

Independent Review into the Scottish Prison Service Talk to Me Suicide Prevention Strategy 2025

Final Report, November 2025

Important Note

This is a detailed report which contains information about mental health care and treatment which some people may find distressing. This report also contains non-attributable feedback from some of the people who have been in receipt of those services under review. Whilst we have made every effort to limit the use of descriptive or distressing content, it was deemed necessary to include some of this information to place an emphasis on certain findings. We advise strongly that, if you might find some of this information triggering, you are supported to read this report in a safe way.

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Dedication

This report is dedicated to the memory of all of those who have died by suicide in Scotland's prisons.

Acknowledgements

The review team are indebted to the many people who contributed to this review and gave their time and expertise. At the outset of this review it was decided that we would not individually name participants or contributors. This was done to ensure privacy and to allow participants to speak freely and frankly to the review team. We do though wish to fully acknowledge all of those who spoke to us and contributed to the review.

We are enormously grateful to the bereaved families who spoke to us, understanding that this involved talking about the most deeply distressing and traumatic events. We are also grateful to the prisoners and prisoners' families who contributed to the review during our site visits, stakeholder meetings or in writing, for giving us a critical perspective on how best to reduce the risk of suicides and self-harm in prisons.

Many staff working across the Scottish Prison Service, NHS Scotland, Sodexo and third sector organisations also contributed to the review. We very much appreciated their help, candour, and thoughtful insights on how prevention in

this critical and lifesaving area can be improved. We are also grateful to those working in policy and analytical services for their support and views during the review.

Finally, we are greatly indebted to Professor Alison Liebling (University of Cambridge) and Professor Sarah Armstrong (University of Glasgow) who acted as academic reviewers. We thank them for their thoughtful analyses and very helpful comments. Any inaccuracies in this report are entirely our responsibility.

“This is an excellent, thorough and sensitively handled review grounded in considerable fieldwork, including with the families of prisoners who have died by suicide...The authors make clear recommendations...based on sound analysis”

Professor Alison Liebling, University of Cambridge

Academic reviewer.

“The report offers an important and much needed deep dive on suicide prevention in Scottish prisons. It is particularly valuable in the range of people consulted including imprisoned people, the families of those who have sadly died by suicide, staff at all levels and from health and prison services.”

Professor Sarah Armstrong, University of Glasgow,

Academic reviewer.

Foreword

Keeping prisoners alive and preventing death by suicide in state custody must surely rate as a top priority of any prison service. Whatever the original intentions, the current situation in Scottish prisons is that suicide prevention is essentially a system for acute crisis management, rather than a broader strategic approach to prevention and wellbeing. The approach known as Talk to Me in practice amounts to a structured attempt to prevent suicide by the removal of physical opportunities for individual prisoners to die by suicide. The three pillars of this approach are the use of safer cells, safer clothing and bedding and fixed interval passive observation. Elsewhere such conditions have often been referred to as 'strip cells.' Fatal Accident Inquiry recommendations have focused on trying to improve this kind of physical prevention of suicide approach, by for example, the elimination of ligature points and the removal of items that a prisoner may use to harm themselves, such as belts and shoelaces.

This review has taken as its starting point the perspective of families of those bereaved by deaths by suicide in prisons. The perspectives of serving prisoners in various roles, including those working in Samaritan based roles, as well as those who have been in crisis and managed using Talk to Me were also listened to. We also encountered some very knowledgeable staff, for example some of the lead prison trainers in this area. They sometimes seemed frustrated by a system which does not support them doing the best job that they can in this challenging area.

Overwhelmingly Talk to Me was viewed as punitive and being likely to discourage prisoners from coming forward. For those who do seek help, the approach was often seen as the antithesis of a therapeutic approach. We heard much talk of 'trauma informed approaches' in relation to suicide prevention but saw little evidence that the current policy supported their enactment. Overall the operation of Talk to Me appeared fundamentally inhumane. Inhumane because the approach is widely viewed as punitive, so discouraging prisoners from asking for help. When they did so the policy acts to remove their sense of personal agency which is, ultimately, not respected.

Throughout the report that follows, a broad-based approach, with a focus on prisoner engagement and therapeutic support and the involvement of a wider range of health and social care professionals is advocated. Albeit we acknowledge that health and social care are largely outwith the Scottish Prison Services direct responsibility. In the final section of the report we set out a series of recommendations for implementation, suggesting a structured actionable plan for adopting changes. There were some indications that this would be positively received from staff too, especially those with a role in suicide prevention. Improved staff training will be key in supporting staff to offer their very best in support of suicidal prisoners. Wider regime changes are also important here, allowing prisoners to engage in constructive and meaningful activities as part of a broader public health approach, rather than one characterised by the sensory deprivation of long periods of cellular confinement for prisoners at risk of suicide.

We recommend the ending of the Talk to Me strategy as now being unfit for purpose. It needs to be replaced with a new approach, in line with wider public health policy approaches in Scotland, designed to reduce rates of suicide and self-harm. As important as the strategy itself though, is the need for leadership. In particular leadership by prison governors and health and social care leaders is fundamental to driving this policy change – this will be key to its future success.

Scotland's prisons need a humane and consistent approach, based on a respect for, and promotion of, the personal agency of prisoners along with constructive activities and positive regimes. We hope that this report is useful in informing such changes.

Professor Emeritus Graham Towl,

Lead Reviewer.

Executive Summary

i. This Independent Review began in Spring 2025. The broad findings were presented to the Ministerial Accountability Board in September 2025. We were asked to examine and review the approach to suicide prevention used in Scotland's prisons, what had been learned from the self-inflicted deaths ¹ and the lessons that might be learned for the future. We were asked to consider whether the current policy in this area remained fit for purpose in preventing further deaths.

ii. It is important to note at the outset that there are no simple or easy solutions to self-inflicted deaths in custody.

iii. The evidence we reviewed stresses the importance of looking at this area broadly, recognising the multiple, individual and complex causes. In our analysis and recommendations we have sought to reflect this. As far as possible the approach in Scotland's prisons should be brought into line with the Scottish Government's wider policy on suicide and self-harm prevention.

iv. Each self-inflicted death represents a tragic and heart-breaking loss. For all, the State had a duty to care for them and these deaths represent a failure of the State in this duty. This is all the more serious because of failures to learn from past mistakes and to make substantive changes.

v. The conclusions we have reached and the recommendations we make have not been arrived at lightly. They are derived from the evidence reviewed.

¹ The term self-inflicted death is used to refer to all deaths where a prisoner has taken their own life regardless of how their intent is later assessed.

In this we felt that it was essential to speak directly to the families of those who had died. We also gathered evidence from families of those currently in prison custody.

vi. We undertook a series of site visits to prisons and a series of stakeholder meetings, as well as qualitative and quantitative analyses of self-inflicted deaths. In addition we also undertook a literature search and review, to examine the evidence base in this area and identify areas of good practice. In looking at this area we were given access to staff and documents within the scope of the review. We also looked at Fatal Accident Inquiry reports on the deaths and Scottish Prison Service Death in Prison Learning Audit & Review (DIPLAR) reports.

vii. In line with previous work, we found that prisoners who took their own lives presented with many vulnerabilities, with many having led chaotic and traumatic lives. Many had lived with serious mental health issues. The young people who died were often also struggling with developmental challenges.

viii. Based on our review we concluded that all those in custody are to some extent vulnerable but that the prison environment often makes this worse. Prison involves separation from families, friends and other established support networks. Prisons themselves are often bleak and difficult environments. This was evident from our discussions with prisoners, staff and other stakeholders. The nature of prisons is likely to lead to feelings of loneliness and to exacerbate any vulnerabilities. Putting back support structures that are broken by imprisonment, or for some putting these in place, requires time and effort. We

have noted through the review that this is something that has wide ranging implications for the way in which prisons should operate.

ix. The disruptive effect of reception into, or moves between prisons, is often made worse by impoverished regimes and 'thin' levels of staffing. A lack of constructive employment, training and education is evident and is disheartening for prisoners and staff. In terms of self-inflicted deaths and self-harm, this is actively harmful. It was clear to us that many prisoners were not being sufficiently engaged in purposeful activities or interventions. This was likely to increase risk, as well as having negative impacts on linked areas such as drug misuse and bullying. Redirection of resources to the health and welfare inputs and community alternatives to short term custody, would provide the individual help that many prisoners need.

x. Effective leadership seems critical to enabling the necessary change in prisons to ensure prisoners are kept safe, as well as helping them towards living safer and more productive lives.

xi. Overall we concluded that the Talk to Me strategy was not working effectively. The original aim and objectives of this policy were not being met. It is unclear whether this was a result of poor implementation, poor policy development, or both. Policy in this area appeared to have become unduly focussed on removal of the means of suicide, at the expense of other preventative measures. Emphasis on passive observation and long periods in safer cells appear out of step with current healthcare approaches. The form of strict suicide observation being used, depending principally on physical

safeguards, appears to be based on deprivation rather than treatment. So in short, prisoners are disincentivised from coming forward to report suicidal ideation. Where they do they have to engage with a strategy which is widely viewed as punitive. This led us to the conclusion that a fresh start was clearly warranted and necessary. In summary we considered the current punitive approach to be inhumane.

xii. The links between current suicide prevention policy and bullying were raised frequently in the evidence received. The current focus of the Talk to Me strategy appeared to increase this, particularly but not exclusively for young prisoners.

xiii. There was clearly significant variability in the availability of health care services in prisons. The basis for this variation was unclear but low levels of provision in some prisons was a concern.

xiv. The quantitative analysis highlighted some of the findings seen in other prison systems. The risk of self-inflicted deaths appeared highest when prisoners were relatively new to the prison where they died. Individual vulnerability seemed to be exacerbated by disrupting existing social and support networks.

xv. Despite the prevalence of mental health issues in prisons there was stark evidence that efforts to reduce self-inflicted deaths and self-harm was not supported by a full range of relevant healthcare practitioners. An excessive load was often being placed on nurse practitioners, with case conferences not being supported by a full range of disciplines.

xvi. We were struck by problems with the exchange and management of information. Problems with sharing information between different agencies and between different parts of the criminal justice system were a recurring theme. Important information here was falling through gaps between different systems and agencies, putting lives at risk. This is exacerbated by the poor state of information technology in place in most prisons.

xvii. As part of this review we looked at the processes that follow a self-inflicted death in prison. Prison staff were often insensitive in the way they engaged with bereaved families. Policy should be developed to address this. In future we felt that meetings with bereaved families should be led by a senior and experienced healthcare or social care practitioner. There should also be a duty of candour for staff towards those managing the post-death processes and the families and friends of the deceased.

xviii. We looked carefully at the current Scottish Prison Service Death in Prison Learning Audit & Review process. These arrangements raised significant concerns. The process and its findings were widely seen to lack independence from the SPS and to be defensive and lacking in critical analysis. The review of this process should ensure greater independence from the SPS and ensure that processes is more analytic, transparent and fair.

xix. We reviewed the current training provision in relation to suicide and self-harm. This appeared to us to be unfit for purpose. There is a need for the current training to be updated and to be more skills focussed for those required to chair case conferences, those training to become trainers and for staff

undertaking initial and refresher training. This training should continue to be delivered in person and should continue to be mandatory.

1. Introduction

1. This review was commissioned by Scottish Ministers, referred to in the Scotland Act 1998, represented by the Scottish Prison Service.

2. The Talk to Me suicide prevention strategy was implemented across the SPS from December 2016. It replaced an earlier policy called ACT and Care which had been implemented in 1998. This was modified in 2005 to incorporate a multi-disciplinary case conference approach to decision making and was also renamed ACT 2 Care ².

3. Responsibility and accountability for the provision of health care services to prisoners in Scotland was transferred to National Health Service (NHS) Health Boards, from November 2011, based on a Memorandum of Understanding.

4. Following this and a series of recommendations arising from FAIs, a national review of the SPS Suicide Risk Strategy was carried out from January 2014. This in turn led to the creation of the current Talk to Me strategy for suicide prevention.

5. Talk to Me involved the renaming of some existing suicide prevention roles at national and local levels. A 'Concern Form' was introduced as a formal

² https://www.sps.gov.uk/sites/default/files/2024-02/ACT2CareSuicideRiskManagementStrategyRevised_2005_Strategies.pdf

mechanism for recording concerns raised about an individual in prison, either from external or internal sources.

6. This policy required a pre-case conference healthcare assessment be completed by a registered healthcare professional, who would also attend the case conference where possible.

7. The designations of 'high' and 'low' risk, following assessment, were replaced with the terms 'at risk' and 'no apparent risk'.

8. Where individuals were in a 'Safer Cell' for 72 hours or more, unit managers were required to attend the next case conference and all subsequent case conferences, until the prisoner returned to normal accommodation.

9. Anyone being managed using Talk to Me within six weeks of any possible release date, would be required to have a reintegration case conference, to address any concerns relating to release.

10. Talk to Me paperwork was developed with the intention that this would be formatted to allow for later electronic scanning and storage.

11. Improved governance arrangements were introduced, with additional audit processes following closure of cases. A minimum of 20% of Talk to Me documents were to be audited by Local Suicide Prevention Coordinators, as a quality control mechanism, with a follow up process from these audits.

12. Several key objectives were set out for Talk to Me from its inception.

These were based ideas of shared responsibility for care of those ‘at risk,’ the adoption of a ‘person centred’ approach and provision of more supportive environments.

13. Talk to Me also has a stated aim of encouraging improved family involvement, subject to individual consent from prisoners.

14. When implemented, Talk to Me was intended to reduce dependence on the use of physical prevention methods, such as ‘safer’ clothing, bedding and accommodation. This was to be achieved by improving contact and levels of support provided to prisoners. It aimed to promote what was described as an ‘asset-based approach’ focussing on prisoners’ individual strengths. The Talk to Me strategy was also intended to reduce stigma and discrimination around mental health and those seeking help.

15. On implementation, the Talk to Me strategy envisaged that the use of ‘Safer Cells’ would be limited to ‘exceptional circumstances.’

16. Talk to Me was also intended to improve post-incident support following deaths, attempts or incidents of ‘severe self-harm’³ and put in place more appropriate arrangements in place to support families.

³ This area has seen the development and use of varied terms. The terms Deliberate Self-Harm (DSH) and parasuicide have historically been common but these have not been used here. Such behaviours involve intent but not necessarily deliberation. The use of simple behavioural descriptions has therefore generally been

17. Talk to Me was reviewed in 2018 and following this several changes were made to the policy and to the content of training for staff ⁴.

This review

18. This review was commissioned to look at the management of those at risk of dying by suicide whilst in the custody of the SPS.

19. The review involved the following:

- i) Meetings with bereaved families and families of prisoners
- ii) Meetings with stakeholders
- iii) Six prison visits where the reviewers focussed upon:
 - a. Reception
 - b. Suicide prevention coordinators
 - c. Healthcare staff
 - d. Residential staff
 - e. Observation of case conferences
 - f. Suicide prevention trainers
 - g. Prisoners
 - h. Prison listeners

adopted here. with use of the term self-harm generally used, except when more precise terms such as Intentional Self-Injury (ISI) and Intentional Self-Poisoning (ISP) seemed appropriate.

⁴ Nugent, B. (2018). Evaluation of Talk to Me. Edinburgh: Scottish Prison Service.

- i. Senior managers/managers
- j. Sampling of Talk to Me documentation and audits
- iv) Analysis of responses to open consultation processes
- v) Analysis of official and open-source data sets
- vi) A review of training materials
- vii) A review of recent Fatal Accident Inquiry (FAI) and Death in Prison Learning Audit & Review (DIPLAR) documents
- viii) Meetings with executive, senior management, and independent inspectorate
- ix) A systematic review of the literature

2. Stakeholder Meetings

20. At the outset of the review we felt it was essential to speak to a wide range of stakeholders and a full list of those who participated is given in the appendices to the report. Speaking to the families of those who have killed themselves in prison was seen as fundamental to the review. The insights of the families of those who have died by suicide have often been insufficiently engaged with previously.

21. Similarly it was felt it was important to hear the views of prisoners, prisoners' families, third sector organisations and staff, with direct and current experience of imprisonment and the way that risk of suicide and self-harm is managed.

Families

22. Family members of those who had killed themselves in prisons and/or who had been on Talk to Me, participated in the review through individual meetings, group-based meetings, and written submissions. All have been referred to simply as family members or families throughout. For reasons of confidentiality and privacy no one has been individually identified.

23. Family members were generally critical of Talk to Me. They saw it as primarily being a policy concerned with protecting the Scottish Prison Service as an organisation and its staff, rather than caring for those at risk of death by suicide in prisons.

24. The policy was seen as punitive and as disincentivising prisoners from coming forward with concerns. It was felt that some staff in prisons used Talk to Me as a threat. The approach of physical prevention and fixed observations was seen as being implemented in a mechanistic and at times insensitive manner. This was felt to have led to further isolation of prisoners. A need for more active and positive support, rather than increasing restrictions, was emphasised.

25. The training for staff in Talk to Me was strongly criticised. Current training was seen as being very basic and in important respects wrong and misleading.

26. It was felt that there was a need for more generic mental health training and relevant skills training.

27. It was widely felt that part of prisoners seeing Talk to Me as punitive may involve the widespread and routine use of body searches ⁵. Here the use of physical body searches ^{6 7} as part of a process concerned with the prevention of suicidal behaviour, was questioned.

⁵ The Scottish Prison Service uses the term body search. This refers to include the physical strip searching of prisoners. The official terminology has been adopted in this review, except where other terms have been used by prisoners or staff.

⁶ Letter dated 10/4/2024 from HM Chief Inspector of Prisons for Scotland to the Cabinet Secretary for Justice and Home Affairs.

⁷ Letter dated 7/5/2024 from Cabinet Secretary for Justice and Home Affairs to HM Chief Inspector of Prisons for Scotland.

28. This was seen as being compounded, for women prisoners, by often high levels of previous trauma.

29. In relation to the implementation of dedicated phone lines to report concerns, family members were supportive and saw this as a positive development. It was though noted that many families and friends did not know about the Talk to Me strategy, or the existence of dedicated telephone lines to raise concerns.

30. It was noted that the term Talk to Me does nothing to suggest, to those outside prisons in Scotland, a policy that is focussed on suicide prevention.

31. Families were often very reliant on raising concerns with visits staff, in the hope of these being passed on to residential staff, with variable results.

NHS staff

32. Two open meetings were undertaken with multi-disciplinary staff employed to work in prisons by health services. These were open to all who wished to attend and several clear and widely shared views emerged from these meetings. These are summarised below, along with more specific ideas and observations that emerged.

33. Overall Talk to Me was viewed as a poor approach to managing the risk of suicide and self-harm. It was widely felt to be predominantly punitive in

nature. This was felt to be seen in a widespread lack of therapeutic input for those managed under Talk to Me, in favour of an excessive focus on removal of the means of suicide or self-harm, isolation and fixed interval observations.

34. Talk to Me was widely seen to be a 'one size fits all' approach. As such it was criticised as being poorly suited to addressing individual needs and lacking in flexibility and responsiveness. In line with this, Talk to Me was criticised as being unduly bureaucratic and mechanistic, acting against better engagement, rather than mere observation. The Talk to Me strategy was contrasted, very unfavourably, with other approaches used in other, typically better resourced settings, such as secure mental hospitals.

35. Most staff who participated felt that there was a need for a more progressive and flexible approach to self-harm and suicide prevention. The need for more flexible approaches to less severe instances of self-harm was especially stressed in the case of women in prison.

36. It was felt by many participants that Talk to Me is often viewed as a threat by prisoners and some staff. This perception acts to discourage prisoners from reporting concerns. Healthcare staff themselves reported often feeling uncomfortable about raising concerns around suicidal ideation by prisoners, because they viewed the likely TTM response to be draconian and counter-therapeutic. Similarly the often-barren nature of 'safer cells' was seen as raising serious concerns. Indeed the very term 'safer cells' was seen as somewhat of a euphemism for 'strip cells'.

37. Several issues were raised around the operation of Talk to Me in practice. These included concerns around the default practice of adopting the most restrictive responses raised at the Talk to Me case reviews. This was seen as being punitive and to be perceived as such by prisoners. It was felt by many that this was often inappropriate and counter-productive. It was also felt that, in this key respect, the policy was acting to undermine the role of the Chairs of case conferences. In some cases primacy seemed to be given to a focus upon protecting the SPS, their teams and themselves. The practice that they would default to what was viewed as the 'safest' option which in practice meant the most restrictive practices in terms of cell location, protective clothing and frequency of checks on the prisoner was a matter of concern.

38. Several of what might broadly be seen as practice issues were also identified. The involvement of nurses at the start of the process, was often seen as not being followed through the management of risk and on to discharge from Talk to Me and subsequent throughcare.

39. The extent of multi-disciplinary working was also felt by many to be poor. Groups such as health service practitioner psychologists were seen to prioritise other areas of their work. Staff involved in the care of the prisoners were often not invited to attend case conferences. Similarly it was suggested that those raising concerns about risk of suicide may not be routinely invited to Talk to Me case conference meetings.

40. The content of training in Talk to Me was seen as needing revision and improvement. In relation to NHS Education, the levels of knowledge amongst nursing staff were noted to be variable, with a need to ensure greater consistency.

41. A pressing need for specific training for those chairing case conference was noted.

42. In relation to professional standards, concerns were expressed about poor levels of confidentiality attached to health information. Concern was also expressed about the application of a rigid one size fits all approach.

43. Practical aspects of care were also raised, such as many patients finding it difficult to wear the poorly fitting 'safer clothing' available. This appeared especially pressing for women in prison, with no routine accommodation being made for menstruation when in 'safer' clothing, with use of unisex clothing more suited to men. This was seen as adversely and unnecessarily impacting on prisoners' dignity. Such routine institutional contempt for the dignity of women prisoners flies in the face of assertions around SPS being 'trauma-informed'.

Third Sector organisations

44. A meeting was undertaken with the Criminal Justice Voluntary Sector Forum (CJVSF) members. CJVSF members deliver a wide range of services for individuals and families in prisons and in the community, with members

working across youth justice, children and families, community justice, social care, employability, health, and housing ⁸.

45. Talk to Me was generally viewed as a poor approach to managing the risk of suicide. Those working with young people in prison reported that they did not always know the prison officer involved in the meeting convened to assess their level of risk. Concern was expressed that case conferences were often missing key staff, for example, taking place without a mental health nurse being involved.

46. Concerns were raised that meetings frequently did not involve partner organisations (who may have relevant intelligence and expertise to inform decision making) – including those from recreational, mental health and wellbeing services.

47. Concern was expressed that the Talk to Me forms were not always accessed by, or accessible to, people making key decisions.

48. It was reported that those supported and worked with, viewed Talk to Me negatively, as a process to avoid. Many saw it as a punishment. For example, one organisation that works with young people in Polmont shared that what were described as Talk to Me cells are categorically viewed as a punishment by young people. This discourages them from being honest about how they are feeling and prevents them from coming forward to start the Talk to

⁸ A full list of members can be found at <https://www.ccpsscotland.org/cjvsf/cjvsf-members/> accessed 23/8/25.

Me strategy. It was suggested that cells used for Talk to Me needed to be 'trauma informed'⁹ and to allow access to services, paperwork and avoid isolation.

49. One organisation noted that they use the system on an almost daily basis and understood that Talk to Me was being used as a threat to young people by some prison officers. Lack of training of prison officers, it was argued, meant that in some instances Talk to Me is frequently viewed as a threat, rather than a wellbeing response.

50. The focus of Talk to Me was seen as being crisis response but it was felt that it needed to be a wellbeing tool as well. It was noted that even Fatal Accident Inquiry reports that have addressed the area have focussed on physical prevention approaches, such as eliminating ligature points and immediate risks, rather than improving people's longer-term wellbeing. The need for a more person-centred, trauma informed and compassionate approach was emphasised. It was observed that as far as members were aware, SPS had never tried the approach used in England of intensive support, where there would be two Samaritans who would sit with the individual and engage with them to provide companionship and support. The wider role of culture within a prison was also observed to be crucial and the importance of trying to measure the quality of prison life was raised¹⁰.

⁹ Auty, K. M., Liebling, A., Schliehe, A., & Crewe, B. (2023). What is trauma-informed practice? Towards operationalisation of the concept in two prisons for women. *Criminology & Criminal Justice*, 23(5), 716-738.

¹⁰ See for example Liebling, A., Hulley, S. and Crewe, B. (2011), 'Conceptualising and Measuring the Quality of Prison Life', in Gadd, D., Karstedt, S. and Messner, S. (eds.) *The Sage Handbook of Criminological Research Methods*. London: Sage.

51. One member organisation reported having a direct linkage with the dedicated concern line. If they received calls through their helpline, these can be raised via the SPS concern line. At present though it was noted that Concern Lines are not explicitly linked to Talk to Me and that they should be. A lack of staff training and information going to families about the concern line and how it may be used was observed. When this organisation has raised concerns, they had been told by some staff that the Talk to Me process is only for people already self-harming, which does not support a preventative approach.

52. Failures in the links between Talk to Me and other relevant policies was noted. Several relevant and recently developed strategies by SPS and Scottish Government should work with and complement any future suicide prevention approaches. For example these would include the SPS Mental Health Strategy ¹¹, the SPS Family and Parenting Strategy 2024-2029 ¹² and the Scottish Government's Suicide Prevention Strategy 2022-2032 ¹³. The need for better support for people in the justice system, who may be at high risk of suicide, is explicitly addressed in the Scottish Government's strategy but that strategy has not been addressed in Talk to Me.

¹¹ Scottish Prison Service (2024). Mental Health Strategy for 2024-2034. Edinburgh: Scottish Prison Service.

¹² Scottish Prison Service (2024). Family and Parenting Strategy 2024 2029: Improve Family Contact and Positive Relationships with Those in Our Care. Edinburgh: Scottish Prison Service.

¹³ Scottish Government and the Convention of Scottish Local Authorities (COSLA) (2022). Creating Hope Together Scotland's Suicide Prevention Strategy 2022-2032. Edinburgh: Scottish Government and COSLA.

53. The impact of transitions through the prison system was raised. For example, the impact on mental health when a person is moved to another prison, and/or progressing through the system to less secure conditions can trigger suicidal ideation and self-harm. Concern was raised that this is often inadequately addressed. The way that the information is gathered and shared was also seen as important. Where someone had been managed on Talk to Me, information stored on the SPS Prison Records 2 (PR2) system ¹⁴ can influence decisions around progression and negatively impact their transition in future, which can be another disincentive to raising concerns.

Senior SPS Managers

54. A meeting with the Governors in Charge group was undertaken. In addition senior managers in prisons had contributed views during site visits. Several managerial and policy issues were raised here. The issue of pre-existing risk in the prison population was raised. Prisons were seen as often acting as a placement of last resort, including for those with complex backgrounds and serious mental health problems, already at elevated risk of taking their own lives. Linked to this it was observed that prisons often receive limited information on prisoners' backgrounds, with difficulty in accessing court, health, and social care records in a timely and reliable way.

55. Concern was expressed around an undue focus on crisis management, typically in response to media reports following deaths in prisons.

¹⁴ This is a database system which records details of all prisoners in SPS prisons.

56. Issues of resourcing and staffing were raised. Staffing in prisons was seen as now being very thin, limiting scope to undertake important areas of work, with a growth in prison numbers making this more acute.

57. In addition the loss of experience was noted, with the largely unplanned development of a relatively young and inexperienced workforce.

58. Low levels of staffing were seen as adversely impacting on even mandatory staff training provision.

SPS Training and Trainers

59. Meetings were undertaken with central SPS training and with trainers in prisons. A few consistent themes emerged here.

60. The quality of the central training package was seen as poor. Much of the information contained was seen as being dated, potentially inaccurate and of limited relevance to Scotland. There was a general absence of up-to-date information on evidence from Scotland and comparable national prison services.

61. Current training was seen as being overly didactic and theoretical. A lack of skills-based training was observed, with the development of practical skills being seen as fundamental to good practice in this area.

62. The lack of performance evaluation of training was seen as a significant problem, particularly for the training of trainers.

3. Site Visits

63. A process of site visits was seen as fundamental to an effective review of the Talk to Me strategy.

64. Site visits were chosen in collaboration with the SPS with the aim of achieving a good geographic and functional spread of prisons and the involvement of wide range of staff and prisoners.

65. The function of undertaking site visits was to develop a realistic understanding of the implementation of the Talk to Me strategy as it is applied in prisons. To do this, we looked at Talk to Me as a process, followed through from prison reception, risk management using the policy framework to the exit from Talk to Me and throughcare. This included eliciting the perspectives of staff and prisoners, as well as direct observation of the Talk to Me strategy and reviews of samples of written documentation.

66. The planned areas of focus during site visits included issues of cell safety and safety audits; the interpretation and application of policy; suicide prevention training and refresher training and the processes of risk assessment, treatment, and management.

HMP & YOI Polmont

67. HMP & YOI Polmont provides the SPS national resource for prisoners aged 18-21 years ¹⁵. It houses young people of all sentence types, including those on remand, short sentence prisoners (less than four years), long sentence prisoners (four years or more), and life sentences. Women prisoners aged 21 transferred from other prisons are also held at Polmont and may be remanded or convicted, with either short- or long-term sentences. Since January 2024, short term low supervision adult male prisoners can be transferred and housed within Polmont.

HMP & YOI Stirling

68. HMP & YOI Stirling is a recently opened prison and Scotland's national facility housing remand and convicted young and adult women. It has a separate Mother and Baby Unit, with two spaces. Stirling receives admissions directly from court. Transfers of individuals from other prisons housing women prisoners may also be accepted. Stirling links to Community Custody Units (CCU) designed to provide safe, secure, 'trauma informed' and gender specific accommodation. These units are designed to develop a range of independent living skills.

¹⁵ In some circumstances prisoners may stay in HMP & YOI Polmont until they are 23 years old.

HMP Addiewell

69. HMP Addiewell is a relatively modern prison, which opened in 2008. It houses adult male prisoners across all levels of security. This includes prisoners on remand, short sentence prisoners, long sentence prisoners, and life sentences. The prison is operated by Sodexo on behalf of the Scottish Government and is currently the only prison in Scotland not operated by public sector prisons.

HMP Dumfries

70. HMP Dumfries holds men remanded in custody for trial and those convicted but remanded for reports from the courts in the Dumfries and Galloway region. The prison also houses short-term convicted male prisoners from the courts or transferred from other prisons. In addition, Dumfries provides a national facility for holding sentenced men, who require to be separated from mainstream prisoners because of the nature of their offence, termed as 'offence related protection prisoners.'

HMP & YOI Grampian

71. HMP & YOI Grampian is a relatively modern prison which was opened in 2014. It was the first and is presently the only purpose-built community facing prison within Scotland, replacing HMP Peterhead. It houses male and female adult prisoners from the North of Scotland. It houses prisoners across all levels

of security, including those on remand, short and long sentence prisoners and those serving life sentences.

HMP Barlinnie

72. HMP Barlinnie is the largest prison in Scotland. It receives prisoners from courts in the west of Scotland and houses remand and convicted male prisoners across all levels of security, including short and long sentence prisoners and those serving life sentences. It provides a national resource for life sentence or long-term prisoners approaching a potential release date.

Interpretation and application of the Talk to Me strategy

73. The Talk to Me strategy appeared to address the risk of suicide in prisons as a process of crisis management. This begins with a focus on estimating risk on reception, with the option to identify acute risk at any later point, from multiple sources. It is therefore open to anyone in the prison, or from outside, to raise concerns in relation to concerns around suicide. This includes the recent addition of formal mechanisms for families and friends to raise concerns about prisoners, via a dedicated telephone line.

74. In outline this involves a process of risk assessment on reception into prison, normally involving both SPS and NHS staff. A Talk to Me document is opened on those deemed at high risk of suicide and this is followed up by a multi-disciplinary case conference. In addition, young prisoners are now automatically managed on Talk to Me for their initial period in custody.

Prisoners can be discharged from Talk to Me following this initial case conference, or may continue to be managed under Talk to Me, through a process of care planning and case conferences.

75. Considerable emphasis is placed on the process of risk assessment on reception by means of a formal Reception Risk Assessment (RRA). This draws on available information about, and assessments of, individuals who appear in court, or who transfer in from other prisons in Scotland or elsewhere. RRAs are undertaken by reception staff and, during normal working hours, registered nurses. In relation to out of hours receptions, nursing assessments were typically undertaken the following day or, if not, then within a few days. RRAs by SPS and NHS staff are undertaken using a standard format. Questions around suicide and related areas of self-harm form only part of the reception process, which includes a wide range of practical issues such as provision of information and initial orientation to the prison. The nursing assessments undertaken address health broadly and are often concerned with complex issues around physical health and addiction. These reception assessments are carried out by nurses from a variety of clinical backgrounds. Those from backgrounds in various areas of physical health are likely to have limited prior training around suicide. Most healthcare staff will have limited training in the specialist area of suicides in prison and other custodial settings, beyond the formal Talk to Me training provided by the SPS. The prisons visited reported generally being able to maintain an acceptable level of continuity in SPS staff working in reception. This allowed for the development of skills in this area of work and a consistency of assessments. The picture in relation to healthcare

assessments was more mixed, with some sites reporting problems with recruitment and retention of healthcare staff.

76. The quality of information available during the RRA appeared variable across the site visits. Limited information often followed prisoners from court. This in turn seemed to be associated with such information being less valuable in identifying possible risks. All the sites appeared to be reliant on paper documentation for social work, healthcare, and reports from third sector organisations. Systems in place to alert First Line Managers (FLM) or nightshift managers to any concerns also appeared to be paper based.

77. For those identified as being at elevated risk on reception, most sites reported a follow up by mental health nursing staff. The time to deliver this varied across sites, with some reporting next day reviews and others reporting significant delays of between three and seven days. The longer delays reported were primarily a function of staffing shortages, rather than decisions to delay such follow up assessments for clinical reasons.

78. Those identified as being at elevated risk will then be subject to a process of care and support planning and regular review, via case conferences. These take place within 24 hours of identification of elevated risk and at regular intervals after this, until a prisoner is taken off the Talk to Me strategy. Some case conferences were observed as part of this review and all were conducted in line with the policy, involving a mix of residential and specialist staff. The case conference approach was reported to be a generally very positive aspect

of the strategy by several SPS and NHS staff. It was seen as an example of good inter-disciplinary working, as well as a highly effective means of identifying support for those identified as being at risk.

79. There were reported problems in adequate multi-disciplinary staff being available for case conferences. Conducting case conferences after 24 hours was also questioned, since at this point there was often little or no additional information or understanding of an individual's level of risk or needs. Staffing case conferences in the way anticipated in the Talk to Me strategy appeared to be difficult, with the range of healthcare staff involved limited. Responsibility often fell on nurses alone, although some sites reported additional support from speech and language therapists. Strikingly though, the levels of involvement of healthcare professions, such as psychologists, appeared very sparse indeed. This applied to both Practitioner Psychologists employed directly by the SPS and those employed by NHS Scotland.

80. Removal from the Talk to Me strategy is the decision of the case conference, following discussion and drawing on the available information. Where prisoners wish to participate, Talk to Me requires that they are encouraged and supported to do so. This policy was in place across the sites visited. An option for family members to participate also exists but was reported to rarely be used. This was attributed by some SPS staff, and some family members, to prisoners' reluctance to cause anxiety by letting their families know they were struggling. There were also clearly practical difficulties

associated with this, in terms of areas such as maintaining appropriate confidentiality and managing access.

81. Across the sites visited, Talk to Me was seen as having some strengths by SPS and NHS staff. There were differences of view over whether the policy was better or worse than its predecessors, 'ACT' and 'Act 2 Care'. It was seen as valuable and important that a specific policy around suicide existed, since this was a 'life and death' issue in prisons. The Talk to Me strategy was seen as raising the importance of suicide in prison as a central issue for all staff. Talk to Me was also viewed positively for its clear multi-disciplinary emphasis. In theory if not in practice this emphasis was seen as a major strength of the approach. Talk to Me's clear risk-based focus was viewed as both appropriate and useful by many.

82. More broadly, Talk to Me was widely seen as a useful guide for structuring the management of risk of suicide in those identified as being at elevated risk. This seemed to be seen as particularly valuable for newer and less experienced staff, with the provision of clear process guidance and support from other staff. The Talk to Me strategy was also seen as making the management of risk more defensible, when subject to external scrutiny.

83. Addiewell is currently the only prison in Scotland operated by a private contractor, Sodexo, which also operate prisons elsewhere in the UK. Addiewell had therefore been able to implement additional Information Technology systems not available in public sector run prisons, to supplement the paper-

based Talk to Me records. The Custodial Management System (CMS) is a computer system, used to manage many aspects of prison life. This includes areas such as prisoner requests and activities. This system is used to record and share additional information. At the time of the site visit, Addiewell staff were also piloting the use of such data to gather a range of information relevant to prisoners' wellbeing. This included areas such as take up of visits, ordering of meals and participation in activities. This was seen as a means of flagging potential concerns about individual prisoners. This IT system was being used to prompt residential staff to speak to prisoners who may not be presenting obvious concerns. We were told that CMS is not compatible with the IT systems used in other Scottish prisons, so this data cannot be transferred.

Cell safety and safety audits

84. The joint FAI undertaken by Sheriff Collins ¹⁶ into the deaths of Katie Allan and William Lindsay (or Brown) and the FAI into the death of Jack McKenzie ¹⁷ all concerned the deaths of young people, held at HMP & YOI Polmont. These FAIs placed considerable emphasis on efforts to remove the means to complete suicide in Scotland's prisons. Removal of easily accessible ligature points and associated means and making all cells safer was emphasised, as an effective means of reducing the likelihood of self-inflicted deaths.

¹⁶ Court ref: FAL-B118-23.

¹⁷ Court ref: FAL-B30-24.

85. Historically other FAIs have also referred to efforts to reduce the risk of suicide by removal of means as a prevention method, although no recent FAIs have addressed this in similar detail.

86. At the site visits it was evident that the inherent and significant risks, associated with the presence of obvious ligature anchor points had been largely addressed during the design stage for the recently built prisons visited. Stirling, Grampian, and Addiewell are all relatively new prisons, constructed using modern designs. In this respect they compare favourably with older prisons in Scotland, such as Polmont, Dumfries and Barlinnie. To varying degrees the designs of older prisons also make it more difficult to address cell safety in a proportionate way. Some of these newer prison designs have had poorer safety records and been viewed more negatively by prisoners than older more dilapidated prisons ¹⁸. A key variable here appears to be the size of the prison, rather than its physical design or the fabric of the buildings.

87. The development of an SPS Ligature Points Audit Tool (LPAT) was proposed, for use during the planning stage of new or refurbished cells. This was seen as allowing for the grading of inherent and significant risk, associated with ligature anchor points. There was felt to have potential to assess and reduce risk and as an alternative to the use of Safer Cells in their current form. There are several examples of good practice in this kind of assessment from comparable environments. These would appear relatively easy to adapt for use

¹⁸ Liebling, A., & Ludlow, A. (2016). Suicide, distress and the quality of prison life. In Y. Jewkes and J. Bennett (Eds) *Handbook on Prisons*. London: Routledge.

in prisons for new cells, refurbishments and to help reduce risk more widely across all prisons.

88. The use of technology to reduce risk has been raised. This includes signs of life monitoring technology to reduce risk of self-inflicted deaths. Such technology may also help to reduce deaths in prison from other causes. A variety of technical solutions were described as available, with many of these also being used in other comparable settings such as secure hospitals.

89. To the best of our knowledge such technology has not been used by the SPS. However, at the time of the site visits there was some piloting of the use of improved technology, in the form of switchable one-way mirrors. It has been suggested that this can make the monitoring of safer cells less intrusive. Evaluation data on this was not yet available and the comments we received were mixed. Life signs monitoring technology was due to be piloted and evaluated.

90. Recommendations had also been made to the SPS that policy in relation to what young prisoners were routinely allowed to have in their possession should be reviewed, with a view to removal of items that are readily capable of being used as ligatures ‘...without ingenuity or adaptation....’¹⁹. This suggests the removal of items such as shoe laces, belts and dressing gown cords. It also extends to items routinely provided by the SPS, such as prison clothing, bedding and items available for prisoners to purchase or have sent in

¹⁹ FAL-B118-23 [2025] FAI 6. DETERMINATION BY SHERIFF SG COLLINS KC. Pp. 3 para. 5.i.a.

to prison. A presumption against allowing young prisoners such possessions was suggested, with this being overcome only in limited circumstances. An example given here was cases where a registered healthcare professional certifies, in writing, that the prisoner is not at risk of suicide and that there is therapeutic reason for permitting possession of such items.

91. This approach raised significant concerns during site visits. Anxiety was expressed that, in practice, this would result in the removal of a wide range of personal items from young people in prison. This would result in harsher conditions likely to be associated with an increase in risk of self-harming behaviours.

92. It seems unlikely, given the inherent challenges involved in accurately assessing risk, that many exemptions would be granted here. The example of healthcare professionals certifying an absence of risk and the therapeutic value of allowed exemptions illustrates this. Also, the conception of 'risk' as quite so black and white seems plain wrong to us – there are degrees of risk. It seems unlikely that many healthcare practitioners would be willing to certify an absence of risk, even where they considered there was therapeutic value in doing so.

93. The intent of such restriction was recognised across site visits but raised consistent concerns that it would be likely to result in young people in prison living in further impoverished environments. There would seem to be an important balance to be struck here, between not giving easy access to items

that clearly present a high risk for some young people and the negative effects associated with removal of often personally important belongings. It was generally felt that such removal of some belongings from young people carried similar risks to the use of safer cells, in terms of having directly harmful effects on areas such as mood and feelings of hopelessness and helplessness and suicidal ideation.

94. As far as 'safer clothing' and 'safer bedding' currently used in Scotland's prisons is concerned, both were seen as being unsuitable, on multiple grounds. They were seen as poorly designed and unfit for purpose. Research has been recommended, in relation to availability and cost of alternative bedding materials to be used in cells by young prisoners in Polmont. The intention here would be to reduce the risk of use as ligatures, whilst striking a balance between safety, needs, and well-being of prisoners in the care of the SPS.

95. Polmont staff appeared very active in seeking to address recent concerns and recommendations arising from FAIs. They have sought to address aspects of cell safety, through a process of extensive audit and action. They have audited and removed obvious ligature points, such as bunk beds in single cells and previously identified ligature points, typically around the in-cell facilities. We understand that Polmont staff are currently in the process of exploring use of in-cell technology for the monitoring of signs of life and ways to manage the balance between efficacy and the potentially invasive nature of such monitoring.

96. Stirling is a modern prison, with issues of cell safety being extensively addressed at the design stage. The design has also seen emerging issues since it has been occupied.

97. Addiewell and Grampian staff both reported similar emerging issues and had experienced design flaws becoming evident over time. For example, the effects of use and wear on the fabric of in-cell facilities had been observed to create new possible ligature points.

98. We were told that Addiewell managed the risk of suicide and self-harm without using identified cells and that all cells were considered 'Safer Cells.' As a result, risk was managed here by removal of items felt to increase risk, rather than relocation to dedicated cells. Staff and prisoners at Addiewell expressed the view that this was more effective.

99. Dumfries and Barlinnie are older designs of prison and for both this places significant limitations on what can be done to modify the fabric of many areas. As with the more modern designs, it was reported that issues were addressed through regular cell checks, although many of these were well known. Checking in both prisons was reported to be security focussed, rather than using specific structured audit methods concerned explicitly with ligature points and environmental safety issues.

Concerns with Talk to Me

100. The site visits suggested multiple concerns with the Talk to Me strategy and its implementation. Talk to Me can be seen to involve three core facets:

- i) Removal of means to complete suicide or to self-harm.
- ii) Implementation a range of safeguarding work.
- iii) Regular monitoring through fixed interval observations, typically every 15, 30 or 60 minutes.

101. It was reported that Talk to Me had come to be widely seen by prisoners as a form of punishment. This was seen as strongly discouraging prisoners, or their families or friends, from reporting concerns. Prisoners also described Talk to Me as often involving a process of isolation and sleep deprivation, with placement in 'safer' cells and being woken up at fixed intervals throughout the night.

102. Concerns were expressed by both staff, prisoners, and other stakeholders that being managed through Talk to Me often involved a series of actions that could reasonably be seen negatively. This might routinely include such things as removal of personal items, regular and visible observation by staff and placement in a sensory deprived environment.

103. There were differing views around the use of designated safer cells with most NHS and SPS staff seeing them as a necessary, in the most severe cases of self-harm and imminent risk of suicide. Others described these as a

'necessary evil' or as being necessary in the absence of adequate staffing and resources to support alternative, more therapeutic, approaches. Few of the prisoners or prisoners' families saw safer cells as a necessary or helpful approach.

104. The safer cells we looked at were very spartan environments, where prisoners may have personal items removed and replaced with clothing and bedding that cannot easily be destroyed. In newer prisons the SPS describes these as being designed to have fewer ligature points but trying to find a balance between having nothing in the cell (that would be austere and may compound an issue) and a fully fitted cell (which has therefore more ligature points).

105. The more modern prison designs were described to us as having attempted to blend the safer cell and standard cell to look similar, with similar fittings and fixtures to help normalise the environment and reduce stigma associated with their use. Efforts to make these environments less severe included provision of access to a television in ways that reduce the scope for self-harm. We were told that location in these cells routinely involved body searching, to remove potentially harmful items. Where prisoners were resistant to the removal of personal clothing this may be done using what was deemed to be necessary force.

106. Concerns were expressed by some SPS and NHS staff that Talk to Me could occasionally be used by prisoners in an attempt to access mental health

services more quickly than would normally be the case. This was seen as often being counter-productive, with Talk to Me management perversely resulting in loss or reduction of contact with families and staff, along with the loss of personal possessions.

107. The 'safer' clothing provided was generally seen as inadequate in multiple ways. It was seen as being poorly fitting, cold, and particularly for women, failing to maintain their dignity. There were concerns that efforts to make the environment safer were not informed by likely prior experiences of physical and sexual trauma, with the ultimately forced removal of clothing and body searches. SPS has officially adopted a 'trauma informed' approach in all its activities in practice it does not seem evident at all in relation to Talk to Me. In short what was reported to us is not consistent with such approaches.

108. The lack of an option for constant observations or one-to-one nursing care independently of the levels of risk assessed, was raised as in relation to those at acute risk. The lack of such provision was seen as a function of inadequate resourcing of this area of work.

109. For those not placed in safer cells, the operation of Talk to Me was still seen negatively. Here the use of interval-based observations was not viewed positively. We were told that observations were being carried out in ways that were seen to have drifted away from the objectives originally set out in the Talk to Me strategy. So, for example, the requirement to check to ensure that someone was alive, was reported to have often come to involve waking

prisoners up during each observation. Reasons for this were variously described. This included such monitoring being described by staff as a 'defensive practice,' where staff could not reasonably be criticised for conducting inadequate checks on wellbeing. Whatever the motives, oppressive checking of this kind is not required as part of the Talk to Me strategy. It also appeared counterproductive in several respects. These would include the effects of sleep deprivation, drawing negative attention from other prisoners to those under Talk to Me management, the disturbance of prisoners in neighbouring cells and the adverse reactions to this. This in turn may be linked to disruption, bullying and violence.

110. Given the above observations, it is perhaps unsurprising that Talk to Me is viewed negatively by prisoners. For young people, the blanket use of Talk to Me during the first 72 hours in custody, had resulted in large numbers being managed using Talk to Me. This would follow them on transfer to adult prisons as a marker of risk, even where no specific concerns were identified. Generally the use of Talk to Me in this way was viewed negatively by prisoners and staff, as drawing attention away from those at elevated risk of suicide. It was also seen as increasing the risk of targeting for bullying. This remains an issue of significant concern.

111. There appeared to be a drift away from the Talk to Me strategy in other respects as well. We observed high levels of use with women, where Talk to Me was often being used to manage issues of long-term self-harm linked to previous trauma. Here the Talk to Me strategy was seen as being far from ideal

but was used in the absence of a dedicated self-harm strategy for women. This had evidently resulted in a very high proportion of women being on Talk to Me.

112. Similar issues were also reported for older men, where concerns were expressed that Talk to Me was not well suited to the needs of this group.

113. Overall the standardised format of the Talk to Me strategy for men, women, young people, and older adults was questioned.

114. The use of 24-hour case conferences was viewed by most as a largely bureaucratic exercise, with new information unlikely to be available within such a time frame. As a result, those participating in these case conferences were generally no better informed than the staff conducting the RRA.

115. We were told that there could be significant delays in receiving Criminal Justice Service (CJS) reports from within Scotland and that this was made worse by the poor inter-operability of IT systems. Reports from other parts of the UK, such as Probation Service reports from Northern Ireland, Wales or England were often never received at all ²⁰.

116. It was suggested that a better approach here would be to replace these case conferences with a one-to-one meeting and more in-depth assessment, to be undertaken by a relevant staff member. Some sites reported adopting this

²⁰ This is an area of shared responsibility.

approach by, for example, undertaking mental health assessments. These were though in addition to 24-hour case conferences.

117. This approach was also reported in cases where prisoners were received too late to complete a nursing assessment on reception. Here individual assessments were reported to typically take place within 24-hours.

118. A small number of staff suggested that the automatic application of Talk to Me for young people, during the first 72 hours in custody, particularly during weekends where activities and association were often very limited, might provide some additional contact and support for prisoners. The use of Talk to Me in this way was not seen as the best way to provide this. The requirement for healthcare assessments here was viewed as an often-poor use of scarce resources. There appeared to be a general view that this period might better be conducted as a period of enhanced 'care planning.' It was suggested that a better approach would be to run a more normal regime at weekends.

119. The site visits raised issues of limited and insufficient resources. It was notable that residential staffing levels were low, with levels of around 35:1 (prisoners to officers) and above typically being reported. Issues of staffing levels in prisons go beyond the remit of this review, except in as far as they impact on suicide prevention. This level of staffing was clearly having an impact on the ability of staff to monitor and support prisoners at high risk of suicide. This was compounded by what had become an often highly bureaucratic and administrative process. In many cases this was associated with poor care

planning structure for those on Talk to Me and a lack of transitional care plans in some cases.

120. Talk to Me was widely seen as a ‘box ticking’ exercise rather than genuine care planning, with a frequent lack of even physical checks when prisoners were unlocked. Criticisms of the automatic use of TTM for the initial period in prison were raised. Some prisoners, stakeholders and staff viewed this as being well intentioned but ultimately unhelpful.

121. Concerns were expressed around the role of media coverage and social media attention in this area, often causing widespread distress. The SPS were widely felt to lack an effective corporate strategy to address a growing trend of sensationalist and irresponsible coverage.

122. Peer support approaches were evident during site visits, involving the employment of carefully selected prisoners as ‘listeners’ and in other peer support roles: such as providing guidance and support on reception, during the early phase of custody and during times of marked stress or transition. Some sites have adopted schemes based on the approach and training used by the Samaritans charity ²¹, whilst others have developed schemes using alternative approaches. At some sites listeners were supported by Chaplaincy services in prisons. These schemes were generally viewed positively by staff and prisoners involved. Some concerns were identified in practice though. These included

²¹ <https://www.sps.gov.uk/about-us/our-latest-news/30-years-life-saving-partnership>

concerns around the level of training and support available to listeners and peer support prisoners. At some sites additional support and training had been identified, in relation to areas such as psychological first aid ²².

123. Some security issues were raised, with scope for inappropriate pressure and potential misuse. Overall none of the broadly security related issues were seen as being unmanageable where appropriate management and accountability was put in place.

124. Given the levels of staffing and growth in population schemes of this kind appeared to us be significantly under used. They were widely seen as having more potential to improve risk identification, care planning, and support for prisoners.

125. High turnover of those working in peer support roles was identified as a significant challenge at some sites, resulting in the repeated loss of expertise and skills. This was sometimes compounded by failure to adequately support listeners and other prisoner-based support schemes such as 'Insiders' working in reception. Some loss is to be anticipated here but it was felt more could be done to reduce this and manage essential turnover.

126. The prisoners we spoke to valued working in these roles but often felt they would benefit from more skills-based training.

²² <https://www.lifelines.scot/post-trauma-support-providing-psychological-first-aid>

127. There were differing views around the use of IT in relation to managing the risk of suicide. The notion of replacing paper-based system with digital systems was seen, to varying degrees, as having the potential to improve current practice by some. Others appeared unconvinced that technical improvements would significantly contribute to this, with concerns expressed that it may in fact reduce the quality of interactions with prisoners which would become centred around a computer screen. This was seen as having potentially unintended consequences, which would impair the management of suicide risk.

128. There was general agreement on the very poor quality of the IT systems in current use in public sector prisons. This was described to us as resting on architecture and systems from the 1990s and as such being severely dated.

129. The NHS Scotland Vision system ²³ is intended for use primary care services. We understand that criminal justice staff do not access to key information held on this system.

130. Staff with experience of the systems used in other jurisdictions and in the private sector also observed how weak and dated the current PR2 system was, in comparison to systems in use elsewhere. It was noted that there was

²³ <https://www.pulsetoday.co.uk/news/technology/major-gp-it-system-migration-on-hold-after-supplier-goes-into-administration/>

no equivalent to the Computerised National Offender Management Information System (C-NOMIS) system in use in England and Wales, or the CMS system used by Sodexo at Addiewell. We understand that any information from these systems is not compatible with PR2 and is currently therefore not available for prisoners on transfer.

131. Concerns were expressed around the PR2 system and its suitability for recording Talk to Me related information. We understood that information held on PR2 is easily changeable by any authorised user, with no obvious indications that changes have been made, or who they have been made by. This raises serious issues around the integrity of any data and accountability, drawing into question the suitability of this IT system.

132. There was a general sense that the current paper-based forms had been poorly designed and that there had been a lack of consultation, during the design phase, with those who would use them.

133. In reviewing samples of Talk to Me forms, it was evident that some staff were being highly effective in using the existing forms to assess risk and develop effective care plans. The Talk to Me booklets could not reasonably be seen as aiding in this, with users having to work around poor formats. More typically though, this had resulted in sparse assessments and care plans.

134. The lack of guidance within the Talk to Me booklets was often commented on, as was the absence of prompts, with options and potential

outcomes. The layout of the proformas was widely reported to be poor, with large amounts of wasted space, along with inadequate space in other areas. This seemed to reflect a lack of consultation around design with end users. In addition it was noted that Talk to Me was involving the closing and opening of new Talk to Me documents, even for prisoners on re-reception. These 'new' Talk to Me documents were then being physically attached to previous Talk to Me documents, with the obvious risks associated with this.

135. These paper-based materials need to be retained for five years and so were presenting significant storage problems for some sites, in the absence of any efficient means to store the materials digitally. Overall there were concerns about seeking to develop any IT solutions based on such a flawed paper-based system.

Talk to Me Training

136. There were a range of views on the Talk to Me training. The fact that the training was a mandatory requirement was viewed positively and contrasts with the findings of the Harris Review in England and Wales ²⁴. This had the clear advantage that training would generally happen. The training was however seen as being excessively focussed on process and audit issues, with a lack of skills-based training. Concerns around the lack of skills training needed to effectively chair case conferences were raised repeatedly with us

²⁴ The Harris Review (2015). Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds. London: OGL.

across sites. A lack of skills training in areas such as care planning, estimating risks and effective audit were similarly of concern.

137. At some sites we saw that trainers had made efforts to work with the training package to make this less didactic and more interactive. They were though clearly constrained by the poor quality of the training materials and the limitations of their own training.

138. The selection of trainers was noted to be variable across sites and as a result the delivery of the training appeared similarly variable. Some trainers were seen as excellent and to be making strong efforts to make a generally weak standard training package better suited to the needs of staff. In other cases this was not felt to be evident and training was seen as poorly targeted, didactic, and inflexible.

139. We understand that the training for trainers does not include an assessment of competence and was seen as being concerned primarily with teaching skills in delivery of a standard package. Better coverage of skills in relation to managing suicide and self-harm in prisons was seen as a critical need here, along with the coverage of how to train skills. Areas such as the effects of abuse and trauma on risk of suicide and the effects of areas such as neurodiversity were also noted as being lacking. Some sites stressed the need to restore refresher training in relation to suicide annually, rather than after three years, to prevent gradual deterioration in practice.

140. Concerns were raised over a lack of mental health input to the training and lack of tailoring of the package to meet needs in this area. The training was described as a generalised package for prison officer with the training being generally seen as unduly simplistic. Some trainers themselves felt inadequately trained and supported, in what is a highly specialist area, involving risk to life. Some felt that there was a clear need for training to be longer, to allow more skills-based work to be undertaken.

141. At a practical level it was noted that some changes had been made in prisons that had made areas of training more difficult. For example, the discontinuation of PR2 'play/sandbox' system was felt to make on the job training on reception assessments more difficult ²⁵. IT 'sandbox' systems generally allow for practice and experimentation, without having an impact on 'live' systems. It was reported that this had been helpful in allowing staff new to reception to develop skills in using the system appropriately and safely.

142. The need for developing skills in areas such as 'psychological first aid' and the provision of a more expansive 'toolkit' of responses for staff was reported. This was seen as including more specialist mental health and expert input in high-risk cases. Where local efforts had been made to increase input from mental healthcare professions in the training, these appeared to be very positively received.

²⁵ Sandbox is a term generally used in IT security to describe an isolated environment, that enables users to run programs or open files without affecting the wider application, system, or platform on which they run.

143. Concerns were expressed over the possibility of expansion of online or 'e-learning' courses to the area of suicide prevention. This was seen as unsuited to this area and being likely to exacerbate existing concerns. There are clear benefits and drawbacks to the use of these digital learning methods. For some areas, this may provide a cost effective and easy to deliver form of training. This is perhaps most likely where the subject matter is largely procedural, such as training in relation to IT security protocols. The approach is generally seen as poorly suited to training that is not highly procedural or is skills-based. As such the use of e-learning appears to be very largely unsuited to the needs identified for more skills-based suicide prevention training.

144. The need for training to guard against the use of vague and generic RRAs was noted. The importance of more clearly distinguishing between approaches to assessing and managing suicide and 'self-harm' in training was also raised, along with a focus on variations between groups such as women, young people, and older men.

145. The training of listeners and other peer-based support roles was generally seen as positive in relation to the training provided by third sector organisations, such as Samaritans. This appears to be closely modelled on the approach used in the community. Other schemes seemed to be more variable and a need for further training, particularly for working in the prison environment, was expressed. Again areas such as 'psychological first aid' and basic counselling skills were suggested as gaps that could usefully be filled.

146. Concerns were expressed to us around the poor 'buy in' from some staff in relation to schemes such as the Samaritans.

147. The frequency of Talk to Me refresher training appeared to have been reduced in terms of duration and frequency, from annually to every three years. The point at which this happened was unclear to us, with a widespread change from annual refresher training to around two hours training every three years. This change was criticised as leading to a greater emphasis on bureaucratic process and meeting audit requirements, rather than addressing issues of risk, risk treatment, and risk management and developing relevant skills.

Recent Fatal Accident Inquiry Recommendations

148. The FAIs conducted by Sheriff Collins, in relation to the deaths of Katie Allan, William Lindsay (or Brown) and Jack McKenzie involved a detailed analysis of the area and produced a series of specific recommendations. These were a recurrent topic during site visits and some of the main points raised are discussed below.

149. Recommendation 14(ii) of the joint FAI into the deaths of Katie Allan and William Lindsay (or Brown) proposed a redesign of the Talk to Me risk assessment forms, with the aim of guiding assessors more effectively. It was suggested that this might include specific prompts or the provision of checklist guidance, questions to be asked and responses being documented at the time of assessment. The aim of these changes would be to enable more accurate

assessment and monitoring of risk and protective factors linked to suicide in Scotland's prisons. Additionally, it was recommended that this should extend to improving ongoing assessment of changes in any of the factors over time. This clearly links to the recommendation 14(iii) made in the FAI, with the Talk to Me initiation forms being redesigned. Here the amendments suggested would be to provide a more guided process for the assessor in relation to risk and care planning, again with specific prompts, checklists, questions to be answered and recorded. Alteration of these forms was seen as a means of better addressing risk by putting in place sufficient and proportionate protective measures.

150. As touched on previously, there was a widespread view across the site visits, that the Talk to Me documentation was poorly designed in multiple respects. Including structured guidance was generally well received but concerns were expressed around the potential impacts of checklists on quality of interactions between prisoners and staff. Use of inflexible checklists was widely seen as undesirable. Striking an appropriate balance between providing structured guidance and allowing for judgement and individualised care was generally seen as important by prisoners and staff.

151. Recommendation 14(iv) of the FAI identified the need for guidance to prison staff in relation to obtaining background information, relative to suicide risk on admission. This would include the types of information which should be sought, when it is appropriate to obtain this, processes to be followed and person or persons responsible for doing so being made explicit. It was recommended that staff should be required to try to obtain background

information relevant to suicide risk from the prisoner's family, relevant health and social care agencies for young people experiencing their first time in prison, and/or where there is evidence suggesting a history of self-harm or attempted suicide. In such cases, it was suggested the default position should be that the prisoner is managed under the Talk to Me strategy.

152. This recommendation was widely seen as problematic. Initial risk assessments in prisons are often being conducted based on very limited information. Efforts to obtain additional information, such as community primary care health records, were reported to be variable, even in the longer term and even when made by NHS Scotland staff. Scope was seen to develop much better retention and exchange of information with criminal justice agencies, with efforts in this area being evident.

153. Recommendation 14(v) of the FAI suggested that guidance on risk assessment should be amended to emphasise importance of reduction of the risk of self-ligature in the context of suicide prevention. The potential for substitution of other methods where ligature points are removed was raised with us during site visits.

154. Current audit practice in this area appeared variable. Much of the risk assessment of the cellular and broader prison environment was reported to be focussed on issues of security rather than safety. Requiring that this be extended to consideration of the cell environment, to assess ligature anchor point risk within cells, as part of the overall risk assessment, was widely seen

as a reasonable and easy extension. Some concerns were raised around the focus on ligature points, with extension to consideration of other risks such as suffocation being raised as similarly important.

155. Recommendation 14(vi) of the FAI links to recommendation 14 (iv) and suggests ongoing risk assessment needs to emphasise the importance of obtaining background information around 'dynamic' risk and protective factors. In addition it suggested that a prisoner's self-report and non-verbal presentation in relation to a risk of suicide should not be taken as determinative, suggesting this should be considered in the light of other information. It stressed that prisoner distress should trigger completion of a concern form and that guidance should place a requirement to review all Talk to Me documentation in relation to the prisoner.

156. The site visits suggested that the value of a requirement to review all Talk to Me documentation was widely recognised. As noted earlier though, obtaining background information was seen as presenting significant difficulties. Here, collection of information from Criminal Justice Social Work Services was seen as a promising source of better and more timely information on active risk and protective factors. The transfer of information appeared dependent on the copying and forwarding of paper records or the use of faxed information. This was widely seen as time consuming and unreliable.

157. The Talk to Me strategy was seen to be heavily focussed on assessing risk using verbal self-reports. Indeed this emphasis can be seen as explicit in

the title of the policy itself. Whether intended or not, this emphasis appears to be associated with an over-reliance on verbal self-reports, often at the expense of important behavioural and environmental indicators of risk.

158. Recommendation 14(vii) observed that the present system of reception assessments appeared to be generally reactive rather than proactive. This was widely recognised across the site visits.

159. Recommendation 14(x) of the FAI was that a transitional care plan should continue to be mandatory for all young people removed from Talk to Me. This was seen as central to ensuring appropriate supports were put in place and follow-up checks took place. Provision of more specific guidance and training for staff, in the completion of these care plans, was recommended for younger prisoners.

160. Transitional care plans are already mandatory as part of Talk to Me. In reviewing documentation though, it was evident to us that such care plans were often rushed, of poor quality or sometimes absent. Training in how to develop transitional care plans was raised with us across sites, with this reported to often be very weak.

161. Recommendation 15 of the FAI concerned the DIPLAR process of internal review by the SPS. It was stressed that the DIPLAR process needed to routinely consider the ligature anchor point risk of the cell, or other place in

which the death by suicide took place, and the nature and availability of the item used as a ligature.

162. Few of those we spoke to during site visits had any recent experience of DIPLARs or had read DIPLAR reports. These reports did not appear to be having a significant impact on practice in the field.

Other areas

163. Several additional areas were considered as part of the site visits, many linked to the findings from previous Death in Prison Learning Audit and Review (DIPLAR) reports, conducted by the SPS, and FAIs which followed the deaths of prisoners in Scotland.

164. There is limited evidence on the relationship between suicide risk and bullying and exploitation in prisons. Bullying was raised as relevant, especially but not exclusively for younger prisoners. This area is largely managed through the SPS 'Think Twice' policy, which was put in place in 2018. This policy is concerned to encourage 'respectful behaviour' in prisons.

165. A full analysis of this policy goes beyond the scope of this review. The site visits suggested to us that the policy response to this area was seen as being poor. It was recommended, following the FAIs referred to above, that systemic change was needed to ensure better intelligence sharing around bullying in Scotland's prisons. This appears to be a shared view, with staff and prisoners across site visits identifying this as a problem, in relation to both

suicide and self-harm. This was identified as a particular problem in young people ²⁶ in custody but was also felt to be an issue for adults.

166. Bullying and exploitation was seen as relevant in two main ways. The first of these concerned the adverse effects on individuals subject to bullying, in terms of increased feelings of fear, anxiety and distress. The second main effect identified concerned the effects of deterring individuals from seeking help or support from staff, or creating pressure to disengage from Talk to Me.

167. Prisoners on Talk to Me were at times felt to be subject to significant bullying and harassment. This appeared to be particularly so in the case of those subject to regular intrusive observations at fixed intervals. The level of disturbance associated with this, especially at night, often extended to other prisoners nearby and was felt to be associated with aggression, bullying and pressure on individuals to remove themselves from Talk to Me.

168. It was widely felt that any new anti-bullying strategies and reporting mechanisms needed to interface effectively with the management of suicide and self-harm risks.

169. Proactive sharing of information relating to suspected bullying and exploitation was generally seen as important to the effective operation of suicide prevention policies. It was also seen as having wider value in creating a safer environment and better prison 'regime.' There is a clear need here to limit

²⁶ We understand that children are no longer admitted to SPS custody.

some 'security' information relevant to this area but some prison services appear to have struck a more successful balance here. There would appear to be no compelling reason why this cannot be done in Scotland.

170. The Management of Offender at Risk Due to Any Substance (MORS) policy was introduced in 2014. The interface between Talk to Me, MORS and Think Twice was seen at some sites as being confused and unclear. This had been raised as a particular issue in paragraphs 36-51 in the FAI into the death of Jack McKenzie. Here recommendations were made around the need to improve the interface between MORS and Talk to Me and improving guidance and training, to reflect the increased risk of self-inflicted death associated with substance use.

171. There was a sense from the site visits that it is important to keep the separate focus of these policies but that this could be better coordinated to maximise the gains.

172. Efforts to ensure high levels of out of cell time were also raised in this context. Long periods of time out of cell were seen as problematic by prisoners and staff, where this involved unstructured association. This was suggested to have mixed effects in relation to suicide and self-harm and shortfalls in structured activities, such as education, training and employment were a serious concern.

173. From the site visits, the routine use of the Talk to Me strategy with young prisoners was questioned. Both staff and prisoners did not generally view this development as positive. Talk to Me was seen as a poor framework for supporting most of those entering prison or transferring from elsewhere. Prisoners reported being unhappy about being managed under Talk to Me and being subject to fixed interval observations and case conferences. Being managed under Talk to Me was also widely seen as a stigma, where being seen as a 'suicide risk' following individuals through their sentence.

174. We were told that this initial 72-hour period might be better managed as a form of enhanced induction, directing higher levels of structured activities, support, assessment, and evidence gathering.

4. Training Provision

175. A brief review of training was undertaken, along with meetings with central Scottish Prison Service (SPS) training services and with trainers in prisons. Some consistent themes emerged from these meetings.

176. A full training needs analysis of suicide prevention training went beyond the remit of this review. A brief review of the centrally delivered training package materials was undertaken.

177. The core training for the Talk to Me strategy was implemented following the decision to introduce the policy and has been subject to several minor revisions. The version reviewed here dated from April 2018 (revised 04/2021 and updated 10/2024).

178. Much of the information in current training did not appear to be relevant to the needs expressed to us by staff and prisoners on site visits.

179. The lack of performance evaluation of the centrally provided training appears to us a significant problem. This runs the clear risk of a significant deterioration in the quality of training at prison level.

5. Qualitative analysis

180. A call for submissions as set out in Appendix 2 was published on 8th May 2025. This used a template based on five key areas. This was disseminated via the Scottish Prison Service (SPS) website and social media. Multiple stakeholders were also identified and invited to contribute to the review.

181. The submissions facility was closed on 8th July 2025. In addition a dedicated encrypted email address was set up to allow free form submissions to the review.

182. A total of 92 submissions were received using the template.

183. Additionally, 17 free form email submissions were received.

184. A reflective Thematic Analysis based approach was drawn on to analyse this qualitative data. The results of this are set out below in an outline of the outputs of the analysis of the submissions data.

Q.1 How effective or otherwise do you think the Scottish Prison Service (SPS) Talk to Me (TTM) strategy is in addressing suicide prevention and intervention in custody?

185. Two core (and competing) themes were evident. There were those responses which characterised the approach as ineffective and those, albeit in lower numbers, that characterised it as having some effectiveness.

186. Those who argued that it was effective focussed on two sub-themes: direct and indirect benefits. The direct benefits were that identified prisoners could be kept physically safe using safer cells, safer clothing and bedding and being regularly checked on. Indirect benefits included accessing mental health services.

187. One 'bridging' theme between those who maintained that it was effective and those who maintained that it was ineffective, centred around the problem of implementation. In other words some argued that had Talk to Me been implemented as intended, then it would have been an effective approach to at least the crisis management aspects of suicide prevention. Whilst others viewed the implementation as reflecting a flawed approach, failing to do more than engage in a process of crisis management, rather than take a broader approach to suicide prevention.

188. The comments around the ineffectiveness of Talk to Me were more prolific. Three sub-themes could be seen here.

189. First, the focus was primarily on taking things away, for example clothing, privacy (due to more frequent staff checks), and ligature points (fewer due to being relocated into a safer cell).

190. Second, Talk to Me has as its focus crisis management, and even if working well would be just one part of any effective suicide prevention strategy.

191. Third and most emphatically, was the view that the policy when implemented was experienced as a punishment and for some could be retraumatising. This was viewed as a significant disincentive to prisoners coming forward to discuss suicidal ideation.

Q.2 What are the main failings or weaknesses of the strategy?

192. Four themes were evident in response to this question. First, what may be deemed procedural or administrative burdens and limitations. Second, the stigma of being identified as being 'on Talk to Me.' Third the view that some prisoners reported purportedly suicidal ideation as a way of addressing some other goal. Fourth, the issue of staff skills deficits.

193. The documentation in support of the Talk to Me strategy was seen as cumbersome. For example, 'the book' used to capture the administrative processes around the Talk to Me, was described as unhelpful and unnecessary. The documentation associated with the process sometimes seemed to reflect defensive professional practices. This was captured in the illustrative example

of the administrative process being viewed as a cynical 'tick box' exercise.

Some reported that there was little scope for positive clinical risk taking, against the risk averse baseline of Talk to Me procedures and processes.

194. The stigmatization of being identified as being 'managed' on Talk to Me procedures was seen as being carried with the prisoner in an unhelpful fashion. Prisoners identified in this way may be further prone to bullying.

195. Some prisoners may report feeling suicidal when they are not. They are making such a report to address another need. This was sometimes referred to pejoratively as 'attention seeking.' Related to this some may be in some sort of 'crisis' whether to do with the relationships with other prisoners and/or some mental health problems. Also some may be self-harming with staff making the decision to manage self-harming behaviour under Talk to Me.

196. There were concerns from staff and others that prison staff and indeed nursing staff may not have sufficient knowledge or skills to undertake the roles asked of them in the Talk to Me procedures. Nurses are all subject to statutory professional regulation and need to not work outside their areas of competence. Prison officers were seen as getting comparatively little training in mental health issues in view of the population they are expected to work with and in this case with individuals who are sometimes at suicidal crisis points.

Q.3 What are the main successes or strengths of the approach?

197. There was less information populating this section of the template. This may well feed into the earlier observation that the problems with Talk to Me were more salient and readily apparent to those contributing the submissions. Nonetheless two distinct themes were covered. First, direct strengths and second indirect strengths.

198. The direct strength identified was in relation to the physical prevention or reduction of the risk of death by suicide as a function of environmentally based interventions, as alluded to previously. In other words, safe cells, safe clothing and bedding and more frequent staff observations of the prisoner.

199. The indirect benefits were seen as including partnership working especially across the NHS and SPS. Although not all agree that this was a strength, with self-identified prison listener contributors questioning the extent of the integration of services across the NHS and SPS.

Q.4 What are the practical improvements you would like to see made?

200. Four themes were evident. First and most prominently a need for more mental healthcare staff involvement. Second a need for a more therapeutically orientated approach to the care of the suicidal. Third a need to reduce the administrative burden involved. Fourth a need for more strategic clarity.

201. The need for more healthcare staff involvement was raised in relation to nursing and other healthcare professionals. For example, the need for more involvement in any clinical review for practitioner psychologists to play a role too, whether from the NHS or SPS. A need for all these staff to receive adequate training, especially in relation to the prison context where the patterns of suicide are different to community-based settings was reported.

202. The second theme was a therapeutic focus on helping the prisoner at several levels. For example, the introduction of body scanners to reduce the need for strip searching. An approach based more on the development of relationships and rapport, rather than primarily on attempts at physical prevention. Improvements in psychological safety were felt to be needed.

203. Third the reduction of the administrative 'burden' around any system of prisoner care of this kind was highlighted by several contributors. The need for the digitalisation of such records was raised.

204. Fourth, in terms of strategic clarity, a need to link suicide crisis management policy with a wider strategy for suicide prevention was mentioned, in addition to more integration with other related strategies such as mental health and drug misuse treatments. The need for an oversight group at SPS HQ also featured as a practical suggestion for a policy improvement ²⁷.

²⁷ There has been a National Suicide Prevention Management Group in the SPS which was paused to allow for a short-term reference group to be established to support an overhaul of Talk to Me. Awareness of this group appeared limited.

Q.5 Do you have any other views or comments that you would like to share on how we can best contribute to suicide prevention and intervention in Scottish prisons?

205. There were three broad themes in answers to this question. First, suggestions in relation to changes in the Criminal Justice System (CJS) as a whole. Second in relation to broader potential changes within prisons and thirdly some suicide prevention specific points too.

206. First, in terms of CJS changes it was suggested that fewer people should be sent to prison in Scotland. The need to challenge the views of politicians and Sheriffs was raised.

207. Second, at the level of the Scottish Prison Service, it was suggested that there is a need for an urgent review of how much time prisoners still spend in their cells with little activity. There is a need to stop setting prisoners up to fail. For example, where prisoners cannot 'progress' to courses that they need complete for open conditions or to get Parole. The need to enhance regimes and make sure that prisoners feel safe was stressed.

208. Third, in terms of some specific suggestions in more effectively addressing suicide prevention there is a need, it was reported, for the SPS and NHS to take a more proactive rather than reactive approach to suicide prevention. The case conference model could be further built upon with more involvement of healthcare staff. It was noted that First Line Managers (FLMs) sit with so much of the 'risk' that they need more training, particularly in areas

such as the chairing of suicide prevention meetings, whatever form they may take. Building relationships is key and the Samaritans trained listeners base their work on a non-judgemental active listening-based approach. Training should focus more on practical skills of this kind rather than merely knowledge base.

209. In summary the overall qualitative feedback appears to be that the Talk to Me strategy, whether due to poor design or poor implementation, is not fit for purpose. Prisoners and many staff viewed it as most likely to be experienced as punishment of some description. The administrative systems are seen as cumbersome and it was felt there is a case for digitalisation. A case is made for more involvement of healthcare staff and above all a move towards a more therapeutic rather than punitive approach was advocated. Situating suicide prevention alongside other germane strategies, such as mental health, seems key to ensure that prisoners are kept safe whilst in state care.

6. Quantitative analysis

210. In common with other jurisdictions ²⁸, the Scottish Government gathers a great deal of information about suicide and self-harm in the community and across the Criminal Justice System.

211. Recent analysis has highlighted some high-level trends in deaths in prison custody in Scotland. In a report that linked data from the Scottish Prison Service with that from the National Records of Scotland, it was possible to look at deaths in prison in comparison to community data.

212. The scope of this analysis was wider than for this review and included all deaths in custody ²⁹. Some findings are therefore only touched on in passing. A total of 345 deaths were considered and marked variations in the number of deaths each year were seen.

213. The rates of death in custody were compared to those seen in the community. The risk of death in prisons was reported to be historically lower than in the community, although by 2020-22 this difference had reduced ³⁰.

²⁸ Ministry of Justice and HM Prison and Probation Service (2024). Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to December 2024 Assaults and Self-harm to September 2024. London: OGL.

²⁹ Scottish Government (2025). Deaths in Prison Custody 2012-13 to 2022-23. Edinburgh: Scottish Government.

³⁰ There are methodological issues associated with quantitative analysis of low frequency events involving small numbers of events and caution is needed in drawing conclusions based on such data. See for example, Hand, D. J. (2008). Statistics: A very short introduction. Oxford: Oxford University Press.

214. Other research findings have suggested that people who have experienced imprisonment go on to die at higher rates, with imprisonment associated with an increase in lifetime mortality ³¹. This research included deaths after custody as well as deaths in prisons.

215. The largest group of prisoner deaths were recorded as 'probable suicide', and these were looked at separately. Here the pattern was different. For 2019-22 and 2020-23, the rate of 'probable suicides' in prison was higher than in the community. This represented a change from earlier periods when the rates had been slightly lower.

216. The risk of 'drug misuse deaths' in prison was reported to be lower than the level in the community, although here the difference had been reducing.

217. The prison population in Scotland has fluctuated over time. It was reported to have grown significantly in 2023 and 2024 remaining above 7,800 since mid-July 2023 ³².

³¹ Graham, L., Fischbacher, C. M., Stockton, D., Fraser, A., Fleming, M., & Greig, K. (2015). Understanding extreme mortality among prisoners: a national cohort study in Scotland using data linkage. *The European Journal of Public Health*, 25(5), 879-885.

³² <https://www.gov.scot/publications/scottish-prison-population-projections-july-2025/pages/overview-of-the-scottish-prison-population-and-court-demand-trends/>

218. The average age of individuals experiencing imprisonment continued to rise in 2023-24 to around 38 years. The proportion of those aged 50 or over also continued to increase ³³ ³⁴.

219. The number of women in prison for 2023-24 increased from 282 to 318 ³⁵ with the number of young people under 21 also going up from 160 to 168.

220. The data for 2023-2024 showed that Scotland had the highest level of imprisonment for comparable European nations ³⁶, with the exception for of England and Wales ³⁷.

221. In the calendar year 2023 a slight increase of 4% in ‘probable suicides’ in the community was reported, with a rate of 14.6 people per 100,000, a slight increase from 14.0 per 100,000 people reported in 2022 ³⁸. In 2024, there were 704 probable suicide deaths in Scotland, a decrease of 86 (11%) from 790 in 2023. Compared to 2023, male probable suicide deaths decreased by 71 (12%) to 518 deaths in 2024, while female probable suicide deaths decreased by 15 (7%) to 186 deaths ³⁹.

³³ Ibid

³⁴ See also <https://scotland.shinyapps.io/sg-prison-population-statistics/>

³⁵ <https://www.gov.scot/publications/scottish-prison-population-statistics-2023-24/>

³⁶ For a brief definition of “comparable nation” see <https://www.gov.scot/publications/independence-modern-world-wealthier-happier-fairer-not-scotland/pages/3/>

³⁷ <https://www.gov.scot/publications/scottish-prison-population-statistics-2023-24/pages/context-and-supplementary-information/>

³⁸ <https://www.nrscotland.gov.uk/publications/probable-suicides-2023/#ch1>

³⁹ <https://www.nrscotland.gov.uk/publications/probable-suicides-2024/>

222. The rate of probable suicide mortality in males was 2.9 times the rate for females in 2024 ⁴⁰.

Data sets: 2009 to 2025 and 2004 to 2024

223. Two data sets on self-inflicted deaths in Scotland's prisons were made available. Preliminary analyses were undertaken of both data sets, to give a descriptive picture of these deaths ⁴¹.

224. One data set was provided to us by the SPS and Justice Analytical Services ⁴². This contained empirical and descriptive data on 240 self-inflicted deaths that had occurred between 2009 and 2025. We have referred to this data set as 'SPS data' throughout.

225. The other data set was provided through the families of prisoners who had died by suicide in prison custody. This was based on collation of open-source (OS) information. This contained empirical and descriptive data covering deaths in prisons in Scotland from 2004 to 2024. We have referred to this as the 'Open Source' or 'OS data' set throughout. In statistical terms both data

⁴⁰ Ibid

⁴¹ Statistical analysis was generally conducted using MINITAB statistical software <https://www.minitab.com/en-us/products/minitab/features/>. Some statics were calculated manually.

⁴² The data requested was recent as possible and includes some medical information was outstanding at the time of reporting. The note below was provided with the data:
- Recent deaths have been marked as 'confirmed' for those where cause of death has been confirmed or 'Apparent' where the SPS is awaiting medical confirmation through the medical certificate of cause of death or Post-Mortem. All deaths prior to 2024 are believed to be confirmed but this may not be reflected in Health Team records as this recorded field was introduced from 2018 records onwards.

sets are small and as such present limitations in quantitative analysis and a need for caution in interpretation.

226. For the purposes of our review we excluded from analysis any deaths attributed to natural causes or homicide. This left cases of self-inflicted death whether these were determined to be 'probable suicide' or of undetermined intent/overdose.

227. For the SPS data set 64% of self-inflicted deaths were categorised as probable suicide and 36% as undetermined intent/overdose. The results for the OS data set were broadly similar, with around 70% of deaths recorded as probable suicides and 30% as due to overdoses.

Deaths by Calendar Year

228. Tables 6.1 and 6.2 show the number of deaths by calendar year from each data set and give three-year rolling averages. Figures 6.1 and 6.2 present this information graphically in the form of line graphs of the numbers of deaths. The two data sets differ in that they cover different periods of time and reflect different means of data collection.

229. Notably the three-year average number of deaths for 2008-11, using the SPS data set, was eight. For 2024 this had tripled to 24 self-inflicted deaths. The OS data showed a marked increase over the same period, from 9 to 21.

Table 6.1 Deaths by Calendar Year and 3-year rolling average SPS data

Calendar Year	Number of self-inflicted deaths	3-year average
2010 ⁴³	10	-
2011	8	8
2012	8	9
2013	9	8
2014	10	9
2015	4	8
2016	14	9
2017	19	12
2018	17	17
2019	18	18
2020	12	16
2021	25	18
2022	20	19
2023	21	22
2024	30	24
Total	225	

⁴³ SPS data set includes deaths from 12/4/2009 to 23/3/2025. Therefore deaths during 2009 and 2025 are not included and the total is less than 240.

Table 6.2 Deaths by Calendar Year and 3-year rolling average OS data

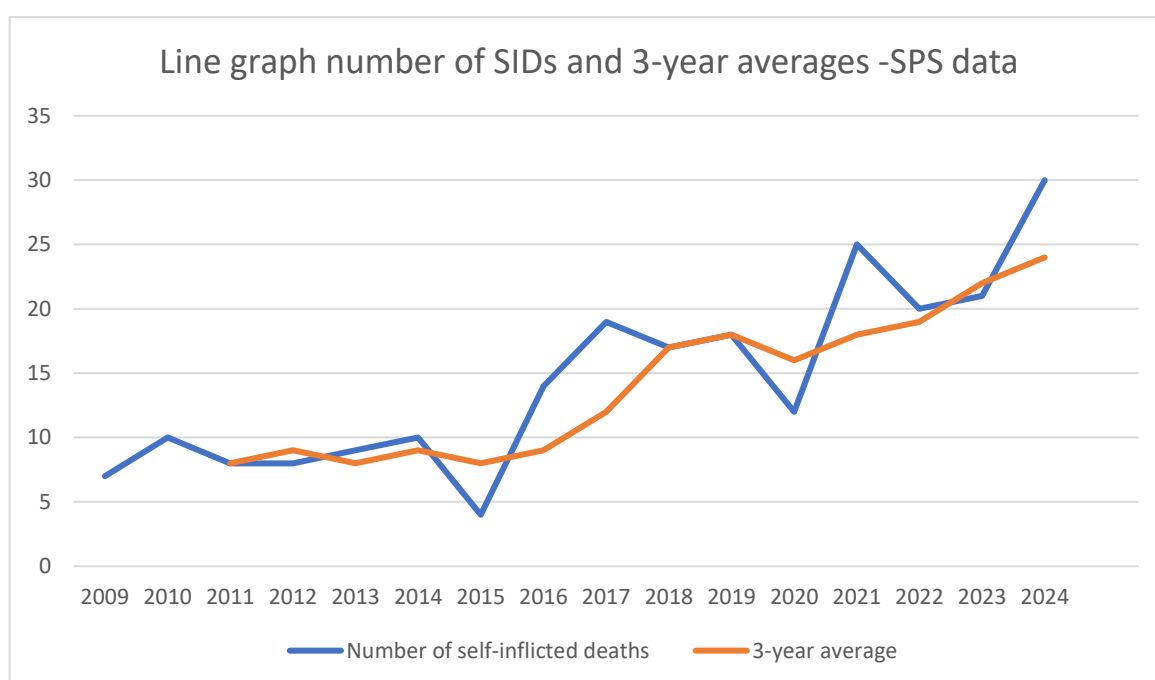
Calendar Year	Number of self-inflicted deaths OS data	3-year average
2004	11	-
2005	11	-
2006	11	11
2007	11	11
2008	7	10
2009	8	9
2010	10	8
2011	8	9
2012	8	9
2013	9	8
2014	10	9
2015	4	8
2016	14	9
2017	18	12
2018	17	16
2019	18	18
2020	13	16
2021	25	19
2022	19	19
2023	19	21
2024	24	21
	275	

230. Figure 6.1 and 6.2 show this information pictorially. Visually both show some variation and a generally flat trend in self-inflicted deaths (SID's) ⁴⁴ up to around

⁴⁴ Self-inflicted deaths include probable suicides and deaths with undetermined intent/overdose.

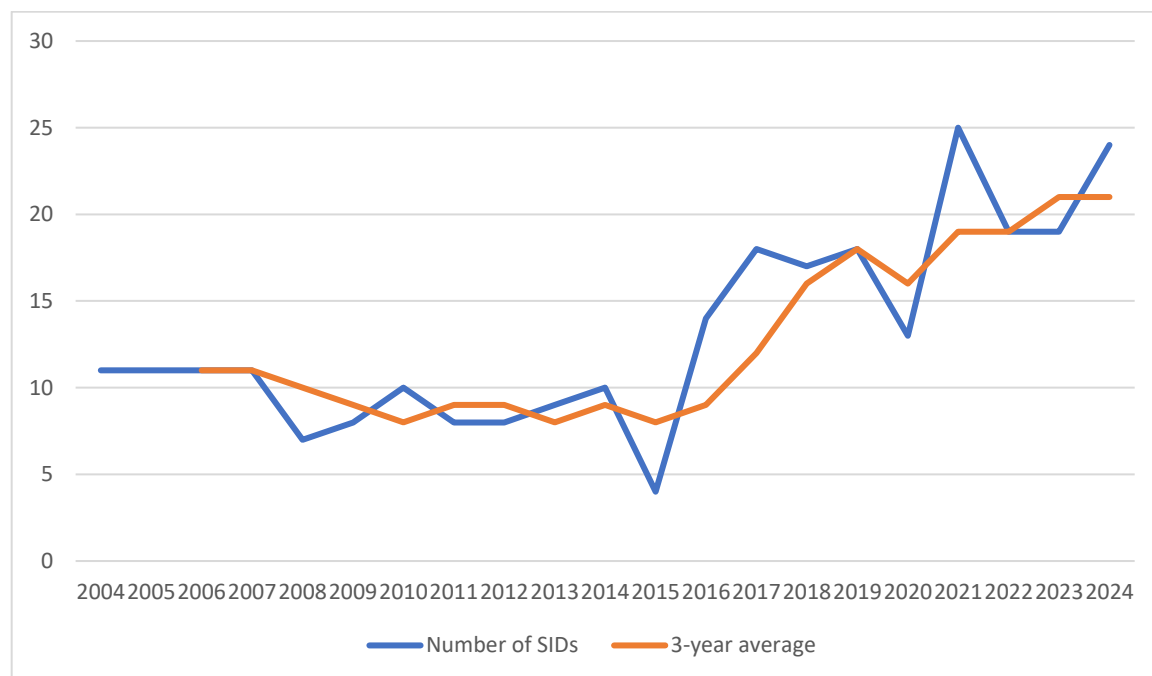
2015, when a low of four deaths was recorded ⁴⁵. From 2016 a clear trend of increasing numbers of self-inflicted deaths seems apparent for both data sets.

Figure 6.1 Self-inflicted deaths and three-year average number of deaths SPS data



⁴⁵ There are several possible explanations for the low number of deaths in 2015. One of these would be that it was a function of the variations typically seen in random events that have a relatively low frequency. Another possibility is that 2015 was a year when management and policy attention was paid to the area of suicide, with the development of a new suicide prevention strategy. This may have had a positive effect by directing more resources and attention towards at risk prisoners. It may also reflect a Hawthorne effect, where behaviour changes as a function of being more closely observed or otherwise measured.

Figure 6.2 Self-inflicted deaths and 3-year average number of deaths OS data



231. Table 6.3 shows the rates of self-inflicted deaths per 100,000 of Average Daily Population in prison for the SPS data set. Three year rolling averages have also been calculated.

232. This shows the high rates of self-inflicted deaths in prison in 2024 compared to rates from 2012-16. Again this suggest that the rates of death were broadly stable or declining, with a notable low rate in 2015. From around 2016 onwards there is a clear upward trend.

Table 6.3 Number and rate of Self-inflicted deaths per 100,000 ADP and 3-year rolling averages by calendar year - SPS data

Calendar Year	Number of self-inflicted deaths	Rate per 100,000 ADP	3-year rolling average
2010	10	126	
2011	8	102	
2012	8	98	109
2013	9	112	104
2014	10	127	112
2015	4	52	97
2016	14	182	120
2017	19	252	162
2018	17	228	221
2019	18	231	237
2020	12	146	202
2021	25	341	239
2022	20	266	251
2023	21	283	297
2024	30	382	310

233. Current rates of self-inflicted deaths appear high when benchmarked against the rates seen in Scotland's prisons in the earlier period analysed.

234. There is significant fluctuation in the annual rates of self-inflicted deaths and this is something that is commonly seen in research into suicide and self-harm ⁴⁶. Some caution is therefore necessary in interpreting the results for individual years.

235. A distinctive characteristic of self-inflicted deaths in Scotland, compared to some other prisons systems, may be the role of high levels of substance abuse and addiction ⁴⁷ ⁴⁸. Table 6.4 therefore shows the rates for only the deaths that went on to be officially recorded as suicide. Here the rates of death are more volatile year to year. Figure 6.3 summarises this pictorially and this suggests a flat or declining trend to a low in 2015. This is broadly followed by an upward trend in rates of suicide to 2024.

236. Perhaps the best benchmark for the SPS in this area is HM Prison Service for England and Wales, where there were 86 apparent self-inflicted deaths in the 12 months to June 2025 (a rate of 100 per 100,000 prisoners). This represented a decrease of 8% from 93 self-inflicted deaths in the previous 12 months (a rate of 110 per 100,000 prisoners). The rate of self-inflicted

⁴⁶ Crighton, D. (2023). Risk assessment in forensic practice. London: Routledge.

⁴⁷ Graham, L., Fischbacher, C. M., Stockton, D., Fraser, A., Fleming, M., & Greig, K. (2015). Understanding extreme mortality among prisoners: a national cohort study in Scotland using data linkage. *The European Journal of Public Health*, 25(5), 879-885.

⁴⁸ Armstrong, S., Allan, L., Cobain, R., Russo, D., & Barkas, B. (2025). Nothing to See Here? Deaths in Custody and their Investigation in Scotland in 2024.

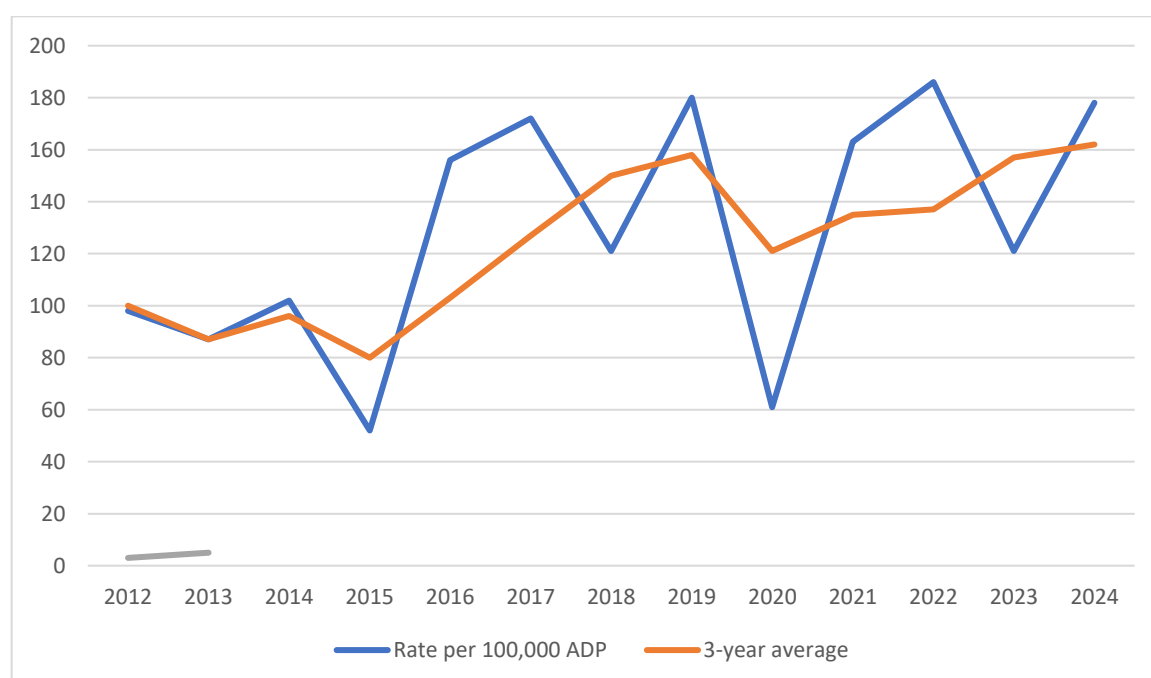
deaths for England and Wales is reported to have remained broadly stable, at a level of around 100 per 100,000 prisoners since the 12 months to June 2018 ⁴⁹.

⁴⁹ Ministry of Justice and HM Prison and Probation Service (2025). Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to June 2025 Assaults and Self-harm to March 2025. London: OGL.

Table 6.4 Number and rate of deaths defined as a suicide per 100,000 ADP by calendar year SPS data

Calendar Year	Number of suicide verdict deaths	Rate per 100,000 ADP	3-year rolling average
2010	10	126	
2011	6	77	
2012	8	98	100
2013	7	87	87
2014	8	102	96
2015	4	52	80
2016	12	156	103
2017	13	172	127
2018	9	121	150
2019	14	180	158
2020	5	61	121
2021	12	163	135
2022	14	186	137
2023	9	121	157
2024	14	178	162

Figure 6.3 Rate and 3-year average rate of deaths recorded as suicide per 100,000 Average Daily Population



237. It is not possible to determine, from the empirical data alone, the reasons for these apparent trends. They are likely to be the result of multiple interacting causes. Notably though, the upward trend in deaths from 2016 followed the introduction of the Talk to Me strategy. This cannot be interpreted as a causal relationship as the period from 2016 also saw many other changes across the SPS, including areas such as staffing and prison regimes.

Gender

238. Women represent around 4% of the Scottish prison population and around 4% of self-inflicted deaths. In addition, two transgender prisoners died

by suicide: one 32-year-old trans woman and one 28-year-old trans man ⁵⁰. The relatively small number of deaths of women and of transgender prisoners means that statistical analysis is not possible ⁵¹.

Table 6.5 Number of deaths by recorded gender – SPS data set.

Gender	Number	% ⁵²
Male	230	96
Female	10	4

Marital Status

239. Most deaths appear to involve prisoners who self-reported being single or in relationships that had broken down, through separation or divorce ⁵³. Around 9% were recorded as being married or in a relationship and this may be lower than for the prison population, where around 17% were recorded as being ‘married or partnered.’

⁵⁰ The SPS subsequently advised that this should be two trans women. One trans woman passed in 2019, prior to updated trans policy and is still noted as male on PR2 which is where the record for gender was taken. She was noted as female in published data but not in the dataset sent for the purposes of this review.
⁵¹ Neuhäuser, Markus, and Graeme D. Ruxton (2024). The Statistical Analysis of Small Data Sets. Oxford: Oxford Academic. <https://doi.org/10.1093/oso/9780198872979.001.0001>

⁵² Percentage figures have all been rounded to the nearest whole number and so may not total 100.
⁵³ SPS subsequently informed that marital status records are often only submitted at the point of a person’s admission to custody and is self-reported. A person may choose not to disclose their status but the field on PR2 is mandatory which may lead to inaccuracy at the point of admission, or their status may change while in custody so it may not reflect their status at the time of death.

Table 6.6 Number of deaths by recorded marital status – SPS data set.

Marital status	Number	% ⁵⁴
Civil partnership	2	1
Common law	13	5
Divorced	6	3
Married	8	3
Separated	7	3
Single	202	84
Widowed	2	1

Ethnicity

240. Those recorded as being white represented 97% of deaths ⁵⁵. In 2023-24 this group represented approximately 93% of the prison population in Scotland.

Table 6.7 Number of deaths by recorded ethnicity – SPS data set.

Recorded ethnicity	Number	%
White	233	97
Black	1	<1
Not recorded	6	3

⁵⁴ Rounded to the nearest whole number.

⁵⁵ SPS subsequently informed that ethnicity is self-reported at time of admission and is mandatory which may lead to inaccuracy in records where a person does not wish to answer the question.

Age at Death

241. The average age at death, based on the SPS data set was 37. Broadly self-inflicted deaths seemed to be seen quite evenly across all age ranges based on SPS and OS data sets.

Legal Status

242. Table 6.8 summarises the legal status of prisoners. Here untried prisoners represent the largest single group of self-inflicted deaths, accounting for around a third of deaths. Those who were convicted and awaiting sentence accounted for around 8% of deaths but 4% of ADP. More than half of the prisoners who died had been sentenced and 29% of deaths involved short-term prisoners. Some of these may have been eligible for community sentencing which is felt by the Scottish Government to be more effective in reducing reoffending ⁵⁶.

⁵⁶ <https://www.gov.scot/policies/reducing-reoffending/community-sentencing/>

Table 6.8 Number and proportion of SIDs by recorded legal status - SPS data.

Legal Category	Number of deaths	Proportion of deaths (%) ⁵⁷
Untried	81	34
Short term prisoners	70	29
Long term prisoners	34	14
Life/ Order for Lifelong Restriction	26	11
Convicted Awaiting Sentence	18	8
Convicted recalled	9	4
Life recall	2	1

⁵⁷ Rounded to the nearest whole number.

Offence Type

243. Table 6.9 summarises the recorded offence types. The largest proportion of self-inflicted deaths involved those charged with, or sentenced for, non-sexual violent crimes. There was though a broad spread of offences including many less serious crimes.

Table 6.9 Number and proportion of SID by recorded offence types – SPS data

Legal Category of Offence	Number of deaths	Proportion of deaths (%) ⁵⁸
Non-sexual crimes of violence	122	51
Crimes against society ⁵⁹	40	17
Crimes of dishonesty	21	9
Sexual crimes	20	8
Anti-social offences	12	5
Missing data	10	4
Damage and reckless behaviour	6	3
Road traffic	5	2
Miscellaneous	4	2

⁵⁸ Rounded to the nearest whole number.

⁵⁹ This term was used in the supplied SPS data set and included offences of crimes against public justice, drugs supply and weapons possession (not used).

Cause of Death

244. Of the deaths defined as probable suicide in the SPS dataset, using a ligature was the most frequently employed method. Around 3% of deaths resulted from lacerations and 1% were attributed to other causes, such as suffocation, or falls.

Time since admission

245. There is substantial empirical evidence to suggest that the early days after admission to a prison are a time of particular risk for self-inflicted deaths. We therefore looked at whether this was true for Scotland, by looking at time from admission to where the person died to their date of death. For both data sets this showed a very wide range, from deaths that happened on the day of admission to some which were many years later. There appeared to be no point during someone's time in prison at which risk of self-inflicted death was totally absent.

246. Deaths though appear to be more common for those recently arrived at the prison where they died. The admission date provided in the SPS data provided the date of admission into custody for that period and the person may have changed prisons several times prior to their death in this period.

247. This is shown pictorially in Figures 6.5 and 6.6 which both show the concentration of deaths in the earlier period after admission. There was also

some evidence to suggest that this effect may have been becoming less pronounced over time.

248. It is important to note here, that the analysis refers to how long the person was in the prison where they died and not how long they had been in custody.

249. There is some evidence to suggest that change of environment may increase risk of self-inflicted deaths, over and above the negative effects of imprisonment.

250. We can clearly see from figures 6.5 and 6.6 that the early period of imprisonment in any prison is a point of inflated risk of deaths by suicide, notwithstanding that this finding is perhaps not as marked as in some of the historic and international literature.

Figure 6.5 Dot plot of time from admission to self-inflicted death - SPS data
2009-2025

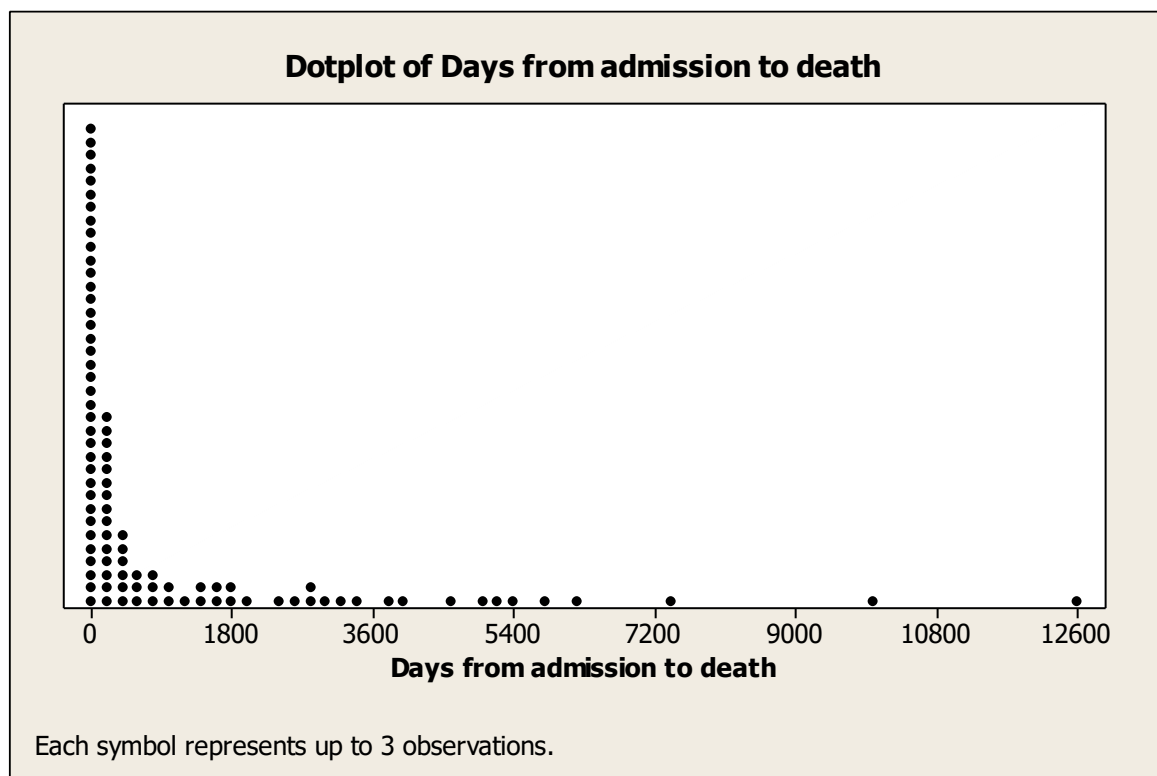
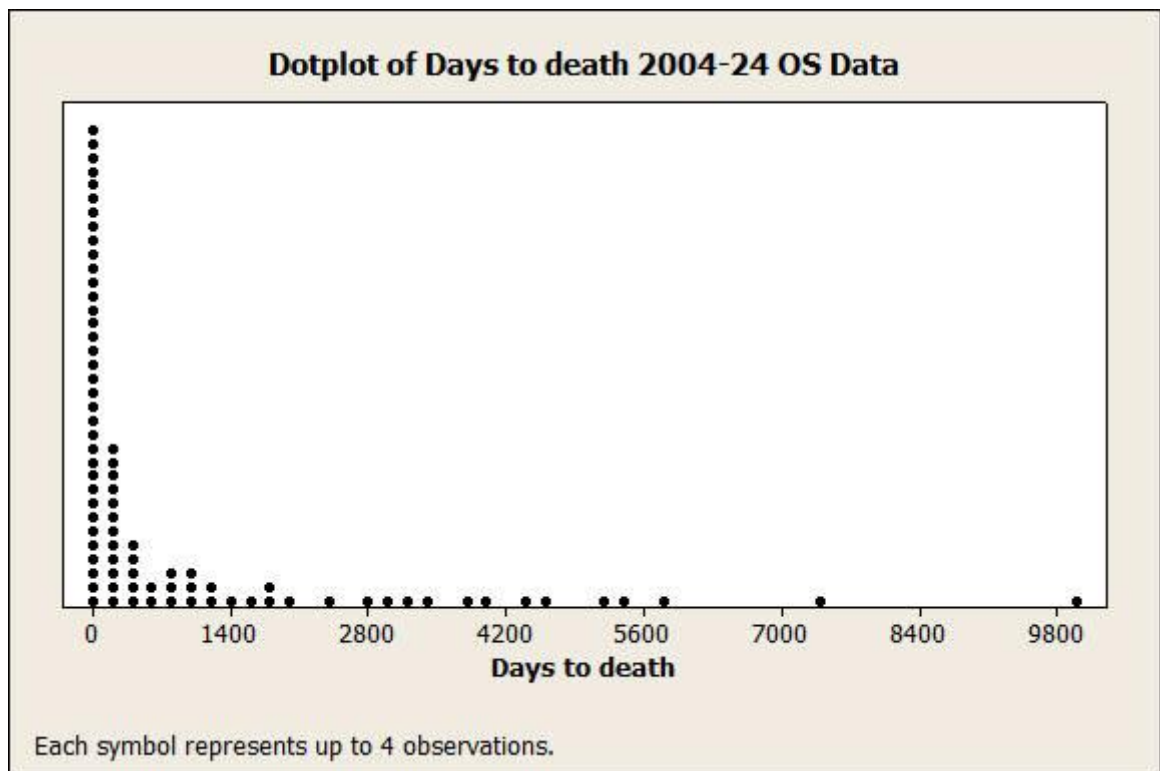


Figure 6.6 Dot plot of time from admission to self-inflicted death - OS data 2004-2024



Risk Management

251. We looked at how many of those who died had been identified and managed as being at risk of suicide. Table 6.12 shows whether Talk to Me (or versions of its predecessor ACT) were in place for individuals at the time of death, or had been in place 2, 7, 30 or more days prior to their death.

252. Perhaps the most relevant finding here is that over half of those who died had not been identified as being at risk. A further 30% had previously been identified as a risk but were not felt to need to be managed using Talk to Me or ACT for more than 30 days.

253. One in ten self-inflicted deaths occurred when the person was being managed under Talk to Me /ACT.

Table 6.12 Self-inflicted deaths by Talk to Me or ACT status – SPS data

Talk to Me /ACT Status	Number of deaths	Percentage of deaths ⁶⁰
No Talk to Me/ACT history	129	54
Previous Talk to Me /ACT >30 days before death	72	30
Live Talk to Me /ACT on date of death	24	10
Talk to Me /ACT ended within 7 days of death	6	3
Talk to Me /ACT ended within 30 days of death	6	3
Talk to Me /ACT ended within 2 days of death	3	1

⁶⁰ Rounded to the nearest whole number.

7. Literature Review

254. An up-to-date review was undertaken to provide a basis for considering the current application of the Talk to Me suicide prevention strategy.

255. The function of reviewing the current evidence base was to (a) inform the areas examined and (b) to inform the recommendations made. As a function of this, the aim was to examine and review the academic and practice evidence of direct relevance to the work of the Scottish Prison Service. This drew on a search of the published academic literature on the area of suicide in prisons, undertaken using standard databases (Psych Net, Science Direct, Cochrane Collaboration and Scholar). These were searched using the following terms:

Suicide or Self-inflicted death or parasuicide

and

Prisons or jails or gaols or custody

256. The literature was searched for the period 1974 to 2024⁶¹. In addition, a search for recent publications from 2025, and for 'grey literature' (unpublished papers) in this area was undertaken separately. The results of these initial searches were then edited. Firstly, duplicate references were removed.

References concerning broad literature reviews of the area, as well as general review articles were removed. A decision was also taken to focus primarily on

⁶¹ A 50-year period was adopted to avoid missing early influential research in this area.

research undertaken within the European Economic Area (EEA), the United Kingdom (UK) and work from Australia and New Zealand. Many of the publications that were exclusively focused on research in other parts of the world were therefore omitted. A great deal of the research into suicides in prisons has been undertaken in North America and increasingly China. The prison systems in these nations are though, generally very different from that of Scotland. As a result, it is often difficult to determine how far any findings may be relevant and informative. Similarly the transferability of any findings and recommendations from these very different prison and legal systems is likely to be problematic. The most direct comparator may well be England and Wales.

257. There has been a continued growth of publications in the area over each decade. The quality of research has shown a more gradual improvement in the reported research. Much of the evidence base in this area appears to be of moderate quality. Some of this is reflective of the difficulties inherent in research into this area, involving as it does comparatively low frequency events, with multiple causes and complex interactions. There are also methodological and ethical limits on the kinds of research studies that can be conducted.

258. Some concentration of research in academic centres (such as Cambridge and Glasgow in the UK) seems present but this appears less marked than in some other areas of forensic research and practice. There continue to be examples of research in this area coming from a wide range of settings and from individual researchers. There is also evidence to suggest

some broadening of research into largely neglected areas, such as efforts to develop theoretical models. Efforts to develop more effective practice appear less developed, with comparatively few studies of adequate quality being found.

259. In line with the scope of the review analysis of the search has been addressed to three broad areas:

- i) Definitional issues.
- ii) Indicators of risk.
- iii) Good practice in reducing death and serious harms.

260. Previous reviews here have also provided detailed coverage of areas such as the risk and protective factors likely to be relevant to suicide in prisons in Scotland ⁶² ⁶³. This coverage has also been summarised below.

Definitional Issues

261. The definition of suicide is a complex one and this varies across jurisdictions, with the approach in Scotland being distinct from other European nations. Within the UK, Suicide ceased to be a criminal offence in 1961. Prior to this, for a death to be defined as suicide, it needed to be proven in line with the criminal burden of proof – ‘beyond a reasonable doubt.’ Although no longer a criminal offence, the requirements to determine a death as being due to suicide

⁶² The Harris Review (2015). Changing Prisons, Saving Lives Report of the Independent Review into Self-inflicted Deaths in Custody of 18-24 year olds. London: OGL.

⁶³ Towl, G.J. and Crighton, D.A. (2017). Suicide in Prisons: Prisoners’ Lives Matter. London: Routledge.

remains high. As a result official rates of suicide, may underestimate the level of such deaths. A significant proportion of deaths that are in fact suicides may be officially recorded as involving unclear or undetermined intent.

262. Within Scotland all deaths that take place in legal custody are subject to mandatory public inquiry. The provisions for this are largely set out in the Fatal Accidents Inquiry (Scotland) Act 1976. The provisions of this fall somewhere between the system of Coroners' Courts used in England and Wales and the system of Criminal Investigation, used for example in Sweden. Here the Procurator Fiscal has broad powers to cite witnesses and direct evidence to be given before a Sheriff. Sheriffs are currently required to cover five areas in their determination:

- i) Where the person(s) died.
- ii) When the person(s) died.
- iii) Any reasonable precautions whereby such deaths or causative accidents might be avoided in future.
- iv) Any defects in systems which contributed to death or associated accident.
- v) Any other factors relevant to the circumstances of the death.

263. Scottish Sheriffs therefore have wider duties in relation to these areas than Coroners in England or Wales but they are not required to determine whether a death was by suicide. In Scotland this is a medical determination, typically made by forensic pathologists.

264. The variations in legal definitions of suicide create significant difficulties in the study of the area. As a result, academic research into suicide has often drawn on epidemiological definitions, which may be applied consistently across different nations. This has typically involved the use of World Health Organization (WHO) International Classification of Disease (ICD) criteria. For example, in the 10th revision of ICD suicides and undermined deaths would be captured under the codes X60-84 plus Y10-34 and Y87.0/Y87.22. This approach has the advantage of focusing on characteristics that are consistently observable, across different legal jurisdictions, so allowing valid comparisons. Here the definition of suicide is likely to be under-inclusive, missing a proportion of self-inflicted deaths, where the individual's intent was unclear or cannot be ascertained. The definition of suicides and undetermined deaths is likely to be over-inclusive, including some genuinely accidental unintended deaths.

265. In relation to deaths in various forms of legal custody, there appears to have been a growing, although not universal, trend towards adopting these kinds of operational definition. This approach was also evident in some early research⁶⁴ although this was not typical and use of legal definitions was common^{65 66}. Much of the literature on suicide in prisons from the 1990's

⁶⁴ Topp, D. O. (1979). Suicide in prison. *The British Journal of Psychiatry*, 134(1), 24–27.

⁶⁵ Dooley, E. (1990). Prison suicide in England and Wales, 1972–87. *The British Journal of Psychiatry*, 156(1), 40–45.

⁶⁶ Dooley, E. (1997). Prison suicide—politics and prevention: A view from Ireland. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 18(4), 185–189.

onwards started from a basis of operational definition of terminology^{67 68 69}.

There has also been a trend towards using the broader definition of self-inflicted deaths in the academic literature and this has been adopted by prison services elsewhere in the UK⁷⁰. This avoids excluding any self-inflicted deaths from consideration but carries the risk of including some deaths that may in fact been accidental. Throughout this review the broader definition of self-inflicted deaths has generally been adopted.

266. In turn the definition of the rates of self-inflicted deaths in prisons is not straightforward. This involves the calculation of rates that are based on the number of self-inflicted deaths and the prison population. This can be calculated in various ways but has typically involved dividing the number of deaths in each period by the average daily population (ADP) of prisons. This provides an estimate of the rate of such deaths based largely on the capacity of prisons. It does not though provide an accurate estimate of the number of people experiencing imprisonment and so being placed at an inflated risk in any given period. An alternative measure adopted has therefore been to look at rates based on the total number of receptions into prison. This measure better reflects the turnover in the population and the, much larger, number of people

⁶⁷ Towl, G. J., & Crighton, D. A. (1998). Suicide in prisons in England and Wales from 1988 to 1995. *Criminal Behaviour and Mental Health*, 8(3), 184–192.

⁶⁸ Liebling, A., & Krarup, H. (1993). *Suicide attempts and self-injury in male prisons*. London: HM Stationery Office.

⁶⁹ Fazel, S., Ramesh, T., & Hawton, K. (2017). Suicide in prisons: an international study of prevalence and contributory factors. *The Lancet Psychiatry*, 4(12), 946–952.

⁷⁰ <https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2025/safety-in-custody-statistics-england-and-wales-deaths-in-prison-custody-to-september-2025-assaults-and-self-harm-to-june-2025#deaths-12-months-to-september-2025>

experiencing that environment ⁷¹. More recently efforts have been made to combine ADP and turnover to give the more precise epidemiological measure of 'person days' or 'person time at risk' ^{72 73}. Use of these different estimates of rates, may lead to quite different conclusions. Most notably, reliance on rate by ADP has been seen to over-estimate the risk of self-inflicted deaths in unsentenced prisoners. Here the proportion of prisoners held on remand may be lower than the sentenced population. The turnover though will typically be much higher, meaning that more remand prisoners will spend time at risk in the prison environment, with ADP not fully reflecting this. It has been observed that this has led to stress being placed on potentially misleading findings around the level of risk associated with remand status in Scotland and in England and Wales ^{74 75 76}.

267. The focus on self-inflicted deaths in Scottish prisons in this review carries with it a risk of some overestimation of the accurate rates of suicide.

⁷¹ There are downsides to the use of receptions, most notably perhaps that they do not take account of how long someone spends at risk in the prison environment.

⁷² Rothman, K. J. and Greenland, S. (1998). *Modern Epidemiology* (2nd Edition). Philadelphia, PA: Lippincott Williams and Wilkins.

⁷³ Alexander, L.K., Lopes, B., Ricchetti-Masterson, K. and Yeatts, K.B. (2015). *ERIC Notebook* (2nd edition). Chapel Hill, NC: University of North Carolina. https://sph.unc.edu/wp-content/uploads/sites/112/2015/07/nciph_ERIC4.pdf

⁷⁴ Bogue, J., & Power, K. (1995). Suicide in Scottish prisons, 1976-93. *Journal of Forensic Psychiatry*, 6(3), 527–540.

⁷⁵ Cooke, D. J., & Michie, C. (1996). Suicide in Scottish prisons: a methodological note. *Legal and Criminological Psychology*, 1(2), 287–293.

⁷⁶ Crighton, D., & Towl, G. (1997). Self-inflicted deaths in prison in England and Wales: An analysis of the data for 1988–90 and 1994–95. *Issues in Criminological & Legal Psychology*, 28, 12–20.

Such definitions may capture some accidental self-inflicted deaths and less commonly may include some deaths by homicide that have gone undetected. In both cases the individuals will have had no intent to die. The numbers involved here are impossible to know but seem likely to be a small proportion of deaths that appear self-inflicted. The alternative approach here would have been to adopt a much narrower definition, closer to legal definitions of suicide and resting on an evidentiary threshold for intent being met. This would inevitably lead to the exclusion of many cases of intentional self-inflicted deaths, where it is difficult to demonstrate thresholds such as 'beyond a reasonable doubt.' In the context of the current review, excluding cases of self-inflicted deaths on such a basis appeared more problematic because it would serve to exclude a large proportion of clearly self-inflicted deaths in prison custody on legalistic grounds ^{77 78}.

Indicators of Risk

268. Early work in this area can be traced back at least to the early 20th century, forming part of pioneering work on the recording and analysis of demographic and health related data on prisons and prisoners ⁷⁹. Current analytical work in this area in the UK can though be traced, largely, from studies beginning in the 1970s. An analysis of 186 suicides of male prisoners held in

⁷⁷ Crighton, D., & Towl, G. (1997). Self-inflicted deaths in prison in England and Wales: An analysis of the data for 1988–90 and 1994–95. *Issues in Criminological & Legal Psychology*, 28, 12–20.

⁷⁸ Mishara, B.L. and Weisstub, D.N. (2024). The Legal Status of Suicide (118-30). In: *Practical Ethics in Suicide: Research, Policy and Clinical Decision-Making*. Cambridge: Cambridge University Press.

⁷⁹ Goring, C. (1913). *The English Convict*. London: H.M. Stationery Office.

legal custody in England, between 1958 and 1971, stressed several differences between the prison population and the general population. A suicide rate three times greater than the community was observed, with the suggestion of this being linked to higher levels of vulnerability. Those with sentences of more than 18 months' duration, or anticipating such a sentence, had high rates of suicide. In addition it was observed that higher rates of suicide were seen during what was described as the early period in custody ⁸⁰.

269. A later study into suicide in prisons undertaken in 1990 drew on a larger sample of 295. This represented 98% of the total for prisons in England and Wales for the period 1972-1987 ⁸¹. During this time the suicide rate was observed to have increased more quickly than the rise in the prison population. The most common method involved the use of ligatures and predominantly took place at night. High levels of previous treatment for mental illnesses and intentional self-injury were observed. Those charged or convicted for violent or sexual offences were also reported to be overrepresented in those who died. Previous suicide attempts were evident in some cases and those serving indeterminate sentences also appeared overrepresented. An association between suicide and both feelings of guilt and being charged or convicted of a homicide offence was reported. Poor communication between staff and inmates was suggested to be a risk factor here, with low levels of proactive and ongoing communication.

⁸⁰ Topp, D. O. (1979). Suicide in prison. *The British Journal of Psychiatry*, 134(1), 24–27.

⁸¹ Dooley, E. (1990). Prison suicide in England and Wales, 1972–87. *The British Journal of Psychiatry*, 156(1), 40–45.

270. Two research projects between 1987 and 1992 looked at suicide and suicide attempts in prison in England and Wales. This work moved away from demographic analysis and the use of statistical data to look at the interactions between prisoners and the prison environment. This involved the use of semi-structured interviews, observational and participant observation methods. There was a focus on those who had attempted suicide or had recorded histories of intentional self-harm and comparison with other prisoners. Differences between these groups were observed in terms of their prior criminal histories and backgrounds. Those who had attempted suicide had histories of more severe disadvantage, violence, and family problems. They also had more frequent contact with social services and criminal justice agencies. Important differences were also noted in their descriptions of life in prison. Here they reported greater difficulties leading to the use of 'poor coping' as an explanatory concept ⁸².

271. A statistical analysis of self-inflicted deaths that occurred between 1988 and 1998 was undertaken based on HM Prison Service data ⁸³. This research involved a sample of 525 cases of self-inflicted deaths out of a total of 600. It built on earlier work involving a smaller sample of 377 official records of self-inflicted deaths in prisons in English and Wales between 1988 and 1995.

⁸² Liebling, A. (1995). Vulnerability and prison suicide. *The British Journal of Criminology*, 35(2), 173–187.

⁸³ Crighton, D.A. (2000). Suicide in prisons: A critique of UK research. In G.J. Towl, M.J. McHugh and L. Snow (Eds.). *Suicide in Prisons*. Leicester, UK: British Psychological Society Books.

272. Here a marked increase in the rates of self-inflicted deaths when assessed against average daily population and receptions into prisons was observed over the period studied. The early period following reception into prison appeared to be one of exceptional risk, with this decreasing dramatically over the first 48 hours and then progressively to reach a baseline level of risk from around 30 days. Here life sentences seemed to further increase risk. Hanging using a ligature appeared the predominant method, accounting for 89% of deaths. Importantly just under one third had been identified as at risk of suicide. A proportion of deaths took place in 'strip cells' and for those under various levels of observation. White and South Asian prisoners appeared at significantly higher risk. Remand status did not appear to be a good predictor, where rates were calculated based on the number of receptions rather than ADP. It was relatively common for those who killed themselves to express intent, with just over half reported as doing so. High levels of prescribed and non-prescribed drug use were also evident. Around 45% also had a history of prior intentional self-injury or self-poisoning. Those with indeterminate sentences and those convicted of serious violent offences appeared to be a markedly greater risk of self-inflicted deaths.

273. An analysis of the 83 suicides that took place in Scottish prisons, between 1976 and 1993 was reported in 1995⁸⁴. Over this time span it was noted that the rates for such deaths in Scottish prisons showed a disproportionate increase, significantly greater than the rise in the prison

⁸⁴ Bogue, J., & Power, K. (1995). Suicide in Scottish prisons, 1976-93. *Journal of Forensic Psychiatry*, 6(3), 527–540.

population. Rates of suicide were higher than for the general population and higher than those seen in some comparable nations. The average age of those who died in prisons was also higher than for the population. It was reported that remand prisoners were overrepresented in the suicide group when compared with the general prison population based on the average daily population figures. This effect disappeared when comparisons were made using annual receptions and was therefore suggested to be a measurement artefact ⁸⁵. Prisoners serving sentences of over 18 months appeared at greater risk and those serving indeterminate life sentences were markedly overrepresented. Those charged with or convicted of violent or sexual crimes also appeared overrepresented. Most of the deaths had taken place during the night shift and hanging by ligature was the predominant method used. The researchers also reported evidence of high levels of previous intentional self-injury and 'psychiatric morbidity.' The early period in custody was reported as a time of exceptional risk, with most deaths occurring less than three months from incarceration and some in less than 24 hours after reception into prison. Of those dying within the first 24 hours, the majority were reported to have established histories of alcohol and/or drug use.

274. An assessment of 472 sentenced prisoners in Spain included a series of structured interviews and assessments. Based on these, an increased risk of suicide was identified in a third of prisoners. High lifetime prevalence of substance dependence and histories of psychiatric diagnoses were reported

⁸⁵ See also Lloyd, C. (1990) *Suicide and Self-Injury in prison: a literature review*. London: HMSO and Liebling, A. (1992) *Suicide in prisons*. London: Routledge. Both cited in Bogue and Power (1995).

and were felt to be predictive of risk following a regression analysis. No socio-demographic risk factors were significant following such analysis. Based on this, the authors suggested that individual ‘psychopathological’ variables are the most powerful factors available to explain suicide risk in prisons and as such essential to risk assessment. They went on to argue that diagnosis and mental health treatment are central to preventing suicide in prisons ⁸⁶. A later study in Spain looked at secondary data drawn from a review of prevalence of diagnosed mental disorders in prisons. This involved a cross-sectional multi-site study design undertaken in 2007-2008, involving five prisons. Here the Plutchik Suicide Risk Scale was used to assess risk, with scores of six or above considered indicative of elevated risk. Data was collected by interview and record searches, with a sample size of 707 male prisoners. Several statistically significant correlates of higher scores on the Plutchik scale were reported. These included having a history of violent offences, being a recidivist, having a family history of mental disorders, presence of diagnosed mental disorders, presence of physical health conditions, contact with a mental health specialist and drug treatment within the previous 12 months. Participation in workshop activity or training courses was also reported to be significantly negatively associated with risk based on the Plutchik scale ⁸⁷.

⁸⁶ Saavedra, J., & López, M. (2015). Risk of suicide in male prison inmates. *Revista de Psiquiatría y Salud Mental (English Edition)*, 8(4), 224–231.

⁸⁷ Vorstenbosch, E., Rodríguez-Liron, A., Vicens-Pons, E., Félez-Nóbrega, M., & Escuder-Romeva, G. (2023). Suicide risk in male incarcerated individuals in Spain: clinical, criminological and prison-related correlates. *BMC Psychology*, 11(1), 11(1): 282 doi: 10.1186/s40359-023-01315-y

275. A study in Italy looked at a sample of 254 prisoners who were assessed across a range of demographic and psychological characteristics, felt to be potentially associated with current suicide risk and lifetime suicide attempts. The study was based on two large prisons in central Italy and used structured psychological interviews and assessments. Prisoners with a recorded history of previous suicide attempts were assessed using a battery of psychological assessments. Here impairment in 'global cognitive functioning' was reported to be a statistically significant predictor of high suicide risk and lifetime suicide attempts. This was found to be independent of diagnosed psychiatric disorders, psychopharmacological treatment, detention status, conviction time, substance use disorder, impulsivity, and illness comorbidity. This study involved a cross-sectional design and relatively small sample size, meaning that any conclusions are necessarily very tentative ⁸⁸.

276. Some studies have addressed self-harm and suicide in prisons as linked areas, although robust information on the characteristics of and links between both is limited. A study of prisoners in England and Wales looked at prevalence of self-harm, associated risk factors and the risk of subsequent suicide. Here the records of self-harm incidents in prisons in England and Wales gathered between January 2004 and December 2009 were analysed. This included 139,195 recorded incidents of self-harm for 26,510 prisoners. Around 5-6% of men and 20-24% of women prisoners had been identified as

⁸⁸ Vadini, F., Calella, G., Pieri, A., Ricci, E., Fulcheri, M., Verrocchio, M. C., de Risio, A., Sciacca, A., Santilli, F., & Parruti, G. (2018). Neurocognitive impairment and suicide risk among prison inmates. *Journal of Affective Disorders*, 225, 273–277.

intentionally self-harming each year. The recorded rates of self-harm were more than ten times higher for women prisoners, with repetition also being common, particularly in women and girls. A subgroup of 102 prisoners was reported to account for 17,307 episodes of self-harm. Self-harm was also reported to be associated with younger age, white ethnicity, prison type, life sentences or being unsentenced. In women prisoners a violent offence against an individual was also reported to be a risk factor. A total of 109 subsequent suicides in prison were recorded, suggesting higher risk in those who had self-harmed, with more than half the deaths occurring within a month of recorded self-harming. Older male prisoners appeared at particular risk of death, as did those who had self-harm with 'high or moderate lethality.' With women prisoners those with a history of more than five self-harm incidents within a year was associated with subsequent suicide ⁸⁹.

277. A study in France looked at the period 2017-2020 and analysed sociodemographic, criminal and prison characteristics for each incarceration from data of the National Prison Service ⁹⁰. This involved a sample of 449 suicides in prison from 358,522 receptions, with the suicide rate reported to be 173 per 100,000 person-years. Several factors were identified as being associated with suicide based on a statistical analysis listed in order of impact:

⁸⁹ Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A., & Fazel, S. (2014). Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *The Lancet*, 383(9923), 1147–1154.

⁹⁰ Vanhaesebrouck, A., Fovet, T., Melchior, M., & Lefevre, T. (2024). Risk factors of suicide in prisons: a comprehensive retrospective cohort study in France, 2017–2020. *Social Psychiatry and Psychiatric Epidemiology*, 59(11), 1931–1941.

- i) Early stage of incarceration and in particular the first week
- ii) Violent offences and in particular homicide.
- iii) French and other European nationalities.
- iv) Age above 40.
- v) Pre-trial incarceration.

278. A recent systematic review of data looking at prisons in England and Wales involved a meta-analysis of risk factors among people in prison, which built on a series of previous studies. This covered the period from Jan 1 2006 to Aug 13 2020 for four databases and for one database for articles published between Jan 1, 1973 and Aug 13, 2020 ⁹¹. Studies were included in the analysis where they reported risk factors in individuals who died by suicide while in prison and in controls from the general prison population. This resulted in 77 eligible studies from 27 countries, with a sample of 35,351 suicides. identified only one new case-control study published since 2006. The authors noted a paucity of recent research and suggested a need for facilitating prison research should be a central part of any strategy to reduce deaths in custody. The strongest factors statistically associated with suicide were reported as:

- i) Suicidal ideation during the current period in prison.
- ii) A history of attempted suicide.
- iii) Occupation of a single cell.
- iv) A current psychiatric diagnosis.

⁹¹ Zhong, S., Senior, M., Yu, R., Perry, A., Hawton, K., Shaw, J., & Fazel, S. (2021). Risk factors for suicide in prisons: a systematic review and meta-analysis. *The Lancet Public Health*, 6(3), e164–e174.

- v) Remand status.
- vi) Being convicted of a violent offence, in particular homicide.
- vii) Serving a life sentence.
- viii) Having no social visits.

279. A review in 2025 looked specifically at deaths from the use of a ligature across a range of criminal justice settings in England and Wales ⁹². This included an analysis of these deaths in prisons between 1999 and 2024. This found that 89% of self-inflicted deaths had involved a ligature and that this was significantly higher than the level seen in the community. Ligature use mainly involved hanging, although for women in prison a higher rate of self-strangulation was seen. Around three quarters of these deaths had involved the use of bedding, 10% the use of shoelaces and 3% clothing.

280. The most frequently used ligature points used by men were windows (47%), beds (19%), door or cell gates (7%), toilets or recess fittings (6%) and privacy screens or furniture (4%). The pattern appeared somewhat different for women with windows representing (40%), beds (13%), door or cell gates (18%) toilet and recess fittings (15%) and privacy screens and furniture (9%). Notably though a wide range of ligature points were seen.

⁹² Independent Advisory Panel on Deaths in Custody (2025). Ligature deaths in prisons in England and Wales: trends and reduction strategies. London: OGL.

281. The review authors suggested that the use of ligatures was largely a function of ease of access but also that prisoners may see this method as causing less suffering.

282. Ligature use was noted to be highly lethal with a fatality rate of around 70%. The method also presented limited opportunity to intervene or resuscitate prisoners, meaning that prevention was key.

283. It was noted that the primary responses to the predominance of this method had involved (i) use of ligature resistant cells (ii) constant supervision (iii) structured risk assessment and (iv) use of ligature tools to aid quick removal of ligatures. In dealing with ligature points the wide range of these was noted, with fixtures and fittings at low heights being used. This was seen to suggest a need for audits of ligature points to look well beyond obvious fixing points. In using observation methods it was noted that these needed to be linked to capacity for prompt response. In the absence of this, the method was seen to be largely pointless, from the perspective of seeking to save lives. Here the use of the monitoring approaches and technology listed, was observed to have reduced deaths by use of ligatures.

284. Some potential responses to deaths associated with the use of ligatures were suggested as being absent, the first of these being a lack of national oversight and strategic direction. In addition the area of workforce training and capacity was noted to be weak, including training in immediate

response and first aid. The quality of training in joint working between health and criminal justice staff was also felt to be generally poor.

285. An alternative approach to the empirical studies outlined above has sought to address the interactions between individuals and institutional environments. This closely links to reviews of the role of prisons more generally and the effects of positive prison regimes more widely ⁹³. These have typically observed the negative effects associated with the growth in use of imprisonment and the current crisis in prisons, including the use of short sentences, lack of purposeful activity and meaningful rehabilitation.

286. Work here has recognised the importance of differential effects in apparently similar institutions, with some having relatively high suicide rates. This suggests a need to study qualitative aspects of environments and interactions, drawing on methods from study of organisational cultures and environments ^{94 95}. Such studies have typically drawn on observation and interviews and have challenged existing research on prison suicide as being vague and taking insufficient account of the interactions between prisoners and environments. This in turn is suggested to have led to failure to recognise the

⁹³ Justice and Home Affairs Committee (2025). House of Lords Paper 153. London: House of Lords.

⁹⁴ Schneider, B., Ehrhart, M. G., & Macey, W. H. (2011). Organizational climate research. *The handbook of organizational culture and climate*, 29, 12169-012.

⁹⁵ Liebling A (2007) Why prison staff culture matters. In J. Byrne, F. Taxman and D. Hummer D (eds) *The Culture of Prison Violence* Boston, MA: Allyn and Bacon.

contribution to prisoner distress, and therefore suicide, associated with experiences of unfairness, disrespect and lack of safety ⁹⁶.

287. Later work in this area has stressed the interaction between observed characteristics of individual prisoners, such as identified mental health problems and the depriving and stressful nature of prison environments. Support for this interactional and intersectional effect comes from evidence of correlations between aspects of prison environments and prisoners' mental health. These have included aspects of prison regimes including:

- i) Lack of purposeful activity.
- ii) Poor levels of social support.
- iii) Low levels of prisoner autonomy.
- iv) Low levels of prisoner safety.
- v) Elevated levels of in-prison victimisation.

⁹⁶ Liebling, A., Durie, L., Stiles, A., & Tait, S. (2005). Revisiting prison suicide: The role of fairness and distress. In A. Liebling and S. Maruna (Eds) *The Effects of Imprisonment*. Cullompton, UK: Willan

vi) Difficulties with prison staff ^{97 98 99 100 101 102 103}.

Good practice in reducing deaths

288. Early work in this area was often based on small sample studies and basic analysis of risk and protective factors. This contributed to a focus by some prison services on screening and monitoring of risk of self-inflicted deaths. Approaches such as incapacitation were also advocated, alongside provision of psychological support and suggestions of transfer of high-risk prisoners to specialised settings. In addition, the need for staff training and inter-agency working was identified by some as a means of reducing rates of

⁹⁷ Goomany, A., & Dickinson, T. (2015). The influence of prison climate on the mental health of adult prisoners: a literature review. *Journal of psychiatric and mental health nursing*, 22(6), 413-422.

⁹⁸ Liebling, A., & Ludlow, A. (2016). Suicide, distress and the quality of prison life. In Y. Jewkes and J. Bennett (Eds.) *Handbook on prisons* 2nd edition. London: Routledge.

⁹⁹ Slotboom, A. M., Kruttschnitt, C., Bijleveld, C., & Menting, B. (2011). Psychological well-being of incarcerated women in the Netherlands: Importation or deprivation?. *Punishment & Society*, 13(2), 176-197.

¹⁰⁰ Van Ginneken, E. F., Palmen, H., Bosma, A. Q., & Sentse, M. (2019). Bearing the weight of imprisonment: The relationship between prison climate and well-being. *Criminal Justice and Behavior*, 46(10), 1385-1404.

¹⁰¹ Favril, L. (2021). Epidemiology, risk factors, and prevention of suicidal thoughts and behaviour in prisons: A literature review. *Psychologica Belgica*, 61(1), 341-55.

¹⁰² Favril, L., & O'Connor, R. C. (2021). Distinguishing prisoners who think about suicide from those who attempt suicide. *Psychological Medicine*, 51(2), 228-235.

¹⁰³ Favril L, Shaw J, Fazel S. (2022). Prevalence and risk factors for suicide attempts in prison. *Clin Psychol Rev*. doi: 10.1016/j.cpr.2022.102190. Epub 2022 Aug 8. PMID: 36029609.

death, with better understanding and identification of valid indicators of suicide risk and potential prevention measures stressed ^{104 105 106 107}.

289. An early review in Scotland led by Derek Chiswick looked at a series of seven deaths that had taken place at Glenochil prison over four and a half years ¹⁰⁸. The review looked at these deaths and the area of ‘parasuicide.’ The review stressed the difficulty in predicting low frequency events such as suicide and the obligations of prison leaders to address this, by effectively managing and supporting those at risk. Here the authors suggested that the procedures adopted at Glenochil had become seriously confused, with the development of a highly punitive element. Until 1983 they noted that the same accommodation and staff were used in the Young Offender Institutions for those undergoing punishment and for those on strict suicide observation (SSO). This has a real resonance in today’s SPS. The reviewers also commented on the limited involvement of health staff as part of an unsatisfactory approach to suicide prevention, involving ‘special’ cells that seen as what the author described as ‘inhumane and unacceptable’, with a procedural emphasis on passive observation and lack of opportunity for engaging in regular conversation and

¹⁰⁴ Albanese. (1983). Preventing inmate suicides: A case study. *Federal Probation*, 47, 65–69.

¹⁰⁵ Blaauw, E., Carrière, R. M., Schilder, F., & van de Lande, S. (1997). Prevention of suicides in penal institutions in the Netherlands. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 18(4), 170-177.

¹⁰⁶ Dooley, E. (1997). Prison suicide—politics and prevention: A view from Ireland. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 18(4), 185-189.

¹⁰⁷ Cox, J. F., & Morschauser, P. C. (1997). A solution to the problem of jail suicide. *Crisis*, 18(4), 178-184.

¹⁰⁸ Scottish Home and Health Department (1985) Report of the Review of suicide precautions at H.M. Detention Centre and H.M. Young Offenders Institution, Glenochil. Edinburgh: Her Majesty’s Stationary Office.

human contact. Principally relying on physical safeguards here was criticised as a form of 'gross deprivation' rather than treatment. Alternative methods based on adoption of good standards of health care were advocated in the form of observation being replaced with assessment and regular review of mental condition and three levels of care: designated 'extra care,' 'close care' and 'special care.' These reflected varied levels of support and skills of staff involved, all to be based in the prison hospital wing.

290. One study evaluated a pilot initiative developed to improve the management of those at risk of self-harm/suicide using the Assessment, Care in Custody and Teamwork (ACCT) approach, to be used in prisons in England and Wales ¹⁰⁹. This involved reception screening, assessment of clinical presentations of prisoners, care planning, and mental health provision for those deemed at risk. Comparisons were made between the period before the pilot. Here it was reported that little change to the reception process was seen, with no change in the proportion of prisoners identified as at-risk. Post reception ACCT documents were reported to be opened more following factors indicative of risk, rather than incidents of self-harm. They were also reported to be more likely to contain higher 'quality' entries, suggestive of improved care and better engagement with prisoners. Prior to the ACCT pilot prisoners deemed at-risk were more likely to be receiving primary mental health care input and those managed on ACCT were more likely to be felt to be depressed but to be

¹⁰⁹ Humber, N., Hayes, A., Senior, J., Fahy, T., & Shaw, J. (2011). Identifying, monitoring and managing prisoners at risk of self-harm/suicide in England and Wales. *The Journal of Forensic Psychiatry & Psychology*, 22(1), 22–51.

receiving no mental health care. Post-closure reviews were also significantly less likely after the introduction of ACCT. Following pilot ACCT was implemented in a phased way across prisons in England and Wales.

An Italian study into prison suicide went on to look at possible prevention methods ¹¹⁰. The authors noted a disproportionate burden of physical and psychiatric diseases in prisoners and the challenges and opportunities associated with this in terms of accessing individuals to diagnosis and treatment. It was reported that half of all Italian prisoners were charged or sentenced for drug crimes. Prevention measures including recognition of psychiatric risk factors and addressing clinical and social needs proactively was stressed. Provision of social and clinical support to prisoners was seen as important in reducing suicide. In line with earlier work ¹¹¹ they suggested measures that should be taken including: (1) Procedures to screen inmates systematically upon their arrival and throughout their stay to identify those at high risk. (2) Initial supervision in dedicated reception wings with appropriate use of restraints and under constant observation. (3) Provision of safer environments to reduce the risk of hanging or self-strangulation, with trauma and resuscitation training for prison staff including provision of emergency response equipment and guidance. (4) Provision of social support. (5) Routine and accessible information on high-risk individuals post screening, with rapid

¹¹⁰ Cinosi, E., Martinotti, G., De Risio, L., & Di Giannantonio, M. (2013). Suicide in prisoners: An Italian contribution. *The Open Criminology Journal*, 6, 18-29

¹¹¹ Shaw, J., Appleby, L., & Baker, D. (2003). *Safer Prisons- A National Study of Prison Suicides 1999-2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness*. London: Department of Health.

tracing of relevant mental health information (6) Development of internal resources or links to community-based mental health services (7) Provision of detoxification facilities for prisoners (8) Prompt follow up of those discharged from prison inpatient facilities (9) Provision of regular staff training and refresher training focused on recognition, assessment and management of suicide risk. (10) A strategy for debriefing following deaths to identify ways of improving suicide detection, monitoring, management and interventions. In addition the positive role of social supports being provided by trained peers were reported as positive, although not a substitute for trained staff.

291. Provision of comprehensive suicide prevention ‘programs’ and peer-focused suicide prevention initiatives have both been advocated as approaches to tackling risk through potentially modifiable factors. A study here drew on a prior review of psychological interventions in the management of suicidal and self-harming behaviours in prisons ¹¹². This had involved a review of English-language articles published in peer review journals. Of these 12 articles were assessed as relevant, with six of these involving broad based suicide prevention interventions: two of these were peer focused. The reviewers concluded that the evidence available suggested that such ‘multi-factorial’ suicide preventative interventions appeared to be effective, with the limited evidence on interventions involving trained peers suggesting these were promising.

¹¹² Barker, E., Kölves, K., & de Leo, D. (2014). Management of suicidal and self-harming behaviors in prisons: systematic literature review of evidence-based activities. *Archives of Suicide Research*, 18(3), 227–240.

292. A later evaluation of the ACCT system used in prisons in England and Wales was reported in 2019. This found staff in prisons were generally aware of the process and its different stages. Staff were also reported to have a good understanding of requirements and other staff groups involved. Good levels of knowledge about when and how to open the ACCT process, along with the actions needed at each stage were reported. Several challenges were though noted, including clear difficulties with the operation of multi-disciplinary case reviews. These appeared to often be inadequately resourced in terms of time to adequately engage with prisoners. Staff time to promptly record detailed observations was also seen as inadequate. Training in this area was reported to have significant weaknesses, including marked variation in both amount and quality of training received. The adequacy of coverage of the specialist area of suicides in prisons was reported to be poor. Linked to this, coverage of areas such as mental health was seen as inadequate. Staff concerns also emerged around accountability, especially around opening and closing the ACCT process, particularly where prisoners went on to die in custody. The researchers also reported a perception of unduly limited discretion in the process. Prisoners interviewed as part of this study generally felt supported when on an ACCT but with some expressing concern that the purpose of ACCT was not being adequately explained. Prisoners also highlighted significant difficulties with the implementation of ACCT. These included concerns around sleep disruption, associated with intrusive night observations. Another key concern for prisoners around ACCT was a lack of sufficient efforts to ensure adequate confidentiality. Both staff and prisoners made suggestions for improvements to ACCT and its implementation in practice. These included

provision of dedicated resources for work with prisoners deemed at high risk of suicide. A need for more frequent and better training was noted, along with guidance on how the ACCT process could be adapted to meet individual need. Improvements to the physical ACCT document itself were made and examples of the development of good local practices were reported. Local developments included such things as the development of a pocket guide for staff, detailing key risks and triggers for suicide and self-harm and providing all new prisoners on an ACCT with a leaflet to explain the aims and nature of the process ¹¹³.

293. A study conducted in the UK and published in 2023 ¹¹⁴ looked in more detail at the use of peer support ¹¹⁵ alongside statutory services. In common with other researchers the authors noted that such approaches may be useful but that many evaluations in this area gave little attention to the differences between volunteering in the community and in prisons. They observed that peer support should be seen as complementary to statutory services. In the prison environment volunteers were, they suggested, routinely exposed to high levels of distress and self-harm, with little structural or personal support. The authors suggested and explored three sub-themes which included the riskiness of peer support; inconsistencies in training and working conditions; and (iii) the value of peer support. for safer service provision. The training and support needs for

¹¹³ Pike, S., & George, R. (2019). The Assessment, Care in Custody and Teamwork (ACCT) process in prison: findings from qualitative research. *Ministry of Justice Analytical Series*. London: OGL.

¹¹⁴ Buck, G., Tomczak, P., Harriott, P., Page, R., Bradley, K., Nash, M., & Wainwright, L. (2023). Prisoners on prisons: Experiences of peer-delivered suicide prevention work. *Incarceration: An International Journal of Imprisonment, Detention and Coercive Confinement*, 4. <https://doi.org/10.1177/26326663231172023>

¹¹⁵ Samaritans. (2011). *A Listener lives here*. Surrey, UK: Samaritans.

peer supporters was stressed, with the availability of support being seen as variable with often 'minimal structural supports' reported to be present. Despite these issues, evidence of positive effects of complimentary peer support approaches were reported, where schemes were appropriately implemented. Many prisoners were also highly motivated to do this kind of work to address unmet needs. Other drivers were also noted though, such as prisons incentivising peer support roles, and the use of implicit and explicit pressures such as impacts on parole or temporary release from prison. The researchers here concluded that peer interventions often lacked adequate training and support and were sometimes viewed as potentially a means of displacing staff roles.

294. There is some work looking at the effects of psychological interventions with prisoners assessed as being at elevated risk of suicide, as well as with those engaging in various forms of self-harm. Cognitive behavioural interventions have been widely applied to address the risk of suicidal behaviour in community and healthcare settings. This has been subject to multiple studies of effects. A comprehensive review of this area in 2017 into the general population and not specifically prisoners, identified 764 published articles, investigating Cognitive Behavioural Therapy (CBT) for suicidal ideation and behaviours in adults. Of these only 26 met the requirements for inclusion in the study and here data were extracted where possible for a meta-analysis. The authors here reported a statistically significant effect. A small to medium effect size was reported for face-to-face delivered CBT in reducing suicidal ideation and behaviour, although significant heterogeneity between the included studies

was noted. The authors also reported that CBT delivered via 'e-health' showed no significant effect in reducing suicidal ideation and behaviour in adults, although here they noted the number of included studies was small ¹¹⁶.

295. This has led to suggestions that the use of psychological interventions have the potential to significantly reduce suicide and self-harm in prisons. The evidence base here is more limited than for community and health settings. Some small-scale work has been undertaken into the feasibility of delivering and evaluating manualised Cognitive Behavioural Suicide Prevention (CBSP) therapy for male prisoners assessed as being at high risk of suicide. An example of this was a small (n=62) pilot randomised controlled trial (RCT) comparing this to Treatment As Usual (TAU) to CBSP, conducted in a male prison in England. Given the study size and duration it would not have been possible to consider the frequency of suicides in prisons and the primary outcome was therefore intentional self-injurious behaviour being identified within a six-month period. Secondary outcomes were described as including dimensions of suicidal ideation, psychiatric symptomatology, personality dysfunction, and psychological determinants of suicide, including depression and hopelessness. This rested on the assumption that these would be indicators of suicide risk in prisons. The authors reported that relative to TAU, CBSP therapy achieved a significantly greater reduction in 'suicidal behaviours' (in fact identified self-harm) with a moderate treatment effect. Significant

¹¹⁶ Leavey, K., & Hawkins, R. (2017). Is cognitive behavioural therapy effective in reducing suicidal ideation and behaviour when delivered face-to-face or via e-health? A systematic review and meta-analysis. *Cognitive behaviour therapy*, 46(5), 353-374.

improvements were also reported across the secondary measures of psychiatric symptomatology and personality dysfunction. Improvements on the psychological determinants used were non-significant. These findings led the authors to suggest that delivery and evaluation of cognitive behavioural suicide prevention therapy was feasible in prisons. They also suggested that such approaches showed significant promise in the prevention of prison suicide ¹¹⁷.

296. Significant claims have been made for the use of specific forms of psychological interventions to address self-harm and suicide in prisons, in particular Dialectical Behaviour Therapy (DBT) appeared popular for some time. DBT was developed and has been widely applied with those diagnosed as having 'borderline personality disorder' (BPD). Efforts to systematically evaluate the effects of DBT on self-harm behaviours and associated negative emotions have however been limited. Work was published on the effects of DBT on self-harming behaviours and negative emotions in patients with BPD in 2021. This involved a meta-analysis of studies in this area and was reported to demonstrate that DBT significantly reduced self-harm and reduced depression. Negligible effects on suicidal ideation and anger were reported. These findings were though observed to be based on a small number of studies, with quality restrictions, meaning any conclusions around the use of DBT were necessarily tenuous ¹¹⁸.

¹¹⁷ Pratt, D. Tarrier, N, Dunn, G, Awenat, Y, Shaw J, Ulph F & Gooding P. (2015). Cognitive-behavioural suicide prevention for male prisoners: a pilot randomized controlled trial. *Psychol. Med.*, 45(16), 3441-51.

¹¹⁸ Chen, S. Y., Cheng, Y., Zhao, W. W., & Zhang, Y. H. (2021). Effects of dialectical behaviour therapy on reducing self-harming behaviours and negative emotions in patients with borderline personality disorder: A meta-analysis. *Journal of Psychiatric and Mental Health Nursing*, 28(6), 1128-1139.

297. A broad review of the effectiveness of various forms of psychological interventions was reported in 2022 ¹¹⁹. This looked at the evidence on effectiveness of interventions in reducing suicide and ‘suicide-related behaviours.’ Studies included men, women, adults, children, and young people, located in prisons and forensic mental health settings. Here review identified 38 studies for inclusion.

298. One RCT has looked at the effects of Psychodynamic Interpersonal Therapy (PIT) delivered over six weeks to a small group of women prisoners, over four to six sessions, with 57 participants ¹²⁰. Those engaging with PIT and the control group reported reduced rates of suicidal ideation but no difference between the two groups was found. The other individual treatment interventions were similarly methodologically limited. Four of these involved adults in prison, one was conducted in a high-security forensic hospital and one was delivered to participants in a mental health court. Four studies did not involve a control group limiting testing for statistical significance. Again small sample sizes for participants were an issue.

299. Changes in legislation or policy have also been looked at with four studies looking at the impacts of these on suicidal thoughts and behaviours in

¹¹⁹ Carter, A., Butler, A., Willoughby, M., Janca, E., Kinner, S. A., Southalan, L., ... & Borschmann, R. (2022). Interventions to reduce suicidal thoughts and behaviours among people in contact with the criminal justice system: A global systematic review. *eClinicalMedicine*, Volume 44, 101266

¹²⁰ Walker, T., Shaw, J., Turpin, C., Reid, C., & Abel, K. (2017). The WORSHIP II study: a pilot of psychodynamic interpersonal therapy with women offenders who self-harm. *The Journal of Forensic Psychiatry & Psychology*, 28(2), 158-171.

adult settings. One example here was the effects of the UK's National Health Service assuming responsibility for prison health services. Such opportunistic studies present methodological problems, as it is often impossible to control many of the variables likely to be involved in any outcomes.

300. Recent work in 2024 has looked at evaluation of the impact of specialist psychological intervention work. This also considered the use of cognitive-behavioural approaches to suicide prevention for men in prisons, identified as being at risk. Analogous in many respects to offending behaviour interventions, these were staff delivered ¹²¹. This was described as involving interrelated areas of work, based on a 'formulation-driven' approach delivered over a six-month period. Up to 20 one-to-one sessions with a healthcare practitioner. There is limited information around the efficacy of this approach.

301. A recent review looked at suicide prevention across criminal justice ¹²². Here the authors adopted a broad-based framework for analysis addressing a range of social, psychological, and environmental factors associated with good practice in reducing self-inflicted deaths in criminal justice settings. Notably there appeared to be an increased risk of death associated with contact with the criminal justice system, when compared to the general population ¹²³. This

¹²¹ Pratt, D., Gooding, P., Awenat, Y., Eccles, S., & Tarrier, N. (2016). Cognitive behavioral suicide prevention for male prisoners: Case examples. *Cognitive and behavioral practice*, 23(4), 485-501.

¹²² Slade, K., & Borschmann, R. (2025). Suicide prevention following conviction within the criminal justice system: a review of good practice using a social-ecological framework. *BMC Global and Public Health*, 3(1), 79-92.

¹²³ Skinner G, Farrington D. (2020). A systematic review and meta-analysis of premature mortality in offenders. *Aggress Violent Behav.* 53:101431.
<https://doi.org/10.1016/j.avb.2020.101431>.

increased risk also appeared evident during the period after release from prison¹²⁴ with rates of 135 per 100,000 person years in the first week after release.

302. The reviewers looked at risk across four areas, looking at individual, relational, community and societal risk factors.

303. At an individual level the presence of suicidal ideation during the current period in custody appeared to be the strongest predictor. This was followed by a history of attempted suicide, a history of intentional self-harm, diagnosis of depression or being on (psychotropic¹²⁵) medicines that work in the brain and affect behaviour, mood, consciousness, thoughts or perception¹²⁶.

304. The analysis of the effects of relationships suggested a strong association between interpersonal conflict and suicide risk, with a clear association between violence towards self and others. Bereavement and exposure to suicide also appeared to be associated with greater risk.

¹²⁴ Borschmann R, Keen C, Spittal M, Preen D, Pirkis J, Larney S, et al. Rates and causes of death after release from incarceration among 1471526 people in eight high-income and middle-income countries: an individual participant data meta-analysis. *Lancet*. 2024;403(10438):1779–88. [https://doi.org/10.1016/S0140-6736\(24\)00344-1](https://doi.org/10.1016/S0140-6736(24)00344-1).

¹²⁵ See www.cqc.org.uk/guidance-providers/adult-social-care/appropriate-use-psychotropic-medicines-adult-social-care

¹²⁶ Zhong S, Senior M, Yu R, Perry A, Hawton K, Shaw J, et al. Risk factors for suicide in prisons: a systematic review and meta-analysis. *Lancet Public Health*. 2021;6(3):e164–74. [https://doi.org/10.1016/s2468-2667\(20\)30233-4](https://doi.org/10.1016/s2468-2667(20)30233-4).

305. At the community level the authors reported the importance of isolation, with those in single cells or in solitary confinement being at increased risk.

Those detained or on remand showed a less marked increase as did those being threatened with violence or those lacking of social visits.

306. At a societal level several aspects have emerged from the evidence base. Within prisons in the UK it is evident that hanging, strangulation and suffocation are by far the most common means used accounting for 95% of deaths compared to 59% in the general population. To some extent this may be a function of the lack of access to alternatives ¹²⁷.

307. The reviewers noted that good practice in suicide prevention has continued to evolve but draw on the World Health Organization template for suicide prevention in custodial settings ¹²⁸. This stresses the importance of understanding imported risk and the impact of environmental factors, as well as understanding and addressing common risks and needs associated with custodial settings.

308. The WHO Live Life framework ¹²⁹ highlights four effective, evidence based, interventions:

i) Restricting access to means.

¹²⁷ Austin AE, van den Heuvel C, Byard RW. Prison suicides in South Australia: 1996–2010. *J Forensic Sci.* 2014;59:1260–2. <https://doi.org/10.1111/1556-4029.12454>.

¹²⁸ World Health Organisation (2000). Preventing suicide in jails and prisons. Geneva: WHO.

¹²⁹ World Health Organisation (2021). Live life: an implementation guide for suicide prevention in countries. Geneva: WHO.

- ii) Interacting with the media to ensure responsible reporting of suicide.
- iii) Fostering socio-economic life skills.
- iv) Early identification and support of everyone affected by suicide.

309. The reviewers go on to note that efforts to accurately predict individual risk of suicide or self-injury appear ineffective and that 'intake screening' should focus on needs related to these areas, which are connected to 'care pathways.' This may include indications of imminent risk such as suicidal ideation, expressions of hopelessness or recent suicidal or self-injurious behaviours.

310. Overall the reviewers conclude that a broad-based public health approach to suicide is likely to be most effective, whilst recognising the costs of this may make such a response impractical in prisons.

8. Fatal Accident Inquiry (FAI)¹³⁰ and Death in Prison Learning Audit and Review ¹³¹ (DIPLAR) reports

311. A Fatal Accident Inquiry (FAI) is a public hearing to establish what happened to cause a sudden, unexplained, or suspicious death in Scotland.

312. Once all the evidence has been led, the Sheriff will issue a document called a Determination, which contains all their findings based on the evidence. They may also make recommendations to prevent other deaths in similar circumstances. FAIs can identify 'reasonable precaution' or the presence of 'defect in system of working'. Recommendations though are not necessarily tied to either of these findings, with Sheriffs commonly finding neither but still identifying that something should be done differently.

313. For the purposes of this review, the eight most recently published Fatal Accident Inquiry (FAI) reports were considered. All concerned deaths that had taken place in the lawful custody of the SPS.

314. Generally the FAI reports can be seen to fall into two groups. One concerned deaths that had not been predicted and that were felt to have been largely unpredictable. Here the presiding Sheriff reports tended to be largely administrative in nature. They provided a determination of the cause of death

¹³⁰ See <https://www.copfs.gov.uk/services/bereavement-support/guide-to-fatal-accident-inquiries/> for further details. Accessed 23/8/25.

¹³¹ See https://www.sps.gov.uk/sites/default/files/2024-02/DIPLARGuidance_Aug2023_Healthcare.pdf for further detail. Accessed 23/8/25.

but did not go into significant detail around the Talk to Me strategy, or the care and management of suicide risk in prisons. As a result this group of reports did not tend to make many recommendations for action.

315. Other FAIs concerned deaths where the judicial view was that the deaths were, to a greater or lesser extent predictable and that the risk should have been actively managed. Here, as well as a determination of the cause of death, the presiding Sheriff tended to look in some detail at SPS policy and practices across the area of the risk of suicide and related areas such as the management of intentional self-harm.

316. This group of FAIs tended to involve more extensive evidence and the detailed examination and testing of evidence, as well as setting out detailed recommendations on the avoidance of further similar deaths. They tended to be critical of the operation of the Talk to Me strategy ¹³².

Death in Prison Learning Audit and Review documents

317. DIPLARs are an internal SPS process for reviewing all deaths in custody. They are described as providing a system for learning from incidents and providing a mechanism to consider the circumstances of deaths and

¹³² Additional detail on the context, findings and recommendations from some of the FAIs are set out earlier in this report and so are not duplicated here.

immediate actions that can be taken ¹³³. We are aware that the SPS has been undertaking a process of independent review and change to this process ¹³⁴ ¹³⁵.

318. The SPS requires a DIPLAR be held when there is a death in prison custody, or when a prisoner in the care of the SPS dies in hospital or any other location external to the prison. The key focus is on the death, the preceding months and the input provided to support the individual and to identify significant areas. DIPLAR findings should be shared with the deceased's family.

319. A sample of nine recently completed and partially redacted DIPLARs were supplied to us by the SPS. These provide descriptions and details of events leading to the discovery of the bodies, including efforts made by staff to, in some cases, try to resuscitate prisoners.

320. Overall the DIPLARs reviewed had most resonance as documents concerned with improving internal administration and providing assurance and recommendations to improve operations.

321. They also provided some passing insights into aspects of culture, with the use of institutional terminology such as 'a controlled feed.' This stark

¹³³ https://www.sps.gov.uk/sites/default/files/2024-02/DIPLARGuidance_Aug2023_Healthcare.pdf

¹³⁴ <https://www.gov.scot/publications/independent-review-response-deaths-prison-custody-second-progress-report/>

¹³⁵ Scottish Parliament Deaths in Custody: Justice Secretary's statement - 27 March 2025 Published 27 March 2025 Topic Law and order. Statement by Cabinet Secretary for Justice and Home Affairs – 27 March 2025.

language appeared at best inappropriate when referring to mealtime arrangements for prisoners.

322. Six of the DIPLARs concerned prisoners who had been managed using the Talk to Me procedures and processes at some point. Four were being actively managed and supported in this way and three were reported to have no previous Talk to Me history. Despite this, all the prisoners were seen in retrospect to have given some indications of experiencing varying levels of distress.

323. A striking quality of the DIPLARs sampled was a clear failure to achieve sufficient independence from the SPS, as the effective commissioner of the reports ¹³⁶. The learning and review aspects of the process seemed to have been driven largely by questions raised by the families of prisoners.

324. These reviews clearly involve the use of significant resources but this does not appear well targeted.

325. The sample of DIPLARs considered did not provide an adequate analysis of the root causes of a death and developing learning for the SPS. Here it seems that moves towards greater independence will be central to a more effective investigation of causes and learning.

¹³⁶ The SPS subsequently informed us that some of the DIPLARs provided may have pre-dated the introduction of the Chair moving away from the local GiC therefore rendered some of the comments out of date.

9. Conclusions and summary

326. Over the course of this review we observed positive aspects of the application of the Talk to Me strategy and have reported these. It was clear to us that those working in Scotland's prisons were making concerted efforts, day in and day out, to support and care for some of the most vulnerable people in the country. There were some very knowledgeable and highly motivated staff clearly wanting to make a difference in suicide prevention. However, it seemed equally clear to us that aspects of the Talk to Me strategy often appeared to impede, rather than aid, these efforts.

327. We were struck by policy in prisons in Scotland appearing to have gone backwards, losing the lessons learnt from previous reviews. The Chiswick review into a series of deaths at Glenochil reported in 1985¹³⁷ and concluded that:

“6.3.3 We think that the methods of managing inmates thought to be at risk of suicide are unsatisfactory. In particular, we consider that the procedure whereby an inmate, identified as suicidal, is secluded for lengthy periods in a special cell to be inhumane and unacceptable. The procedural emphasis on passive observation, the lack of opportunity for the inmate to engage in regular conversation and the denial of human contact are misplaced and contrary to modern notions of psychiatric care. We think that this form of

¹³⁷ Scottish Home and Health Department (1985) Report of the Review of suicide precautions at H.M. Detention Centre and H.M. Young Offenders Institution, Glenochil. Edinburgh: Her Majesty's Stationary Office.

strict suicide observation, which depends principally on physical safeguards, is a form of gross deprivation rather than treatment, and should be abolished." ¹³⁸.

328. We have reached similar conclusions in relation to the operation of the Talk to Me strategy. The strategy was widely seen as punitive, often involving long periods of seclusion and isolation in safer cells and passive observation, rather than therapeutic engagement and management. As with the review 40 years ago we viewed this as inhumane and wholly unacceptable.

329. The Talk to Me strategy was clearly introduced with very positive aims. It was intended to be an approach that was centred on the individual and focussed on their needs. As such this would be in line with current views around the importance of past trauma and the SPS adoption of purportedly 'trauma informed' approaches. It would also fit with efforts to address mental and physical health needs of prisoners, including issues of neurological diversity.

330. Despite these laudable aims, it was apparent to us that Talk to Me was *emphatically not* working in this way.

¹³⁸ Ibid.

331. In developing effectiveness approaches to prevention, we felt that the WHO Live Life framework ¹³⁹ provides a good basis. The WHO framework stresses four broadly defined and evidence-based interventions. Most obviously perhaps are interventions designed to restrict access to means.

Complementary to this are interventions to improve the individuals social and life skills. Less obviously perhaps are interventions with a range of media to discuss the subject area constructively and raise awareness of risk and support resources. The importance of efforts to identify and support all of those affected by deaths is also stressed.

332. Aspects of the Talk to Me strategy appeared to be working well and the approach to reception screening was noteworthy here. This often appeared to be functioning well, despite the often-high numbers of receptions and movements and the often-unpredictable levels of workload involved. Use of new technology often appeared helpful here, with examples of the use of body scanners as a more efficient and dignified method of searching prisoners. Similarly the use of digital systems for translation, in combination with peer support schemes and first night supplies of essential provisions at some prisons. All seemed important in making the process of entering prison less stressful. Given the widely replicated finding that the early period after reception is a time of exceptional risk, such work appears critical.

¹³⁹ World Health Organisation (2021). Live life: an implementation guide for suicide prevention in countries. Geneva: WHO.

333. Joint working between SPS and NHS staff in reception appeared positive, with examples of seamless interagency and multi-disciplinary working. Variations in levels of NHS support across different health boards was also reported.

334. There are some suggestions in the academic literature that use of new technologies, in the form of actuarial risk assessment instruments may be of additional value here, providing more accurate predictions of risk. The WHO though do not stress this as an evidence-based approach. Having looked in some detail at the evidence here, we felt that the expense of adopting this technology was not yet justified. Based on this review it appeared to us that resources would be better directed towards improved staff training and support.

335. The increased risk in the early period after admission may be a function of the shock of being newly imprisoned, with prisoners having to adapt to a new environment. It does though seem to go beyond this, with even those who have previous experience of imprisonment who are moved being affected by such disruptions. This appears to us to be largely a function of disrupting social support and other networks ¹⁴⁰. Here moving prisoners and potentially changing locations within prisons may negatively impact on the experience of prison life. As a result reducing non-essential movement of prisoners seems a very useful precautionary measure to reduce the risk of self-inflicted deaths.

¹⁴⁰ Auty, K. M., & Liebling, A. (2024). What is a 'good enough' prison? An empirical analysis of key thresholds using prison moral quality data. *European Journal of Criminology*, 21(5), 725-753.

336. The many examples of effective working that we observed typically involved committed and skilful staff trying to work with a policy that they often found frustrating. Talk to Me was widely reported by staff, prisoners and third sector organisations to be bureaucratic, inflexible and counter-therapeutic.

337. We were struck by the extent to which prisoners saw Talk to Me as being a punitive process or in some cases a punishment. This view was also expressed by prisoners' families and third sector organisations. Such views seem to be a function of the extent to which the focus had increasingly been on removal of means and passive observation. These appeared to us to have increasingly become dominant, at the expense of other responses concerned with developing social and life skills.

338. In line with other research, most deaths had involved prisoners who had not been identified as currently needing Talk to Me support ¹⁴¹ and a large proportion of self-harm went undetected ¹⁴². Efforts to accurately identify those most at risk are difficult but there was little evidence here that Talk to Me had been helpful in driving the adoption of broad-based approaches. Most notable here perhaps is the 'Creating Hope Together - Scotland's suicide prevention

¹⁴¹ Armstrong, S., Allan, L., Cobain, R., Russo, D., & Barkas, B. (2025). Nothing to See Here? Deaths in Custody and their Investigation in Scotland in 2024.

¹⁴² The Talk to Me Strategy does not relate to self-harm.

strategy 2022 to 2032.’ This adopts outcomes that largely mirror the WHO approach discussed above. These relate to:

- i) The importance of driving environmental change addressing the psychological, social, cultural, economic, and physical environment.
- ii) Developing community understanding of risk factors, prevention, and organisations able to respond in helpful and informed ways to provide support.
- iii) That everyone affected by suicide, suicidal thoughts or behaviours can access appropriate and timely support to promote wellbeing and recovery.
- iv) That suicide prevention is planned and delivered across agencies, drawing on the experiences of those with experience of the area and subject to ongoing monitoring and evaluation.

339. Talk to Me appears to have become increasingly detached from these broader public health policy aims in Scotland. This is a serious concern given the high rates of deaths in those who have experienced imprisonment, where there appears to have been a growing neglect of psychological and social drivers of risk.

340. The current use of ‘safer’ cells in Scotland’s prisons appears in large part like ‘strip cell’ conditions historically used in other secure settings ^{143 144 145}.

¹⁴³ Liebling, A., & Hall, P. (1993). Seclusion in prison strip cells. *BMJ: British Medical Journal*, 307(6901), 399.

¹⁴⁴ Coid, J., Petruckevitch, A., Bebbington, P., Jenkins, R., Brugha, T., Lewis, G., ... & Singleton, N. (2003). Psychiatric morbidity in prisoners and solitary cellular confinement, II: Special ('strip') cells. *Journal of Forensic Psychiatry & Psychology*, 14(2), 320-340.

¹⁴⁵ Scottish Home and Health Department (1985) Report of the Review of suicide precautions at H.M. Detention Centre and H.M. Young Offenders Institution, Glenochil. Edinburgh: Her Majesty’s Stationary Office.

This appears to us an inappropriate response to those who are distressed and presenting a high risk to themselves. Effective approaches to suicide prevention in prisons should clearly not be punitive and need to be seen as such, by those who need to seek help.

341. Those prisoners felt to be presenting exceptionally high levels of risk to themselves, would be more appropriately managed in a healthcare setting, where they may require continuous support and monitoring.

342. The use of body searches and removal of normal clothing is likely to further increase distress for many prisoners, reducing their willingness to engage with efforts to reduce risk. Such approaches may very well also make it much less likely that prisoners will report suicidal ideation. Prisons also contain high numbers of individuals who will have suffered serious sexual and physical assaults in childhood and as adults. Faced with the prospect of these physical body searches, it seems many will be deterred from sharing their concerns. Again this means that it becomes more likely that those at risk will not be identified or supported.

343. The current application of Talk to Me was often seen as increasing the effects of environmental and personal deprivation already associated with being in prison. The application of fixed interval monitoring, particularly at night, was seen to be associated with sleep deprivation. Examples here included reports of the unnecessary waking of prisoners at fixed 15-minute intervals throughout the night.

344. Current numbers of prisoners and staffing did appear to be impacting, with residential staff often finding it difficult to complete all the required administrative tasks. In this context, work that could be viewed as discretionary became harder to do. Notably many self-inflicted deaths and a great deal of self-harm occurs in the evening and overnight, where staffing will be at its lowest.

345. In this context, it is surprising that peer support schemes and third sector organisations have not been more extensively drawn on, to provide a means of accessing additional resources. The development of peer support schemes and third sector provision have several potential advantages, including expansion of available support. They also have potential to create more constructive work for prisoners, developing relevant, transferable and pro-social life skills.

346. The use of technological monitoring systems has been largely neglected in prisons and there is little evidence on efficacy. Such passive monitoring systems have been trialled in secure hospital settings ¹⁴⁶ with some positive findings. They are not though a substitute for active approaches. These may have the potential to reduce the need for observation by residential staff, allowing for less intrusive continuous monitoring.

¹⁴⁶ Dewa, L. H., Broyd, J., Hira, R., Dudley, A., Hafferty, J. D., Bates, R., & Aylin, P. (2023). A service evaluation of passive remote monitoring technology for patients in a high-secure forensic psychiatric hospital: a qualitative study. *BMC psychiatry*, 23(1), 946. doi.org/10.1186/s12888-023-05437-w

347. The case conference process is fundamental to Talk to Me and appeared to be a very positive aspect of the policy. There was though clear evidence of a critical training gap here. A range of complex and high-level skills are involved in effectively chairing multi-disciplinary meetings of this kind. These meetings involve critical decision making, that is liable to be subject to later forensic scrutiny. In common with some other areas of work in prisons, it cannot be reasonably assumed that such skills can be 'picked up' without systematic training and support. We formed the view that the lack of skills-based training for those chairing case conference meetings needs to be addressed urgently.

348. We were struck by the limited extent of the disciplines engaging with the Talk to Me work. This work appeared to be falling primarily on residential and nursing staff. We did see examples of other disciplines being involved, including social work and speech and language therapists. This was not though common across sites and many case conferences could more accurately be characterised as bi-disciplinary. This meant that case conference chairs were often presented with a limited range of expertise, supports and interventions that they could draw on to manage risk. For the case conference approach to work well and gain maximum benefit, it needs to draw on the full range of appropriate multi-disciplinary skills and expertise.

349. The Talk to Me strategy appeared to be especially poorly suited to the needs of women in prison. Women prisoners appeared to present with often

quite different needs to men, with higher levels of identified self-harm and prior sexual trauma. Any new policy needs to address this gap in provision.

350. During the review process we looked at the current training for Talk to Me. The standard training package used appeared to us to be poor and this was echoed by participants across the review process. It appeared to us to contain information that had fallen out of step with the evidence base. Training was widely seen as being overly didactic with general concerns from prisoners, staff and third sector organisations over the lack of skills training.

351. A key part of the WHO approach appeared to be missing from work in prisons altogether. This concerned positive engagement with the community and media. At present such engagement appears to provoke significant anxiety from staff and the approach to the media appears reactive, following deaths in prisons. There was little evidence of efforts to actively work with the community and media to develop positive work in this challenging area.

352. Similarly evidence of a systematic approach to identifying and supporting those who have been affected by suicide and self-harm in prison seemed absent from Talk to Me strategy.

353. It was clear to us that when families have met senior managers from prisons, to discuss the death by suicide of their loved ones, such meetings have not always gone as well as they could. Although the most senior manager, with overall responsibility for the prison, it is questionable whether prison

Governors are best placed to undertake this work. Other staff appear to us potentially more suited and this is an approach that has been adopted in other jurisdictions ¹⁴⁷. In future we felt that such meetings and family liaison might be better led by a nominated senior and experienced health or social care professional.

¹⁴⁷ Ministry of Justice and HM Prison and Probation Service (2024). Follow up to Deaths in Custody Policy Framework. London: Ministry of Justice.

10. Recommendations for Implementation

Strategic and systemic improvements

354. Talk to Me should be discontinued and replaced with a new policy framework. The new framework should be consistent with wider public health policy in Scotland seeking to reduce self-inflicted deaths and self-harm.

355. Any replacement of Talk to Me should:

- i) Address the importance of environmental change in terms of prison regimes as well as the removal of means of suicide and self-harm from the physical environment.
- ii) Seek to develop community understanding within prisons and the wider community into risk factors, prevention, and organisations able to respond in helpful and informed ways to provide support.
- iii) Ensure those affected by suicide, suicidal thoughts or related behaviours can access appropriate and timely support, to promote their wellbeing and recovery.

356. The name of any new framework should make clear its function to reduce self-inflicted deaths and self-harm in a way that can be easily understood by prisoners and their families.

357. The current binary nature of Talk to Me should be replaced with an approach that recognises different levels of risk and need.

358. All cells and common areas in Scottish prisons should be audited, using a suitable audit tool, to identify risks and make these as 'safe' as reasonably possible.

359. Emphasis on using small numbers of identified 'safer cells' should be reduced and use of these cells should be phased out across the SPS.

360. The approach to the prevention of self-inflicted deaths should stress psychological and social approaches to improve personal agency and work with prisoners, in ways designed to manage risks and support individual development.

361. Case conference chairs should be able to draw on a wider range of regulated healthcare staff, to support multi-disciplinary working and contribute to risk assessment, risk treatment and risk management work.

362. The current approach of adopting the most restrictive conditions, based on the view of a single member of a case conference, should cease immediately. Decisions on the best way to balance risk and needs should be determined by the case conference chair, informed by the views of participants.

363. SPS practitioner psychologists should proactively engage with any new suicide prevention strategy and this work should become the top priority for this group of staff. This could include the development and implementation of an

on-call system for the provision of acute psychological support. It could also include provision of appropriate psychological consultancy, training and support for staff and liaison with other specialists.

364. The contractual arrangements with NHS based practitioner psychologists could helpfully be clarified by the SPS, to determine (i) whether contracted work includes the provision of one-to-one therapeutic interventions with prisoners assessed as being at high risk of suicide and self-harm (ii) referral mechanisms if this is the case.

365. Non-essential prison transfers and moves, such as those for completion of offending behaviour courses, should be minimised.

366. Provision of offending behaviour courses should be delivered on a peripatetic basis, built around the needs of prisoners, to minimise disruptive transfers from prison to prison.

367. The needs of women in this area are distinct from those of men. Any new policy should have a gendered lens.

368. Greater use should be made of third sector organisations and 'peer support' approaches. This should include provision of:

i) Assistance and reassurance to prisoners on reception.

ii) Provision of support and psychological first aid to prisoners at high risk of self-inflicted death and self-harm.

369. Use of body searches of prisoners identified as being at elevated risk should be replaced with the use of body scanners wherever possible.

370. The clothing and bedding currently designated as 'safe' should be replaced with clothing and bedding that is more fit for purpose.

371. Updates to Information Technology systems available to staff in prisons should include provision for recording information relevant to suicide and self-harm prevention. This should include 'flags' where there is relevant health or social care concerns or involvement. Development should involve prison staff with substantial practical experience. The replacement information technology system should record detail of all additions and changes made.

372. The current internal review process (DIPLAR) lacks clear impendence from the SPS. It appears largely ineffective as a means of providing critical internal analysis and reviews of deaths in custody. It should be replaced by a review process that is more independent of the SPS and which is tasked with analysis of the root causes of deaths and making recommendations for improved practice. This process should:

- i) Have independent Chairs.
- ii) Encourage more proactive involvement of families of those who have died.

We understand that that the Scottish Government has taken steps and work is already underway to improve the independence of the DIPLAR process ¹⁴⁸.

373. Policy and guidance should be developed for how prison should engage with bereaved families.

374. There should be a duty of candour for staff towards those managing the post-death processes and the families and friends of the deceased.

375. We strongly recommend closer monitoring and evaluation of any new strategy. Specifically we recommend two types of evaluation to monitor implementation and practice:

- i) A process evaluation involving regular assessments of whether the strategy is being implemented as intended.
- ii) An outcome based evaluation looking at outcome data, such as rates of self-inflicted deaths, benchmarked against the data on self-inflicted deaths from HM Prison and Probation Service.

Training

376. Specific training for those chairing case conferences should be developed and implemented. This training should be skills based. Given the critical nature of this area of training, these courses need to be performance

¹⁴⁸ Scottish Government (2024) Death in Prison Custody – Action Plan – Update July 2023. Edinburgh: Scottish Government.

assessed on a pass or fail basis. This training should be mandatory for all those chairing case conferences and linked to SPS career progression requirements.

377. Staff training in suicide prevention should be updated to reflect the current evidence base in this area.

378. The provision of training for trainers should continue to be delivered in person. It should be more skills-based, with regular updating and refresher training. Given the critical nature of this area of training, these courses need to be performance assessed and need to be assessed on a pass or fail basis.

379. Training and refresher training updates for prison staff are no longer fit for purpose and need to be revised to reflect the current evidence base. This training needs to be in person and should become more skills based, with greater coverage of practical responses to commonly seen mental health problems.

380. Specialist training for regulated healthcare staff, addressing the area of suicide and self-harm in prisons, should be developed and implemented.

381. Expansion of the role of selected prisoners in support roles would require additional training and support. Those engaged in such work would benefit from training in basic counselling skills and psychological first aid, as well as the types of training provided by third sector organisations such as the Samaritans.

382. The replacement information technology system should include a sandbox function to assist with staff training in the appropriate use of the system.

Practice

383. The approach to suicide prevention should adopt good standards of health care with the use of fixed interval observations being replaced with assessment and regular review of mental health along with checks which are not at times predictable to the prisoner.

384. There should be greater discretion to provide support and to allow items in possession, where these are judged by multi-disciplinary case conferences to be useful in reducing risk whilst not presenting an unacceptable risk.

385. Prison Governors should be proactive in disseminating work on suicide prevention. Each prison should have a bespoke suicide prevention strategy, drawn from the overarching organizational strategy. This should be widely developed (with stakeholders) and disseminated to staff, prisoners, third sector partners and the public.

386. Meetings with bereaved families of prisoners to discuss the death by suicide of their loved ones should be led by a nominated senior and experienced health or social care professional.

Appendix 1 - Members of the Review Team ¹⁴⁹

Graham Towl

Graham Towl is Professor Emeritus and was lately Professor of Forensic Psychology at Durham University and held visiting Professorial roles at Newcastle upon Tyne and Glasgow Universities. He has extensive experience of working across criminal justice, having been the Chief Psychologist in the Ministry of Justice. Prior to that he was Head of Psychological Services (HM Prisons and Probation Service). He has previously been a member of the Independent Advisory Panel on deaths in custody, which advises UK ministers on deaths in custody and was a member of the Harris Review (2015) into Self-inflicted Deaths in Custody of 18-24 year olds. He is currently the Chair of the Scottish Advisory Panel on Offender Rehabilitation (SAPOR).

David Crighton

David Crighton is a Consultant Psychologist and was lately a Professor of Forensic Psychology at Durham University. He has previously held visiting academic roles as a Professor at Roehampton University London and London Metropolitan University. He has extensive experience of forensic mental health and work in prisons, having previously been Deputy Chief Psychologist in the Ministry of Justice. Prior to that he worked in the North East region of the NHS

¹⁴⁹ **Faye Horsley (Assistant Professor, Northumbria University)** contributed to aspects of the evidence review and initial project planning.

as a Consultant Psychologist. He is currently a panel member of the Scottish Advisory Panel on Offender Rehabilitation (SAPOR).

Clare Collyer – Project Manager

Clare Collyer is a highly experienced programme and project manager with a wide range of experience in the expeditious delivery of commissioned academic research.

Appendix 2 - Call for submissions

Talk to Me Review: Call for Views 8th May 2025

Views are being sought on how best to support vulnerable people in custody at times of crisis. An independent review is being undertaken into the Scottish Prison Service's Talk to Me suicide prevention strategy. It is part of the wider response to the FAI recommendations following the deaths of Katie Allan and William Lindsay at HMP & YOI Polmont.

The review is being led by Professor Graham Towl and Professor David Crighton, who are experts in suicide prevention and prison mental health. They are keen to also include the insight of stakeholders and individuals, who have experience and expertise in this area.

To do this they are issuing a call for views and providing an opportunity to answer a series of questions in a form available [here](#).

If you would like to be further involved, please feel free to contact TTMreview@proton.me

The final deadline for submitting views has been extended by a week and is now 8 July 2025. <http://www.sps.gov.uk/about-us/our-latest-news/talk-me-review-call-views>

Appendix 3 - Stakeholder Engagement

Meetings were held with the following stakeholders:

Criminal Justice Sector Voluntary Forum

Deaths in Prison Learning and Review Group (Chair)

Family members

Governors in Charge

HM Inspectorate of Prisons for Scotland

NHS Trust staff working in prisons

Professor Sarah Armstrong

Scottish Prison Service College, Polmont

Scottish Prison Service representatives (including CEO, Programme Manager, Health, Policy, and Data representatives)

SPS Suicide Prevention Coordinators

Ministerial Accountability Board

Appendix 4 – Literature Search

1. Abruyn, S. (2023). A Social Disorganizational Theory of Suicide 1. *Sociological Forum*, 38(2), 298–323.
2. Albanese. (1983). Preventing inmate suicides: A case study. *Federal Probation*, 47, 65–69.
3. Alessi, N. E., McMannus, M., Brickman, A., et. al. (1984). Suicidal behaviour among serious juvenile offenders. *American Journal of Psychiatry*, 141, 286–287.
4. Andrade, J., Gomes, H., Gonçalves, R., & Castro-Rodrigues, A. (2023). Suicide concerns among pretrial detainees: validation of the Portuguese version of the SCOPE-2. *The Journal of Forensic Practice*, 25(4), 452–461.
5. Angelakis, I., Austin, J. L., & Gooding, P. (2020). Childhood maltreatment and suicide attempts in prisoners: a systematic meta-analytic review. *Psychological Medicine*, 50(1), 1–10.
6. Annalisa, F., Letizia, B., Luca, R., Mancino, M., Marisa, M., Nicola, N., & Gianmarco, T. (2017). Prevention of suicide behind bars: first Italian results. *Egyptian Journal of Forensic Sciences*, 7:28. doi10.1186/s41935-017-0028-4
7. Anno, B. J. (1985). Patterns of suicide in the Texas Department of Corrections 1980–1985. *Journal of Prison & Jail Health*, 5(2), 82–93.

8. Arboleda-Florez, J., & Holley, H. L. (1988). Development of a suicide screening instrument for use in a remand centre setting. *The Canadian Journal of Psychiatry*, 33(7), 595–598.
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