

DAY 4

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First Witness Statement
Her Majesty's Prison Service
Michael Gibbs
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Exhibits MG1- MG4

Prisons and Probation Ombudsman

Investigation no 01/2007

**INVESTIGATION INTO THE ATTEMPTED SUICIDE OF 'D' WHILST IN
CUSTODY AT HMP PENTONVILLE ON 27 DECEMBER 2001**

EXHIBIT MG4



SUICIDE AND SELF-HARM PREVENTION

Date of Issue / Amendment	Click on Number for link to reference
04/11/2002	Supersedes AG30/1993, IG1/1994 & 79/1994, PSI 32/1997 & 27/2000 & "Guide to policy & procedures: caring for the suicidal in custody"
Amendments can be tracked in the Numerical Index.	
PSI Amendments should be read before and in conjunction with PSO	
07/11/2003	PSI 51/2003 – New Suicide/Self- Harm Warning Form

PRISON SERVICE ORDER 2700 SUICIDE AND SELF-HARM PREVENTION

INTRODUCTION

Purpose

1. The Prison Service has a duty of care for all prisoners and staff. This Prison Service Order (PSO) provides the Service with instructions on identifying prisoners at risk of suicide and self-harm, and on providing the subsequent care and support for such prisoners, and support for the staff who care for them. This PSO replaces a number of previous instructions, and sets out mandatory requirements, explaining for example that Samaritan confidentiality is not in conflict with Prison Service suicide and self-harm prevention strategy. It brings existing



policy in line with the direction of the Prison Service's targeted but holistic approach to suicide prevention (the move from 'awareness' to 'prevention') and the broader context (decency, safety, the concept of the healthy prison).

2. The guidance document **Suicide Prevention Strategies** incorporating Safer Custody Cell Protocols and The Role of Samaritans and Samaritan-Supported Listeners is being issued in conjunction with this PSO. Additional copies of this document are available from Safer Custody Group (see paragraph 9, Contact Points).
3. This PSO does not reflect the substantive changes likely to be necessary as the learning from the current Safer Custody Programme is assessed and codified. This Programme comprises the Safer Locals Programme and a series of related projects on pre-reception; reception/induction; care of at risk prisoners; detoxification; peer support; the learning aspects of investigations into deaths in custody; and violence reduction. A new generation of replacement PSOs is planned for 2004.

Performance Standards

4. This PSO underpins the Performance Standard on Suicide and Self-harm Prevention issued in July 2002.

Impact and Resource Assessment

5. This PSO supersedes the following:

AG 30/1993	New Suicide Awareness Training Pack
IG 1/1994	Caring for the Suicidal in Custody
IG 79/1994	Additional guidance on Caring for the Suicidal in Custody
PSI 32/1997	The Role of the Samaritans
PSI 27/2000	Caring for the Suicidal in Custody: Eliminating Strip Cells
	Guide to policy and procedures: Caring for the Suicidal in Custody (1997)

The key requirements remain unchanged from previous arrangements and therefore have no significant additional impact on resources.

The Trade Unions have been consulted about the contents of this PSO.

Implementation

6. This PSO comes into effect on 1 January 2003.

Mandatory Action

7. *Governing Governors and Directors of contracted-out prisons must ensure that all staff involved in the care of prisoners are aware of the contents of this PSO.*

All mandatory actions are in Italics.

Audit and monitoring

8. *Areas and establishments must put in place systems to enable compliance with the mandatory actions set out in this PSO. Audit will comply with the Audit Compliance and Self-Audit Standard.*

Contact Points

9. For further Safer Custody Group advice on the suicide and self-harm prevention policy set out in this PSO contact:
 Mike Gibbs, Room 601, Abell House ☎
 Jenny Rees, Room 601, Abell House ☎

For advice about safer custody cells protocols contact:
 Terry Stocks, Room 639, Abell House ☎

For advice about research and training contact:
 Jo Paton, Room 637, Abell House ☎
 Louisa Snow, Room 601, Abell House ☎

For advice on Samaritans and Listeners contact:
 Kathy Biggar, Room 639, Abell House ☎

Brodie Clark
Director of Security

*ELOs must record the receipt of the Prison Service Order **Suicide and self-harm prevention** in their registers as issue **160** as set out below. The PSO must be placed with those sets of orders mandatorily required in Chapter 4 of PSO 0001..*

Issue no.	Date	Order no.	Title and / or description	Date entered in set	ELO signature
160	XX/XX/98	2700	SUICIDE AND SELF HARM PREVENTION		

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CHAPTER 1: RESPONSIBILITIES

1.1 Introduction

The principle of shared responsibility does not mean that staff are not accountable. All members of staff have clear responsibilities under the F2052SH (self-harm at risk form) system. Examples of further staff roles that may be appropriate to some areas and establishments can be found in the guidance document accompanying this PSO.

1.2 Any member of staff

A F2052SH can be raised by any member of staff who is concerned that a prisoner may be at risk of self-harm or suicide. For F2052SH procedures, see Annex B.

1.3 Area/Operational Managers and the Director of High Security Prisons

Area/Operational Managers and the Director of High Security Prisons must validate annually the suicide prevention strategy in each of their establishments.

1.4 Governors / Directors of contracted-out establishments

1.4.1 Governors and Directors have overall responsibility for the implementation of suicide and self-harm prevention policy and procedures within their establishment. Particular responsibilities may be delegated to the Suicide Prevention Team (SPT). A local policy statement, plus instructions and protocols must be drawn up, outlining a multi-disciplinary, multi-agency approach to suicide prevention (see Annex A).

1.4.2 *Governors and Directors must:*

- *Appoint a SPT leader (unless they undertake this role themselves).*
- *Monitor implementation of local policy and procedures, and review annually, identifying the target for the audit rating for the following year.*
- *Appoint Suicide Prevention Trainers.*

1.5 Suicide Prevention Team Leaders

The SPT leader will have key responsibility for the implementation and development of the local suicide prevention strategy (see Annex A), and compliance. Training is available for the SPT leader, who can be supported by a deputy team leader and/or a Suicide Prevention Co-ordinator.

1.6 The Suicide Prevention Team (SPT)

1.6.1 Membership of the SPT

Membership should reflect the Service's multi-disciplinary approach to suicide and self-harm, and include representatives from key areas of the prison and from a range of disciplines. *It must include:*

- *SPT leader, who will chair the meetings.*
- *Suicide Prevention Co-ordinator (where available).*
- *Suicide Prevention Trainers.*
- *Anti-bullying Co-ordinator.*
- *Representative from health care.*

1.6.2. Meetings and functions of the SPT

1.6.2.1 *The Suicide Prevention Team must have meetings at least every three months at which:*

- *Self-harm incidents are examined and monitored*
- *The quality of F2052SH procedures is monitored*
- *The local preventative strategy is reviewed and updated.*

1.6.2.2 *The meetings must be minuted and copied to the Senior Management Team and the Area Suicide Prevention Co-ordinator.*



CHAPTER 2: EARLY PERIOD IN CUSTODY

The quality of the reception and first night experience for some prisoners is of such significance that it can either confirm a sense of hopelessness and despair or present an opportunity for stability and improvement in a prisoner's feeling of well being and will to live.

2.1 Reception and first night

Governors should ensure that, in addition to security, the guiding principle in management of the reception and first night processes is the Prison Service's duty of care to prisoners.

2.2 Reception health screen

An assessment of possible risk of suicide or self-harm will be made by a member of the health care team on the day of reception as part of the health screening procedure for all receptions. (See Health Care Standards for Prisons in England and Wales (1994) no's 1 & 5, and the Standard on Health Services for Prisoners).

2.3 Cell sharing assessment

New prisoners must have the cell sharing assessment form completed to inform the decisions about cell allocation. (See PSI 26/2002 - Cell-Sharing Assessment Tool).

2.4 Reception and first night staff

2.4.1 When receiving prisoners with F2052SHs staff should talk to the prisoner and to escort staff, to check whether the risk is current or historical. Any difficulties concerning information sharing and F2052SH procedures in relation to contracted escort staff should be forwarded to the SPT leader, for discussion at the SPT meeting and follow-up with the contractor and/or the appropriate PECS Monitor.

2.4.2 *Staff in reception should be competent in using F2052SH procedures and must be prepared to implement F2052SH procedures themselves, in discussion as necessary with health care staff.*

2.5 Identifying next of kin

Efforts should be made, particularly during the reception and first night screening processes, to identify whom the prisoner considers next of kin. The establishment should have clear details as to who, in the event of the prisoner suffering a serious illness, having a serious accident, or committing a serious incident of self-harm, the prisoner would wish them to contact.

2.6 Phone contact

2.6.1 *Samaritans' phone number must be displayed by every phone that is provided for prisoners' use. Wherever possible, prisoners should be provided with the opportunity for relative privacy when wishing to make*

such telephone calls, e.g. by use of dedicated cordless "Samaritans phones".

- 2.6.2. Prisoners should be given the opportunity where possible (see the Reception Standard) to make contact with their family or close friends from reception regardless of their ability to pay for use of the phone. *However: It must be ensured that prisoners who are subject to restrictions under PSO 4400, Protection from Harassment Act 1997, are not given access to people they are not allowed to contact.*

2.7 Drug withdrawal and detoxification

There is a significant relationship between drug withdrawal and suicide. *Failure to take medication or sharp mood swings must be treated as risk factors and reported to appropriate health care and residential staff.* All clinical services should be in accordance with PSO 3550 (Standard for the Clinical Management of Substance Misuse) and with the Department of Health Clinical Guidelines (1999).

CHAPTER 3:REQUIRED ACTIONS FOLLOWING INCIDENTS OF SELF-HARM

3.1 Introduction

- 3.1.1 For the purpose of this Order, 'self-harm' is any act where a prisoner deliberately harms themselves irrespective of the method, intent or severity of any injury.
- 3.1.2 An act of self-harm should always be taken seriously. Even if the prisoner appears to be using self-harm as a means of gaining something, it is still a desperate act and the prisoner should be helped to find constructive ways to meet the underlying need.

3.2 Immediate action following incidents of self-harm or attempted suicide

For initial action following self-harm see Chapter Two of PSO 2710 (Follow up to Deaths in Custody). For emergency procedures and equipment see Annex C and Annex D to this PSO.

3.3 Reporting requirements

- 3.3.1 *All incidents of self-harm must be recorded on incident report forms and an F213SH self-harm/attempted suicide form completed. Noose/ligature making must also be reported on the F213SH, but anorexia, bulimia nervosa and food refusals should not be reported using this form.*
- 3.3.2 *All incidents of self-harm must be reported to National Operations Unit through the Incident Reporting System (see Chapter 2 of PSO 1400, Reporting of Incidents). Serious incidents (those where the prisoner involved requires resuscitation and/or transfer to an outside hospital as a result of self-harm) must also be reported to NOU by telephone.*

3.4 Follow-up actions, and care for prisoners who have self-harmed

- 3.4.1 *A F2052SH must be opened, where there is not one already, following any act of self-harm (see F2052SH procedures in Annex B). In the case of prisoners who repetitively self-harm, i.e. within two months of the closure of the last F2052SH, the previous F2052SH may be re-opened.*
- 3.4.2 The prisoner should be asked if they are being bullied or intimidated, and if so the Anti-Bullying Co-ordinator should be notified.
- 3.4.3 *After consultation with the prisoner, the nominated next of kin must be notified, unless:*
- *There is a clinical reason not to, or;*
 - *If aged 18 and over, the prisoner does not consent, or;*

- *The prisoner's support plan indicates otherwise (e.g. in the case of a prisoner who repetitively self-harms).*

3.4.4 Where appropriate, after serious incidents of self-harm consideration should be given to allowing the prisoner themselves the opportunity to notify the next of kin by a phone call and/or an extra exceptional visit.

3.4.5 If the prisoner is taken to hospital, the F2052SH should travel with them. Staff on bed watch should include any pertinent observations in the daily supervision and support record in the F2052SH, including any information provided by specialist services at the hospital, e.g. the deliberate self-harm team.

3.5 Post-incident support

3.5.1 Dealing with suicide attempts, or other serious incidents of self-harm, can be as stressful as dealing with a death. The SPT and Care Team should work closely on an agreed strategy to support staff and prisoners following a death in custody, and also following a serious incident of self-harm.

3.5.2 Support for staff involved in an incident should be offered in every case, and should be based on Chapter 5 of PSO 2710 (Follow Up To Deaths In Custody) and PSO 8150 (Post Incident Care for Staff).

3.5.3 Witnessing a suicide attempt or incident of self-harm is a traumatic experience for prisoners too (also see Prison Discipline/Adjudications Manual re: mitigation). Where necessary, prisoners should be seen individually and support should be offered over the subsequent days and weeks.



CHAPTER 4: MANAGING PRISONERS IDENTIFIED AT- RISK TO SELF (on an open F2052SH)

4.1 Accommodation of at-risk prisoners

For safer cell protocols and suggestions for alternatives to the use of unfurnished accommodation, see Section Four of the guidance document accompanying this PSO.

4.1.1 Shared accommodation

At-risk prisoners should be routinely allocated to shared accommodation, unless the prisoner represents a risk to others, their behaviour is too disturbing to other prisoners or shared accommodation is not available. Two at-risk prisoners should not share a double cell. If it is not advisable or practical to place a prisoner on an open F2052SH in a shared cell, the reason for the allocation to a single cell should be recorded in the F2052SH, and additional protective measures put in place to compensate for the added risk. (For further details on the accommodation of at-risk prisoners, consult PSI 26/2002 cell-sharing risk assessment).

4.1.2 Segregation

4.1.2.1 *Prisoners who are at risk of suicide or self-harm must not be routinely held in the segregation unit under Rule 45 GOOD (YOI Rule 49) unless, exceptionally, they are such a risk to themselves or others that no other suitable location is appropriate. Such prisoners must only be placed in a segregation unit in exceptional circumstances, or where all other options have been tried, but considered inappropriate and only where it is possible to provide the degree of continual care identified as necessary in the prisoners' care plan. A case review must be held as soon as possible to take account of events leading up to the decision to segregate. If the decision is taken to locate prisoners at risk of self-harm within the segregation unit this must be for as short a period of time as possible, and the temporary nature of this must be reflected in the care plan.*

4.1.2.2 *A mental health assessment must be undertaken by health care staff of all prisoners at risk of suicide or self-harm who are placed in a segregation unit, and the reviewed care plan implemented. The European Court has ruled that failure to follow such procedures for prisoners suffering from a mental disorder can constitute a breach of Article 3 (cruel and inhumane treatment). The decision to segregate must also be regularly reviewed by health care staff. The prison doctor must ensure that he or she is fully aware of the conditions in which prisoners in the segregation unit are being held, and the effect of segregation on individual prisoners. A doctor must visit all prisoners segregated at least once every three days. Wherever possible, and certainly where health needs dictate it, segregated prisoners must be visited by a doctor or nurse more frequently than this. A note of each*

visit must be made on the prisoner's IMR. The Governor must arrange for a prisoner to leave segregation if a doctor so advises on medical grounds. If a nurse visiting a prisoner in segregation has concerns about a prisoner's state of health, the nurse must inform a doctor as soon as possible (see PSO 1700, Management of Segregation Units). It is preferable that a nurse visits such prisoners on a daily basis.

4.1.2.3 Special consideration should be given to prisoners on an open F2052SH who are segregated either under Rule 45 (YOI Rule 49) or who are subject to an adjudication or have been located in the segregation unit as a result of their adjudication hearing. The risk of locating the prisoner in a single cell in these circumstances should be considered. Adjudicators should consider the implications of the punishment they may impose on a prisoner who is found guilty at an adjudication, and who is subject to F2052SH procedures, such as removal from association, loss of canteen and cellular confinement (see the Prison Discipline/Adjudications Manual).

4.1.2.4 In establishments with Listener schemes, every effort should be made to allow prisoners held in the segregation unit access to Listeners. *There must not be a general ban on Listeners visiting the segregation unit.* Any refusal to allow a prisoner in the segregation unit access to a Listener should be documented, e.g. in the F2052SH and the Segregation Log/Occurrence book, giving the reason for the refusal, the prisoners response to refusal, and in non-F2052SH documentation, the prisoners current F2052SH status, i.e. 'open', 'closed', 'due for review'.

4.1.3 Special accommodation

4.1.3.1 *Prisoners identified as being at risk of suicide or self-harm must not be placed in an unfurnished cell. Precise definitions of the terms unfurnished rooms, strip cells or strip conditions are now blurred across the estate. In the context of caring for prisoners identified as being at risk of suicide/self-injury, strip cell and strip conditions refer to bare unfurnished cells which do not contain furniture, fittings, bedding and clothing.*

4.1.3.2 *In exceptional circumstances, such prisoners who are additionally identified as violent or refractory may be held in special accommodation (as defined in PSO 1600, Use of Force), for the shortest possible time. Once the violent or refractory behaviour has ceased, such prisoners must be removed from special accommodation. Appropriate supervision measures must be in place to ensure the safety of the prisoner during the period they remain in special accommodation. During this period, staff must continue to document all observations and changes in circumstances in the daily supervision and support record in the F2052SH.*

4.2 Supervision of at-risk prisoners

4.2.1 *The case review for each prisoner on an open F2052SH must decide on the level of supervision required and must specify this in the support plan, including:*

- *The level of observation for those prisoners in single cells.*
- *The level of observation for those prisoners in shared accommodation at times when they are left alone.*

Where the support plan specifies that a prisoner can not be left alone in their cell, arrangements for continuing companionship must be made (even for short periods, e.g. whilst a cellmate is at court, work, education, on exercise, or attending an appointment).

- *Whether the prisoner requires intermittent supervision.*

This can only be authorised by a doctor or nurse (in consultation with the duty Governor) or the duty Governor (in consultation with a doctor or nurse).

Intermittent supervision is where the prisoner is checked at least five times an hour at irregular intervals. The checks must not be spaced at regular, and therefore predictable, intervals. In the past, prisoners being checked at predictable intervals have killed themselves between supervision times. These checks must be recorded in the daily supervision and support record of the F2052SH.

- *Whether the prisoner is at acute risk (a heightened and immediate determination to carry out the act) and therefore requires constant observation.*

Constant observation can only be authorised by a doctor or nurse (in consultation with the duty Governor) or the duty Governor (in consultation with a doctor or nurse). Constant observation is where the prisoner is observed by a designated member of staff who remains constantly in his or her presence (in accordance with each establishment's local strategy).

4.2.2 Prisoners placed under constant observation should be urgently referred for mental health assessment. *Their case must be reviewed as soon as is practicable, and certainly within 4 hours (or immediately prior to unlock the following morning in cases where the prisoner is placed under constant observation during the night) and every 4 hours thereafter for the remainder of that establishment's core working day. In those exceptional cases where this level of crisis lasts beyond 24 hours, further case reviews must be held at least three times during that establishment's core working day. Acute suicidal crisis is usually temporary and the aim of the case reviews should be to reduce the level of supervision progressively as the prisoner's condition improves. The temporary nature of this level of supervision must be reflected in the support plan.*

4.2.3 Supervision of the suicidal should be active, involving supportive contact rather than mere observation.

4.2.4 Staff should ensure that they are able to clearly identify which prisoner in a shared cell is on an open F2052SH, e.g. which bunk they are using, and make necessary arrangements to ensure that the prisoner can be clearly observed.

4.2.5 It is not appropriate to use Listeners to take over the supervisory role of staff, nor should Listeners have access to a prisoners' F2052SH.

4.2.6 *When an at-risk prisoner is in the HCC or under intermittent supervision or constant observation elsewhere in the establishment, a doctor or nurse must be consulted before any news known to be unfavourable to the prisoner is communicated to him or her.*

4.3 Movement of at-risk prisoners

4.3.1 Movements within the prison

The fact that a prisoner has an open F2052SH must not preclude their movement around the prison. Attending the gym, workshops, education and visits may form part of the support plan put in place to assist the prisoner.

4.3.2 Changes of residential location

4.3.2.1 *Changes of residential location must be noted on the front cover of the F2052SH.*

4.6.2.2 *Governors should ensure that internal systems are in place to facilitate good communication between the different locations of prisoners at risk of self-harm. They should ensure that the F2052SH form accompanies the prisoner when he or she changes residential location.*

4.3.3 External movements

4.3.3.1 *The F2052SH will travel with an at-risk prisoner when he or she is escorted outside the establishment. The F2052SH must be readily visible to the escort staff; it **must not** be put in the sealed pouch with the IMR (for movements to hospital see paragraph 3.4.5.).*

4.3.3.2 *Dispatching staff must complete the Prisoner Escort Record (PER) accurately (see PSO 1025, Communicating Information about risks on Escort or Transfer – The Prisoner Escort Record). Receiving staff (whether prison, contracted escort or other agencies) must also be notified by way of a verbal briefing when an at-risk prisoner is to be handed over into their care. Any significant information on the PER must be highlighted as part of these procedures.*

4.3.3.3 *Contracted escort staff must, when taking over responsibility for prisoners, make an immediate check for F2052SH status, checking observation requirements and the content of support plans. They must document relevant observations, contacts, events, changes in mood, behaviour or circumstances in the PER and in the daily supervision and support record in the F2052SH.*

4.3.3.4 *Where prisoners appear at court whilst on an open F2052SH and are released on bail, but remain within the care of a criminal justice agency, then information should be passed to that agency. The F2052SH should be returned to the 'sending' prison for filing in his/her core F2050.*

4.3.4 Transfers

4.3.4.1 *All establishments must accept a prisoner on an open F2052SH. Transfer may form an integral part of their support plan, for example locating the prisoner closer to home, and may be an appropriate tool to support a prisoner at heightened risk.*

4.3.4.2 *The intention to transfer a prisoner on an open F2052SH must be discussed with the receiving establishment, and relevant information must be conveyed either with or ahead of the prisoner.*

4.3.4.3 *The proposed transfer, and issues arising from it, must be discussed at a case review with the prisoner (in the case of Category 'A' and 'E' list prisoners additional discretion about transfer arrangements should be maintained).*

4.3.4.4 The prisoner should be given information about the regime and facilities of the new establishment, helped to prepare, and subject to security considerations given the opportunity to contact family and friends prior to the transfer.

4.3.4.5 *The F2052A (history sheet) must be used in addition to the PER to record that an open F2052SH is in existence when transferring prisoners.*

4.4 Removal of items in possession

Personal items including shoelaces and belts must not be removed from at-risk prisoners as a matter of course. The reasons for the decision to remove or return items must be recorded in the prisoner's F2052SH.

4.5 'Safe self-harming'

It is not Prison Service policy to promote 'safe self-harming'. Although some prisoners may suggest that it would be helpful to allow this, *staff must not issue razor blades or other potential instruments of self-harm to prisoners with the express intention of assisting them to hurt themselves.* But neither should prisoners be punished for self-harming or unnecessarily denied such items as razor blades for normal activities. Only in rare circumstances should a prisoner be placed on report for self-harming, such as when the incident has put others lives at risk, e.g. by way of a cell fire (see also Prison Discipline/Adjudications Manual re: self-harm). Prisoners should be offered help and support to address the underlying need.

CHAPTER 5: SAMARITANS AND PEER GROUP SUPPORT

For further information on the role of Samaritans and Samaritan-supported Listeners, see the guidance document supporting this PSO.

5.1. Prisoner information and contact

Prisoners must be advised of the existence and availability of Listeners, other peer supporters and Samaritans. They must have timely access to Listeners in establishments where these schemes operate. They must also have the facility to contact Samaritans by telephone privately, preferably by means of a direct, dedicated line or pre-programmed cordless phone. The same facility must also be made available to Listeners needing to debrief after a call-out, or needing confidential support.

5.2 Working with Samaritans

Samaritans' National Prison Support Team launched a new 'Risk 1' strategy in 2001. Its objective, like that of the Prison Service, is to achieve 'a year-on-year reduction in the number of suicides occurring in prisons'. The work of Samaritans, and of the Listeners they train and support, is an integral part of the Prison Service's suicide and self-harm prevention strategy.

5.3. Promoting the partnership

5.3.1 *All members of the Suicide Prevention Team and the Care Team must have copies of the guidance document supporting this PSO, incorporating 'The Role of Samaritans and Samaritan-supported Listeners'. This guidance document should also be made widely available to all staff.*

5.3.2 Prison Service establishments and Samaritan branches are encouraged to sign a Service Level Agreement, which is not legally binding, but expresses intent and clarifies commitment on each side. A model SLA is available from the Suicide Prevention Policy Unit in the Safer Custody Group. The content of the SLA should be jointly reviewed each year. (See PSO 4190, Strategy for Working with the Voluntary and Community Sector).

5.3.3 All Listeners, including those from the VP Unit, should be trained and attend support group meetings together

5.4 Understanding confidentiality

5.4.1 The principle of total confidentiality is central to the work of Samaritans and this applies equally to their work in prisons, including that of prisoner Listeners.

5.4.2 Samaritans allows exceptions to its principle of confidentiality only in the following very specific circumstances:

- Samaritans and Listeners will not accept a confidence which contravenes the Prevention of Terrorism (Temporary Provisions) Act 1989, since updated to the Terrorism Act 2000, as amended by the Anti-Terrorism, Crime and Security Act 2001.
- Samaritans and Listeners will call for help, without consent, where a caller is attempting to take their own life and has reached a condition where it is clear that they are unable to make their own decision.

5.5 Access to establishments

5.5.1 It is essential that staff do everything possible to help volunteers to make best use of their time and to reduce avoidable delays in entry to the prison.

5.5.2 Every effort should be made to facilitate the swift completion of security clearance procedures.

5.5.3 Where circumstances arise which will prevent entry to the prison, Samaritans due to visit that establishment should be informed as soon as possible.

5.6 Other peer support schemes

Establishments running alternative peer support schemes instead of Samaritan-supported Listeners must not use the word 'Listeners' in their schemes' name, as this can lead to serious misunderstanding when prisoners transfer between establishments running different schemes.

Annex A

AREAS TO BE COVERED BY A LOCAL SUICIDE AND SELF-HARM PREVENTION STRATEGY

Local instructions must comply with national policy.

Local instructions must be clearly stated and made available to all staff.

All establishments must have a local suicide and self-harm prevention strategy. This must be consistent with the 'Suicide and Self-Harm Prevention' Standard, take into account local requirements, be applicable to the operation of the establishment on a 24 hour basis, and include reference to the following.

1. *A suicide and self-harm prevention policy statement, for wide publication and display to staff, prisoners and visitors. This must include measures to reduce self-harm, and be available to prisoners' families on request.*
2. *Membership, meeting schedule and terms of reference for the Suicide Prevention Team.*
3. *Action to be taken (can be emergency orders) by all staff following an incident of self-harm, or when there is concern that a prisoner is at risk, including:*
 - *Ensuring speedy access to a suicidal prisoner by (a) health care staff and (b) external paramedics for transfer to outside hospital;*
 - *Escorting prisoners to hospital who have cut their wrists and cannot be put into mechanical restraints (see Incident Management Manual – PSO 1400);*
 - *Staff entering multi-occupancy cells;*
 - *Requesting/authorising an ambulance to attend.*
4. *Checking F2052SH status in reception area when prisoners are being escorted outside the establishment (can be part of a general escort checklist) and where prisoners return to prison after a period on bail.*
5. *Responding to individual physical and mental health problems during detoxification.*
6. *Allocating accommodation for prisoners at risk suicide or self-harm.*
7. *When to use the establishment's specialist designations, e.g. safer cells.*
8. *Undertaking constant observation, covering; the rotation of observing staff, interactivity between observing staff and the prisoner, and when and how the prisoner can participate in normal regime activities.*

9. When category 'A' and 'E' list prisoners subject to the F2052SH procedures may be held in shared accommodation.
10. *Ensuring prisoners in shared accommodation who have been risk-assessed as needing constant company are not left alone, for example when cell-mate is at work or a visit.*
11. *Either;*
 - *ensuring the movement of the F2052SH with the prisoner when he/she participates in activities (in which case, to preserve discretion, local arrangements must be developed to ensure the F2052SH is conveyed as discreetly as possible), or*
 - *informing the receiving member of staff (e.g. in the prisoners' workplace) of the prisoner's status, and to allowing them to input to the F2052SH daily supervision and support record.*
12. *Ensuring that, where available, prisoners have access to Samaritans, Listeners and other organisations that can offer support.*
13. *Notifying outside agencies of known suicide or self-harm risk when prisoners are being discharged into their care or supervision.*
14. *Receiving and recording, and passing to the area of the prison where the prisoner resides, information coming into the establishment from families, agencies and other parties outside the establishment who have a concern for a prisoner who may be at risk of self-harm or suicide.*
15. *Aftercare following the closure of F2052SHs.*
16. *Monitoring the level and nature of incidents of self-harm in the establishment, and ensuring the accurate recording of these on the Incident Reporting System.*
17. *Maintaining staff and prisoner awareness, ensuring in particular that all staff are aware of what is required of them in order to deliver an effective suicide and self-harm prevention strategy.*

Methods to achieve this include:

- (i) *reminding staff of key policy and procedures at least annually;*
- (ii) *circulating policy documents, briefings and instructions to staff;*
- (iii) *training to help staff identify and manage prisoners at risk of suicide or self-harm, and to raise awareness of the local preventative strategy.*

Annex B

F2052SH PROCEDURES

Unless specified otherwise, these procedures refer to all staff. For further procedures relating to accommodation, supervision and movements of at-risk prisoners, see Chapter Four.

In the event of any incident of self-harm, or cause for concern that the prisoner may be at risk, open a F2052SH (where there is not one open already) and where there has been an incident of self-harm also complete a F213SH self-harm/attempted suicide form. In the case of prisoners who repetitively self-harm, i.e. within two months of the closure of the last F2052SH, the previous F2052SH may be re-opened

Where information reflecting a concern for a prisoner who may be at risk of self-harm or suicide is received from outside the establishment, record concerns, e.g. in the observation book and in the F2052A (history sheet), along with the action taken.

It is important that staff are aware of which prisoners in their care are on an open F2052SH. All staff must ensure that when coming on duty they make an immediate check for open F2052SHs on the prisoners in their care, checking the observation requirements and content of support plans for each one carefully. Whenever staff hand over prisoners on an open F2052SH to colleagues, they must always appropriately brief that member of staff.

Opening the F2052SH (front cover & page 1)

Complete the front cover and page 1, recording the reasons for concern - including details of any information received from a third party - and pass the form to the manager of the unit where the prisoner resides (unless opened by a member of the health care team, who will refer direct to the HCC for assessment - page 5 of the F2052SH).

When opening a F2052SH, inform the central registration point (usually the control room) and enter the given number on the cover.

Inform the prisoner about the F2052SH process, and record their comments and any relevant events in the daily supervision and support record in the F2052SH.

Contracted escort staff must record the incident and opening of the F2052SH on the PER, and pass on the information verbally to reception staff, and hand over to them the PER and the F2052SH.

Record, or ensure that it is recorded by the relevant wing staff, that a F2052SH has been opened in the observation book, and in the F2052A (history sheet) giving reasons.

Initial action (page 2)

The manager of the unit where the prisoner resides must:

- *On receipt of the F2052SH, speak to the prisoner and initiating member of staff, consult health care and other relevant staff and check F2050, particularly for previous F2052SHs, adding any relevant information from it to the new F2052SH.*
- *Decide, in consultation with health care staff, whether to manage the prisoner on the residential unit or refer initially to the HCC, and document reasons on page 2.*
- *Where managing the prisoner on the residential unit, take initial action to help the prisoner, and document on page 2.*
- *Ensure that, where available, prisoners on an open F2052SH have been offered the opportunity to talk to a Listener and/or Samaritan.*
- *Ensure a case review is held within 72 hours, and document a summary of the review and agreed support plan on page 3.*

A doctor, nurse or health care officer must, where the F2052SH has been raised by non health care staff:

- *Obtain the IMR and discuss prisoner's needs with the Residential/Wing/Unit Manager, checking for any medical risk factors.*
- *Record the raising of any F2052SHs in the IMR (whether or not referred) and in the F2050A, together with any advice given or assessment of the prisoner.*

A contribution to the initial assessment may be made by a member of the health care team on the wing, if available. This should be recorded on page 2 or page 7, not on page 5, which is for referrals only.

Health care assessment (page 5)

A health care officer or nurse must interview prisoners who are referred for health care assessment or treatment under F2052SH procedures as soon as possible; the prisoner must also be referred to a doctor as soon as possible, and in any event within 24 hours of any referral to HCC. A record of these assessments must be made on page 5 of the F2052SH and in the IMR.

A doctor or nurse, depending on the stage of the assessment process, must decide, in consultation with the other members of staff involved in the prisoners care, whether the prisoner should be located in the HCC or on ordinary location, and provide an appropriate management plan.

Record of case review and support plan (page 3 & 4)

Draw up an agreed prisoner's support plan in consultation with other departments and agencies.

The manager of the unit where the prisoner resides must:

- *Ensure the support plan is implemented and the daily supervision and support record is maintained.*

- *Ensure further multi-disciplinary case reviews are held as necessary, including in the event of a further act of self-harm, (unless an alternative review level in the event of further self-harming is specified in the support plan).*
- *Seek guidance from health care staff and co-operate with related case reviews and with those in other departments.*

Members of the health care team:

Routine case reviews are not required when a prisoner is located in the HCC on a regular scheduled basis in recognition of the fact that the prisoner will in this circumstance have a nursing care plan. However, it is good practice to do so when possible, and a *nursing care plan must not be used in place of the F2052SH. A case review must be conducted in the HCC:*

- *When a prisoner harms themselves (unless an alternative review level in the event of further self-harming is specified in the support plan).*
- *Prior to the prisoner's discharge to normal residential accommodation.*

"Open" F2052SHs / further observations (pages 7-10)

Report any further observations (including at night) and contacts with the prisoner and subsequent follow up action in the daily supervision and support record, including any change in mood or behaviour, failure to collect prescribed medication (as informed by health care staff) and any information received from outside the establishment. Bring any concerns to the attention of the manager of the unit where the prisoner resides.

Ensure all F2052SH entries are legible and dated - print name (not signature) next to all entries - and that whenever possible entries demonstrate meaningful interaction, e.g. conversation, with the prisoner.

The manager of the unit where the prisoner resides must consult health care staff again if the prisoner deteriorates and requires further medical assessment, documenting reasons in the daily supervision and support record. Refer immediately to health care centre if self-harm occurs, or risk appears acute.

Discharge from HCC/transfers/return to Residential Unit (page 6)

All discharges and transfers subject to an open F2052SH, must be seen by a member of the health care team prior to discharge.

A case review must be held, prior to a prisoner being discharged, following an in-patient stay, involving where possible staff from the unit to which the prisoner will be discharged. When a prisoner is discharged, a verbal hand over must be provided to the receiving unit. It may be appropriate for contact with health care staff to continue as part of the support plan.

A member of the health care team must complete the F2052SH page 6 when the prisoner returns from the HCC to normal residential accommodation, whether or not he or she has been admitted as an in-patient, providing relevant information relating to risk, after seeking patient's consent, and documenting consent in the IMR.

Closing the F2052SH

The F2052SH will be closed at a case review when the prisoner appears to be coping satisfactorily. When deciding on closure, the chair of the case review must be a minimum grade of SO or Nurse Grade F. The case review will agree after-care or follow-up requirements.

The reasons for closure and any aftercare plans must be recorded in the F2052A (history sheet) and in the report of the case review in the F2052SH. The front cover of the F2052SH must be noted, and the closed F2052SH must be securely stored in the core F2050.

Health care and the central registration point (usually the control room) must be informed of the closure.

The F2052SH must not be closed at the point where the prisoner leaves health care for normal location. This is to ensure the prisoner has successfully adapted to normal location.

Quality control

Unit managers must check observation books daily to ensure entries indicating risk of suicide or self-harm are promptly and appropriately actioned, and ensure that:

- *Staff follow the F2052SH procedures.*
- *Health care staff have been informed of all new open F2052SHs.*
- *All staff with prisoners on open F2052SHs in their unit are made aware of the support plan's contents, and that handovers take place.*

A Residential Manager or duty Governor must audit the quality of F2052SH entries at least twice a week, draw deficiencies to the attention of line managers, monitor the response, and record that they have made these checks.

Annex C

ACTION FOLLOWING SELF-HARM: EMERGENCY PROCEDURES

All cases

1. Summon help and request emergency medical assistance and first aid equipment.
2. Enter the cell as soon as possible, following the local strategy for safely doing so.
3. Give concise report on handover to health care staff.

Hanging

1. Support the body to reduce constriction. Staff should be aware of the potential for injury to themselves from such a process, and should consider utilising any alternative methods of support, such as items of cell furniture (see manual handling guidelines).
2. Cut the prisoner down.
3. Cut and then release the ligature immediately the prisoner has been cut down, preserving the knot if possible.
4. Place the prisoner on his / her back on a flat, solid surface.
5. Check for signs of life, i.e. breathing, pulse, any movement of the body.
6. If not breathing and / or no pulse is present, clear airway and attempt resuscitation, using a face mask with non-return valve, unless rigor mortis of the limbs has clearly set in. (Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death, making it virtually impossible to bend the wrists, elbows or knees).
7. If conscious / revived, place in recovery position.

Cutting

1. Check for level of consciousness and breathing or bleeding.
2. If not breathing and / or no pulse is present, clear airway and attempt resuscitation using a face mask with non-return valve.
3. If conscious / revived, priority is to reduce bleeding.
4. Use rubber gloves and follow universal infection control procedures.
5. Apply direct pressure over wound using sterile dressing.
6. Raising injured limb may also reduce blood loss.

Overdose / poisoning

1. Do not try to make prisoner vomit.
2. Encourage prisoner to drink water or milk if corrosive substance taken.
3. If not breathing, clear airway and attempt resuscitation using a face mask with non-return valve.
4. Look for clues and ask what substance taken.
5. Keep any containers/bottles and surplus tablets.

Self-harm by fire

1. If necessary, and if safe to do so, douse fire before approaching casualty, with reference to local fire safety training.

2. Avoid inhaling fire fumes.
3. Remove casualty from proximity of fire.
4. Lay casualty on the ground to prevent flame from attacking face and head.
5. If necessary to smother flame, tightly wrap casualty in blanket/sheet or similar.
6. If casualty is not breathing and /or no pulse is present, clear airway and attempt resuscitation using a face mask with non-return valve.
7. Douse burnt areas with copious amounts of water and keep wet.

Jumping from a dangerous height

1. Likely multiple injuries, skeletal or internal (which may not be instantly evident).
2. Control major bleeding, but do not move patient.
3. Use rubber gloves and follow universal infection control procedures.
4. If not breathing, clear airway and attempt resuscitation using a face mask with non-return valve:
5. Do not move casualty in case of spinal / major bone injury.

Swallowed foreign body

1. Provide nil by mouth in case of need for surgery.
2. Monitor bowel movements for any items passed.

Annex D

ACTION FOLLOWING SELF-HARM: EMERGENCY EQUIPMENT

Emergency Response Kits for residential areas

Emergency Response Kits must be available in all residential areas and will include the items specified below.

The manager of each unit must provide regular checks of the Emergency Response Kit on the unit, and ensure that it is replenished after use (checks should take place at least monthly, and be signed and dated as checked).

The manager of each unit must ensure that night staff are aware of the location of emergency equipment.

Staff in all residential areas must have ready access to a sealed pack containing the following:

- 1 pair paramedic shears (ligature scissors)
- 2 CPR face masks, with non-return valve (for resuscitation attempts)
- 2 resuscitation aids with non-return valves
- 3 pairs rubber gloves (2 medium, 1 large)
- 1 spillage kit
- 2 large ambulance dressing (to stem large bleeds / wounds)

Specialist equipment to be held in the health care centre

In addition to the Emergency Response Kits above, specialised resuscitation equipment for use in responding to incidents of self-harm, including the items specified below, must be available in the HCC and health care staff should have training in its use:

- 1 Resuscitator bag and mask
- 3 masks (various sizes)
- 4 Guedel airways (sizes 1, 2, 3, 4)
- 1 suction (hand portable)
- 1 pen torch
- 1 sphygmomanometer (portable)
- 1 stethoscope
- Rigid collars