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Suicide prevention: prisons

Summary

Warning: This briefing discusses suicide and self-harm, which some readers may find distressing.

Suicides in prisons in England and Wales

In 2023, provisional statistics show that there were 93 suicides in prison custody in England and Wales. This represented a rate of 10.8 suicides per 10,000 prison population, a rise on the 2022 figure of 9.4.

Over the past twenty years, the lowest rate of suicides per 10,000 prisoners was around 7 in 2008-2012 and the highest was 15 in 2016. The suicide rate rose between 2012 and 2016 but has declined overall since. Over the same period, the proportion of prison deaths attributed to suicide has declined by 28 percentage points: down from 58% of all deaths in 2002 to 30% in 2023

The rate of suicides among male prisoners is higher than that in the male general population. An Office for National Statistics study of deaths between

2008 and 2019 found that the risk of male prisoners dying by suicide was 3.9 times higher than the general male population between 2008 and 2019.[1]

Prison service response

The Prison Service Instruction, Safer Custody, issued by HM Prison and Probation Service to all prisons in England and Wales, details actions which must be taken by prisons to try to reduce incidents of self-harm and deaths in custody. It says staff must identify prisoners at risk of self-harm and/or suicide.

The September 2023 suicide prevention strategy notes that the Ministry of Justice:

- has committed funding for the Samaritans' Listeners Scheme to March 2025
- will continue to roll out suicide and self-harm prevention training for prison staff
- is planning to install new ligature-resistant cells, focusing on the highest-priority prisons.

The Scottish Prison Service published the Talk to Me: Prevention of Suicide in Prisons Strategy in 2024. The strategy is currently subject to a review.[2] The Northern Ireland Prison Service updated its Suicide and self-harm prevention policy in 2013.

HM Inspectorate of Prisons

In his Annual Report 2023-24 the Chief Inspector of Prisons for England and Wales, Charlie Taylor, noted a considerable increase in suicide and self-harm in some men's prisons, with rates of self-harm doubling in some of the prisons inspected. The report stated that, despite increases in self-harm, "work to identify and address the root causes often lacked any real grip from leaders in some of the riskiest prisons".[3]

In terms of suicide, the report noted that the quality of early learning reviews following death or serious self-harm was often poor, with on occasion no systematic review or investigation to ensure lessons could be learned.[4] It also

1 ONS, Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2019, 26 January 2023. The number of suicides recorded in prisons during this time might not be the same as the number recorded in the Safety in Custody statistics due to different practices.

2 SP WA 30 January 2023, S6W-14048

3 HM Chief Inspector of Prisons for England and Wales, Annual Report 2023-2024, HC 218, 10 September 2024, p21

4 As above

noted limited support, stating that access to peer support, such as 'listeners' trained by the Samaritans, was poor, particularly at night.[5]

[5] As above

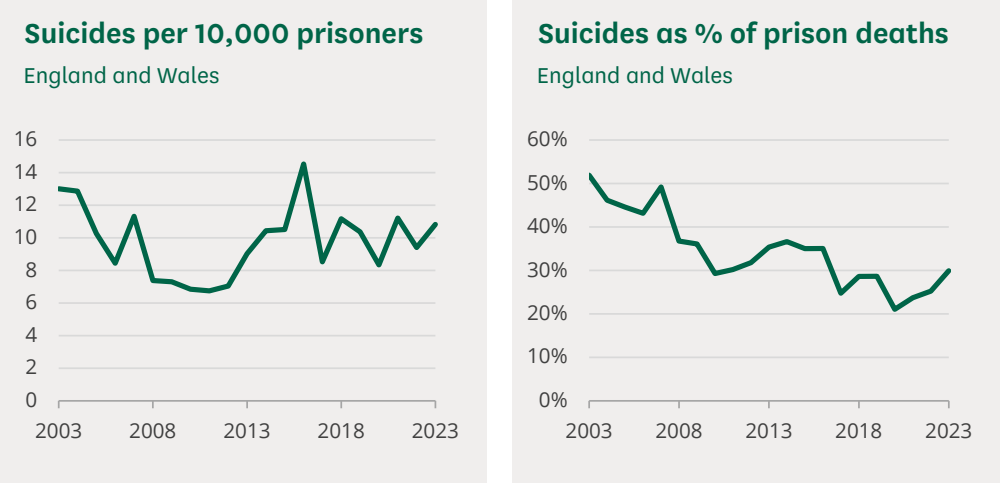
1 Number of suicides in prison custody

The Ministry of Justice (MoJ) publishes quarterly figures on a quarterly basis on the number of suicides in prisons in England and Wales.[6]

In 2023, there were 93 suicides in prison custody in England and Wales. This represented a rate of 10.8 suicides per 10,000 prison population, a rise on the 2022 figure of 9.4.[7]

The 2023 figures are provisional. Given that cause of death is not always apparent, the most recent quarters of data usually contain cases which are still awaiting the coroner's decision as to cause or manner of death. There were 30 deaths recorded as awaiting further information in 2023 at the time the annual statistics were published.

The chart below shows the number of suicides relative to the size of the prison population in each year since 2002.[8] The lowest relative number was around 7 per 10,000 prisoners (2008-2012) and the highest 15 per 10,000 prisoners in 2016. The suicide rate rose between 2012 and 2016 but has declined overall since, albeit with some fluctuation. Over the same period, the proportion of prison deaths attributed to suicide has declined by 28 percentage points: down from 58% of all deaths in 2002 to 30% in 2023.



Source: Ministry of Justice, Safety in custody statistics

Only a small number of suicides occur among female prisoners (an average of four per year over the past 20 years), so the overall prison suicide rate broadly mirrors the male rate. The low number of prison suicides among

6 Ministry of Justice, Safety in custody statistics. These capture self-inflicted deaths, which are broadly the same as suicides but which may include some cases in which it was not a person's intention to take their own life.

7 As above. 'Deaths data tool'; Ministry of Justice, Offender management statistics quarterly

8 This is relative to the average annual prison population. It does not capture the total number of individuals in custody at any point throughout the year but is an indicator of the daily average.

women prevents meaningful consideration of separate female prisoner suicide rates.

The rate of suicides among male prisoners is higher than that in the male general population. An Office for National Statistics (ONS) study of deaths between 2008 and 2019 found that the risk of male prisoners dying by suicide was 3.9 times higher than the general male population between 2008 and 2019.[9]

This may be due to the demographic and socio-economic profile of prisoners being different to the general population (younger, higher prevalence of mental health problems or substance misuse, etc). It is not clear from the statistics what part, if any, incarceration itself plays on the likelihood of suicide.

Prison suicide statistics for Scotland are not routinely compiled, although a list of all deaths in custody can be found on the website of the Scottish Prison Service.[10]

The Northern Ireland Department of Justice does not publish regular statistics on prison suicide; however, it has disclosed figures periodically in response to requests.[11]

9 ONS, Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2019, 26 January 2023. The number of suicides recorded in prisons during this time might not be the same as the number recorded in the Safety in Custody statistics due to different practices.

10 Prisoner Deaths (sps.gov.uk)

11 Deaths in custody: disclosures | Department of Justice (justice-ni.gov.uk)

2 Reducing deaths in custody

2.1 Prison service policy

The Prison Service Instruction Safer Custody, issued by HM Prison and Probation Service (HMPPS) to all prisons in England and Wales, details actions which must be taken by prisons to try to reduce incidents of self-harm and deaths in custody.[12] It says staff must identify prisoners at risk of self-harm and/or suicide. Prisoners at risk of harming themselves must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures set out in the PSI.

The September 2023 suicide prevention strategy notes that the Ministry of Justice:

- has committed funding for the Samaritans' Listeners Scheme [13] to March 2025
- will continue to roll out suicide and self-harm prevention training for prison staff
- is planning to install new ligature-resistant cells, focusing on the highest-priority prisons.[14]

In answer to a PQ in December 2023 concerning steps being taken to reduce the number of suicides in prison, then Parliamentary Under-Secretary for the Ministry of Justice said that as of September 2022, the government have increased the number of Full Time Equivalent Band 3-5 prison officers in post by 1,441 so as to "provide more support for prisoners and better monitor the risk of harm". In addition, he stated that they were developing and introducing a new staff safety training package (covering "suicide and self-harm prevention, understanding risks, triggers and protective factors") alongside a revised case management approach in prisons for supporting people at risk of suicide and self-harm. The minister also reiterated the government's commitment to the Samaritans Listener scheme, adding an additional support service has been designed in collaboration with the charity to reduce the risks of further deaths following a self-inflicted death.[15]

Previously, in answer to a PQ in March 2023, the government set out steps it was taking to address self-harm and suicide in prisons. This included safety training for staff covering suicide and self-harm prevention; a suicide

12 HM Prisons and Probation Service, Managing prisoner safety in custody: PSI 64/2011, updated 13 July 2021

13 The Listener Scheme (Samaritans.org)

14 DHSC, Suicide prevention in England: 5-year cross-sector strategy, 11 September 2023

15 PQ HL1339 [on Prisoners: Suicide], 19 December 2023

prevention learning tool developed in partnership with the Samaritans; and guidance distributed nationally on supporting prisoners who self-harm. The response said a "staff toolkit helps staff to assess risk effectively and promote supportive conversations in the early days of custody".[16]

During a debate in January 2024, the then Advocate-General for Scotland, Lord Stewart of Dirleton, laid out plans for additional funding to expand the prison workforce to help address this issue. He also referred to the Prisons Strategy White Paper [17], which "includes plans to make prisons safer for staff and prisoners". In the debate, it was noted that the extent of mental health problems amongst prisoners, and the delays in referrals to appropriate medical services, may serve as a contributing factor for the increased suicide rates and occurrences of self-harm amongst the prison population. It was also noted that one-third of prison suicides occur early on within the first week of custody. The Advocate-General for Scotland outlined steps the government were taking in order to address this, including digitally streamlining the reception process to flag risk information, and providing a risk identification toolkit to train staff to risk and provide support for managing risks.[18]

The National Institute for Health and Care Excellence (NICE) has published a guideline – Preventing suicide in community and custodial settings – aimed at, amongst others, those working in prisons.[19]

The Scottish Prison Service published the Talk to Me: Prevention of Suicide in Prisons Strategy in 2024.[20] The strategy is currently subject to a review.[21] The Northern Ireland Prison Service updated its Suicide and self-harm prevention policy in 2013.[22]

2.2 HM Inspectorate of Prisons

In his Annual Report 2023-24 the Chief Inspector of Prisons for England and Wales, Charlie Taylor, noted a considerable increase in suicide and self-harm in some men's prisons, with rates of self-harm doubling in some of the prisons inspected. The report stated that, despite increases in self-harm, "work to

16 PQ HL5680 [on Prisons: Suicide], 6 March 2023
17 Ministry of Justice, Prisons Strategy White Paper, 7 December 2021
18 HL Deb 31 January 2024, vol 835, col 1168-1170
19 NICE, Preventing suicide in community and custodial settings, NG105, 10 September 2018
20 Scottish Prison Service and NHS Health Scotland, Talk to Me: Prevention of Suicide in Prison Strategy 2016-2021, 2015
21 SP WA 30 January 2023, S6W-14048
22 Northern Ireland Prison Service, Suicide and Self harm prevention policy (PDF), 2011, updated 2013

identify and address the root causes often lacked any real grip from leaders in some of the riskiest prisons".[23]

In terms of suicide, the report noted that the quality of early learning reviews following death or serious self-harm was often poor, with on occasion no systematic review or investigation to ensure lessons could be learned.[24] It also noted limited support, stating that access to peer support, such as 'listeners' trained by the Samaritans, was poor, particularly at night.[25]

The Chief Inspector's Annual Report 2022-23 for England and Wales noted similar failings. It highlighted weaknesses in measures to prevent suicide and self-harm. As with the 2023-24 report, the 2022-23 report said that, in some prisons, there was insufficient analysis of data to understand the main causes of self-harm, and at others, serious incidents were not systematically investigated to learn lessons.

Prisoners repeatedly told the inspectorate that the frustration and anxiety caused by long periods locked up, and a lack of purposeful activity and interventions, contributed to self-harm.[26]

The Chief Inspector said the inspectorate had frequently reported on a poor use of the ACCT process for those at risk of suicide or self-harm, with problems including a failure to identify risks and triggers, gaps in care plans and a lack of meaningful recorded observations by staff.[27]

In January 2019, Peter Clarke, then Chief Inspector of Prisons, called for an independent external inquiry on self-inflicted deaths in prisons:

> … Is it time, after years and years and years of the same faults, same mistakes, same admissions leading to self-inflicted deaths, is it time for there to be an independent external inquiry into this whole subject?
>
> It is no exaggeration to say it is a scandal. People in the care of the state are dying unnecessarily in preventable circumstances.[28]

2.3 Independent Monitoring Boards

Then Chair of the Independent Monitoring Boards, Dame Anne Owers, when giving oral evidence to the Justice Committee in July 2019, expressed surprise

23 HM Chief Inspector of Prisons for England and Wales, Annual Report 2023-2024, HC 218, 10 September 2024, p21
24 As above
25 As above
26 HM Chief Inspector of Prisons for England and Wales, Annual Report 2022-2023, HC 1451, 5 July 2023, p27
27 HM Chief Inspector of Prisons for England and Wales, Annual Report 2022-2023, HC 1451, 5 July 2023, p28
28 'Prison suicide rate is a scandal, says HM chief inspector', The Guardian, 9 July 2019

that there is much less public and ministerial concern about deaths in prisons when contrasted with deaths in police custody. She said:

> I well recall that, when they [deaths in police custody] went up from an average of 15 a year to 17, the then Home Secretary, now Prime Minister, called for an independent inquiry led by the former Lord Advocate of Scotland to find out what was going on. At the same time, suicides in prisons rose to 119. Obviously, the Prison Service was very concerned about that, but I do not think there is commensurate concern, which seems to me to be a problem.[29]

2.4 The Prisons and Probation Ombudsman

The Prison and Probation Ombudsman (PPO) carries out independent investigations into deaths and complaints in custody. The PPO's Annual Report 2019/20 (PDF) said it was troubling that many of its investigations into self-inflicted deaths during the year found that the same failings kept occurring and it was repeating recommendations made before.[30]

The PPO's 2020/21 Annual Report (PDF) noted the concerns the PPO identified in its investigations that year had remained the same as in previous years, although a particular theme during the pandemic had been a lack of staff contact with prisoners.[31]

The PPO's 2021/22 Annual Report (PDF) said its recommendations relating to suicide and self-harm prevention again included assessing prisoners based on their risk factors, accurate record keeping and care plans and carrying out meaningful welfare checks, including after court appearances and the deaths of family or friends.[32]

The 2022/23 Annual Report (PDF) added to the previous recommendations to include "opening an ACCT where there are risk factors, including if an ACCT is not open, and documenting the risk information considered and the reasons for not starting ACCT procedures", "attending case reviews, which should be thorough and multidisciplinary where needed" and "ensuring information is shared across prison and healthcare staff".[33]

The PPO's 2023/24 Annual Report (PDF) added probation staff to those recommended to be involved in information sharing.[34] It also said that in that reporting year, some of the national recommendations around preventing suicide included recognising asking to see a Listener (a prisoner trained by the Samaritans to offer peer support) as raised risk of suicide indicator, and

29 Justice Committee, Oral evidence: Prison governance (PDF), HC 2128, 16 July 2019, Q366
30 Prison and Probation Ombudsman, Annual Report 2019/20 (PDF), CP 301, November 2020, p42
31 Prison and Probation Ombudsman, Annual Report 2020/21 (PDF), CP 519, September 2021, p59
32 Prison and Probation Ombudsman, Annual Report 2021/22 (PDF), CP 738, October 2022, p63
33 Prison and Probation Ombudsman, Annual Report 2022/23 (PDF), CP 928, September 2023, p51
34 Prison and Probation Ombudsman, Annual Report 2023/24 (PDF), CP 1107, July 2024, p30

amending policy to recognise appearances at family court as a potential trigger for suicide and self-harm.[35]

The Independent Advisory Panel on Deaths in Custody (IAPDC) is a non-departmental public body which provides independent advice to the Government on the prevention of deaths in custody. It responded to the PPO's 2022/23 annual report saying it underscored key challenges within the prison service including workforce pressures, staff training and experience and the growing capacity crisis.[36] The IAPDC published a report in September 2023 which examines how suicide can be prevented in detention.[37]

35 As above, p25-26

36 Independent Advisory Panel on Deaths in Custody, press release, IAPDC responds to the Prisons and Probation Ombudsman's annual report 2022/23, 15 September 2023

37 Independent Advisory Panel on Deaths in Custody, "It's time things change": Priorities for detention for the Department of Health and Social Care's suicide prevention strategy, (PDF) September 2023

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