...people who injure themselves are far more likely to go on to commit suicide at some later stage, without help, or without some change to their life situation'*. It would appear that half of suicides have a history of self-harm prior to the suicidal act (Dooley, 1990; Liebling, 1992).

A review by Gunnell and Frankel (1994) concluded that there is no one identifiable group upon whom an intervention can be focused to reduce the suicide rate. The one exception is the population that has harmed themselves already. In the year after an episode of self-harm the risk of suicide is 100-times the general population rate.

Psychiatric history

The literature on suicides and self-harm in the wider community indicates that mental illness is strongly associated with both acts. In the prison context it is less clear-cut. Some literature points to a relationship between psychiatric history and suicide in prison. Wortley (2002, p.139) states, *'As might be expected, there is a relatively high incidence of mental health problems among prison suicide victims'.* Liebling (1993) notes, however, that a history of psychiatric treatment is less likely among prison suicides than among those in the community. UK studies suggest that only a third of prison suicides have a history of psychiatric illness, as opposed to 80-90% of those in the general community (Dooley, 1990; Backett, 1987). However, Wortley also suggests that the high incidence of suicide and self-harm is directly related to the prison experience. This implies that situational factors are particularly important in prison suicides.

Power, McElroy & Swanson (1997) found nearly half of those who had self-harmed had previous outpatient psychiatric treatment, 32% had received previous inpatient treatment and 21% had received treatment while in hospital. This suggests that while in prison, at risk prisoners who develop symptoms of distress may be treated within the prison hospital setting. However, formal psychiatric illness may not be as much of a difficulty as predicted, not least because inmates with diagnosed psychiatric conditions should not be in prison.

History of Substance Abuse

Liebling (1994) suggests that suicide rates are disproportionately higher amongst those with high levels of substance abuse. Livingston (1997) confirmed this in his literature review, where between 59% and 74% of self-injuring prisoners abused or were dependent on drugs prior to incarceration. Towl and Crighton (1998) are slightly more specific in suggesting that withdrawal from drugs is a major factor in suicides during the first few weeks of custody.

Bullying

Several authors (Livingston & Beck, 1997; Power & Spencer, 1987; Toch, 1975) have suggested a relationship between bullying and suicidal behaviour. Blaauw, Winkel and Kerkhof (2001) report that the files of 34% of the suicide victims noted that they had felt bullied. Inch, Rowlands and Soliman's (1995) study indicated that 44% of their sample of self-harmers had been bullied. In two of Liebling's studies (Liebling, 1992; Liebling & Krarup, 1993) over two thirds of self-harmers expressed problems with their fellow inmates compared to much lower levels among control groups.

Interestingly, Power and Spencer (1987) reported that 50% of the young offenders who self-injured reported doing so to avoid friction with other prisoners. By injuring themselves, these prisoners would apparently be placed under increased observation, which would prevent them from further harassment. A further 28% reported injuring to change location, which may itself have been to avoid being bullied. Livingston (1997) notes that this constitutes a large proportion of self-injuring behaviour in young offenders motivated by a desire to avoid victimisation.

Recent Life Events

Livingston (1997) contends that the occurrence of major recent life-events, particularly recent interpersonal loss, appears to be strongly associated with the onset of self-injurious behaviour in both male and female adult prisoners. Wool and Dooley (1987) found that 43% of self-injurious episodes had been a reaction to domestic problems. Liebling and Krarup (1993) in their model, referred to individuals who commit suicide or self-harm as 'poor copers'. They tended to be young prisoners experiencing considerable psychological distress who were unable to cope with the prison environment. The reasons given for self-harming behaviour involved some precipitating factor or incident.

Prison Type

Custodial setting has been identified as an important risk factor for suicide and self-harm (Livingston, 1997). Wool and Dooley (1987) found adult male prisoners held in local prison to be over-represented. This is potentially due to legal or custodial status. Specifically, the population of local prisons comprise a large number of prisoners on remand and as indicated earlier this has been identified as a risk factor (Bogue & Power, 1995). Another possible contributing factor to the relationship between prison type and suicide may be increased throughput and overcrowding – both relatively more common in local prisons (Towl & Crighton, 1998).

Table 10 and Figure 4 indicate that the vast majority of self-inflicted deaths in prison occur in Category B Locals.

In terms of self-harm, according to recent figures produced by the Safer Custody Group, Category B prisoners have a higher rate of self-harm than Category C (60 per 1000 prisoners compared with 14 per 1000 prisoners). Females and Juveniles also have high comparative rates (377 per 1000 and 108 per 1000 prisoners respectively).

Establishment type	1994	1995	1996	1997	1998	1999	2000	2001
All establishments	**62**	**59**	**64**	**70**	**83**	**91**	**81**	**72**
Male establishments	**57**	**53**	**55**	**56**	**72**	**71**	**64**	**41**
Local prisons	40	35	41	40	62	60	53	32
Open Training (Cat D)	--	--	1	--	--	--	--	--
Closed Training (Cat C)	6	8	5	5	3	8	5	5
Closed Training (Cat B)	9	5	5	10	5	1	6	3
Closed Training (dispersal)	2	5	3	1	2	2	--	1
Young Offender Institutions	**4**	**1**	**7**	**11**	**8**	**11**	**9**	**25**
Open YOI	--	--	--	--	--	--	-	--
Closed YOI	1	2	5	5	2	8	6	19
Remand Centre	3	2	2	6	6	3	3	6
Female Establishments	**1**	**2**	**1**	**1**	**3**	**4**	**8**	**5**
Prisoners under escort	**--**	**--**	**1**	**2**	**--**	**5**	**--**	**1**

Table 2. Number of self-inflicted deaths in prison by type of establishment, from 1994 to 2001. (NB: Reproduced from Home Office, 2003)

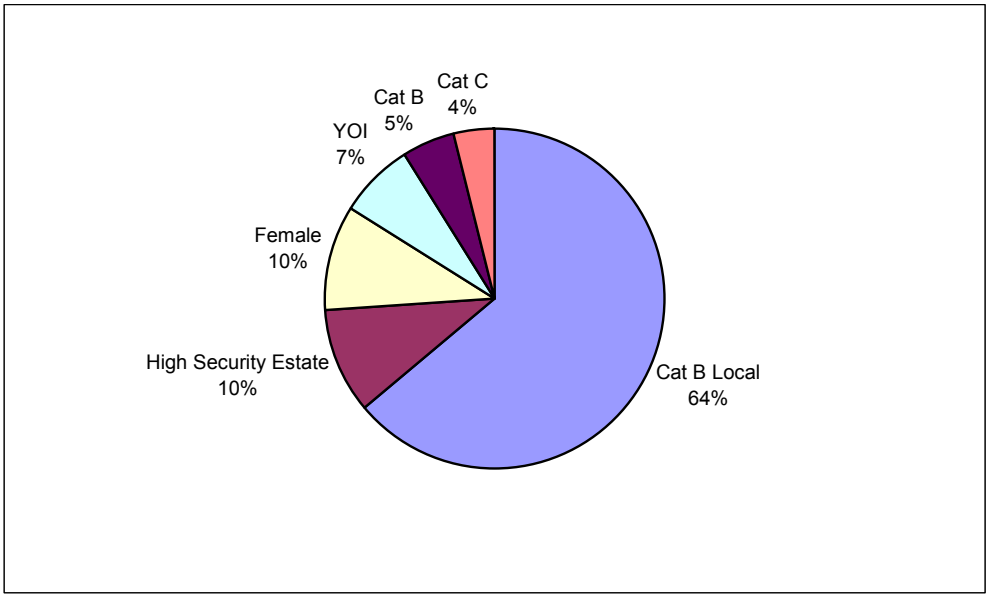

Fig. 4. Self-inflicted deaths by prison type, for 2002. (NB: Adapted from Safer Custody Group, 2003, unpublished report)

Temporal Factors

Lloyd (1990) notes that few researchers provide details of the impact of temporal variables (time of day, time of week, etc.) on suicide. Topp (1979) found no significant differences in time of day. While conversely, Dooley (1990) concludes that approximately half of suicides occurred between midnight and morning, with the rest being evenly distributed across the day. Bogue and Power (1995) reported most suicides occurring between 9 p.m. and 6 a.m. Lloyd noted that weekends were the most likely time that suicides occurred. It was also found that summer was a particular 'at risk' period.

Latency

Research indicates that suicides are most likely to occur shortly after reception into custody. Topp (1979) and Backett (1987) both found that 60% and 41% of their sample, respectively, committed suicide in the first month of custody. Dooley (1990) found that 46% of suicides occurred within the first month. Bogue and Power (1995) reported that two-thirds of suicides occur in the first three months of imprisonment and that four-fifths killed themselves within one year of reception into prison.

Location

Research indicates there is considerable cross-national variation regarding the impact of physical location on suicide and self-harm and may reflect how at risk prisoners are managed in various countries.

In the UK, Liebling (1997) found that a third of the self-harm incidents occurred in single cells. Most of the suicides occurred in what she termed 'normal locations'. In Bogue and

Power's (1995) study the majority of suicides occurred in single cells. Similarly, Towl and Crighton (1998) found 71% of prison suicides occurred where an individual was located in a single cell, compared with 23% located in a shared cell (in 7% of cases the information was not recorded). However, the majority of prisoners are housed in single cells.

British studies have found that a significant proportion of suicides have been in medical accommodation (Lloyd, 1990). Topp (1979) found that 30% of suicides occurred in the prison hospital accommodation. Lloyd argues that this is not surprising given that those identified as most at risk are often put into hospital accommodation or isolation. Figure 5 demonstrates the vast majority of self-inflicted deaths (approximately 70%) occur in single cells.

There is evidence to suggest that the use of isolation cells may enhance the chance of suicide among prisoners (Liebling, 1992; Towl & Crighton, 1997; Hayes & Rowan, 1998), though Lloyd (1990) notes that British studies fail to differentiate between isolation for suicide prevention purposes and isolation for punishment.

Research consistently indicates that, for both adult prisoners and young offenders, there is a strong relationship between the use of isolation and/or segregation and suicide and self-harm (Livingston, 1997). The problems associated with the use of isolation for at risk prisoners are further compounded by reports that young offenders are often reluctant to admit suicidal ideas to staff for fear of being placed in a strip cell (Liebling, 1991). Though the use of strip cells for prisoners at risk of suicide or self-harm was officially eliminated in 2000.

Length of sentence

Long-term and indeterminate sentences increase the risk of suicide and self-harm (Towl & Crighton, 1998), particularly in the early stages of custody. Early researchers such as Topp (1979) and more recent researchers such as Dooley (1990) agree that the length of sentence is significantly related to suicide risk.

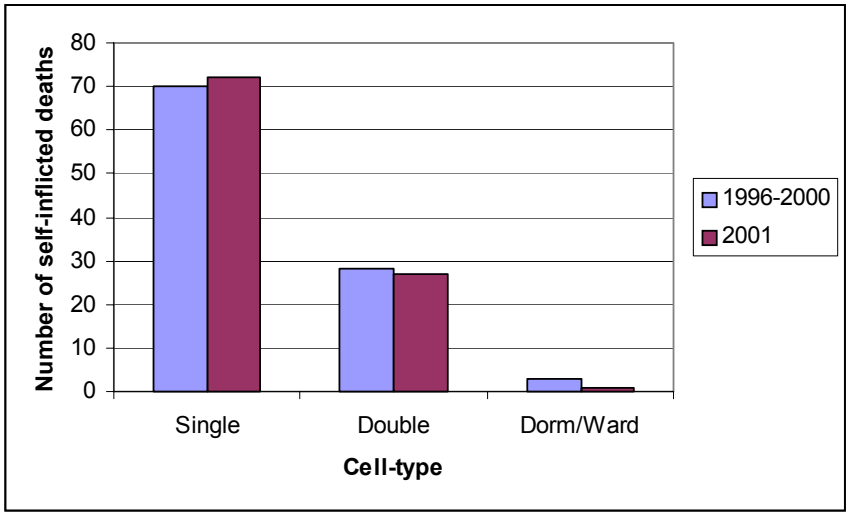

Fig. 5. Number of self-inflicted deaths by cell-type. (NB: Reproduced from Safer Custody Group, 2002)

References

Backett, S. (1987). Suicide in Scottish prisons. *British Journal of Psychiatry*, 151, 218-221.

Blaauw, E.; Winkel, F. & Kerkhoff, A. (2001). Bullying and suicidal behaviour in jails. *Criminal Justice and Behaviour*, 28, 279-299.

Bogue, J. & Power, K. (1995). Suicide in Scottish Prisons, 1977-93. *Journal of Forensic Psychiatry*, 6(3), 527-540.

Camilleri, P.; McArthur, M. & Webb, H. (1999). *Suicidal Behaviour in Prisons: A Literature Review*. School of Social Work, Canberra: Australian Catholic University.

Dooley, E. (1990). Prison suicide in England and Wales, 1972-87, *British Journal of Psychiatry*, 156, 40-45.

Eyland, S.; Corben, S., & Barton, J. (1997). Suicide Prevention in New South Wales Correctional Facilities. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 18(4), 163-169.

Gunnell, D. & Frankel, S. (1994). Prevention of suicide: aspirations and evidence. *British Medical Journal*. 308: 1227-1233.

Hayes, L. & Rowan, R. (1988). *National Study of Jail Suicides: Seven Years Later.* Alexandria, VA. National Centre of Institutions and Alternatives. National Institute of Corrections, U.S. Department of Justice.

Home Office (2003). *Prison Statistics England and Wales 2001*. London: Home Office.

Inch, H.; Rowlands, P. & Soliman, A. (1995). Deliberate self-harm in a young offenders institute. *Journal of Forensic Psychiatry*, 6(1), 161-171.

Liebling, A. (1991). *Suicide and Self-Injury Amongst Young Offenders in Custody*. Unpublished Ph.D Dissertation, Cambridge University. Cited in...

Liebling, A. (1992). *Suicides in Prison*. London: Routledge.

Liebling, A. (1993). Seclusion in prison strip cells: a practice to be ashamed of. *Bristish Medical Journal*, 307, 399-340.

Liebling, A. (1994). Suicide Amongst Women Prisoners. *The Howard Journal*, 33(1), 1-9.

Liebling, A. (1997). Risk and Prison Suicide. In H. Kemshall, & J. Pritchard (Eds.), *Good Practice in Risk Assessment and Risk Management*.

Liebing, A. & Krarup, H. (1993). *Suicide Attempts and Self-Injury in Male Prisons*. London: Home Office.

Livingston, M. (1997). A review of the literature on self-injurious behaviour amongst prisoners. In G.J. Towl (ed.) Suicide and Self-Injury in Prisons*, Issues in Criminal and Legal Psychology*, 28. Leicester: British Psychological Society.

Livingston, M. & Beck, G. (1997). A cognitive-behavioural model of self-injury and bullying among imprisoned young offenders. *Issues in Criminology and Legal Psychology*, 28, 45-49.

Lloyd, C. (1990). *Suicide and Self-Injury in Prison: A Literature Review*. London: Home Office.

Morrison, S. (1996). Custodial Suicide in Australia: A Comparison of Different Populations. *Medicine Science and the Law*, 36(2), 167-177.

Power, K.; McElroy, J. & Swanson, V. (1997). Coping Abilities and Prisoners Perception of Suicidal Risk Management. *The Howard Journal*, 36(4), 378-392.

Power, K. & Spencer, A. (1987). Parasuicidal behaviour of detained Scottish young offenders. *International Journal of Offender Therapy and Comparative Criminology*.

Royal College of Psychiatrists (2002). *Suicide in prisons*. Council Report CR86. London: Royal College of Psychiatrists.

Safer Custody Group (2002). *Safer Custody Report for 2001: self-inflicted deaths in Prison Service custody*. London: HM Prison Service.

Safer Custody Group (2003). *Suicide Prevention Co-ordinators Conference May 2003 Unpublished Report*. London: HM Prison Service.

Toch, H. (1975). *Men in Crisis: Human breakdown in prisons*. Chicago: Aldine.

Topp, D. (1979). Suicide in Prison, *Journal of British Psychiatry*, 134: 24-27.

Towl, G.J. & Crighton, D.A. (1998). Suicide in prisons in England and Wales from 1988-1995, *Criminal Behaviour and Mental Health*, 8, 184-192.

Wilkins, J. & Coid, J. (1991). Self-mutilation in female remand prisoners: I. An indicator of severe psychopathology. *Criminal Behaviour and Mental Health*, 1: 247-267.

Wool, R. & Dooley, E. (1987). A study of attempted suicides in prisons. *Medical Science and the Law*, 27 (4), 297-301.

Wortley, R. (2002). *Situational Prison Control: Crime Prevention in Correctional Institutions*. Cambridge: Cambridge University Press.

APPENDIX C: FOCUS GROUP SCHEDULE

GUIDELINES

WELCOME

Hello, my name is ..... and I work for the Jill Dando Institute for Crime Science (University College London). We have been commissioned to conduct research into the effectiveness of the 'Safer Cells' program in reducing self-harm and suicide among inmates. A key component of this research is gaining your input into the programs effectiveness. Please feel that you can contribute freely to the discussion. Everything you have to say will be of value and do not be afraid to voice an opinion that is different to someone else's.

Ask everyone to individually introduce himself or herself.
Inform participants that you plan to record the session and seek consent to do so.

GROUNDRULES (to be agreed upon by participants)

Keep Focused
Maintain momentum
Get closure on questions

DISCUSSION

After each question is answered, carefully reflect back a summary of what you heard to clarify participant's views.
Ensure even participation. If one or two people are dominant then call upon others or adopt a round-table approach.

CLOSING THE SESSION

Thank everyone for his or her contributions. Inform them that a research paper will be produced as a result of this research and once finalised will be disseminated to participants.

IMMEDIATELY AFTER THE SESSION

Verify that the tape recorder worked (if not write as much of what was said as you can remember immediately).
Review your written notes and make any changes necessary.
Write down any observations made during the session (e.g. participation levels, suprises, etc.).

QUESTIONS FOR DISCUSSION

Rationale/process for safer cells use

What reasons do you have for placing prisoners in safer cells?

How is that decision reached?
(Probe participants for exact details of the process)

What are the strengths of this process?

What are the weaknesses of this process?

Are there any changes you could suggest to improve this process?

Alternative management strategies for suicide and self-harm

What alternative management strategies to safer cells, both past and present can you think of?

What are your experiences of managing at risk and/or difficult prisoners with and without the safer cells?

Prompt comparisons with previous methods such as:

- The use of strip cells
- Use of segregation
- Use of restraints
- Removal of bedding
- Increased surveillance
- staff training and awareness

Were there any other initiatives designed to reduce suicide and self-harm introduced at the same time as the safer cells?

Have there been any other initiatives designed to reduce suicide and self-harm since the introduction of safer cells? If so ***when*** were they introduced?

Cell design comparison

In terms of the usefulness of safer cells, how do they compare with other (i.e. normal cells in the prison) cell designs and other ways of managing self-harm and suicide?

In terms of physical design, what are the strengths of the safer cells?

In terms of physical design, what are the weaknesses of the safer cells?

Are there any changes that you would suggest to improve the design of safer cells?

Consequences of Safer Cell use on inmates

Have you noticed any unintended consequences in terms of the treatment of inmates who have spent in the safer cells?

Prompt for the following:

- Increased stigmatisation
- Victimisation
- Violence towards the inmate

Have you noticed any unintended consequences on the health and/or behaviour of inmates who have spent time in the safer cell?

Prompt for the following:

- Physical health
- Psychological symptoms (such as depressive or emotional behaviour)
- Violence to other inmates and/or staff
- Vandalism of the cell
- Access to services/ impact on daily routine

What feedback or comments do you receive from inmates placed in the safer cells?

Are inmates reluctant to report problems that they are having because they do not want to be placed in the safer cell?

Do you have any other comments to make in relation to anything we have discussed today?

Thank you for your participation.

APPENDIX D: INTERVIEW SCHEDULE

GUIDELINES

1) PREPARATION

Before the interview, determine through prison contact person, the exact location of the safer cell that the prisoner is in/has been in and record (e.g. Reception unit, Healthcare Unit, A-Block (the specific building), etc.).

LOCATION OF SAFER CELL: _____

Choose a setting with little distraction.
Please note, all interview questions and instructions that the interviewer is to say are in italics.

2) INTRODUCTION

Hello my name is _____ from the Jill Dando Institute of Crime Science. We are doing some research into Safer Cells and how they affect prisoners. An important part of this research is talking to individuals like yourself that have experience with the Safer Cells.

I have a number of questions I will ask you that relate to Safer Cells, such as: your opinion of the cells; how they compare to other cells; the design of the cells and how that affects behaviour; and how other inmates treat people in the safer cells. Some of the questions I will ask will be personal. One thing I will ask about is self-harming behaviour. So if you don't want to answer them then you don't have to. You also have the right to withdraw from the interview at any stage, and this will not affect you in any way.

Everything that you tell me today is completely confidential and at no stage will you be identified in our final report. However, prison staff will be informed if:

If you tell me about any crime that you intend to commit in prison. So, you should not mention anybody's name during this discussion.
If you tell me about a crime you have committed in the past that you have not yet been arrested, charged, or convicted.
something you have said leads me to believe that either your health and safety, or the health and safety of others around you, is at immediate risk;
something you have said leads me to believe that there is a threat to security;

In these situations, we will inform a member of prison staff, who may take the matter further.

I would like to record the interview to save me taking notes the whole time. No one will have access to the tapes and they will be erased as soon as I have finished making notes from them. Is it okay for me to tape the interview? (If 'no', then DO NOT record and take notes. If 'yes', then turn on the tape recorder)

Do you have any questions about the interview at this stage?

Clarify that the individual has read and understands the Information Sheet and has signed the consent form.

3) QUESTIONS FOR DISCUSSION

Rapport Building Section and initial information gathering

'First of all, I am going to ask you some basic questions about Safer Cells'.

At the moment, are you in a Safer Cell?

If 'No', have you been in one before?

Where is (or was) it?
Reception Unit/First Night Centre (interviewer please tick the appropriate location)
Normal Location _
Health Care Unit _
Segregation Unit _
Other (please write) _____

What was it like? (ask question broadly but make sure you elicit information about the design of the cell so you as an interviewer understand basically what the cell is like physically)

How long have you been (or were you) in the safer cell?

Inmate opinion of Safer Cell, including in comparison to other cells

'Now we are going to move on to some questions about Safer Cells and how they compare to other cells in this prison'

What is it like being in a Safer Cell compared to other cells you have been in?

Prompt comparison with alternative locations.

How does the safer cell compare to a normal cell?

Have you ever been in a strip cell? – that is the cell with no furniture at all in it. How does that compare with the Safer Cells?

Have you ever been in a gated observation cell? – That is the one with the bars so that the prison officers can see you all the time. How does that compare with the safer cells?

Have you ever been in a time out room? – That is the room Samaritan-trained listeners often use the one with the soft chairs, coffee table, and coffee machine. How does that compare with the safer cells?

Do you prefer to be in a cell with someone else in it or by yourself?

If you had a friend in a similar situation would you want him/her to be in a Safer Cell?

Are there any good things about being in the Safer Cell?

Are there any bad things about being in the Safer Cell?

Consequences of being placed in Safer Cell on inmates

‘ We are now going to move onto some questions about how other prisoners treat you when you are in a Safer Cell, and how you behave when you are in a Safer Cell’.

Does staying in a Safer Cell affect your daily life, like getting to go to the gym or other prison activities?

Have you had any problems from other inmates or staff because you’re in a Safer Cell?

Prompt for the following (including when and where?)

- Have you been threatened because you are in a safer cell?
- Have you been left out of any activities or lost friends because you are in the safer cell?
- Has another inmate physically attacked you because you are in the safer cell?
- Have you had any other problems as a result from being in the Safer Cell?

Prompt for the following (including why, when and where?)

- Has staying in the Safer Cell effected your health?
- Has staying in the Safer Cell affected your mind or head or emotions at all?
- Has it ever made you feel angry? If yes what did you do?
- Have you ever wanted to ‘smash-up’ the safer cell? (probe for details)

Personal history of suicidal behaviour and self-harming

Why do you think you were moved to a Safer Cell?

‘Now we are going to talk about some things people sometimes find hard to talk about. What we are going to talk about is how sometimes people in prison feel so unhappy that they want to hurt themselves. Because this is hard to talk about, we don’t want you to talk about this if you don’t want to. Do you feel able to talk about these things?

If ‘YES’, ‘...If it becomes too hard to talk about, just tell me and we will go on to something else. Is that okay?

If ‘NO’, ‘...That’s fine, we can go on to something else’.

Have you tried to hurt yourself since you’ve been in prison? (If yes) Can you tell me about this?

If yes, have you ever wanted to hurt yourself while you have been in the safer cell? Have you ever tried since being in the safer cell? Where were you when this happened?

If attempted suicides are not raised...

Some people in prison feel so low that they want to kill themselves. Have you ever felt so low you've wanted to kill yourself since you've been in prison?

Did you ever get to the point of trying?

If yes, have you ever wanted to since you were in the safer cell? What happened? (probe for why they didn't if they wanted to, what they did if they did, etc.)

Alternative or displaced suicidal and/or self-harming behaviour

Thinking about when you were in the safer cell, has there ever been a time when you were going to harm yourself but you couldn't because of the physical structure of the cell? (explain where necessary on an individual basis)

If the participant is uncertain, then prompt with design features of safer cell

While in the safer cell, if there was a time that you wanted to harm yourself, did you try another way because of the structure of the cell?

If the participant is uncertain, then prompt with design features of safer cell

While in the safer cell, if there was a time that you wanted to hurt yourself, did you wait until you were moved from that cell to another one?

Need transition questions to ease back to less sensitive topics

Do you have any other comments on anything that we have discussed today, or anything relating to your experience in the Safer Cell?

Demographic information

'Finally, I just wanted to get a few personal details from you for our study'.

Male Female

What is your age? _____ years, _____ months

How long have you been in prison? _____ years, _____ months

What is the length of your prison sentence? _____ years, _____ months

What type of offence were you imprisoned for? _____

‘That is really about it for today about. Thank you so much for all the information that you have given me. If you have any questions at all or need to talk about any problems you may have the contact details for the Prison Staff member to talk to is _____ (name, title). If you would like to specifically talk to me about anything today, then this person can arrange for me to get in contact with you.

4) IMMEDIATELY AFTER THE INTERVIEW

Review your written notes and make any changes necessary.
Write down any observations made during the session (e.g. participation levels, surprises, etc.).