**DEPARTMENT OF JUSTICE**

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**Lord Morrow MLA**
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**Parliament Buildings**
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**16 July 2013**
**AQW 24760/11-15**

**Lord Morrow (Fermanagh and South Tyrone) has asked:**

To ask the Minister of Justice for a copy of the Northern Ireland Prison Service policy on managing serious self harm and deaths in custody.

**ANSWER**

The Northern Ireland Prison Service does not currently have a separate managing serious self harm and deaths in custody policy. These issues are reflected in the current Suicide and Self Harm Prevention policy, which is available on www.dojni.gov.uk/index/ni-prison-service/nips-publications/policy_reports.

A copy of the Prison Service's Suicide and Self Harm Prevention Policy has also been placed in the Assembly library.

**DAVID FORD MLA**

**BACKGROUND:**

- Lord Morrow is referring to a 'new' policy which was alluded to in response to a death in custody report.

- The Prison Service intends to review the Suicide and Self Harm Prevention Policy which was introduced in February 2011. Some preliminary planning work has been undertaken with a view to splitting the management of 'suicide prevention' and 'post-incident management of deaths in custody' into two separate policies and streamlining the Supporting Prisoners at Risk Booklet and Guidance.

- This review has not yet been initiated due to competing priorities and the volume of reactive work which has impacted on the finite resources within NIPS HQ Safer Custody Branch.

- Due to the volume of the NIPS Policy and Standard Operating Procedures a copy will be placed in the Assembly Library.

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NORTHERN IRELAND

PRISON SERVICE

# SUICIDE AND SELF HARM PREVENTION POLICY

# 2011

## *CONTENTS*

## POLICY STATEMENT

The Northern Ireland Prison Service (NIPS) takes its responsibility for the safe custody of those in its care very seriously. NIPS will take all practical and reasonable steps to ensure that prisoners who identify as being at risk of self harm or suicide are effectively managed, through the process of multi-disciplinary assessment and care planning. Processes will be in place to monitor agreed pathways for care, and to record observations and engagement by prison staff and other professional agencies engaged in the care of those in custody.

## 1. POLICY AIM AND OBJECTIVES

### Aim

1.1 The Northern Ireland Prison Service (NIPS) Suicide and Self Harm Prevention Policy aims to identify vulnerable prisoners at risk of self harm or suicide, and provide the necessary support and care to minimise the harm an individual may cause to himself or herself throughout their time in custody. The Service recognises that this is an important priority and one that demands a holistic approach. Prisoners become vulnerable for many reasons. Vulnerability is often presented as an inability to cope with personal situations and/or the prison environment and where, without some form of intervention the likelihood of self-harm or loss of life is imminent. The Service's definition of a vulnerable prisoner is;

'**An individual whose inability to cope with personal situations within the prison environment may lead them to self harm. Some at risk prisoners will display their inability to cope through their actions or behaviours or the manner in which they present, others may give little or no indication."**

This policy replaces the NIPS Suicide & Self Harm Prevention Policy (2006) and the Addendum of January 2009, and has been endorsed by the Prison Service Management Board.

### Human Rights Considerations

1.2 This policy recognises the statutory requirement on NIPS under Articles 2 and 3 of The Human Rights Act to ensure that appropriate steps are taken to safeguard life and manage vulnerable prisoners in a manner which is commensurate with the level of risk posed.

1.3 Article 2 dictates that authorities have a positive obligation to protect life whenever they know or ought to know of a real and immediate risk to the life of a particular person, even if the threat to life comes from the individual themselves.

1.4 The Northern Ireland Prison Service's positive obligations are not absolute. They depend on what is reasonable and practicable in the circumstances of each case. All interventions must be proportionate, timely, reasonable and necessary in the prevailing circumstances.

1.5 When deciding what positive steps are appropriate to protect life within its area of judgment, it is legitimate for the Service to take account of human right considerations and any other circumstances relating to each case.

**Objectives**

1.6 The outworking of this policy is contained in the form of Standard Operating Procedures, and is aimed at ensuring vulnerable prisoners are recognised early and supported for as long as necessary throughout their custodial sentence through;

<u>Identification</u>

- Screening every prisoner on arrival to prison and identifying wherever possible, those immediately or potentially at risk;
- Encouraging vigilance on the part of all staff to identify those individuals who appear to be at risk during their time in prison.

<u>Intervention</u>

- Assessing by working collaboratively in a multi-disciplinary manner, the clinical, psychological, personal and social circumstances of each individual prisoner identified as at risk;
- Agree a care plan which sets out the level of observation and meaningful engagement through interaction with the individual

concerned. This will be determined by consideration of the identified needs of each individual prisoner that is managed by a multi-disciplinary team composed of members with appropriate skills;

- Ensuring that clinical and psychological support is available and offered in appropriate cases;
- Maintaining maximum contact and support from staff and persons outside the prison (where appropriate) in aiding a prisoner's recovery from a crisis.

Regime Management

- Have in place effective and widely publicised Anti-Social Behaviour Procedures;
- Offer regime opportunities that will provide, as far as possible, a quality of life in prison which is conducive to good mental health and personal well being;
- Reduce the opportunity for suicide through periodic reviews of the physical environment and management procedures affecting prisoners; and
- Having effective Review Procedures and Information Management systems for recording, monitoring and self audit.

Policy Implementation

- Ensure that each establishment has a Suicide and Self Harm Prevention Team that meets at regular intervals and effectively discharges its responsibilities, as well as a Safer Custody Group;
- Ensure that there are good communications between all disciplines on self harm and suicide related matters;
- Ensure that each establishment has a manager designated as the Suicide and Self Harm Prevention Co-ordinator;
- Ensure that Listener / Peer Support Schemes are in place at each establishment;

- Ensure that each establishment delivers the objectives of this policy and the Standard Operating Procedures.

Training

- Ensure, through awareness training, that all staff understand the NIPS Policy on Suicide and Self Harm Prevention and Standard Operating Procedures, and the positive contribution they can make to improving the quality of life for prisoners in their care;
- Ensure that training in Suicide and Self Harm Prevention procedures is made available to Healthcare staff, Reception staff, Residential staff, Safer Custody Group members and any other staff who are likely to have contact with vulnerable prisoners as a priority.

## 2. ROLES AND RESPONSIBILITIES

### ALL STAFF

2.1 All staff carry an equal and continuing responsibility for the management of prisoners under their care considered to be at risk of suicide or other acts of self harm.

2.2 **All staff** in direct or indirect contact with prisoners are required to:

- Be aware of the NIPS Suicide and Self Harm Prevention Policy, the Standard Operating Procedure and their establishment's local strategy and instructions;
- Understand their role in contributing to the implementation of the policy;
- Complete the SPAR training course;
- Be familiar with the SPAR booklet;
- Be familiar with the measures that may help to prevent a prisoner harming himself or herself;

- Be prepared to intervene and support any prisoner through a period of crisis, either individually or as a member of a multi-disciplinary team;
- Report the details of any prisoner whose behaviour is giving cause for concern, with due regard to issues of confidentiality and information sensitivity;
- Identify prisoners who may be at risk, and open a SPAR booklet;
- Appreciate the importance of personal contact in helping prisoners to cope with imprisonment.

2.3 There are particular roles and specific responsibilities assigned to individual groups of staff in implementing this policy. These are set out in Annexes A to N. The responsibilities of prisoners are set out at Annex O.

| | |
|---|---|
| Reception Officers | Annex A |
| Healthcare staff | Annex B |
| Prison Officers (Residential staff) | Annex C |
| Residential Managers | Annex D |
| Suicide & Self Harm Prevention Coordinator | Annex E |
| Night Guard Manager | Annex F |
| Night Custody Officers | Annex G |
| Probation Officers | Annex H |
| Psychology staff | Annex I |
| Prison Chaplains | Annex J |
| IMB Members | Annex K |
| Samaritans Volunteers | Annex L |
| Head of Learning & Skills | Annex M |
| Governing Governor | Annex N |
| Prisoners | Annex O |

## Audit

The Head of Custody Branch will have corporate and oversight responsibility for the full implementation of this Policy and Standard Operating Procedure in conjunction with each establishment. This Policy and Standard Operating Procedure will be reviewed in March 2013 or sooner if required.

**ANNEX A**

## ROLES AND RESPONSIBILITIES

### RECEPTION OFFICERS

Reception staff are best placed to assess the potential vulnerability of newly committed prisoners. They should:

- Have a working knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Identify prisoners' needs and give information about what help is available;
- Obtain relevant information about a prisoner's mental and physical state from staff responsible for escorting the prisoner from court, and from the PSNI where the prisoner is transferred from their custody. This information must be taken into consideration by reception and healthcare staff on committal;
- Commence and complete the Cell Sharing Risk Assessment Form;
- Encourage prisoners to disclose concerns to staff;
- Ensure that the appropriate Residential Manager is made aware that a prisoner is on an open SPAR;
- Reception staff must inform the staff of the residential area where the prisoner is to be located if the prisoner returns from court with an open SPAR.

**ANNEX B**

## HEALTHCARE

The role of healthcare staff is to determine and deliver appropriate healthcare services to prisoners from committal to discharge; and in some cases post-release. On committal, a key healthcare function is to complete a comprehensive healthcare assessment as soon as practicable.

Healthcare professionals must always ensure that pertinent information is contemporaneously recorded on EMIS and PRISM, where appropriate, and where necessary that relevant information is passed on to supervising staff verbally. Healthcare Staff responsibilities are to:

- Have a working knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Assess risk during the initial healthcare screening process as part of the reception procedure and as necessary during the period of custody;
- Complete their section of the Cell Sharing Risk Assessment form;
- Consider whether any problem identified can best be dealt with clinically or by the involvement of others in a multi-disciplinary team approach;
- Develop in conjunction with other stakeholders individual treatment plans as appropriate;
- Contribute to preventative measures for at-risk prisoners located in the Healthcare Centre;
- Contribute to support and care plans drawn up by Residential Managers for at-risk prisoners in residential accommodation where appropriate;
- Ensure that, where appropriate, relevant medical information is shared through medical markers;

- Contribute to development of a strategy for the management of any prisoner returning to normal location from the healthcare centre;
- Respond to the scene of an incident of self harm or attempted suicide and administer appropriate clinical care.

**ANNEX C**

## PRISON OFFICERS

Prison Officers have are in regular contact with prisoners and are best placed to identify a prisoner at risk and assist him or her through a period of crisis. Officers must ensure that the SPAR booklet and instructions are passed on and understood by relief staff. This communication should be logged. Officers will:

- Have a working knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Be fully conversant with the SPAR procedures and the requirements for observation, engagement and record keeping;
- Be aware of cell emergency unlock procedures;
- Be observant of prisoners who may be displaying attitudes and behaviours that indicate they aren't coping or are at risk of self harm;
- Report any concerns about prisoners who may be vulnerable to the House / Block Manager and / or to the Suicide and Self Harm Prevention Coordinator;
- Ensure that detailed records are made in the SPAR log book, of any conversation with the prisoners considered vulnerable;
- Ensure that a detailed handover is given to new staff reporting for duty and record briefing in their journal.

**ANNEX D**

## RESIDENTIAL MANAGER

The role of the Residential Manager is to support staff in the identification of those prisoners at risk of self harm or potentially suicidal and to coordinate their management in normal location or through a recommendation to the Duty Governor for transfer to an Observation Cell. Residential Managers at all levels have specific responsibility to ensure proper arrangements are in place in each residential area for the management of the self harm and suicide procedures.

Residential Managers' responsibilities are to:

- Have a working knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Ensure instructions to staff on local procedures, including emergency measures in responding to incidents of self harm or suicide, are available in their area of responsibility ;
- Be fully conversant with their role in the SPAR procedures;
- Ensure that staff who identify a prisoner at risk open a SPAR booklet;
- Ensure details are initiated on PRISM;
- Before the end of duty and in consultation with other staff and Healthcare, put in place an immediate action plan to keep the prisoner safe until the first case review and care plan are put in place. The immediate action plan is for the **next 48 hours**;
- Inform attendees and chair multi-disciplinary case review. Intervals between case reviews must **not exceed 7 days;**
- Ensure PRISM is updated and include the specific details of the case review and the action points to be followed up;
- Ensure that all Healthcare stipulations on preventative measures for prisoners in their area of responsibility are recorded and carried out;

- Check all logs on a daily basis to ensure staff are following up on the care plan and that the prisoner is engaging with staff and participating in the regime and activities identified in the care plan;
- Ensure a minimum of two conversational checks are carried out daily by staff and sign all logs accordingly. If conversational checks are not being carried out, the Residential Manager should make an entry in the log including the names of staff they have spoken to about the lack of conversational checks. **This entry should be highlighted;**
- Ensure observations are being maintained as per SPAR booklet;
- Residential Managers must sign for the quality of the entries made by their staff in the log books. They must sign, date and time all pages of the log;
- Once a manager has signed and dated the log pages they are accepting they are satisfied with the content / quality of the entries made by their staff and have addressed any failings;
- Refer any specific concerns identified from the logs or in discussion with staff to the Suicide and Self Harm Prevention Coordinator;
- Contribute to the development of a safe environment by ensuring all areas are free from unnecessary items and specifically that only those items required by staff to carry out their responsibilities are in place;
- Ensure that staff coming on duty are fully briefed on ongoing concerns in relation to prisoners subject to SPAR – this includes briefing of Night Custody Officers and residential staff taking up duty in the morning;
- Record such briefings in the daily journal/log;
- Ensure a supply of serious incident log books are readily available for all Residential areas they have responsibility for.

**ANNEX E**

## SUICIDE AND SELF HARM PREVENTION COORDINATOR

A Suicide and Self Harm Prevention Coordinator, at first or second line manager level (SO/PO) will be appointed in each establishment. The primary function of the Suicide and Self Harm Prevention Coordinator is to coordinate and manage the delivery of the Suicide and Self Harm Prevention Policy and in particular the Supporting Prisoners At Risk (SPAR) procedures. This requires the Suicide and Self Harm Prevention Coordinator to:

- Have a working knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Ensure close communication between disciplines and a multi-disciplinary approach to the management of at-risk prisoners;
- Assist the Training Department, when possible, in the planning and delivery of training in policy procedures and processes arising from this policy;
- Ensure that staff are supported in their work with prisoners at risk of self harm or suicide, and also following their involvement in incidents of self harm or suicide;
- Ensure that arrangements are in place for staff to effectively respond to any incident of attempted suicide, particularly from strangulation. This includes easy and immediate access to approved cut down tools in all residential areas;
- Undertake the role of Samaritan Liaison Officer (unless this role is specifically designated to another officer);
- Act as a contact point for Listeners where appropriate (see above);
- Liaise with Custody Branch at PSHQ in relation to the Service's Suicide and Self Harm Prevention Policy;
- Attend Safer Custody meetings with PSHQ;
- Monitor compliance with the Suicide and Self Harm Prevention Standard;

- Promote and ensure the correct completion of all necessary documentation;
- Support the prisoner induction programme by ensuring the procedures are regularly updated;
- Monitor and record the level and nature of incidents of self harm, and monitor the effectiveness of follow-up action;
- Interrogate PRISM daily to identify incidents of self harm that may require further investigation and report to the Safer Custody Governor;
- Interrogate PRISM daily to confirm that all relevant information relating to an incident of self harm or the raising of a SPAR is properly recorded in the relevant areas of PRISM, thus permitting accurate data capture;
- Facilitate the investigation of suicides and investigate incidents of self harm where appropriate;
- Monitor care plans;
- Ensure, as far as possible, that the regime enables vulnerable prisoners to participate in purposeful activity and provides a good quality of life;
- Ensure compliance with prescribed procedures;
- Raise any specific concerns if an individual prisoner is displaying behaviour that suggests a heightened likelihood of self harm or attempted suicide;
- Liaise where appropriate with the family in specific cases where ongoing concerns remain;
- Alert the Deputy Governor / Governor to any specific concerns where additional support / interventions are required;
- Regularly review a representative sample of all observation logs to ensure observations are being carried out correctly and that engagement and conversations with prisoners are recorded in logs;
- Provide advice on any policy issues which require to be addressed;
- Monitor and ensure accurate recording of all information in relation to suicide, attempted suicide and self harm, on PRISM;

- Monitor the use of CRC1 documentation and observation cells;

Maintain, on PRISM, a record of the use and authorisation of anti-ligature clothing, anti-ligature bedding and/or mechanical restraints.

It cannot be over emphasised that the Suicide and Self Harm Prevention Coordinator has a significant responsibility in ensuring the SPAR procedures are operated correctly. In his / her absence, a relief coordinator should be identified who is equally knowledgeable about the procedures.

Whilst the role of the Suicide and Self Harm Prevention Coordinator is specifically designed to monitor, quality assure and confirm the effective operation of the suicide and self harm procedures, the Suicide and Self Harm Prevention Coordinator should also link closely with the Challenging Anti-Social Behaviour Coordinator.

**ANNEX F**

## NIGHT GUARD MANAGER

The Night Guard Manager should undertake a nightly patrol or patrols in accordance with the local orders that set out the arrangements for periodical checks of all areas during the night. The Night Guard Manager will:

- Have a working knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Satisfy himself/herself that NCOs are aware of their responsibilities regarding Suicide and Self Harm prevention;
- Confirm that observation logs/journals are being kept appropriately;
- Ensure that SPAR observations are being completed on prisoners in observation cells in randomised periods of not more than 15 minutes, and that there is no recognisable, predictable pattern to observations;
- Ensure that other observations requirements are completed in accordance with the care plan;
- Obtain verbal authority from the on call Duty Governor for a prisoner to be placed in the observation cell and a SPAR booklet opened ;
- Ensure the Duty Governor signs the relevant authorisation section of the SPAR booklet the next morning;
- Record any occurrences of self harm or attempted suicide in their journal and report it directly to the Duty Governor/Manager the next morning. In turn the matter should be referred to the Suicide and Self Harm Prevention Coordinator.
- Visit each residential area a minimum of 3 times during the night and record it;
- Check SPAR entries to ensure observations are being carried out;

- Check the CCTV log of observations of prisoners accommodated in an observation cell;
- Observe each prisoner subject to a SPAR in his/ her cell and note the visit on the SPAR;
- Ensure observations are being maintained as per SPAR booklet. Check, by observing all prisoners subject to a SPAR whilst in the accommodation area, and record the check in the appropriate SPAR log;
- Ensure that staff are aware of their opportunity to rotate during the night in order to have a break;
- Respond to any concerns raised by NCOs during the night in relation to individual prisoners;
- Ensure NCOs are aware of cell emergency unlock procedures.
- Prior to their handing over to day staff, the Night Guard Manager must brief the Duty Governor and any appropriate residential managers of any concerns about individual prisoners and their care plans, and record same in their journal.

**ANNEX G**

## NIGHT CUSTODY OFFICER

Night Custody Officers (NCOs) responsible for supervising areas in which prisoners are located overnight will be responsible for observing and implementing the instructions on the SPAR. NCOs must ensure that the SPAR and instructions are passed on and understood by relief staff. This communication should be logged. The NCO will:

- Have a working knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Be aware of cell emergency unlock procedures;
- Observe each prisoner subject to a SPAR in his / her cell, carry out other requirements of the SPAR booklet, and note the visit on the SPAR;
- Ensure SPAR and instructions are passed on and understood by relief staff;
- Record all conversations with the prisoner subject to a SPAR;
- Ensure that a detailed handover to new staff reporting for duty occurs on SPAR prisoners and record the briefing in their journal.

**ANNEX H**

## PROBATION OFFICERS

Probation Officers are often in a position to be aware of external as well as internal factors which may assist the multi-disciplinary approach to risk assessment of prisoners. Their specific responsibilities are to:

- Ensure they have a knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Share relevant information gained from field probation contacts with staff managing the prisoner. Such information may assist the assessment process;
- Open a SPAR on any prisoner whose behaviour indicates a risk of self harm or suicide and advise the prisoner's Case Manager;
- Provide support to those at risk, either individually or as part of a multi-disciplinary team, and where possible assist them to maintain links with their families.

**ANNEX I**

## PSYCHOLOGISTS

The role of the psychologist is to provide psychological support, as required, to assist local management. The psychologist's responsibilities are to:

- Ensure they have a knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Open a SPAR on any prisoner whose behaviour indicates a risk of self harm or suicide and advise the prisoner's Case Manager;
- Provide support where appropriate to programmes which assist vulnerable prisoners in coping with their imprisonment;
- Assist, where appropriate, in assessing prisoners as part of a multi-disciplinary management approach.

**ANNEX J**

## PRISON CHAPLAINS

Prison Chaplains are often in a position to be aware of prisoners who may be fearful, anxious or vulnerable to the point of self harm. They are often aware of a prisoner's personal problems and are able to support a prisoner through a particular time of personal crisis. Lead Chaplains are required to ensure that they and all other Chaplains are aware of this policy and of the actions they must take when they have concerns about a prisoner. This includes being able to open a SPAR booklet when necessary. Lead Chaplains will ensure that visiting Chaplains are also aware of this policy.

The Chaplain's responsibilities are to:

- Ensure they have a knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Open a SPAR on any prisoner whose behaviour indicates a risk of self harm or suicide and advise the prisoner's Case Manager;
- Offer support, where appropriate, to any prisoner they consider to be at risk of self harm or suicide;
- Assist, where appropriate, in assessing prisoners as part of at multi-disciplinary management process.

**ANNEX K**

## MEMBERS OF INDEPENDENT MONITORING BOARD (IMB)

Independent Monitoring Board (IMB) members have an obligation to visit prisons and prisoners and report to the Minister of Justice on the facilities and conditions provided. This policy, which is intended to reduce the incidence of self harm and suicide, applies to IMB members who should:

- Ensure they have a knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure; (individual members may wish to take a particular interest in wider issues concerning suicide in the prison environment);
- Monitor the use of the policy in addressing vulnerability at a local level;
- Open a SPAR on any prisoner whose behaviour indicates a risk of self harm or suicide and advise the prisoner's Case Manager;
- Offer support, where appropriate, to any prisoner they consider to be at risk of self harm or suicide ;
- Have a representative attend the prison in the aftermath of a suicide or serious act of self harm.

**ANNEX L**

## SAMARITANS VOLUNTEERS

Prisoners may have access to Samaritans by telephone or through the Samaritans "Listener" scheme. All prisoners will be given free access by telephone to Samaritans. A Listener Scheme or peer support scheme should be in place at each establishment and prisoners should be encouraged to volunteer. Training to become a Listener will be delivered by the Samaritans, who will also act as a support mechanism for Listeners.

Arrangements with the Samaritans will be agreed between Headquarters and the Director of Samaritans through a Memorandum of Understanding (MOU). Establishments will have a Service Level Agreement in place for day to day management of the scheme at a local level. Local Service Level Agreements will complement the requirements of the MOU. Samaritans volunteers attend establishments on a regular basis and hold meetings with Listeners. Within the prison context the Samaritans volunteers should:

- Be aware of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Train prisoners as Listeners and provide ongoing support where appropriate.

**ANNEX M**

## HEAD OF LEARNING AND SKILLS

Teachers and vocational trainers have regular contact with prisoners and are ideally placed to identify changes in their mood and demeanour. All teachers and trainers must have a sound knowledge of this policy and the procedures to follow if they have any concerns. Their specific responsibilities within this policy are to:

- Ensure they have a knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Open a SPAR on any prisoner whose behaviour indicates a risk of self harm or suicide and advise the prisoner's Case Manager;
- Provide support to those at risk, either individually or where appropriate as part of a multi-disciplinary team.

**ANNEX N**

## THE GOVERNING GOVERNOR

Governing Governors must take personal responsibility for the implementation of the Suicide and Self Harm Prevention Policy within their establishment. Whilst retaining overall responsibility, they may delegate individual tasks to other members of their Senior Management Team or to the local Safer Custody Team as appropriate. The Governor's responsibilities are to:

- Have a working knowledge of the Suicide and Self Harm Prevention Policy, the SPAR Local Strategy and the Standard Operating Procedure;
- Give all staff in the establishment a clear lead by demonstrating their commitment to implementing this policy and Operating Standard;
- Ensure the implementation of a local strategy in their establishment that communicates and delivers the aims and objectives of this policy;
- Issue notices to staff and Governors Orders on local procedures, and emergency measures to respond to incidents of self harm or suicide;
- Ensure, through training, that all staff are aware of their responsibilities in regard to this policy;
- Keep the policy and procedures under regular review and instigate a Suicide and Self Harm Prevention review on at least an annual basis;
- Ensure the effective and regular operation of local Suicide and Self Harm Prevention teams;
- Ensure that an effective system of multi-disciplinary case review is in place;
- Hot and cold de-briefs to include both prisoners and staff following any serious self-harm injury event or a suicide.

**ANNEX O**

**PRISONERS**

Prisoners can also fulfil a very valuable role because of the close daily contact they have with each other. The Governor will ensure that all prisoners are made aware of the support services available and they should be encouraged to be aware of risk indicators and to notify staff or Listeners if they have concerns about a fellow prisoner.

Prisoners will also be encouraged to take responsibility for their own well-being through attendance and involvement in SPAR case conferences and through agreement on care plans.

NORTHERN IRELAND

PRISON SERVICE

# SUICIDE AND SELF HARM PREVENTION 2011

## STANDARD OPERATING PROCEDURE

Contents Page

## Summary of Suicide and Self Harm Prevention Standards

## Standards

### Chapter 2 : Risk Assessment at Committal

1: Risks associated with vulnerability at committal phase are identified.

2: Committal areas are designed to minimise fears, anxieties and vulnerability.

3: Environmental and cell sharing risk assessments are completed for new committals before being allocated to a first night cell on the committal landing.

4: First night custody procedures are in place.

5: Establishment induction programmes will contain approved information to help prisoners adapt to safe living in custody.

### Chapter 3: SPAR Process

6: All prisoners who have self harmed or those considered as being at risk of completing self harm will be placed on a SPAR

7: Prisoners identified as vulnerable will be continually risk assessed and care planned until risks are mitigated.

8: All prisoners placed on SPAR will be supervised effectively according to their Care plan in residential areas or where deemed necessary in Healthcare

9: Residential Managers will ensure keep safe plans are developed as part of the SPAR process for the first 48 hours.

10: Briefings on SPAR keep-safe plans for vulnerable prisoners will be made by Residential Case Managers to staff involved with the prisoner and to relief staff at shift handovers.

11: All initial case reviews will be completed within 48 hours of being placed on SPAR

12: The period between SPAR Case Reviews will not exceed 7 calendar days.

13: Post Closure interview to be completed within 7 days of final case conference.

14 Contemporaneous logs will be kept during periods when prisoners are being managed by the SPAR process.

**Chapter 4. Additional Support Measures**

14: A 'Listener' or suitable peer support scheme will be in operation at each establishment to meet vulnerable prisoner needs.

15: Each establishment will hold a call off list of trained Listeners or support volunteers.

16: Only prisoners assessed as having a serious and immediate intent to self harm will be placed in an observation cell.

17: Residential Managers will hold a daily review of the need to retain vulnerable prisoners in observation cell conditions.

18: Anti-ligature clothing will be available for use in observation cells when authorised and based on risk assessment.

19: Observations at intervals of no more than 15 minutes will be enforced when use of an observation cell has been authorised.

**Chapter 5: Vulnerable prisoner transfers, temporary releases and discharges, Productions at Court etc**

21: Information regarding vulnerable prisoners being transferred to another establishment or produced at Court or transferred into Police Custody must be included in accompanying paperwork.

**Chapter 6. Safety Checks and Head Counts**

22: Completed night custody safety checks and head counts are to be made in accordance with establishment orders; and, in the

case of vulnerable prisoners, in accordance with the frequency and standard set in their keep-safe or care plans.

**Chapter 7. Managing Incidents of Self Harm & Death by Suicide**

23: Staff emergency self harm intervention contingency plans are communicated; and staff are trained to implement them.

**Chapter 8. Post Incident Management**

24: Death in custody contingency plans are communicated and staff trained to implement them.

25: Hot and cold de-briefing must take place following a serious incident of self harm or death in custody.

**Chapter 9. Internal Reviews of incidents of Self Harm**

26: All incidents of self harm will be recorded on PRISM

27: An internal review will be conducted into serious incidents of self harm

28: The Director of Operations will ensure that action is taken commensurate with an independent investigation into incidents of serious self harm where there are protracted incapacitating affects.

29: Professional counselling services will be available for all staff involved in serious or fatal incidents of self harm.

**Chapter 10. Monitoring and Continuous Improvement**

30: All instances and periods involving the use of observation cells, special clothing and mechanical restraints are recorded on PRISM and monitored.

31: Structures will be in place at establishment level and at Headquarters to regularly monitor and review performance in

delivering the Suicide and Self Harm Prevention Policy and Standards for Operation

32: All establishments and Headquarters Safer Custody Risk Registers and Performance Improvement Plans will be audited annually.

33: Quarterly Safer Custody Reports are made to PSMB with an annual performance report included within the NIPS annual Corporate and Business Plan Report

# SUICIDE AND SELF HARM PREVENTION STANDARD OPERATING PROCEDURE

## Chapter 1. Introduction

This Standard Operating Procedure (SOP) must be read in conjunction with the Northern Ireland Prison Service Suicide and Self Harm Prevention Policy 2010. All staff are required to read and understand their responsibilities in relation to the Suicide and Self Harm Prevention practices in the policy and the SOP

The 2010 policy replaces the 2006 version and the addendum issued in January 2009. While retaining much of the important detail from previous documents, the policy and SOP have been updated to reflect continuous improvement and provide operational guidance to enable staff at all levels to incorporate the requirement and the spirit of the policy within individual job roles. They also provide clarity to help ensure that immediate action is taken to save lives of prisoners who are contemplating self harm.

The policy and this SOP will help improve the prison environment and achieve the highest standards associated with external inspection and international best practice of decency and respect for those in our care. They are living documents and are subject to continuous review and improvement.

### 1.1 Aim of Suicide and Self Harm Prevention Policy

The Northern Ireland Prison Service (NIPS) Suicide and Self Harm Prevention Policy aims to help staff identify vulnerable prisoners at risk of self harm or suicide as early as possible and give them the necessary support and care to minimise the harm they may cause to themselves during their time in custody. This is an important priority and one that demands a holistic approach.

A vulnerable prisoner is defined as;

> '**An individual whose inability to cope with personal situations within the prison environment may lead them to self harm. Some at risk prisoners will display their inability to cope through their actions or behaviours or the manner in which they present, others may give little or no indication."**

This SOP sets out the procedure for managing a vulnerable prisoner, including the Supporting Prisoners At Risk (SPAR) process. It is **each manager's responsibility** to ensure that their staff are fully aware of all of the standards and are able to implement all parts of the process.

These Standards do not operate in isolation from other important structures and processes such as the provision of Healthcare and Forensic Mental Health Services; the NIPS Anti Social Behaviour Policy; the provision of therapeutic regimes for those in crisis; or support for vulnerable prisoners to effectively discharge from prison to community. Rather, they are integral to our mainstream processes for managing prisoners on a daily basis.

The over-riding emphasis is on care and support and the attention to detail that is necessary to keep people safe from self harm. Suicide and self harm prevention is the responsibility of <u>everyone</u> within the Service regardless of position, rank, job or location. All staff are required to become conversant with this manual and how these Standards impact on their job and responsibilities.

In line with this SOP, establishment Governors are required to put in place local arrangements which take account of the specific needs related to their prison population.

This SOP will be subject to regular audit by Performance and Standards Unit, and further revision if necessary.

## Chapter 2. Risk Assessment at Committal

**Standard 1: Risks associated with vulnerability at committal phase are identified.**

### 2.1 Assessment on Reception

Prisoners on committal will undergo a range of interviews and assessments by discipline staff, Healthcare staff, Probation Officers, Prison Chaplains and others as they are processed through Reception and onto the committal landing where they will spend their first days and nights in prison custody. It is during these early days and nights that prisoners – whether sentenced or on remand - will be anxious and concerned about their families, homes, jobs and their personal safety.

From the moment prisoners arrive in Reception, the aim is to identify those who may be at immediate risk of suicide or self harm. Every prisoner must be formally assessed for risk of self harm or attempting suicide following:

- First reception into prison custody;
- Reception after conviction and/or sentence; and
- Reception after transfer to another establishment.

### 2.2 Initial Interview and Assessment on First Reception

All staff involved in the committal process have a part to play in determining levels of vulnerability beyond the levels of stress and anxiety usually expected of someone entering prison. Reception staff must process and assess people as thoroughly as possible and time, care and vigilance must be given to observing each prisoner at the beginning and throughout the committal process. Where there may be concerns about a person's emotional, physical or mental condition staff should open a Supporting Prisoner At Risk (refer to Chapter 3).

At the first reception interview, Healthcare staff will play an important role in identifying vulnerability as they complete the health screening form and make an initial assessment of the potential risk of self harm or suicide. Care must be taken to gain as much information as necessary as this will inform comparative assessments at any subsequent reception interviews. All forms will be retained on the prisoner's medical record – with as much information as possible recorded on EMIS.

Healthcare assessments will be organised to allocate sufficient time to discuss the issues arising from the screening process and to create an environment in which prisoners are encouraged to voice their fears or concerns.

The screening process requires Healthcare staff to make their observations in combination with any other observations or assessments that may be available from the Police Service (PACE), Probation Service and PECCS (and the interview itself), to determine the presence of any of the main risk indicators. The screening form should also be used to record any other relevant information regarding the prisoner's physical or mental health. Following the health screening, Healthcare staff will record the preliminary classification of risk in the appropriate section.

In some cases the initial assessment may indicate no risk at present and no immediate action required. Where the assessment indicates that the prisoner may be at risk and may require further assessment, a Supporting Prisoner At Risk (SPAR) will be opened by Healthcare staff and a keep-safe plan put into place by the receiving Residential Manager (refer to Chapter 3 for the Supporting Prisoners At Risk process).

At this early stage in custody risk factors <u>may</u> include the following:

- a previous history of self harm or suicide ideation / attempts;
- a history of mental ill health;

- drug or alcohol misuse;
- risk identified by Police or field Probation reports (including pre-sentence history and post sentence interview reports);
- conviction or remand for murder, a sexual offence or an offence involving children;
- any indication that the prisoner will not be contacted or supported by family or friends;
- an abnormally withdrawn or depressed manner;
- an excessively anxious appearance;
- a tendency to talk about suicide.

The list is not exhaustive, however, and should a prisoner's behaviour lead any member of staff to suspect that they may be at risk of self harm or suicide, they should report the matter immediately to the manager responsible for the prisoner and open a SPAR. The primary concern is to protect the prisoner who may be at risk.

Further information on risk factors and how to recognise risk are set out in Appendix 1.

### 2.3 Interview Environment

**Standard 2: Committal areas are designed to minimise fears, anxieties and vulnerability.**

The committal interview can be an uncomfortable and fearful experience and may take place at a time when there is pressure on committal staff to process a large number of new committals. The physical environment can have an impact on the effectiveness of the screening and the reception area should, therefore, be pleasantly decorated and the interview conducted in a separate and furnished room either in the reception area or other appropriate location.

**Standard 3: Environmental and cell sharing risk assessments are completed for new committals before being allocated to a first night cell on the committal landing.**

If a prisoner is deemed to be at risk of self harm they should be allocated a cell in an environment where the risks posed can be adequately managed. This may require the need for doubling up with another prisoner. In such instances, the Cell Sharing Risk Assessment forms must be reviewed.

Alternatively, to facilitate further risk assessment or to take immediate and affirmative action, a prisoner may be temporarily accommodated in an observation cell, if available. This will only be done with the permission of the Duty Governor and following the completion of all committal risk assessments, the relevant authorisation pro forma and consideration of all other interim accommodation measures.

## 2.4 The Induction Period

**Standard 4: First night custody procedures are in place.**

First night induction will commence from when the prisoner arrives on the committal landing. It will be done by the Committal Landing Officers and may involve further assessment to determine vulnerability, if necessary. Committal Landing Officers must take time and care and be vigilant in observing each prisoner throughout the induction process. They should offer as much practical support as possible to help prisoners get through the early hours and days of being in custody. First night custody packs should contain the basic essentials of soft drink, snacks, tobacco etc to help lessen fears and anxiety. Prisoners on committal landings should be allowed and encouraged, where appropriate, to phone relatives as soon as possible; and be allocated a designated officer to raise concerns or questions with. Committal Landing Officers must commence SPAR procedures immediately where prisoners are

experiencing a personal crisis. First night custody procedures will be approved by Custody Branch and subject to audit.

**Standard 5: Establishment induction programmes will contain approved information to help prisoners adapt to safe living in custody.**

The main induction programme will commence within 48 hours of committal. Each establishment will operate an induction programme that will effectively aid prisoners whether sentenced or remanded to custody to cope with adapting to prison life and to make the best use of their time spent in custody. This will be done in conjunction with Offender Management standards and procedures.

It must be emphasised that the assessment and management of self harm risk is not purely a "first days in custody exercise" or seen as a responsibility of Healthcare or Reception staff only. It is a continuing, shared, multi-disciplinary staff responsibility that continues until all risks of vulnerability have been sufficiently mitigated and/or when the prisoner is eventually and successfully discharged.

During the early period of custody many prisoners, especially those on remand, feel particularly vulnerable. It is important that all staff are alert to any changes in mood and behaviour which may signify an increased risk of self harm. It is possible to identify signs of those not coping well by observing their behaviour and by asking simple, open questions to establish how well they are settling in, what family contact they have had and their social contact with others in the prison. Further information on risk factors and how to recognise risk are set out in Appendix 1.

## Chapter 3. Supporting Prisoners At Risk (SPAR)

**Standard 6: All prisoners identified as being at risk of self harm will be placed on a SPAR.**

The **Supporting Prisoners At Risk** (SPAR) process has been developed to help staff identify, at an early stage, symptoms or behaviours that suggest a prisoner may be in personal crisis and who may need additional and immediate support and care. SPAR enables staff to provide immediate assistance in these cases. All of the information and instructions required to operate the SPAR process is contained in the SPAR booklet. The booklet is divided into three sections as follows:

- Section 1 – contains a risk matrix to help staff assess the level of crisis or extent of the prisoner's desire to self harm and a keep-safe plan to help protect the prisoner for the next 48 hour period;

- Section 2 – provides the structure for staff to conduct an assessment interview with the prisoner to more accurately assess the triggers or reasons behind the crisis he or she is experiencing;

- Section 3 – ensures that once the initial keep-safe plan has been implemented, on-going care and attention and continuous review take place until the risks are sufficiently mitigated.

The booklet is purposely designed to keep all the necessary documents together. All of the instructions on how to manage a prisoner through each stage of the process are clearly set out. Booklets will be readily available for staff in all key areas of establishments.

### 3.1 SPAR Referral Procedure

Any member of staff, or those with permission from the Governor to work with prisoners on a regular basis, can open a SPAR at any time where they have a concern about a prisoner's well being. Opening a SPAR booklet means they should begin recording as much detail as possible on the referral page of the SPAR booklet to enable an effective assessment to be made. Staff should not hesitate to open a SPAR where they have concerns for a prisoner's safety. It may not be necessary for the process to progress beyond the first review stage but it is always better to be cautious and to take immediate and early action.

**Standard 7: Prisoners identified as vulnerable will be continually risk assessed and care planned until risks are mitigated.**

This will mean continually engaging with the prisoner to check if anything is wrong, finding out how they are feeling and offering to help. What they say to you must be recorded in the booklet in the form of a 'pen picture' in bullet form. The most important factor is always to safeguard the prisoner and alert those who can assess his or her needs. Once the SPAR booklet is opened it should be passed to the Manager in charge of the prisoner's residential location.

**Standard 8: New committals placed on SPAR will be supervised effectively in residential or healthcare areas.**

Staff responsible for supervising the area in which the prisoner is located will be responsible for observing the instructions in the SPAR booklet and ensuring that it is passed to, and understood by, relief staff. This briefing should be logged in the journal and the observation log. Managers should check to ensure that all significant observations about the prisoner are recorded in writing on the SPAR and made available to the Nurse Officer along with the screening form prior to any further assessment.

Where a prisoner has been in custody before, any previous medical records should be reviewed by a Nurse Officer as soon as practicable.

**Standard 9: Residential Managers will ensure keep safe plans are developed as part of the SPAR process for the first 48 hours.**

Where a prisoner is placed on a SPAR their Residential Manager will discuss with them what has been written and record how they feel about it. The Residential Manager should, during this initial interview in the SPAR process, seek the person's consent to inform, when the time comes, those with whom they will be living on release or authorities with whom they will have contact. The Residential Manager should record the prisoner's consent on the appropriate page of the SPAR booklet.

Managers will consult with the person who opened the booklet, other wing staff and Healthcare staff and will put in place an immediate **keep-safe plan** until the first case review can be held and care plan agreed. The keep safe plan can remain in place for **48 hours before the first review takes place**.
The role of the Residential Case Manager in the SPAR process is set out at Appendix 2.

**Standard 10: Briefings on SPAR keep-safe plans for vulnerable prisoners will be made by Case Managers to staff involved with the prisoner and to relief staff at shift handovers.**

Where a keep safe plan is in place it must be completed and implementation commenced, according to SPAR procedures, before the member of staff who opened the SPAR booklet goes off duty (see Chapter 5 for procedures to be followed by PECCS staff).. Night Custody staff must be advised of the action taken and continue to monitor the situation.

All cases of reported self harm incidents will be recorded on PRISM. These will be regularly reviewed by the Suicide and Self Harm Prevention Coordinator and Safer Custody Governor.

### 3.2 Initial Case Review

**Standard 11: All initial case reviews will be completed within 48 hours of being placed on SPAR.**

The initial Case Review must be completed within 48 hours of opening a SPAR and will usually follow on from the initial keep safe planning process and the assessment interview. The Residential Case Manager and the Case Assessor (see Appendix 3 for role of SPAR Case Assessor) for the prisoner can be the same person whose job it is to take responsibility for managing the prisoner in their care. The initial Case Review should be attended by:

- The member of staff who raised the initial concern;
- The assessor who completed the interview;
- Healthcare;
- Landing staff;
- Others relevant to that prisoner (e.g. representatives from Probation and Psychology);
- The prisoner (for at least part of the review). (some prisoners may find this daunting so, where appropriate, the Case Manager may act as their advocate and feed back directly to the prisoner without the need for them to attend).

Convening an initial Case Review will be the responsibility of the Residential Manager. Case Reviews will be held on each prisoner on an open SPAR to discuss the assessor's interview and to agree a plan of support and actions to be formed into an ongoing care plan. There will be engagement with the prisoner in crisis on the development of their care plan. The care plan must include:

- Clear direction on the observation and supervision required; it is not sufficient to state “should be closely monitored by staff”;
- Instructions on interventions to address the prisoner’s needs, for example, “out of cell 2 hours in the morning, 2 hours in the afternoon”; or “engage in work and/or education”, or “attend gymnasium”;
- Actions allocated to a responsible member of staff to ensure that the care plan is implemented and reported back at the next case review;
- Monitoring by Residential Managers;
- Encouragement for prisoners to build up their own support networks and coping strategies over the course of the reviews.

**Standard 12: The period between Prisoners' Case Reviews will not exceed 7 calendar days.**

At the end of the initial Case Review a date must be set and agreed for the next Case Review. **The maximum period between Case Reviews is 7 days**. Once a date is set the Case Review must occur on that date unless the prisoner's situation deteriorates, in which case the review should be brought forward.

Where possible the Residential Case Manager should arrange the Case Review to be held at a time when he or she will be on duty. This will help to maintain continuity with the vulnerable prisoner. It is the Case Manager's responsibility to ensure that details of the Case Review and all action points to be followed up are input onto PRISM.

Once the Case Review date has been set, the Case Manager will inform attendees, giving them as much notice as possible. The Case Review Conference will be attended by the Case Manager, the prisoner's Class Officer and a Healthcare Officer but where the prisoner has been allocated an Offender Case Manager (Probation Officer) or Sentence Manager it will be appropriate for them to attend too. Other professionals may be consulted for advice or invited to attend as necessary.

**SPAR CARE PLANNING**

Care plans should be linked to other support mechanisms or agencies. The following is a list of some of the options that should be considered. The list is not exhaustive:

- Mental health support;
- Family support / interventions (visits, phone calls , Family Officers etc);

- Professional support services (Listeners, Samaritans, Chaplaincy);
- Diversion activities (structure to their day);
- Links to PREPS Manager (returning to work and other supported work activities);
- Safer Custody and REACH/OUTREACH referral (In Maghaberry);
- Consideration where appropriate for Home Leave or Resettlement leave periods.

Prisoners should be encouraged to sign their care plan to enhance ownership and encourage them to engage in and comply with the actions it contains to aide their recovery. If they have agreed to do something and they do not comply, this must be recorded in the log. If the prisoner refuses to sign the care plan this must be recorded along with the reasons why.

### 3.3 Prisoners on SPAR Residing in Healthcare

Where a vulnerable prisoner is residing in Healthcare, the Healthcare Manager will assume responsibility as the SPAR Case Manager. This will be the same level of responsibility as that of Case Managers (refer to Appendix 2 for responsibility details).

### 3.4 Closing a SPAR Booklet

The SPAR process can **only** be closed on a prisoner at the Case Conference with the unanimous agreement of all present. The most current care plan must be discussed and assessed for all action points having been met or the level of risk having been reduced or mitigated to a level that enables the individual to cope with any remaining difficulties.

In discussion with the prisoner, the Case Manager must find out how the prisoner is feeling and coping. This information should be recorded in the SPAR booklet. It may be appropriate for the prisoner to attend their final case conference. The prisoner should be encouraged and supported in building up their own support networks and coping strategies.

**Standard 13: Post Closure interview to be completed within 7 days of final case conference.**

Where a decision has been by Case Conference to close a SPAR, there must be at least **one post-closure interview** with the prisoner to discuss their feelings and concerns. This should be conducted by the prisoners' Class Officer or delegated officer and should be completed within 7 days of the final case conference. The possibility of further follow up interviews should be considered if the interviewing officer feels the prisoner would benefit from it. If the risks return, or new concerns about the prisoner's safety arise, they may need to be placed on a SPAR again.

If a prisoner moves location after the SPAR booklet is closed but before the post closure interview, it is the responsibility of the Case Manager who closed the SPAR to complete this process, even at another location (unless the prisoner is discharged).

When a SPAR has been closed and signed off (a post closure interview will have been held), the completed booklet will be sent to the Suicide and Self Harm Prevention Coordinator who will quality assure it and pass to the General Office to be held with the prisoner's file or arrange for its storage elsewhere in a secure cabinet where it can be easily retrieved. Closure of the SPAR booklet will be recorded on PRISM by the Case Manager.

## Chapter 4. Additional Support Measures

There are a range of other support measures in place to help manage vulnerable prisoners and provide support and encouragement to them. The Care Plan should include details of the support measures used in each case.

This Chapter sets out the measures that may apply.

### 4.1 Telephone monitoring

A SPAR Case Review may call for monitoring of telephone calls, with the help of security teams. If so, the Suicide and Self Harm Prevention Coordinator will put arrangements in place for the prisoner's conversations to be downloaded and monitored by staff.

### 4.2 Family involvement

Where serious concerns continue and risk of self harm remains high, the prisoner's family may need to be informed and involved in the Case Review process; however issues of consent and confidentiality need to be determined. Special visits could be arranged and opportunities taken to speak directly with the family. It is difficult to be prescriptive and each case should be viewed on its own merits.

### 4.3 Volunteer Peer Support schemes

The Prison Service is fully committed to encouraging Volunteering Services and support for prisoners while in prison custody. Volunteers can bring hope and comfort to those who may otherwise be experiencing anxiety, depression, personal crisis, self harming or worse. Peer Support includes any form of encouragement-based support given to prisoners either by other prisoners, members of NIPS staff or community-based volunteers in a way that:

- nurtures positive relations;
- promotes mental, emotional, physical and spiritual well-being;
- helps those concerned to cope with their prison sentence;
- develops positive attitudes of themselves and others;

- supports family ties and instils tolerance towards others; and,
- helps to draw out and develop inner strengths to enable prisoners to effectively return to the community.

**Standard 14: A 'Listener' or suitable peer support scheme will be in operation at each establishment to meet vulnerable prisoner needs.**

This Standard refers to all prisoners in custody who, whether placed on SPAR or not, should have access to peer support when deemed safe and appropriate.

In particular, the SPAR Case Review should also consider whether a prisoner would benefit from the services of an appropriately trained Listener or support volunteer (Hydebank Wood). Allowing vulnerable prisoners to communicate with Listeners or support volunteers can have a positive influence and may have a moderating effect on the prisoner's behaviour and inclination towards self harming.

**Standard 15: Each establishment will hold a call off list of trained Listeners or support volunteers.**

The names of trained Listeners or support volunteers will be drawn from a rota system on PRISM and called-off accordingly. Prisoners generally will have their cells marked with the "On Call Listener" sign. It may not always be possible to make arrangements to use the Listener Cells in residential areas. In such cases managers will give specific consideration as to whether a Listener will be provided. There are many other considerations to be taken into account before engaging a Listener or support volunteer, particularly at night when it may be difficult to provide staff cover to escort Listeners and to remain in the vicinity while the meeting takes place. That said, where the need for a Listener is greatest managers must make every effort to facilitate a meeting even if only for a limited period. In the exceptional case where it is not possible to facilitate access to a Listener or support volunteer, a record of

the request and the reason(s) for refusal must be recorded in the Day Manager/Night Guard Manager/Healthcare Manager's journals and SPAR booklet observation log if applicable. A record of whether any other support mechanism was provided – e.g. Samaritans telephone – should also be made.

### 4.4 Observation levels and records

The SPAR Care Plan should provide advice on the level of observation required. All observations, conversation checks and details of any engagement with the prisoner must be clearly recorded in the logbook section of the SPAR booklet. All entries must be contemporaneous and made by the person completing the observation or conversation check and not by a third party after the event. Similarly, observations completed by way of CCTV should be recorded in a logbook for that purpose, by the person completing the observation. Care plans must state the level of observations required. If it is not recorded, the observation level will default to not more than 15 minutes until a decision is agreed and recorded in the Care plan.. Observation levels can only be reduced (e.g. 15 minutes to hourly) by a decision taken during a Case Review. However the level of observations can be increased (e.g. hourly to 15 minutes) at any time if deemed necessary and the reason why noted. **This should be written in red or highlighted in the SPAR booklet**.

If it is considered that self-harm or death is a possibility, consideration should be given to accommodating the prisoner in an observation cell. Observation cells, however, should not be considered as a **"first option"** for an at risk prisoner and, wherever possible, prisoners should be accommodated and managed in the "normal" environment, allowing them to retain personal possessions, access to television and staff that they have come to know. It is better to try to manage a crisis "in association" with others, rather than in "isolation" in an observation cell.

Following evening lock up, the safer custody magnetic signage or other appropriate signage should be used to indicate to staff on duty that a) a

prisoner is vulnerable and b) the level of observation they are under. Signage must be removed prior to morning unlock.

### 4.5 Placing prisoners in observation cells

**Standard 16: Only prisoners assessed as having a serious and immediate intent to self harm will be placed in an observation cell.**

Observation cells are purposely designed to manage prisoners who present a significant risk to themselves and should not be used for any other purpose.

The authority to place prisoners in observation cells is delegated to the Duty Governor. The assessment and authorisation process for use of observation cells is contained in the SPAR booklet under the heading Special Accommodation.

The Residential Manager for the person in crisis will ensure that the Special Accommodation section of the booklet is completed and signed by the Duty Governor, ideally before the person is moved to the observation cell. Where this is not possible (e.g. during the night), the Duty Governor must sign the authorisation as soon as possible after coming on duty the next morning. If no observation cell is available in the prisoner's current location the Residential Manager for the prisoner must liaise with the managers of other locations to secure the use of an observation cell elsewhere.

Where demand for observation cells exceeds availability, priority will be given to those **deemed at greatest risk** of imminent serious self harm or death. In such cases, the Governor may wish to consult local staff, including Healthcare, to help identify which prisoners are at the greatest risk. Those not placed in an observation cell will be managed within their own location and their care plan adjusted and reviewed accordingly. The Duty Governor will be consulted throughout this process together with Healthcare staff.

Residential Managers with responsibility for observation cells will ensure that the cells are properly maintained and that all equipment is available and in full working order. This also includes a full supply of bedding materials, anti-ligature clothing and slippers if the person is prohibited from wearing personal clothing and shoes (refer to standard 18)

**Standard 17: Managers will hold a daily review of the need to retain vulnerable prisoners in observation cell conditions.**

There is no minimum period for a prisoner to remain in an observation cell; however no one will be held in an observation cell for longer than is necessary. As such, the Residential Manager in charge of the area where the observation cell is located, in conjunction with the Case Manager, will hold a daily review to determine the continuing risk of self harm or suicide. If it is considered that a prisoner should be moved out of an observation cell, a Case Conference must be held to ratify that decision. As a minimum, the Case Conference should consist of the Residential Manager with responsibility for the observation cell, an officer with responsibility for monitoring the person in the observation cell, a Residential Manager or Class Officer with responsibility for the prisoner in normal residential accommodation and a Healthcare Officer. This may result in a prisoner being returned to his original location within a few hours. Prisoners who are located in an observation cell will have their bed 'held' for them at their original location. The factors which inform the decision to remove the prisoner from the observation cell should be recorded in the notes of the Case Conference.

If it becomes apparent during the Review that the prisoner's condition is such that more attention from Healthcare staff is required, a referral should be made to the Healthcare Manager to determine whether it would be in the prisoner's best interest to be moved to a Healthcare observation cell.

**Standard 18: Anti-ligature clothing will be available for use in observation cells when authorised and based on risk assessment.**

Prisoners placed in observation cells will not automatically be given anti-ligature clothing and should retain their personal clothing unless the case review considers there is a heightened risk of self harm. In that case, the prisoner's personal clothing will be removed and replaced with anti-ligature clothing. Shoe laces and belts **will** be removed as a matter of course and, if necessary, personal shoes will be removed and slippers provided.

Approval for the use of anti-ligature clothing within the observation cell must be endorsed by the Duty Governor on the authorisation form in the SPAR booklet.

The decision to cease using anti-ligature clothing can only be taken at a Case Conference when those attending are satisfied that the risk of using personal clothing to self harm has significantly reduced. The reason(s) for reaching the decision must be recorded in the notes of the Case Conference.

A duvet will be provided to the prisoner (more than one duvet may be provided if he or she asks for it or if they show signs of being cold). If a prisoner abuses their duvet it will be removed and replaced with anti-ligature bedding.

### 4.6 Supervision of observation cells - landing staff

**Standard 19: Observations at intervals of no more than 15 minutes will be enforced when use of an observation cell has been authorised.**

All prisoners accommodated in observation cells **will** be subject to observations at intervals of not more than 15 minute by landing officers and through CCTV camera coverage in the Secure Pod, Control Room or Class Office. **There will be no exceptions**. Landing staff will record their observations in the SPAR booklet observation log section. Secure Pod, Control Room and observation bubble staff will record their observations using appropriate logs.

Observations will be carried out in a way that avoids predictability or patterns being formed that could be discerned by the person under observation. The stark isolation of being held under 15 minute observations can in some circumstances heighten feelings of anxiety, depression and increase the compulsion for self harming. As such, the person's keep-safe or care plan, where appropriate, should consider periods out of the observation cell during the day to encourage controlled movement and association with staff and other prisoners.

Even when out of the observation cell for periods of time the prisoner will remain subject to observations at intervals of not more than 15 minutes **unless otherwise stated in the Care plan in the SPAR booklet.** Landing staff will continue to record in the SPAR booklet as normal, staff observing via CCTV will record in their log when the prisoner leaves the observation cell and re-enters it.

If the prisoner is out of their residential location for any reason, the SPAR booklet will accompany them and observations will continue to be completed by the staff that then have responsibility for the prisoner.

### 4.7 Completion of Observation Logs

**Standard 20: Contemporaneous log entries will be kept during periods when prisoners are being held in observation cells.**

All entries, whether in the SPAR booklet or specific observation cell log sheets or CCTV logs must be made contemporaneously by the person completing the observation or conversational check and not by a third party. Entries should reflect the content of any conversation held or observations noted regarding the prisoner's mood, demeanour etc at the time. In the case where observations of not more than 15 minutes are in force, arrangements must be in place to ensure that officers have access to log books/sheets and that effective recording takes place according to the conditions set for the person under observation. Where a prisoner is interviewed or receives support from

a healthcare professional, a record should be made in the SPAR logbook section. The record should include information that can be shared without breaching medical confidentiality.

In addition, Night Custody Officers (NCOs) in Secure Pods, Control Rooms and Class Offices should complete the night guard journal provided. It is the responsibility of each NCO to ensure the journal accurately reflects events as they arise during the night.

The journal should include:

- An outline of the hand-over briefing completed by the House / Block Manager;
- Details of individual prisoners subject to SPAR procedures, including a brief history of any specific concerns;
- Confirmation of equipment checks completed within the Secure Pod, Control Rooms and Class Offices, specifically that the intercom is working between the observation cell and the pod;
- A record of visits by the Night Senior Officer / Principal Officer to the house, and confirmation that the Senior Officer has been briefed on the prisoners who are subject to SPAR arrangements;
- Details of all unusual occurrences, for example, emergency unlocks;
- Details of staff rotation recording the time the handovers took place and which officer has taken up post.

Residential Managers must regularly check log books/sheets and CCTV logs and sign them accordingly.

## CHAPTER 5. Vulnerable prisoner transfers, productions at Court, Police Custody, temporary releases and discharges from custody.

### 5.1 Vulnerable Prisoners at Court

**Standard 21: Information regarding vulnerable prisoners being transferred to another establishment or produced at Court or transferred into Police Custody must be included in accompanying paperwork**

Where a prisoner at a court location is placed on SPAR, it is the Senior Prison Custody Officer's (SPCO) responsibility to ensure there is a 'keep safe' plan for that prisoner until they reach the Reception of the establishment they are to be lodged in. The keep safe plan should cover issues relating to the safety of the prisoner while in court holding cells and the transportation of the prisoner to the receiving prison. It is the responsibility of the SPCO to ensure that the receiving prison is aware that a SPAR booklet has been opened. Prison Reception staff must ensure the Residential Manager of the accommodation block where the prisoner will be living is informed that a SPAR booklet has been opened on the prisoner at court. The Residential Manager will assume immediate responsibility for the SPAR process and will confirm or amend the immediate action plan and inform landing staff and Healthcare staff accordingly. This is the only occasion when the person who opened the SPAR will be unavailable and this reason should be noted accordingly.

### 5.2 Vulnerable prisoners transferred to another establishment

Where any prisoner is being transferred from one establishment to another it is important that all information - especially medical records - are transferred with them. This includes the IMR11 form (Transfer Information (Medical)) which the sending establishment should complete with an update of any change in circumstances or health needs that have arisen since the initial reception interview.

Any special instructions to the receiving establishment and the open SPAR booklet must accompany the prisoner during transfer and be passed to Reception staff on arrival. Under no circumstances should a vulnerable prisoner be transferred without all of the relevant information and the receiving Governor and Healthcare staff informed.

### 5.3 Vulnerable Prisoners Requiring Mental Health Care at New Establishment

The Prisoner Allocation Board will not transfer vulnerable prisoners who require ongoing mental health interventions unless the necessary facilities and resources to continue treatment and support are available at the receiving establishment.

### 5.4 Production of Vulnerable Prisoners to Court

Where a prisoner who is being managed by the SPAR process is required to attend court, Healthcare staff should be asked to advise on whether the person is fit to attend. If unfit to attend, the establishment's General Office will contact the court and seek an adjournment of proceedings, where appropriate.

Where it is considered that the court appearance should proceed, the accompanying SPAR booklet must be handed over to the Prisoner Escorting and Court Custody Service staff (PECCS). The Prison Reception Officer will make an entry to this effect in the SPAR daily log.

Once the prisoner has been delivered to court, the PECCS Escort Officer must hand over the SPAR booklet to the Manager of the Court Custody Suite and record this in the SPAR booklet daily log section. Relevant entries must be made by PECCS staff in accordance with the instructions in the SPAR booklet during the time the prisoner is in their care. When the prisoner is leaving court custody, the Court Custody Manager must record these details

in the court journal and ensure the PECCS Escort Officer signs the entry to confirm receipt of the SPAR booklet for the return journey to prison.

### 5.5 Vulnerable prisoners discharged at Court

Where a prisoner who is being managed on an open SPAR booklet is discharged at court or receives a non-custodial sentence (for example Bail, Hospital Order, Probation or Community Service Order), the PECCS staff must immediately inform the establishment's General Office of the outcome of the court proceedings and record that they have done so in the SPAR booklet. The General Office of the establishment must, in turn, inform the Duty Governor. In all cases the PECCS staff must return the SPAR booklet to the discharging establishment on completion of court proceedings.

It will then be **the responsibility of the Duty Governor** to ensure that, as soon as practical, all those who have been involved in managing the prisoner under the SPAR process take steps to close the process. Where concern remains that the discharged person may be in danger of seriously self harming steps should be taken by Healthcare Staff to inform their General Practitioner. If consent has been given by the prisoner, in the Sharing Information section of the SPAR booklet, then this information may be shared with identified others. This includes next of kin.

### 5.6 Vulnerable prisoners returned from Court to a different establishment

If a prisoner is to be returned to a different prison establishment, the Senior Prisoner Custody Officer (SPCO) will notify the discharging establishment and will also inform the receiving establishment as soon as possible that the prisoner is on an open SPAR. Reception staff in the receiving establishment must check that the SPAR booklet has been kept up to date and includes a 'pen picture' of the prisoner's mood and behaviour, along with observations of

PECCS staff. Healthcare staff in the receiving prison must be notified of the arrival of the prisoner by Reception staff.

### 5.7 Vulnerable prisoners transferred to Police Custody

When a vulnerable prisoner on an open SPAR is to be transferred to police custody, the **'Inmate Under Escort Form' (see Appendix 4)** containing all relative Security and Healthcare information will be handed over, together with the form entitled **Certificate to Transfer and Release into Police custody after arrest under PACE.** (Staff escorting prisoners to PSNI stations **must** read and understand the conditions contained in NS35/10 regarding handover procedures). The SPAR booklet will not be given over to the Police; however the most important details regarding vulnerability and actions being taken by NIPS at the time of transfer of responsibility must be clearly outlined on the Inmate Under Escort Form. The SPAR booklet will be retained by Reception staff and entries resumed as normal on the prisoner's return to the establishment.

### 5.8 Requests for Temporary Release by Vulnerable Prisoners

A vulnerable prisoner may be eligible for Home Leave or Compassionate Temporary Release (CTR). Authorisation for pre-release home leave is the responsibility of the Governor; authorisation for CTR is the responsibility of Prison Service Headquarters. In either case, in reaching a decision, careful consideration must be given to the prisoner's personal circumstances and level of risk of self harm or suicide.

### 5.9 Release on Completion of Sentence or On License

When a prisoner on an open SPAR is time served and there is concern that he or she may be at risk of significant self harm following release, then

information may be shared between staff in the prison and others concerned with the prisoner's care and welfare in the community. This may include the person(s) with whom the prisoner will reside on release, or authorities with whom they will have contact. The Residential Manager should ask Healthcare staff to inform the prisoner's General Practitioner (where known).

The prisoner will already be aware of our procedures for information sharing and will have completed the "Agreement to Sharing of Information" page in the SPAR booklet during the initial SPAR interview with the Residential Manager. The prisoner will therefore know that information relating to the specific risk and risk reduction will be shared with, for example, Probation Staff, even if they have withheld their permission.

The Residential Manager may call upon the assistance of the establishment's Offender Management Unit to support a vulnerable person's discharge and resettlement.

Prior to release the prisoner should be told where he or she may obtain external support or counselling if needed.

If the vulnerable person is a foreign national prisoner being handed over to the Immigration Service then details of the risk assessment and the elements of the Care Plan must be included in the paperwork that NIPS gives to Immigration Service personnel.

## Chapter 6. Safety Checks and Head Counts

As an integral part of their core duties, Residential staff are required to carry out safety checks and head counts. This applies to any part of the prison at any time of the day or night and for any activity that prisoners may attend or participate in.

In any situation and at any time, staff must know where prisoners are and be able to confirm that they are alive and well. The purpose of a safety check is to establish that a prisoner is present and alive. The purpose of a head count is to establish that a prisoner is present and accounted for.

Safety checks are usually carried out at morning unlock, lunchtime lock up, tea time lockup, and evening lockup.

Head counts are normally carried out when prisoners are in cell and at particular times of the core day, in addition to the evening lock up and morning unlock check.

**These procedures are particularly important when managing prisoners who require close attention and observations, especially during periods of lock up, and who are being managed under the SPAR procedures.**

### 6.1 Safety checks and Head counting prisoners at night

**Standard 22: Completed night custody safety checks and head counts are to be made in accordance with establishment orders; and, in the case of vulnerable prisoners, in accordance with the frequency and standard set in their keep safe or care plans.**

For all prisoners a safety check will be completed by the Night Custody Officers (NCOs) on taking up duty as part of the shift handover and again as part of the morning unlock and shift hand handover to day staff.

In confirming that the prisoner is alive and well, safety checks should take account of:

- anything unusual in regard to the person's behaviour or mood;
- any obvious signs of distress or self harming activity;
- anything unusual in regard to cell contents or layout;
- potential disruption to the good order and safety of the prison.

During the night guard period and in addition to the safety checks a minimum of three headcounts will be completed, in line with local Governors Orders. NCOs will ensure prisoners are accounted for and that there is no activity giving rise to concern that the person is at risk or attempting to undermine the security, good order and control of the prison.

Night custody head counts when prisoners are asleep should be made as quietly as possible, taking care not to deliberately waken prisoners. Preferably, observations should be completed using torchlight via the observation flap in the cell door. Only when it is not possible to be satisfied that all is well, should the light be switched on.

If there is any doubt or concern regarding a person's safety the cell door must be opened, in accordance with the establishment's safety and security instructions for night time unlocks, and a physical check made. Night Custody Officers (NCOs) should therefore always be prepared for an emergency cell entry during a night custody safety check or head count.

If, during a head count, there is nothing unusual observed and there is no cause for concern the NCO will record that a check was carried out and that nothing unusual was observed. Prisoners **should not be wakened** unless there are concerns that would require the cell to be opened for a safety check or there is a specific requirement to conduct a safety check as determined by the requirements of the Care Plan. Even in these circumstances, if movement

is observed and there are no concerns then that may be sufficient to meet the Care Plan safety check.

The frequency of safety checks (over and above those normally completed) for prisoners on SPAR must be identified in the Care Plan and will be followed without deviation.

Prisoners accommodated in observation cells will be observed at intervals of not more than 15 minutes, in accordance with the default observation requirements for such accommodation. The NCO should visit the cell at unannounced and unpredictable times within the 15 minute period and should record such visits, along with observations on the prisoner's state, in their journal.

In all instances, while the prisoner's care is paramount, it is important for staff when making safety checks and head counts to do so thoroughly and appropriately, but as quietly and as respectfully as possible.

## Chapter 7. Managing Incidents of Self Harm

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**Standard 23: Staff emergency self harm intervention contingency plans are communicated; and staffs are trained to implement them.**

The action taken following discovery of an incident of self harm or attempted suicide and the timing of such action is a crucial element in securing, as far as possible, a successful outcome to an incident. It is important that all establishments develop, maintain and regularly review their contingency plans including emergency unlocks, for such incidents. Governing Governors should ensure that the procedures identified represent, within physical constraints, the timeliest and most efficient response; particularly for the unlocking of cells (where appropriate), getting rescue equipment to the scene, securing appropriate healthcare assistance at the scene (by providing accurate information to staff required to respond) and notifying other key personnel.

### 7.1 Contingency Planning

Contingency plans in each establishment must identify prioritised actions, timing of actions, and the persons responsible for carrying them out. These should reflect the change in procedures between day, evening and night shifts. There is no standard format for incident contingency plans as they must reflect local requirements due to the differing physical layout of prisoner accommodation areas within individual establishments and across the prison estate. However, the following key elements must be included in all plans for handling incidents involving suicide or self harm:

- Arrangements are in place during lock up periods which allow staff rapid access to **cell keys for emergency unlock**, or selective electronic cell unlocking, thus minimizing the response time in dealing with an incident;

- A cut down tool is issued to staff drawing keys, thus minimising the response time in dealing with an attempted hanging. In addition a Merlin mask, a small renewable supply of spill packs, waterproof dressings and disposable gloves must be placed in an accessible central location in every prisoner accommodation area the location of which **must** be made known to all staff;
- Arrangements for an emergency response by Healthcare staff to the scene of an incident;
- Central co-ordination of the incident by the Emergency Control Room / Communications Room, where an up-to-date list of key personnel to be contacted will be maintained. The Emergency Control Room/Communications Room will maintain a real time time-log of events and interventions as and when they occur.

### 7.2 Immediate Action on Discovery of an Incident

A prisoner who inflicts a serious self injury on himself should be treated in a calm and non-hostile manner and should not be left alone, even to summon help, as they may attempt further injury if left unattended. Following an alarm or an emergency cell unlock, staff must be prepared to respond to very serious incidents of self harm that may be unpleasant to deal with and that may typically involve the following:

- Hanging or suffocating

  If a prisoner is discovered hanging or suffocating, swift action is imperative as a lapse into unconsciousness and death can occur very quickly. It is known that if a ligature is sufficiently tight, death may occur in seconds rather than minutes. Upon discovery, the officer should raise the alarm by appropriate means and commence primary rescue procedures. Others should be detailed to summon Healthcare assistance and collect rescue equipment. The following course of action must be followed:

1. Call for assistance and enter the cell or area as quickly as possible;
2. **Support the weight of the body** to reduce constriction;
3. With the assistance of a second person, **cut the ligature using the Cut Down tool** above the noose or knot;
4. **Immediately cut the ligature from around the neck** as attempts at resuscitation will be useless if the ligature continues to restrict the airway. Do not spend time trying to undo or tamper with the ligature knot;
5. **If the casualty is unconscious, check breathing and pulse**. Where there is a pulse but the casualty is not breathing, apply artificial respiration. Where neither sign is present, a combination of artificial respiration and chest compression is required. This procedure is known as Cardiopulmonary Resuscitation (CPR).

- Suspected drugs overdose

The symptoms of an individual who is suspected of taking a drugs overdose will vary, depending on the type and amount of the drug that has been taken. Staff will need to inform Healthcare staff and assess if there is any immediate action necessary to preserve life. The following course of action must be followed:

1. **Call for assistance** and enter the cell or area as quickly as possible;
2. **If the casualty is unconscious, check breathing and pulse**. Where there is a pulse but the casualty is not breathing, apply artificial respiration. Where neither signs are present, commence **CPR** procedures;
3. **If the casualty is unconscious, place them in the recovery position** to prevent ingestion of vomit. **Do not** attempt to make the casualty vomit as this may cause further harm;

4. **Try to obtain information on the type and amount of the substance taken**, either from the casualty, others in the locality or from material in the cell. Retain empty medicine containers or samples of vomit and make available to Healthcare staff when they arrive on the scene.

- Swallowing corrosive substances

Many household cleaning materials contain poisonous substances which may cause chemical burns and may be particularly dangerous if swallowed. Such substances retained in prisoner accommodation areas should be securely stored in clearly marked containers and be accessible only to nominated individuals.

Where it appears a casualty's lips are burned by corrosive substances, the following course of action must be followed:

1 **Call for assistance;**
2 **Wash away any residual chemical** on the skin with plenty of water;
3 **Avoid contamination** from the chemical or the rinsing water;
4 Do **not** try to induce vomiting.

- Severe external bleeding

Severe external bleeding at the face or neck can obstruct the airway so the immediate first aid priority is to maintain the airway, breathing and circulation. The following course of action must be followed:

1. **Call for assistance;**
2. **Apply direct pressure**, using gloves as required, with a sterile dressing, pad, towel, fingers or palm, to cover the wound. (If an object is still protruding, apply direct pressure on either side of

the object.) **Do not** use a tourniquet as it could make the bleeding worse and may result in tissue damage or gangrene;

3. **Gently raise and support an injured limb** above the level of the casualty's heart (be conscious that the limb itself may be fractured);
4. **Get the casualty to lie down.** This may help as it will reduce blood flow to the injury site and minimise shock.

Before dealing with blood spillages or open wounds, staff should protect themselves by observing existing safe working practices; including covering any sores or open wounds they may have with waterproof adhesive dressings and using disposable gloves and spill packs. Hands should also be washed thoroughly in soap and water following administration of treatment.

## Chapter 8. Post Incident Management

### 8.1 Action to be taken following an act of self harm or suicide attempt

A prisoner who has committed an act of self harm or has attempted suicide will be given prompt medical treatment if appropriate. Where suicide has been attempted, suitable preventative measures must be taken to forestall a further attempt. In making an assessment, the examining Healthcare staff will have access to previous SPAR information on the prisoner's Healthcare record (EMIS) and PRISM. Once the prisoner has been treated for injuries sustained, the Residential Manager will arrange a Case Review to manage the prisoner's well being.

The wishes of the prisoner should be taken into account when considering if immediate family or next of kin should be informed of an act of self harm or attempted suicide. **However, in the case of an inmate under 18 years of age there is an obligation to notify next of kin**. It is essential that this is handled with care and sensitivity and the Governor should, in the first instance, inform **the Case Manager** *(*Probation Officer) with responsibility for the inmate; the establishment **Lead Chaplain** and the **Child Protection Coordinator**. Unless the prisoner wishes to make personal contact with his or her next of kin, one of the above may be in the best position to make the initial contact, either by telephone or through a personal meeting. All cases of reported self harm incidents will be recorded on PRISM and regularly reviewed by the Suicide and Self Harm Prevention Coordinator and Safer Custody Governor.

## 8.2 Action to be taken following a death in custody

**Standard 24: Death in custody contingency plans are communicated and staff trained to implement them.**

Despite the implementation and efficient operation of suicide prevention measures, there remains the risk that a prisoner may take his or her own life. Where a death in custody occurs it may not be immediately apparent that the cause of death was suicide. In all incidents of death in custody, therefore, the cell or area in which death occurred must be sealed and protected from contamination and the following procedures implemented.

## 8.3 Protecting the scene from contamination

The Governor will ensure that a member of staff is detailed to prevent anyone from entering the area other than those specifically required to, until the emergency services and PSNI arrive. A serious incident log must be maintained at the scene and will include a record of all those entering or leaving the scene. Serious incident log books **must** be available in all residential areas.

Using the contingency plans, the ECR (or other designated personnel) will immediately notify the following personnel of the time and preliminary assessment of cause of death:

- The Doctor, who will be responsible for certifying that the prisoner is dead. The cell or other location where death has occurred must be sealed until the arrival of the police, who are tasked to investigate the circumstances of any sudden unexpected death.
- The Governor in charge;
- The Police and, following their investigation of the scene, the nominated Funeral Directors;
- The next of kin; (see also Section 9.3)

- The Coroner;
- The Prisoner Ombudsman;
- Lead Chaplain;
- Chairman or other nominated member of the Independent Monitoring Board;
- Prison Service Headquarters (Operational Management between the hours of 0800 and 1800 week days, or the NIPS Duty Director outside these hours), who in turn will notify the Director General, the Director of Operations and the NIPS Press Office;
- Health Care Manager; who will inform the,
- Assistant Director for Prison Health.

The PSNI will appoint an investigating officer to consider the circumstances of any unexpected death; this is primarily to ensure that no criminal offence has been committed and to report initial findings to the Coroner.

The area where the death occurred is regarded as a crime scene and is sealed until the Scenes of Crime staff from PSNI have examined it and concluded their work. Managers must maintain discipline in the incident area. This is a key part of crime scene management. Other individuals and agencies, such as the establishment's Probation Manager, the Samaritans and Staff Associations can be informed once the initial stages of the incident are managed.

### 8.4 External investigation by Prisoner Ombudsman

All deaths in custody must be reported **immediately** to the Prisoner Ombudsman (up to date contact details must be kept in all ECR's), who will investigate the incident. The Governor will ensure that the Suicide and Self Harm Prevention Coordinator or a delegated person gathers information requested by the Ombudsman. The Ombudsman's terms of reference include deaths from natural causes, accidental deaths; homicides, those that are apparently self inflicted, and those occurring within 14 days of being released

from prison custody. All staff must fully co-operate with the Ombudsman's investigation.

The aim of the Ombudsman's investigation will be to establish the circumstances and events surrounding the death, examine and make recommendations on whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence; and, in conjunction with the Department of Health and Social Services and Public Safety, examine relevant health issues and clinical care, where appropriate. The investigation will also provide explanation and insight for bereaved relatives and assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under Article 2 of the European Convention of Human Rights, by ensuring as far as possible that the full facts are brought to light, any relevant failing is exposed, any commendable action or practice identified and any lessons are learned.

On receipt of the Prisoner Ombudsman's final report into a death in custody, the Director of Operations will convene a meeting to discuss any recommendations arising from the report. An action plan will be agreed at the meeting outlining the recommendations which have been accepted and detailing lead responsibility and timescale for implementation of each recommendation. The Governor of the establishment involved will appoint a senior member of staff to monitor progress on local implementation of the action plan. Any amendments to be made to the Prison Service Suicide and Self Harm Prevention Policy will be the responsibility of the Head of Custody Branch, NIPS HQ.

**Standard 25: Hot and cold de-briefing must take place following a serious incident of self harm or death in custody.**

### 8.5 Hot de-briefing

In all cases involving a serious incident of self harm or death in custody, hot de-briefing will take place and will involve all of the staff (where possible) who were closely involved with the incident.

The hot de-brief will be held by the Duty Governor or the most senior manager at the time (depending on the circumstances of the case) and will take place as soon after the incident has been brought under control as possible. During the hot de-brief staff should have the opportunity to express their views in relation to how the situation was discovered, managed and any additional support or learning that could have assisted. In addition, the hot de-brief is an opportunity to identify if staff themselves require specific support. A record of this meeting can be made using the template at Appendix 5 along with a list of attendees. A copy of the hot de-brief report will be given to the Head of Custody Branch and, where death has occurred, the establishment should make a copy available to the Prisoner Ombudsman.

### 8.6 Cold de-briefing

A cold de-brief will take place within 14 days of the incident to provide opportunities for staff to further reflect on the events surrounding the death in custody and to, perhaps, identify any additional learning from the events. The cold de-brief **is not** intended to be a comprehensive investigation into the circumstances. Rather, it is an opportunity for staff to express their views and share their thoughts about the incident and their role and involvement in it. A member from PSHQ Custody Branch will attend the cold de-brief to support the Governor conducting it. A record of this meeting can be made using the template at Appendix 6. A copy should be given to the Head of Custody Branch and, where death has occurred, the establishment should make a copy available to the Prisoner Ombudsman.

## Chapter 9 Internal Reviews of Incidents of Self Harm

### 9.1 Recording and Reviewing Minor Incidents of Self Harm

**Standard 26: All incidents of self harm will be recorded on PRISM**

Minor incidents such as scratching or cutting may need to be attended to by Healthcare staff. The details of these events must be recorded on the Injury Report form on PRISM so that trends and underlying causes can be analysed and identified by establishment Suicide and Self Harm fora and by Safer Custody fora..

Custody Branch at Headquarters will maintain a central record of all recorded self harm incidents for the Service and will produce quarterly reports and analysis of self harming incidents by type, gender, age, nationality, sentence length and religion, for Governors and Managers.

The Suicide and Self Harm Prevention Coordinators Forum will regularly review trends from minor self harming incidents and will take steps to minimise further incidents and, where trends indicate, identify levels of support for potentially vulnerable prisoners/groups.

### 9.2 Recording and reviewing Serious Incidents of Self Harm

**Standard 27: An internal review will be conducted into serious incidents of self harm.**

Unfortunately there have been a number of serious incidents of self harm by prisoners in the past and, almost certainly, prisoners will continue to self harm in the future. The prison environment is less conducive to a suicide act taking place because of the close proximity of staff and other inmates and because prisoners are observed and supervised so much.

Inevitably, however, there will be prisoners who are determined to self harm and where this has resulted in a serious injury then an internal review, led by Custody Branch, will be carried out and a report produced using the template at Appendix 7.

The threshold criteria for such an internal review will be when one or any combination of the following criteria is met:

- An act of self harm took place and death would or could have occurred but for the intervention of staff;
- The harm caused by an act of self harm required immediate medical intervention to resuscitate and revive;
- The immediate response required an ambulance to be called to the establishment and the person to be taken to an outside hospital for treatment.

The internal review will be commenced within 24 hours of the incident occurring and completed within 4 days from commencement. The purpose of the internal review is to:

- Assess the incident against NIPS policies and procedures;
- Monitor our handling of the person in the period before, during and immediately after the incident;
- Share and develop best practice; and,
- Note actions and lessons learned.

The internal review will be conducted in 2 parts as follows:

**Part 1.** To be completed within 24 hours of the incident occurring to provide an immediate, factual overview to inform establishment managers and Headquarters of the nature and seriousness of the incident and to inform the next set of steps to be taken.

**Part 2.** Will provide a full and factual analysis of the processes involved in the care of the prisoner before, during and after the incident. The analysis will consider key points for learning and make recommendations for future self harm minimisation and system and environmental improvement.

To provide a consistent approach and to ensure a complete and accurate assessment the internal review should take account of all relevant information to hand. The critical document review matrix at Appendix 8 indicates the range of information to be considered and where it can be sourced (although this may differ slightly in each establishment).

The Suicide and Self Harm Prevention Coordinator for each establishment will ensure that arrangements are in place for them to gain immediate access to all of the information listed as well as any other information deemed necessary and approved by the Safer Custody Governor or the Head of Custody Branch at Headquarters.

To avoid duplication and for completeness, the internal review will also act as a shared review between the discipline side and Healthcare. As such the Suicide and Self Harm Prevention Coordinator and the Healthcare Manager will have a shared role in contributing to the production of the report and analysis. The Assistant Director of Health and Head of Nursing Services and Clinical Governance will ensure that the final report reflects the role of Healthcare staff involved in the incident and procedures used, as well as identifying lessons learnt and recommendations for continuous improvement.

The internal review is not part of the NIPS Staff Code of Conduct or disciplinary process and will not investigate professional misconduct and/or staff performance. However, where there are obvious signs of prisoner neglect or behaviour that breaches professional conduct, recommendations will be made for consideration to be given to a disciplinary investigation being carried out.

### 9.3 Serious Self harm incidents with protracted long- term consequences

**Standard 28: The Director of Operations will ensure that action is taken commensurate with an independent investigation into incidents of serious self harm where there are protracted incapacitating affects.**

Generally, all cases involving serious self harm and death in custody will be reviewed internally by NIPS or externally by the Prisoner Ombudsman as appropriate. However, an investigation by an independent agent or agency may be required where a prisoner self harms to the point where:

- without *immediate* intervention the prisoner would have died;
- as a result of the incident the prisoner has suffered permanent or long-term serious injury; *and*
- as a consequence of the long-term injuries sustained the individual's ability to know, investigate, assess and/or take action in relation to the circumstances of the incident has been significantly affected.

In such cases the prison establishment in which the incident occurred will inform Custody Branch and the Director of Operations, who will monitor the prognosis of the person and in consultation with Health Services, will determine if the threshold to trigger this type of investigation has been reached.

As with any serious incident of self harm, this approach is in line with the Government's (and NIPS) responsibilities, under Article 2 of the European Convention on Human Rights (the right to life).

In such cases, in order to preserve all relevant information for the investigators the following steps will be taken:

- The cell or area where the incident took place will be temporarily sealed;
- Where there are concerns that other inmates may have been involved in the incident, the PSNI will be informed immediately:
- Where there is no PSNI involvement and before returning the cell for cleaning and reallocation it must be thoroughly photographed, with each item belonging to the prisoner catalogued and photographed:
- Paraphernalia such as ligatures, self-cutting instruments, traces of ingested substances and any written notes left by the prisoner should also be photographed and where possible, preserved:
- A critical document review will be carried out with hard copies of documents prepared and sealed for storage (Appendix 8).

All evidence will be removed from the establishment and kept in secure cabinets in Custody Branch until handed over to investigators. The Prison Service Head of Custody Branch will keep the Prisoner Ombudsman informed of the prisoner's condition and of developments as they occur.

### 9.4 Serious injury or death: Contacting the Family or Next of Kin

Where a prisoner is seriously injured or hospitalised or has died, the Governor in charge or Duty Governor must inform, as a matter of urgency, the immediate family or next of kin or arrange for another appropriate person to do so. Depending on the geographical location of the prisoner's family and travelling time involved, it may be more appropriate for the Governor in charge to arrange for a family Chaplain or local PSNI officer to inform the next of kin. Informing relatives must be handled with sensitivity and sympathy. In the case of a death in custody, it would not be appropriate, at such an early stage, to suggest that the possible cause of death was suicide. Determining the cause of death is ultimately a matter for the coroner.

The Governor in charge should ensure that confirmation is received from the person contacting the next of kin that information regarding the serious injury or death has been given and that details of the contact are recorded.

Immediate queries from the next of kin on the day of the incident may best be handled by the Duty Governor or other nominated person. Thereafter, a contact person should be established within the prison to whom the next of kin may direct residual queries and/or make arrangements to collect personal belongings. Governors will decide if this person should be a Governor, member of the Safer Custody Group, Chaplain, member of the Independent Monitoring Board or other suitable person. A death in custody is a very traumatic event for a family and it may also be useful for the Chaplain or Independent Monitoring Board member to offer to visit the next of kin in their own home.

Integral to the NIPS duty of care, the Governing Governor must send a letter of condolence to the next of kin as an expression of sympathy. It may be necessary for the next of kin to attend the prison to make a formal identification or collect belongings, or they may ask if they can do so. In making such arrangements Governors should ensure that:

- An appropriate member of staff meets the visitors and escorts them throughout (this may be the designated family liaison officer);
- A Chaplain and member of IMB is available to assist;
- Security arrangements are kept to a minimum and exercised discreetly; and
- A member of healthcare staff is available should the relative(s) require assistance.

### 9.5 Impact of the serious injury or death of a prisoner on Staff

**Standard 29: Professional counselling services will be available for all staff involved in serious or fatal incidents of self harm.**

Staff involved in discovering a serious or fatal incident of self harm may find the experience difficult and distressing. Governors should:

- exercise flexibility in responding to staff needs,
- ensure that support is available to help them deal with such situations,
- ensure that all staff are made aware of the external professional counselling services that are available,,
- ensure that as part of the hot and cold de-brief process staff are able to speak openly of events without recrimination or alienation.

If, during the de-briefing process, managers notice signs of anxiety, hyper-tension, stress or change in normal behaviour they should speak privately to the staff member(s) about their feelings and, where there are continuing concerns, inform the establishments' Head of Healthcare and Head of Personnel to determine the most appropriate course of action for the Officer(s).

### 9.6 Impact of the death or serious self harm of a prisoner on other prisoners

The friends or cell mates of a deceased or seriously injured prisoner may also have difficulty coming to terms with such unexpected events. In some cases cell mates may have raised the alarm in the first instance. Governors will address any post incident needs of prisoners by making the relevant internal or external help available. Cell mates or those who raised the alarm may find themselves caught up in a prolonged process of interviews with external and internal agencies about the events leading up to the incident. This can further raise emotions and anxiety in an already stressful situation. Managers and staff must be alert to this potential impact and take steps to ensure the prisoner's well being minimising, as far as possible, any circumstances that may create vulnerability.

In cases where prisoners are caught up in serious incidents they should be placed on a SPAR with a care plan to help support them through the stages of the investigative process.

### 9.7 The Coroner's Inquest

Staff with responsibility for a deceased prisoner in the period immediately before his or her death, those involved in discovering the body and clinical staff who attended the scene, may be asked to make a statement to the investigating PSNI Officer, in addition to the normal reports made to the Governor. These police statements will be presented to the Coroner, who may elect to subpoena some or all of the Officers as witnesses at the inquest into the death. Staff who are asked to provide a police statement are encouraged to make the statement as detailed and as contemporaneous with events as possible. Statements to the police or the Coroner should be based on the details contained in staff communication sheets prepared immediately following the event. For advice on completing Coroner or PSNI statements staff should contact their establishment Training Office, Safer Custody Governor or Custody Branch, Headquarters. Appendix 9 contains some further guidance for those called as witnesses.

Governors should nominate a member of their **Senior Management Team** to act as inquest liaison officer. It will be the senior manager's responsibility to ensure that subpoenaed officers are available to attend court and to provide advice to staff on their responsibilities at the inquest.

### 9.8 Coroner's Court Recommendations

A member of Headquarters Custody Branch, or a delegated person, will attend Coroner's Court hearings to record any points of learning or get advance warning of issues that may require further consideration.

The Coroner's Court may make recommendations for the Prison Service to consider and any that are accepted will be included in establishment and Headquarter action plans and Safer Custody risk registers. Establishment Governors in conjunction with the Head of Custody Branch will then be required to take account of and remedy any deficiencies in systems, processes or staff training as soon as is practicable.

## Chapter 10. Monitoring and Continuous Improvement

**Standard 30: All instances and periods involving the use of observation cells, special clothing and mechanical restraints are recorded on PRISM and monitored.**

Details of all incidents of self harm must be recorded accurately on PRISM so that statistics and information can be collated and analysed.

The Suicide and Self Harm Prevention Coordinator will ensure that details are being recorded and correctly entered onto PRISM

Additionally, all instances and periods involving the use of observation cells, Anti-ligature clothing and mechanical restraints will be recorded on PRISM. This must be recorded in the "CRC details" menu contained in the Safer Custody section.

### 10.1 Suicide and self harm monitoring

**Standard 31: Structures will be in place at establishment level and at Headquarters to regularly monitor and review performance in delivering the Suicide and Self Harm Prevention Policy and Standards for Operation.**

Implementation of the Prison Service Suicide and Self Harm Prevention Policy will be monitored at three levels as follows:

Level 1 – local Suicide and Self Harm Prevention Coordinators will carry out a daily review of open SPARS and convene meetings to monitor incidents of attempted self harm or suicide within their establishment. Specific trends and occurrences will be monitored and must be reported to the Governor along with any matter of concern relating to the local implementation of the Suicide and Self Harm Prevention Policy;

Level 2 – each establishment Safer Custody Governor will convene regular and frequent meetings to monitor the effectiveness of key policy requirements and their impact on reducing incidents of self harm. This will help improve overall performance in the Safer Custody arena;

Level 3 – The Head of Custody Branch, Prison Service Headquarters, will regularly monitor and review the rate and severity of self harming incidents across the Service and the effectiveness of corporate policy and standards implementation.

For levels 1 and 2, the establishment Governor will determine who should attend these meetings and the contribution they will be expected to make. The Head of Custody Branch at Headquarters will agree with Governors their establishment representatives at level 3 meetings.

### 10.2 Audit

**Standard 32: All establishments and Headquarters Safer Custody Risk Registers and Performance Improvement Plans will be audited annually.**

The Head of Custody Branch at Headquarters, in conjunction with Governing and Deputy Governors, will ensure that an annual audit programme is developed, agreed and applied by the Performance and Standards Unit. The audit will take account of establishment and Headquarters Risk Registers and Safer Custody Performance Improvement Plans.

**Standard 33: Quarterly Safer Custody Reports are made to PSMB with an annual performance report included within the NIPS annual Corporate and Business Plan Report.**

The Head of Custody Branch at HQ will report progress to the Prison Service Management Board through the Director of Operations on a quarterly basis. The Head of Custody Branch will also provide an annual report on Suicide and Self Harm Prevention Policy performance for inclusion in the NIPS annual report.

**Appendix 1**

## Recognising Risk

As staff begin to establish a relationship with prisoners, they can more easily pick up on significant changes in mood and behaviour which identify an individual as being at risk. People who attempt suicide may show distress or an intention to take their own life. This can often be detected by observing, listening and talking to them. Some people may, however, be adept at concealing their intent to self harm so staff should be aware of a prisoner's body language, what they say, how they say it, their reaction or response to questions and how they respond to the environment. Any of the following could be an indication that the prisoner is asking for or needs support:

Triggers

- Drug or Alcohol misuse
- Irrational behaviour
- Increase in severity or occurrence of self harm
- Hostile rejection of help
- Withdrawal from social contact
- Change in routines, habits, appearance
- Injuries not readily accounted for
- Anxious appearance
- Withdrawn or depressive manner
- Talks about death or suicide
- Rejection of support by family or friends

Events

- First reception into prison custody
- Bail refusal
- Reception after conviction/sentence
- Reception after transfer
- "Bad visit" of phone call, mail (may invoke a spontaneous reaction)

- Conviction for sexual & high media interest offence
- Anniversary of offence (particularly if violent of where victim was known or a child)
- Inability to cope
- Violence – including bullying

Additional factors

- Previous history of self harm or suicide ideation
- A history of mental ill health
- Relationship or family problems
- Longer sentence than expected
- Suicide (or attempt) by someone known to them
- Home leave refusal or similar
- Bad news from external contact
- Any unusual, untoward or bizarre behaviour
- Current suicide plan?
- Pain that sometimes feels unbearable
- No resources
- Risk identified by Police, Probation family or other staff

Physical Changes

- Lack of interest/pleasure in everything
- Lack of physical energy for no apparent reason
- Disturbed sleep
- Change/loss of appetite, weight
- Increase in minor illness
- Presents injuries which cannot be adequately accounted for.

This list is not exhaustive and should a prisoner's behaviour lead any member of staff to suspect that they may be at risk of self harm or suicide, they should report the matter immediately to the manager responsible for the prisoner and open a SPAR. The primary concern is to protect the prisoner who may be at

risk and there will be no reproach for staff who report unusual behaviour which subsequently turns out not to be significant.

There are some key differences related to the age and gender of prisoners and how or why they may self harm:

**Young offenders** tend to be more impulsive, and their attempts are more likely to be related to lack of coping with the stress of their prison experience or problems outside. They are less likely to be open about their feelings or willing to discuss concerns with staff. They are also more vulnerable to Anti-Social Behaviour and are more impressionable and therefore susceptible to peer pressure and copycat activity.

**Adult male prisoners** are more likely to plan a determined suicide attempt. This is more likely to be related to the nature of their offence, anxieties about family or worries about release.

**Female prisoners** may be under additional pressures such as separation from children or elderly relatives for whom they are the primary carers; experience of previous sexual abuse or violence; and clinical depression (though these issues can also affect men). Patterns of female suicidal behaviour suggest that women may also think through the processes of suicide more systematically in terms of time, method, style and place.

More detailed information and guidance on juveniles and females will be made available to staff at Hydebank Wood.

**Appendix 2**

**Role of Case Manager**

Ensuring instructions to staff on local procedures, including emergency measures in responding to incidents of suicide or self harm are available in their area of responsibility;

- Ensuring that staff who identify a prisoner at risk initiate a SPAR booklet;
- Ensuring details are initiated on PRISM;
- Before the end of duty and in consultation with other staff, put in place an immediate action plan to keep the prisoner safe until the first case review and care plan are put in place. The immediate action plan is for the **next 48 hours**;
- Informing attendees;
- Chairing case reviews. (the interval between case reviews must **not exceed 7 days);**
- Ensuring PRISM is updated with a summary of each case review;
- Ensuring that any Healthcare stipulations on preventative measures for prisoners in their area of responsibility are recorded and carried out;
- Checking all logs on a daily basis to ensure that staff are following the care plan and that the prisoner is engaging with staff and participating in the regime and activities identified in the care plan;
- Ensuring a minimum of two conversational checks are carried out and recorded daily by staff. Signing all logs accordingly;
- Referring any specific concerns identified from the logs or in discussion with staff to the Suicide and Self Harm Prevention Coordinator;
- Ensuring that all staff areas are free from clutter and specifically that only those items required for the staff to carry out their responsibilities are in place.
- Ensuring that staff coming on duty are briefed on ongoing concerns in relation to prisoners subject to SPAR process – this

includes briefing of NCOs and residential staff taking up duty in the morning;

- Record such briefings in the daily journal / log;
- Ensuring a supply of serious incident log books are readily available in the house.

**Appendix 3**

## Role of the SPAR Case Assessor

- To conduct the initial in-depth interview with the prisoner to identify the issues of immediate concern;
- To listen intently to these concerns and to record them in bullet point form in the SPAR booklet;
- To provide initial care and support to the prisoner;
- To make an informed decision as to the immediacy of any initial action, additional to that already in place in the Keep Safe Plan;
- To attend the initial Case Conference and pass on observations gathered during the interview.

**Appendix 4**

## Inmate Under Escort Form

Inmate Under Escort forms are produced by General Offices. General Office staff should ensure that the form is completed and contains the following information:

- The details of the Care Plan in place and the observation requirements agreed as necessary;
- The detail of any contact that must be made if the prisoner is released from custody or returned to a different establishment.

**Appendix 5**

## Template for Hot de-brief

| RECORD OF HOT DEBRIEF OF SERIOUS SELF HARM/DEATH | |
|---|---|
| Prisoner's Details: | |
| Normal Location: | |
| Location of incident: | |
| Date/time of incident: | |
| Type of incident:<br><br>Hanging;<br>Ligature:<br>Cutting;<br>Self poisoning;<br>Overdose;<br>Other (please state); | Details: |
| Access to location:<br><br>How obtained;<br>Who by?<br>Any difficulties? | Details: |
| Immediate Action:<br><br>Cut down? How?<br>Resuscitation?<br>CPR required?<br>Healthcare response?<br>Out to hospital? | Details |
| Access by Emergency Services:<br><br>Any difficulties? | Details: |
| Aftercare:<br><br>For staff; By?<br>Other prisoners; By? | Details: |
| What actions went well? | Details: |
| What actions need remedial action? | Details: |
| Signature | Print Name |
| Date | |

**Appendix 6**

## Template for Cold de-brief

| RECORD OF COLD DEBRIEF OF SERIOUS SELF HARM/DEATH | |
|---|---|
| Prisoner's Details: | |
| Current Location: | |
| Location of incident: | |
| Date/time of incident: | |
| Brief details of incident (as recorded on hot debrief record) | Details: |
| Outstanding issues from hot debrief: | Details |
| Specific actions to be completed: By whom? | Details: |
| Aftercare for staff – concerns? | Details: |

| | |
|---|---|
| Aftercare for prisoners – concerns? | Details: |
| Referrals for Commendations | Details: |
| Signature | Print |
| Date | |

**Appendix 7**

## Template for Internal Review

### NIPS REVIEW OF SERIOUS SELF-HARM INCIDENT

This form must be completed by the Safer Custody Manager, Custody Branch, PSHQ, in consultation with the Suicide & Self Harm Prevention Coordinator in the establishment where the incident of serious self harm occurred.

The completed form must be copied to the prisoner's file and Healthcare, with the original being retained by the Head of Safer Custody at PSHQ.

| | |
|---|---|
| Please provide your contact details (inc e-mail address): | |
| Prisoner's Name: | |
| Prison Number: | |
| Prison: | |
| Date & time of incident: | |
| Date of Birth: | |
| Nationality: | |
| Date of Committal: | |
| Date committed to current prison: | |
| Location (state whether normal, SSU, Healthcare): | |
| Offence: | |
| Sentenced/Remand: | |
| Occupancy (single/shared): | |
| Observation Cell? – Yes/No: | |
| Details of the self harm incident: (Hanging? Overdose? Cutting? Ligature? Where were the injuries made? | |
| Type of cut down tool used (if applicable): | |
| Describe injuries sustained: | |
| What time was the alarm raised? | |
| How was the alarm raised? | |
| What time was the cell door opened? | |
| What time were the emergency services called? | |
| What time did the ambulance arrive at the main gate? | |
| What time did the ambulance crew arrive at the scene? | |
| What time did the ambulance leave the prison? | |
| Resuscitation required? | |
| Transferred to Outside Hospital? (If yes, date out and returned to | |

| | |
|---|---|
| establishment) | |
| Was Life Support required? | |
| SPAR open prior to incident?<br>(if yes, what were the Obs as stated in the Care plan?) | |
| Had prisoner been managed previously on a SPAR? | |
| SPAR opened since incident? (if not opened before) | |
| Is act of self harm different from that for which the original SPAR was opened?<br><br>If yes, how was it different? | |
| Any signs of long term impairment resulting from the injury? | |
| Have the NOK been informed?<br><br>If so, when and by whom?<br><br>If not, why not: | |
| List the relevant documents (hard copy & PRISM) that have been completed in relation to this event (IMR12 & Self Injury Report on PRISM) | |
| Is it recommended that the incident be investigated by an external body? | |
| High level time log of the event, combining ECR log and recall from officers involved? | |

| REVIEW OF RELEVANT/AVAILABLE DOCUMENTS |
|---|

| |
|---|
| Record comments relating to the content of SPAR booklets/observation logs. Were the requirements of the Care plan carried out effectively? Are there any omissions relating to the provision of adequate care of the prisoner? Is there learning from any good practice noticed? |

| |
|---|
| NIPS Spar Booklet/Observation Logs:<br>How was Care plan carried out? |

INSPECTION OF ACCOMMODATION SITE

Note observations of the accommodation in which the prisoner was housed. Ligature points? Health & Safety issues? If an Observation cell – authority signed – equipment in working order – safety clothing issued? CCTV coverage – has this been recovered?

**Assessment of place where self harm incident took place:**

Signature : _____ Safer Custody Manager, PSHQ

Signature: _____ Suicide & Self Harm Prevention Coordinator

Date: _____

Information used to compile this report :

- PRISM Self Harm ☐
- PRISM SPAR ☐
- SPAR booklet ☐
- PRISM Healthcare ☐
- Prisoner file ☐
- Visits record ☐
- Discussion(s) with staff ☐
- Others (specify): _____ ☐

**PRISM SPAR Details**

**SPAR Booklet Details:**

**PRISM Healthcare Details**:

**EMIS Details:**

**Prisoner File Details:**

Police Log/PACE:

NIPS Committal Log:

Committal Warrant:

Cell Sharing Risk Assessment:

Pre-sentence report:

Sentence Plan:

PBNI Ace Score:

LAPP/PPANI Report & Rating:

Home Leave Applications:

**i. Visits Record Details**

**ii. Telephone Calls (outward):**

**Phone calls made by Prisoner** (details of time, duration, who they were to)

**Analysis of calls,** with summary of any relevant conversations/comments:

**Verbal and written reports**

**Discussions with Staff:**

**Discussions with family members:**

**Discussions with other prisoners:**

**Health & Safety report of the immediate area where the self harm incident took place:**

**Is the cell fit for use again?**

**Object/equipment used in the self-harm incident:**

**Has the incident scene been photographed?**

**Summary of Internal Review**

**How was the prisoner cared for:**

i. Before the incident

ii. During the incident

iii. Following the incident

Are policies, procedures are in place at establishment, and instructions are in place?

Yes/No

Were policies, procedures and instructions followed in this case?

Yes/No

If not, what was the reason?

Lessons Learned:

Good practice that should be noted and shared:

1.

2.

3.

4.

Recommendations for improvement:

1.

2.

3.

4.

Name:

Date:

Initials & Date

Referred to Safer Custody Governor:
Copied to Governing Governor/Deputy Governor:
Referred to local Safer Custody Group:
Referred to HQ Safer Custody Group:

**Appendix 8**

## Critical Documents Review Checklist

| | | Security Office | General Office | OASIS | PRISM | VIRBS | C'way | Other |
|---|---|---|---|---|---|---|---|---|
| 1 | ECR Log | | | | | | | |
| 2 | Secure Pod Log (if under obs) | | | | | | | |
| 3 | Committal Warrant | | | | | | | |
| 4 | Safer Custody Profile Report | | | | | | | |
| 5 | Offender Management Profile Report | | | | | | | |
| 6 | Criminal Record Review | | | | | | | |
| 7 | Committal Sheets | | | | | | | |
| 8 | PSNI Lodgement Log | | | | | | | |
| 9 | SPAR record | | | | | | | |
| 10 | Cell Sharing Assessment | | | | | | | |
| 11 | Staff Incident Communication sheets | | | | | | | |
| 12 | Hot De-brief | | | | | | | |
| 13 | Healthcare summary report | | | | | | | |
| 14 | PPANI Lap Report | | | | | | | |
| 15 | Visits Log last 4 months | | | | | | | |
| 16 | Telephone Log last 4 months | | | | | | | |
| 17 | CCTV log immediate to incident | | | | | | | |
| 18 | Challenging Anti Social Behaviour log | | | | | | | |
| 19 | Chaplains Committal Log | | | | | | | |
| 20 | NIPS Scene preservation log | | | | | | | |
| 21 | Duty Governor Incident report | | | | | | | |
| 22 | Security report/Assessment | | | | | | | |
| 23 | Prisoner Complaints Log | | | | | | | |
| 24 | Drug Testing Log | | | | | | | |
| 25 | | | | | | | | |

**Appendix 9**

**Guidance Notes for Witnesses at a Coroner's Inquest**

Where a prisoner dies in custody, the evidence at the inquest is always heard in a Coroner's Court by a jury and staff who were involved in the incident may be called to give evidence.

If you are called to the witness box your statement will be read by the presenting official and you may be asked some clarifying questions by the Coroner and, where applicable, the legal representative acting for the deceased's next of kin.

Short, simple, honest answers to the questions posed are all that is required. It is not necessary to relate your full knowledge of the prisoner unless it is relevant to the question posed. If you do not remember certain details or do not know the answer to the question it is perfectly in order to say so. The inquest may be held months (and in some cases over a year) after the prisoner's death so saying that you can't remember is preferable to giving an inaccurate answer that may confuse rather than clarify the situation for the Coroner and jury.

Once you have given your evidence you will be asked to sign your statement and unless asked to return to the witness box to clarify some detail to help the jury reach a verdict you will have no further involvement in the inquest.

The jury's task is to return a verdict to the Coroner covering the following eight matters.

1. Did the deceased take his/her own life i.e. death by suicide?
2. If so, did he/she take his/her own life whilst the balance of his/her mind was disturbed?
3. Were there any defects in the prison which contributed to the death?

4. If so, what were these?
5. In what respects did the said defects cause or contribute to the death?
6. Were there any reasonable precautions that could have been taken whereby the death might have been avoided?
7. If so, what were these?
8. Are there any other factors relevant to the circumstances of the death?

Note that cases prior to the commencement of the Human Rights Act may have a narrower remit and may seek to determine just four key facts: who the prisoner was and when, where and how he or she died.

The Coroner will not permit speculation of any potential civil or criminal liability arising from the death.