Thematic report by HM Inspectorate of Prisons

The use of the person escort record with detainees at risk of self-harm

A thematic review

October 2012

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Published by:
HM Inspectorate of Prisons
1st Floor Ashley House
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LONDON
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Foreword

This two-stage report was initiated at the request of the Independent Advisory Panel of the Ministerial Board on Deaths in Custody and further work was commissioned following a discussion of the first-stage findings at the Ministerial Board.

It describes the process by which information about a person's risk of self-harm is transferred and used as they move between police custody, court and prison and on other external journeys. The main vehicle for conveying this information is the person escort record (PER) and its associated documentation. The PER, therefore, is a crucial part of how the state fulfils its duty of care for vulnerable people in custody.

The two key issues that emerge from the report are familiar from other settings where different agencies have to co-operate to fulfil a duty of care – maintaining quality in large-scale processes where risks might be infrequent but serious for the individuals concerned, and ensuring communication between the operational staff involved is effective and informed by a good understanding of each others' needs.

The report explores these issues in detail and makes recommendation that we hope will be helpful in achieving improvement. The research that underpins the report also inevitably touched on wider issues concerning the care of people at risk of self-harm in custody and suggests some further work that might help improve that care overall.

Nick Hardwick **October 2012**
Chief Inspector of Prisons

Glossary

This glossary explains some of the terms used in this report.

ACCT
Assessment, care in custody and teamwork self-harm monitoring documentation
ACPO
Association of Chief Police Officers
Asset
Youth Justice Board assessment documentation for young people
CEO
Court enforcement officer
Dip sampling
A quality control process used by police forces in which a representative proportion of files are selected and inspected
NOMS
National Offender Management Service
NPIA
National Policing Improvement Agency
NSPIS
National strategy for police information systems – Police Service computerised custody record system
PACE
Police and Criminal Evidence Act 1984
PECS
Prison Escort and Custody Services
PER
Person escort record form
PNC
Police national computer
P-Nomis
Prison national offender management information system
PSR
Pre-sentence report
SystmOne
Health care computer database
Trigger
An event that might cause a person to self-harm
YOI
Young offender institution

1. Introduction and purpose

1.1 In August 2011, HM Inspectorate of Prisons was asked by Professor Stephen Shute, a member of the Independent Advisory Panel of the Ministerial Board on Deaths in Custody, to inspect a sample of person escort record forms (PERs). The purpose of this work was to explore the extent to which information about the risk of self-harm to individuals obtained during their detention in police custody was accurately recorded and likely to be useful in subsequent care planning. We published our interim report of that work in January 2012. We recommended that further research should be completed in prisons and young offender institutions (YOIs) to see the extent to which information conveyed in PERs was helpful in managing the care of prisoners and young people vulnerable to self-harm. The Ministerial Board asked the Inspectorate to undertake that research, which then became stage two of this thematic review. It suggested a number of changes to improve the PER. During the final stage of the review in summer 2012, we held focus groups of PER users to test our recommendations about changes to the PER and its accompanying documentation.

1.2 A redesigned PER had been issued in 2009 and was implemented during 2010. Prison Service Order 1025 (2009) provides detailed guidance on the use of the revised PER. It specifies that:

> *'the PER is the key vehicle for ensuring that information about the risks posed by prisoners on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody. It is a standard form agreed with and used by all agencies involved in the movement of prisoners. The form highlights the risks posed by and the vulnerability of prisoners on external movement, provides assurance that the risks and weaknesses have been identified and communicated to those who are responsible for the prisoner and provides a record of events during a prisoner's movement.'*

1.3 PERs, when properly completed, are expected to help to prevent suicide, self-harm and other serious incidents. A PER is not a risk assessment tool but is designed to convey information about assessed risks to others who may need to know about them. A PER must be completed for every escorted external movement of a prisoner, whether responsibility transfers to another agency or not, and to whatever destination. PERs are used when prisoners are transferred from police custody to court, from court custody to prison, and from prison to court or another prison. They are also used when prisoners are escorted to appointments outside the prison, such as to hospital or as part of a police investigation. The *Guidance on the safer detention and handling of persons in police custody,* published by the Association of Chief Police Officer and National Policing Improvement Agency, specifies that the PER may be completed by a detention officer who is trained and competent to do so, but that responsibility for the content and sign-off of the form remains with the custody sergeant, who is also responsible for ensuring that any supporting documentation is attached. Forces should have systems for the quality assurance of completed PERs.[1]

1.4 Documentation that may be used in conjunction with the PER includes the following:

- The custody record that, as a generic term, includes detention logs, risk assessments and care plans. Custody records are completed by police custody sergeants or detention officers when a detainee is admitted to a police custody suite and during the period of

[1] ACPO/NPIA (2012) *Guidance on the safer detention and handling of persons in police custody* (second edition); Wyboston, NPIA.

detention. The detention log is a record of events during police detention, including observations, interviews, reviews under the provisions of the Police and Criminal Evidence Act (PACE) 1984, medical intervention etc. The PER also incorporates a detention log for the period during which a detainee is escorted or in court custody. That detention log is completed by escort or court custody contractors. Care plans specify details of the detainee's care in police custody, such as the frequency and method of observations. The police national computer (PNC) records details of every detainee and will contain 'markers' if someone previously in detention has been deemed a risk to him or herself or to others. The PNC will normally be consulted by a custody sergeant when a detainee is being booked into police custody and any warning markers noted as part of risk assessment and care planning. Police custody staff can also request that new warning markers are added to the PNC if a new risk becomes apparent during detention in police custody.

- Self-harm warning forms. These are supplied by the National Offender Management Service (NOMS) to escort and court custody contractors who are required to complete them if they become aware of a self-harm risk while a detainee is being escorted or in court custody. One of the police forces that participated in this thematic also completed self-harm warning forms, in addition to recording information about self-harm on the PER.

- The assessment, care in custody and teamwork (ACCT) monitoring system for managing risk of self-harm in prisons. NOMS describes the ACCT process as: 'a prisoner-centred, flexible care-planning system which, when used effectively, can reduce risk. The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed.'[2] When an ACCT is opened through the raising of a 'concern and keep safe' form, a trained ACCT assessor must interview the prisoner within 24 hours. The ACCT must then be reviewed by a group of relevant staff, including the residential manager, a health care representative and any other staff who know the prisoner, within a further 24 hours.

1.5 This report focuses on the use of PER forms to convey information from police custody to court custody and then to prison, but its recommendations should also be applied to other situations in which PERs are used, such as the transfer of immigration detainees.

1.6 The PER is one element in a range of processes by which the state fulfils its duty of care to those at risk of suicide and self-harm. The Inspectorate's regular programme of inspections of prisons and police custody repeatedly identifies unacceptable variations in how these processes are applied. The accounts we obtained from prisoners and detainees during this thematic review were consistent with those wider concerns. Some prisoners we interviewed gave examples of poor support from staff and degrading treatment, which risked exacerbating the risk that they would harm themselves. A few prisoners recalled police, escort and court custody staff asking them how they were feeling and offering basic reassurance, which they appreciated and found helpful, while others said staff barely spoke to them. Such unacceptably wide variations in the care provided were reflected in the different standards that we found in the completion and handling of PER forms and the information about self-harm that they are designed to convey.

1.7 Efforts to improve the PER system need to be stepped up alongside continued attention to improving the effectiveness and consistency of all aspects of the identification and care of prisoners at risk of harming themselves.

[2] Ministry of Justice, National Offender Management Service (2012) *Management of prisoners at risk of harm to self, to others or from others (Safer Custody).* PSI 64/2011. London, Ministry of Justice.

2. Methodology

2.1 The first stage of this thematic review, the inspection of PERs in police custody suites, commenced in August 2011 and finished in December 2011. We inspected 181 PERs in five police forces and Metropolitan Police Service boroughs: Nottinghamshire, Northamptonshire, Hounslow, Tower Hamlets, and South Wales. Inspectors read each PER and answered 21 questions about the information in the form (see pro forma questionnaire in Appendix I). This work was integrated with, but additional to, our usual inspection methods, findings from which this report also draws upon. Written information from the PER or custody record that was particularly striking was also noted.

2.2 The second stage of the thematic review took place during April and May 2012. We conducted fieldwork at five establishments: HMYOI Feltham and HMPs Styal, Doncaster, Brixton and Holme House. Through observation of reception, interviews with staff and prisoners, and inspection of records we explored the extent to which information contained in PERs is helpful to staff in prisons and young offender institutions when assessing risk of self-harm and devising care plans. We identified some common gaps in the information in PERs, and considered the implications of those gaps for the care of vulnerable prisoners and young people. That enabled us to make recommendations in this report about how the PER and its associated processes can be improved. We also met the mental health in-reach team at HMP Pentonville, which had established systems for ensuring information about self-harm was conveyed from policy custody and courts to the prison.

2.3 In July 2012 we held two focus groups of police custody, court custody and escort, and prison reception staff at Holme House and Pentonville to explore with them how the flow of information about self-harm can be improved. Participants worked together to identify strengths and weaknesses of the current PER and its associated documentation, and to suggest possible changes to improve the quality of information about self-harm.

2.4 We are grateful to all the police forces that contributed to the first stage of this thematic review, to the governors, director and staff of the establishments that took part in the second stage fieldwork, and to the escort and court services, prisons and police forces for their help in convening the focus groups.

3. Findings from the first stage of the thematic review

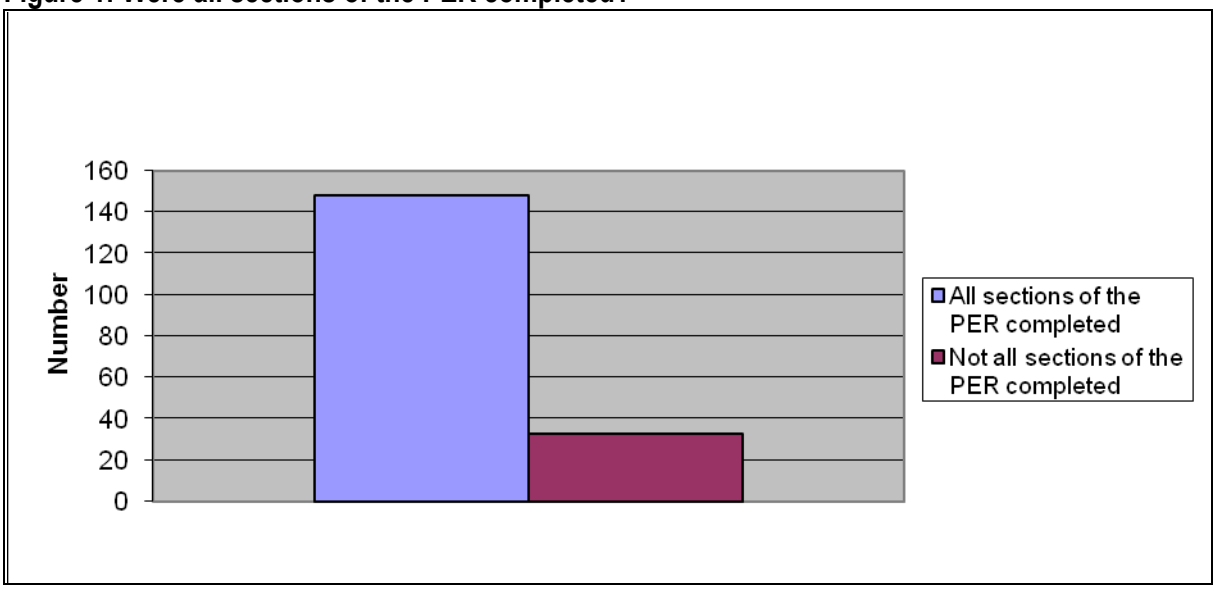
The inspection of PERs in police custody suites

3.1 Many PERs were partially or completely illegible. Those that could not be read at all were disregarded and did not form part of the sample. The PER copy retained by the police is the bottom (fourth) of four carbon pages. Custody and escort staff have to write firmly in ballpoint pen for their writing to reproduce clearly on that copy.

3.2 We found that in most police stations PERs were untidily stored, often bundled into box files separately from custody records. Pages had sometimes become detached from each other, which made extracting data even more difficult. In some instances, it appeared that pages from one detainee's PER had become mixed up with pages from another. Two custody suites did not keep copies of PERs at all. Only one of the five police forces, South Wales, undertook quality assurance checks of PERs. That force also provided training to staff about PER completion, and the quality of PER information in South Wales was significantly better than the others.

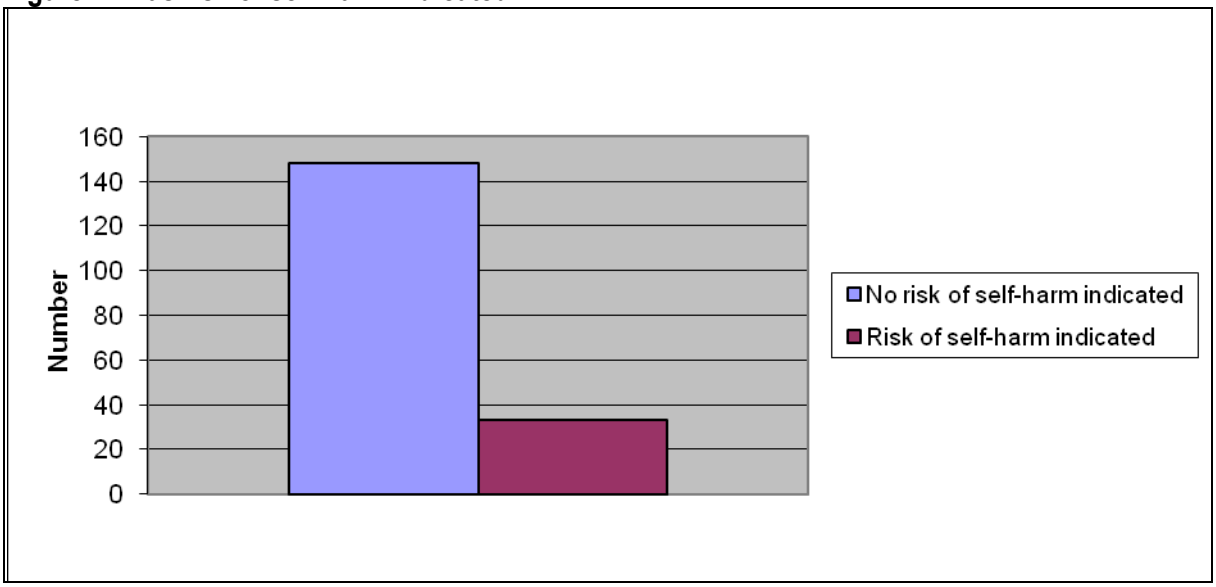
3.3 We found that 33 (18%) of the 181 PERs inspected were not fully completed. Missing information included staff names, a list of additional documents that should have been attached and contact details of the escort service. (Some of the figures below do not add up to 100%. This is because we were unable to read some PERs in their entirety, and we could not always obtain data for every relevant field.)

Figure 1: Were all sections of the PER completed?



3.4 Of the 181 PERs read, 42 recorded that a risk of self-harm had been identified (23% of the sample).

Figure 2: Was risk of self-harm indicated?

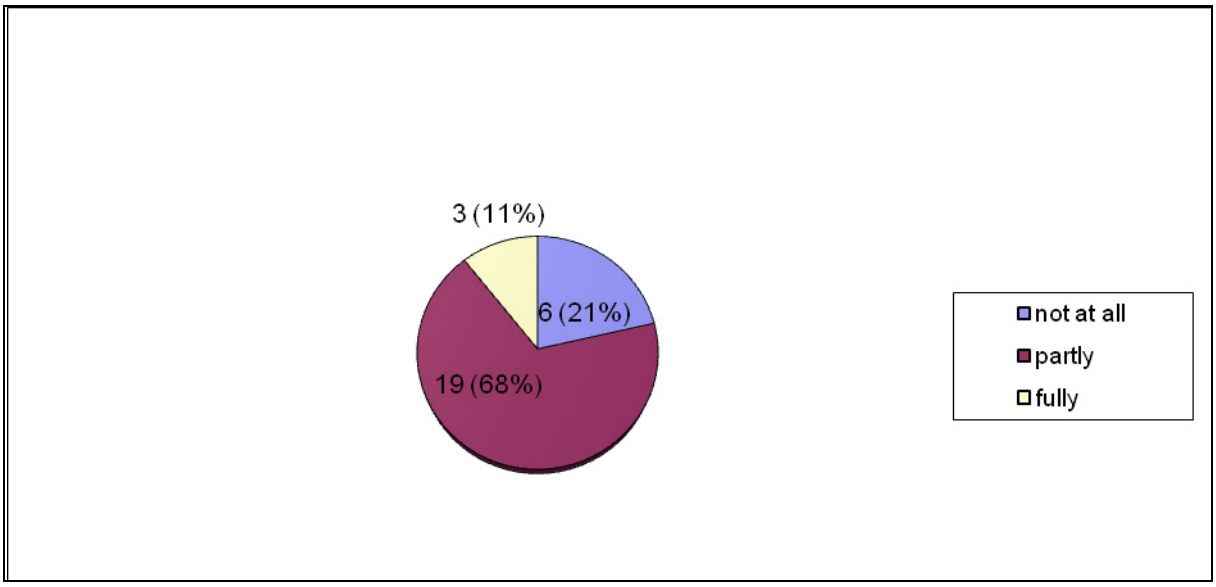


3.5 Where a risk of self-harm was identified, details of what had happened were specified in 12 (29%) of the 42 cases. We found that 10 of these PERs contained vague statements about self-harm that would have been more meaningful if they had included information normally elicited during booking-in. These statements included 'self-harm in prison in 2006', 'O/D the other night' and 'may try to kill himself in custody'. Similarly, the source of self-harm information was recorded in only a few PERs. The information in a PER about risk of self-harm should come from the police national computer (PNC), the risk assessment conducted during booking in and any subsequent revisions, and the detention log. Where there is a self-harm warning marker on the PNC, the police should produce a PNC printout and attach it to the PER, but this rarely happened other than in South Wales. An example of unusually full information about the nature of the self-harm was contained in a South Wales PER that included the detainee's own comments about his wish to harm himself.

3.6 In some cases, because information about self-harm was so scant, it tended to mask the potential seriousness of recent behaviour in custody. A PER recorded that the detainee had used part of a zip fastener to try to cut his arms in 2011, yet the custody record showed that during the current period in police custody he had threatened to kill himself. As well as cutting himself, he had banged his head on the floor repeatedly and had been placed in restraints.

3.7 We were particularly concerned about the relatively low rate of consistency between information about risk in the PER and the custody record. We found that the information was broadly consistent in only 11% of the 28 cases in which the risk information in the PER was legible, and partly consistent in 68%. It was judged to be not at all consistent in 21% of cases where we were able to read both the PER and the custody record.

Figure 3: To what extent were risks noted in the PER consistent with risks described in the custody record? (n=28)



3.8 Examples of inconsistency included an entry in the PER that the detainee 'threatened self-harm 2011' but the custody record risk assessment recorded 'no issues'. Another PER recorded no risk of self-harm, yet the custody record noted 'self-harm marks on PNC and arms (old)'. Some of the inconsistencies suggested questionable risk management practice in police custody. For example, a PER recorded 'numerous cuts to wrists, threatened suicide in custody', and the box indicating mental health problems was ticked. Yet the custody record simply stated 'wrists inspected – no cuts'. Similarly, a PER recorded 'suicidal on...' (a recent date). The custody log recorded that the detainee was put on 30-minute observations, with no rationale for not having more frequent or comprehensive observations despite the recent expression of suicidal intent. It might be that even though most police IT systems used during the booking in of detainees flag PNC risk information, it is sometimes not taken into account during care planning.

3.9 In no PERs was the box ticked to indicate that a copy of a care plan had been attached to it. It seemed that only South Wales police were completing a self-harm warning form and attaching it to the PER. This was done in seven of the 12 South Wales cases (58%) where the PER noted a risk of self-harm.

3.10 For accountability, and to ensure escort staff can be contacted if other personnel have concerns about a detainee and need information, PERs should record details of the escort service. Of the 181 PERs inspected, in 55 instances (30%) not all sections of the form were legible, and the section that records this information tended to be the least well completed. However, it is likely that this information was legible in the top copy which would be seen at the receiving establishment.

3.11 We judged that only 10 (24%) of the 42 PERs that indicated a risk of self-harm included information that would be helpful to the receiving establishment for determining the level of risk and devising a care plan or ACCT self-harm monitoring. Criteria in reaching this judgement included whether information about self-harm was contextualised with an explanation of its source, if it was dated, and if information from the risk assessment and the detention log was provided.

3.12 Our discussions with police in custody suites about PERs suggested that some staff did not fully understand the importance of the information they contain. PER completion was sometimes described as a bureaucratic process for minimising liability in the event of a death in custody, rather than seen as an important tool in planning and delivering detainee care.

4. Summary of key issues and recommendations from stage one

4.1 The bottom copies of PERs tend to be difficult to read and in many custody suites they were stored carelessly, making quality assurance checks difficult. We found that PERs were completed to a higher standard in the one force that quality assured them.

Recommendation: The possibility of moving away from a paper-based PER towards an electronic record that might be easier to complete, clearer to read and more open to quality control should be investigated. In the meantime, police services should ensure PER copies are filed carefully with the custody record to facilitate quality assurance checks, which should be included in regular custody record dip sampling. Where quality assurance reveals concerns about PER completion or the risk assessment process, there should be training or other focused interventions to improve quality.

4.2 Completed PERs tended to have little information about the nature of self-harm or the source of the information. It was rare for information provided by the detainee to be included in the PER.

4.3 There were marked inconsistencies in information about self-harm contained in PERs and custody records. It was not always evident that custody staff asked detainees about self-harm information flagged by PNC warning markers. This might suggest that while such markers were usually noted, they were not always addressed during the booking-in risk assessment process, but were nevertheless recorded in the PER. It seemed that some information that came to light during detention (such as a self-harm attempt) did not precipitate an overt revision of the risk assessment, but was nevertheless entered on the PER when the detainee was transferred.

Recommendation: Forces should review existing custody staff training about risk assessment and care planning. Training should ensure that custody staff can effectively integrate completion of PERs with their wider functions in risk assessment, risk management and detainee care. Training should equip staff to take information from the PNC into account when completing risk assessments and revise them when necessary. The source and nature of all information about risk of self-harm should be known and understood by staff responsible for detainee care.

4.4 Only one police force in this study told us that its officers routinely completed suicide/self-harm warning forms and sent them to the receiving establishment with the PER. Some custody staff told us that they were not aware of the forms.

Recommendation: The role of the additional documentation associated with PERs should be clarified and, if police custody staff are required to complete them, there should be a process to check them before the detainee is transferred.

4.5 Only 10 of the 42 PERs that indicated a risk of self-harm contained information that we judged would be helpful in the assessment of self-harm risk at the establishment to which the detainee was transferred.

Recommendation: There should be further research in prisons and young offender institutions to explore the extent to which PERs are effective in ensuring good risk assessment and care planning.

5. Findings from the second stage of the thematic review

The use of PERs in prisons and YOIs

5.1 In the second stage of the thematic review we undertook, at the request of the Ministerial Board on Deaths in Custody, the further research that we recommended in paragraph 4.5. We set out to explore three areas of concern that had arisen from stage one of the thematic:

- the extent to which information contained in PERs is helpful to staff in prisons and young offender institutions (YOIs) when assessing risk of self-harm and devising care plans
- identifying common gaps in information contained in PERs
- how PERs and their associated processes can be made more effective and enable the protection of vulnerable detainees to be improved.

5.2 The Ministerial Board also asked us to look at the extent to which health care staff found the health care computer database, SystmOne, to be a useful means of recording information about self-harm. We obtained data from:

- observation of receptions at the five participating establishments
- semi-structured interviews with 18 prison officers or managers, 32 prison health care staff and 19 prisoners and young people
- reading 30 ACCT folders and observing one ACCT assessment interview (some prisoners and young people recently subject to ACCTs had been released or transferred, were unavailable due to education or work commitments, or did not wish to be talk to us, so it was not possible to interview everyone whose ACCT we had read)
- reading the core records of 12 prisoners and young people who had recently been subject to ACCTs. We were told by staff involved in ACCT reviews that background information about prisoners' self-harm was available in core files, so it was important to ascertain the accessibility of such information in at least one establishment.

5.3 Demographic information about the prisoners and young people we interviewed was as follows:

Number of prisoners	**Age**
3	17 or younger
3	18-21
6	22-29
4	30-39
2	40-49
1	50-59
	Gender
14	Male
5	Female
	Ethnicity

14	White British
2	White Irish
1	Black British/Caribbean
1	Mixed heritage – white/black Caribbean
1	Other ethnic group
1	**Foreign national**
18	Not a foreign national
10	Considered themselves to have a **disability**[3]
9	Did not consider themselves to have a disability

5.4 All the prisoners and young people we interviewed were recently or currently subject to an ACCT. Fieldwork was completed by four HMIP inspectors and four specialist health care inspectors.

How helpful is PER information in assessing risk of self-harm and devising care plans?

5.5 Prison reception staff, nurses and ACCT assessors told us that PERs were useful as a means of flagging up that self-harm was an issue, but they cited other documentation – clinical records (which should only be accessible to health care staff), Asset (for young people) and the NOMS offender database P-Nomis – as more helpful in informing risk assessment. This was because the information in those systems was often more detailed and, unlike most PERs, usually contained an indication of the level and immediacy of risk.

5.6 In many but not all instances where the PER indicated a risk of self-harm, establishments received self-harm warning forms (most of which were completed by court custody staff), but these were not always attached to the PER. That meant that self-harm warning forms could easily become separated from the PER, and so reception staff might not know of the self-harm risk, especially because police, court custody or escort staff often failed to tick the box on the PER to indicate that additional documentation had been completed. Staff regarded self-harm warning forms as important because they 'flagged' an immediate concern, but these forms were not always received for every prisoner or young person for whom an immediate risk of self-harm was indicated, and the depth of the information they contained about history of self-harm, patterns and triggers was described as 'hit-and-miss'. Prison staff said they never received them from court enforcement officers (CEOs), who raise a PER for each detainee they arrest for non-payment of fines etc, some of whom might be vulnerable.

5.7 The extent to which reception staff were proactive in gathering information about self-harm varied greatly between the five establishments we visited. Reception staff at some showed a particularly strong commitment to helping vulnerable new prisoners, and there were good procedures in place, but this was not the case at all of them.

5.8 In most instances, court mental health diversion staff, or court custody officers, would contact the prison reception to alert them to the arrival of self-harmers, but some escort staff lacked information or detailed knowledge of vulnerable detainees. At Styal, we observed reception staff ask the escort contractor, 'is there anything else we need to be made aware of?' The

[3] Many of the prisoners who identified themselves as having a disability described a learning disability, such as dyslexia.

reply was, ' I don't know, I have been driving the vehicle', and he made no effort to check with his colleague if there was any further information that staff needed to know. Reception staff at three of the five establishments relied heavily on their health care colleagues to assess self-harm for new receptions and, if necessary, to initiate ACCTs. At one establishment, reception officers barely spoke to incoming prisoners other than to check their name. Here, the reception nurse told us that she always 'rifled through' as many PERs as she could to find information about self-harm, and placed the yellow (second) copy of the relevant pages, and any self-harm warning forms, in the prisoner's health care file. However, there was not always time to go through each PER thoroughly, so self-harm information might be missed, particularly if a self-harm warning form had not been completed. She added that she would, in any case, check SystmOne and the confidential medical file for any self-harm information for each incoming prisoner she saw. SystmOne (see paragraph 5.20) should not be relied upon as a substitute for information about self-harm that ought to be noted in the PER. This is because it would not contain information about a detainee who had expressed an intent to self-harm in police or court custody but who had not previously been in prison.

5.9 At Holme House, there was a handover sheet that accompanied the PER and the ACCT for outgoing prisoners subject to ACCTs, which required escort staff to confirm that they had been briefed about the prisoner. This was good practice.

5.10 We were told that close links between prison safer custody and/or mental health in-reach teams and local court mental health diversion schemes helped ensure accurate and immediate notification of risk of self-harm and its nature. Health care staff at Holme House were very positive about the prison's safer custody team, which they believed had improved the management of self-harm. At Pentonville, we talked with staff from the mental health in-reach team that covered the prison and the local magistrates' court. The team also liaised closely with mental health nurses working in the custody suite at Islington police station. Team members shared information about self-harm rapidly and routinely across the local police, court and prison, including HMP Holloway, which was also part of the scheme. The team manager emphasised the importance of enabling staff who had concerns about a prisoner's self-harm to form, record and communicate a view (a basic assessment) about the likely level of risk, and that view must be informed by information about triggers (an event that might cause a person to self-harm) obtained from the prisoner and any existing documentation. The role of the PER in these structures was secondary to that of SystmOne. This, we were told, was because information in the PER tended to lack the detail required, and because the PER did not encourage the person completing it to record their view about the immediacy of any risk.

5.11 The ACCT system is central to the management of risk of self-harm in custodial establishments, and during transfer to or from courts and between prisons. ACCT assessors told us they rarely saw PERs, which at most establishments went from reception into the prisoner's or young person's core file. They said they did not necessarily see self-harm warning forms, and that the information they contained was not always available to them when ACCTs were reviewed. They might have access to that information if it was contributed by health care staff who had opened the ACCT on reception, or if the self-harm warning form was kept in the ACCT folder or wing file. At some establishments, reception staff transferred information from the PER on to other documents, such as a reception handover sheet that accompanied the prisoner or young person from reception to the wing. There are potential risks in that practice, as information could be lost, misinterpreted or ascribed to another prisoner. A photocopy of the self-harm warning form could convey the information more reliably.

5.12 Some prisoners, young people and staff told us that an open ACCT conveys stigma, and this might lead vulnerable prisoners to downplay their risk to avoid an ACCT being opened. We saw the distinctive bright orange ACCT folders lying around in wing offices, discussed openly on reception, and referred to in the hearing of other prisoners. While it is right that ACCT folders should stand out and be immediately recognisable, it is important that prison staff maintain confidential and sensitive information securely. When a prisoner or young person is not currently subject to an ACCT, that does not imply the absence of any significant risk of self-harm.

5.13 At all establishments, there was a PNC check of new arrivals the next day to look for 'markers' about violence and self-harm. Access to the PNC is restricted to a very small number of prison staff who can read information about self-harm but cannot add any information to it. PNC information is important for completing cell sharing risk assessments, as well as the management of self-harm, and therefore it should be available on the day the prisoner or young person arrives. In the first stage of this thematic review, we found that some police staff attached a PNC printout to the PER when there were risks of self-harm, but this practice was not widespread, and some focus group participants told us they did not think they were allowed to do that because of data protection. The Information Commissioner's Office has advised us that attaching a PNC printout to a PER in those circumstances will not breach data protection legislation, provided that the amount of information disclosed is proportionate.

Identifying common gaps in information contained in PERs

5.14 The extent to which staff chased up missing information varied. Some always telephoned court custody officers, some said they never did, and none said they contacted the police. Prison staff believed the telephone numbers of court escort contractor control centres included on the PER were of little use, as control centre staff would not have any first-hand knowledge of the prisoner or young person. There were many complaints about inadequate information in PERs, for example, 'tried to kill himself in 2011'. Some staff said that parts of the PER were often unreadable due to poor carbon copies, including the yellow (second) copy that reception health care staff used at some establishments.

5.15 The difficulty or reluctance that staff described in chasing missing information exacerbated the limitations of PERs that were not completed fully or clearly, or where the accompanying documentation was missing.

5.16 While ACCTs were often opened by reception health care staff who might have had access to the PER and self-harm warning form, ACCTs were very often assessed and reviewed without the benefit of any background information, unless the review was attended by health care staff. They tended to be the only personnel who had ready access to information about previous self-harm thoughts or behaviour. Of the 30 ACCTs we read, 26 (87%) made no reference to existing information, although most staff told us they tried to look at P-Nomis, the Asset (for young people) and pre-sentence reports (PSRs) before ACCT reviews. Many of the ACCT folders we read contained no record of health care involvement in reviews. This is a frequent finding in prison inspections and we often recommend that prisons should ensure the attendance of health care staff at ACCT reviews. An ACCT assessment we observed was very nearly completed with no information other than what the prisoner himself had told staff, until a nurse came in near the end of the meeting with some historic information. While prisoners themselves are an important source of information, the receipt of historic information should not be left to chance, particularly with the tendency of some prisoners to avoid the stigma of an ACCT being opened. For example, a prisoner we interviewed had recently attempted to throw himself off a bridge on the anniversary of his brother's death after jumping from the same bridge. This was a vulnerable time of which staff should be aware, which could have been

documented, but prisoners and young people might not volunteer such information in an ACCT assessment interview. It is this type of information that heightens the immediacy of risk and which the PER should prompt staff to record. Although the PER cannot be expected to hold all relevant information, it should be used as a pointer to areas of significant concern and to where detailed information can be found.

How PERs and associated processes can be made more effective and help improve the protection of vulnerable detainees

5.17 There was rarely any information in the PER or accompanying documentation about the context in which the self-harm took place, what the prisoner said about it or the prisoner's mood. Prison staff told us they would like to have that information. Few prisoners told us the police asked them about self-harm and how they were feeling, except during booking in at the police custody suite. Some had attempted self-harm after booking in. Some police forces and CEOs still used the previous, obsolete version of the PER.

5.18 P-Nomis might have potential for greater use in transferring information about self-harm, but staff felt it needed a self-harm search tool that would quickly bring up any details about a detainee's self-harm. Pre-sentence reports were also described as useful, but not all prisoners have a PSR, and it is unsatisfactory that probation staff fax reports to the prison on the next working day when the information is needed immediately.

5.19 Requiring police or court custody staff to make a basic assessment of risk and its immediacy might encourage them to talk with detainees. When inspecting police custody suites, we expect risk assessment to be a dynamic process where risk is reviewed during the detainee's period in custody in the light of changing circumstances. In the first stage of this thematic review, we described the inconsistency between information about risk in the PER and in the police custody record, and we noted the lack of information in PERs about what detainees themselves say in police custody about their self-harming. These findings suggest that, in many instances, police custody staff either do not talk sufficiently to detainees about how they are feeling or that, when they do, new information does not find its way on to the PER, even though it may have led to a revision of the care plan.

The role of SystmOne

5.20 The Ministerial Board asked us to include in this thematic an exploration of the extent to which SystmOne is an effective tool for health care staff in managing risk of self-harm. In the five establishments we visited during fieldwork, we found that the reception first health screen of new arrivals on SystmOne was a suitable mechanism for making robust assessments of self-harm. However, in inspection reports we have been critical of the restricted availability of SystmOne in some establishments and, occasionally, the lack of computers equipped with SystmOne in prison receptions. In a recent prison inspection, we found that not all the establishment's health care staff had been trained in using SystmOne. Although in most prisons health care staff who undertake initial health care screenings use SystmOne, there are still some establishments where ready access is lacking. In those circumstances, there is a risk that staff may have no historical information about a prisoner's or young person's previous self-harming when they determine if an ACCT should be raised. The PER did not follow the prisoner or young person into health care in all establishments, although at one the reception nurse took out the yellow copies (the first carbon copy of each PER) of many of the PERs received – this was in response to a death in custody investigation. In some establishments, there was clear information that health care staff were involved in ACCT reviews, but that was not the case in all.

5.21 There is a potential concern about the use of the term ‘medical’ rather than ‘health care’ information in the PER. If the form is to be subject to further revisions, this would be a good opportunity to consider a change in terminology.

5.22 Historic medical information for prison transfers was available on SystmOne, although there were some discrepancies. For example, one case recorded no information from outside sources, despite a self-harm warning form in the health care file. At one establishment, written information received from outside the prison was scanned into SystmOne, which was a potentially useful initiative. At another, all prisoners subject to an ACCT had a separate health care plan that was regularly reviewed.

6. The focus groups

6.1 We convened two focus groups in July 2012 to bring together police custody sergeants and detention officers, court custody and escort staff, and prison reception officers, health care staff and ACCT assessors. The focus groups took place at HMPs Holme House in Stockton-on-Tees and Pentonville in London. We asked the focus groups to answer three questions:

- What aspects of the PER currently work well, and what needs improvement?
- What changes, if any, should be made to the PER and its accompanying forms?
- How can we ensure consistent, good quality information in PERs?

6.2 The Holme House and Pentonville focus groups produced broadly similar findings. Police custody staff said they valued the opportunity to discuss self-harm issues with prison staff, with whom they normally had no contact, and vice versa. Similarly, while escort staff had regular contact with police and prison staff, they had little knowledge of how the information they handled was generated, and how it was used at receiving establishments. Earlier in this report we referred to our perception that some staff saw the completion of PERs primarily as a means of limiting their organisation's liability in the event of a death in custody (paragraph 3.11). While this was not how the focus group participants said they treated PERs, they did think that their lack of knowledge about the uses to which self-harm information was put might sometimes mean that PERs were completed routinely with little thought taken. They believed this could lead to the staff completing PERs not being focused on the protection of vulnerable people, resulting in a lack of care in providing information.

6.3 The focus groups considered that the PER required too much information and tried to cover too many functions in one document. Prison staff echoed the findings from the second stage fieldwork, that the information they wanted – about the level and immediacy of risk and the context of previous self-harm – was rarely supplied because the PER did not require police or court and escort staff to provide it. They made a range of suggestions about how the PER could be improved, which included:

- The PER should have a prominent box to indicate the degree of concern about self-harm, with space, and prompts, for recording the rationale for that assessment. There should be fields for historical, recent or current self-harm, and a means of indicating if the risk is standard or high.
- All pages should be perforated to allow their separation from the cardboard sections, to facilitate copying and storage.
- Problems with the carbon copies should be resolved.
- There should be a better means of conveying supporting documentation, such as a pocket for self-harm warning forms, to minimise the chances of loss.
- There should be a checklist that custody sergeants sign to ensure there has been a clear basic assessment of risk and that all accompanying documentation is complete.
- The possibility of combining the PER with the self-harm warning form should be explored.
- The self-harm warning form should incorporate space for the prison or YOI to record the action they have taken in response to the risk.
- Guidance on completion should be revised so that it is more focused on the distinct roles of the staff responsible for completing each part of the PER.
- NOMS should provide revised training materials to police services and court custody and escort contractors to enhance staff's understanding of how the information they supply is used.

6.4 The groups wanted more space in the PER for contextual or historic information, a more logical flow to the information, and restructured guidance on completing the PER. There was widespread support for the development of an electronic PER that would overcome the difficulty for many in reading handwritten information. This, they thought, should be able to work alongside other computer systems, such as the police NSPIS custody record system, P-Nomis, the escort contractor's online detention log, etc. We understand that some police forces are considering developing an electronic version of the PER. The prospect of different organisations establishing various systems that could be incompatible with each other and with other systems is a concern.

6.5 In relation to ensuring good quality information, the focus groups suggested concise guidance for specific settings – such as separate guidance notes for police staff, with checklists to remind staff to note particular information. Most participants wanted better training to enable them to understand how the information they were providing or using was generated, or how it would be used, and how their work fitted into the wider context of protecting people in custody who are vulnerable to self-harm. Some police staff told us they had never heard of ACCTs. We handed round some blank ACCT folders and explained how the system works, after which participants said they could now understand how and why the quality of the information they supplied was so important. Some suggested that a short training film would be helpful. The focus groups wanted a quality assurance process, such as dip sampling, to ensure that PERs were completed to a consistently high standard. Two senior custody officers said that, as a result of attending the focus group, they would brief their colleagues about the importance of PERs and check they had understood this. All were enthusiastic about the opportunity to contribute to the improvement of the flow of information about self-harm, and many said they would like to test any new version of the PER before implementation.

7. Summary of key issues, recommendations and examples of good practice from stage two and the focus groups

7.1 The following key issues and recommendations from the second stage of this thematic review, which address how PERs and their associated processes can be made more effective, are informed by findings from the first stage, previous prison, police custody and court custody inspections, and the work of the focus groups.

7.2 Because the information in PERs was regarded as being less detailed than that in pre-sentence reports, Assets and other reports and on P-Nomis, prison and YOI staff found the PER to be of limited use. ACCT assessors did not usually see PER documentation. For that reason, valuable information that might be contained in a PER or a self-harm warning form – such as a self-harm attempt in police or court custody – could be overlooked in risk management and care planning. Some detainees, especially adults with little previous contact with criminal justice agencies, might come into prison with no information about them other than the PER. Self-harm warning forms were not always sent with the PER to clarify a current concern. The exchange of information about vulnerable detainees was described as very efficient at Pentonville, where the mental health in-reach team worked not only in the prison but also in the courts and police custody suites that it served.

Recommendations

1. NOMS should establish mechanisms to encourage Prison Escort and Custody Services (PECS), police services, prisons and the PECS contractors to work together regionally to improve the quality and flow of information about self-harm. This should include quality assurance, provision for notifying police national computer markers, consistency in the use of self-harm warning forms, staff training, and convening an inter-agency forum to steer improvements and resolve any problems.

2. The inter-agency forums should create opportunities for operational staff and managers working in police custody, escorts, courts and prisons to have a regular structured meeting to learn about each other's work and understand the importance of generating accurate and comprehensive information about self-harm.

7.3 Some prisons relied on health care staff to screen prisoners for self-harm on reception, yet the ACCT assessment and review process is managed by residential staff. Contributions by health care staff to that process were often left to chance, which has also been a finding in many recent prison inspections. Many prison inspections have also found that not all reception health screening staff had access to the SystmOne clinical IT system or were trained in using it.

Recommendations

3. All prisons that receive prisoners from court should be part of the multi-agency forum proposed in recommendation 1 above, to promote understanding among other agencies of their information needs and to resolve difficulties with PER information.

4. Prison reception health care screenings should only be done by health care staff who have been trained in the use of SystmOne and who have access to it during the screening interview.

7.4 Police detention officers and court custody/escort staff who participated in the focus groups had a very limited knowledge of how the information about self-harm that they were recording or conveying was used in receiving establishments. They had little understanding of what was needed to enable accurate risk assessment and effective care planning, but were keen to contribute to those processes. Nevertheless, their collective experience and insights generated a range of ideas about how the PER and its accompanying processes can be revised to enhance the provision of information that prison and YOI staff say they need for effective risk assessment and care planning.

Recommendation

5. NOMS should incorporate suggestions from the focus groups in revising the PER and developing new guidance and training materials, which should be tested with groups of staff before implementation.

7.5 During this thematic review, we could not avoid going beyond the remit of focusing on self-harm information recorded in PER forms. It would have been inappropriate, and a wasted opportunity, to have ignored the wider arena of risk management and detainee care in which PERs are used. Accordingly, we make three further recommendations about that wider context that, if implemented, could lead to tangible improvements in the care of detainees who are vulnerable to harming themselves.

Recommendations

6. The Ministerial Board on Deaths in Custody should commission work to develop the coverage of courts by mental health diversion teams, and to strengthen joint working between court and prison mental health services.

7. Prisons and YOIs should regularly review their arrangements for managing risk of self-harm in order to improve the accessibility and quality of information, ensure all relevant staff contribute to the assessment, care planning and review of detainees who might be vulnerable to self-harm, and enhance the skills and competence of all staff involved in that work.

8. Staff training should encourage police, court custody and escort staff to talk with detainees, particularly when concerns have been identified, as part of the process of actively monitoring their mood. It should equip staff to recognise and ask about any significant evidence of increased risk of self-harm, record it and note it on the PER, and it should provide staff with basic awareness of how information about risk of self-harm is used.

Examples of good practice

7.6 *At HMP Holme House, reception staff completed a handover sheet that accompanied the PER and the ACCT for outgoing prisoners subject to ACCTs, which required escort staff to confirm that they had been briefed about the prisoner.*

7.7 *The work of the mental health in-reach team that served HMPs Pentonville and Holloway as well as local magistrates' courts and police custody suites enabled information about self-harm to be shared effectively between police, court and prison staff.*

8. Conclusions

8.1 This short thematic review has provided a good opportunity to consider the process that the PER provides for conveying information about self-harm, from the originators of that information in police custody suites to its 'end-users' working in prisons and young offender institutions.

8.2 The key findings and recommendations from stage one of the thematic review provide a strong rationale for improving the training of staff involved in recording self-harm information. Stage two and the focus groups showed that many staff, despite their best intentions, did not understand what information they should provide. That is because they had no knowledge of how it would be used at its destination and how important it ought to be in helping to safeguard vulnerable people. Such a significant gap in their knowledge might have led to a focus on protecting the organisation rather than a more appropriate concern with improving outcomes for detainees. It could explain the finding that some police detention officers remembered to record information about PNC warning markers but did not note in the PER what detainees did while in police custody, or what they said about their feelings. Such first-hand information can give a fuller, different and more helpful picture to that provided by PNC markers. Lack of quality assurance prevents such deficits being picked up and addressed day-to-day. Indeed, some of the deficits that we found, such as the lack of quality assurance and the tendency of custody sergeants to leave the completion of PERs to detention officers, are the subject of requirements in *Safer detention and handling of persons in police custody* that are often unfulfilled.

8.3 We were glad to find during recent police custody inspections that some forces have now acted to improve quality assurance following the publication of the report of the first stage of this thematic review.

8.4 Findings from the second stage echo some previous prison inspection reports. They include the frequent non-availability of information about triggers and the context in which detainees had previously harmed themselves, and the paucity of important background information in processes, such as ACCT, that are central to the care of vulnerable detainees. The problem was not that information was lacking, but that it was not conveyed effectively to those who needed to see it. Changes in the design of the PER and its accompanying documentation, improvements in how the information is stored and disseminated in establishments, and better participation by key staff in ACCT assessments and reviews could all ensure better use of that information.

8.5 As well as suggesting changes to the design of the PER, the focus groups also underlined the importance of staff training in completing PERs, basic risk assessment and understanding how information is used. Our interviews with prisoners and young people reinforced the imperative that training should help staff to see that punitive responses to self-harm are unacceptable and unproductive. Prisoners and young people who had self-harmed told us they valued custodial staff asking how they were feeling and expressing empathy. That approach builds trust and helps gain important information, and is a prerequisite for putting in place effective measures to safeguard vulnerable people.

9. Recommendations from stages one and two

Stage one

To NOMS

9.1 The possibility of moving away from a paper-based PER towards an electronic record that might be easier to complete, clearer to read and more open to quality control should be investigated. In the meantime, police services should ensure PER copies are filed carefully with the custody record to facilitate quality assurance checks, which should be included in regular custody record dip sampling. Where quality assurance reveals concerns about PER completion or the risk assessment process, there should be training or other focused interventions to improve quality. (4.1)

To all police forces

9.2 Forces should review existing custody staff training about risk assessment and care planning. Training should ensure that custody staff can effectively integrate completion of PERs with their wider functions in risk assessment, risk management and detainee care. Training should equip staff to take information from the PNC into account when completing risk assessments and revise them when necessary. The source and nature of all information about risk of self-harm should be known and understood by staff responsible for detainee care. (4.3)

To NOMS/ and all police forces

9.3 The role of the additional documentation associated with PERs should be clarified and, if police custody staff are required to complete them, there should be a process to check them before the detainee is transferred. (4.4)

To Ministerial Board on Deaths in Custody

9.4 There should be further research in prisons and young offender institutions to explore the extent to which PERs are effective in ensuring good risk assessment and care planning. (4.5)

Stage two

To NOMS

9.5 NOMS should establish mechanisms to encourage Prison Escort and Custody Services (PECS), police services, prisons and the PECS contractors to work together regionally to improve the quality and flow of information about self-harm. This should include quality assurance, provision for notifying police national computer markers, consistency in the use of self-harm warning forms, staff training, and convening an inter-agency forum to steer improvements and resolve any problems. (7.2.1)

9.6 The inter-agency forums should create opportunities for operational staff and managers working in police custody, escorts, courts and prisons to have a regular structured meeting to learn about each other's work and understand the importance of generating accurate and comprehensive information about self-harm. (7.2.2)

9.7 All prisons that receive prisoners from court should be part of the multi-agency forum proposed in recommendation 1 above, to promote understanding among other agencies of their information needs and to resolve difficulties with PER information. (7.3.3)

9.8 Prison reception health care screenings should only be done by health care staff who have been trained in the use of SystmOne and who have access to it during the screening interview. (7.3.4)

9.9 NOMS should incorporate suggestions from the focus groups in revising the PER and developing new guidance and training materials, which should be tested with groups of staff before implementation. (7.4.5)

9.10 Prisons and YOIs should regularly review their arrangements for managing risk of self-harm in order to improve the accessibility and quality of information, ensure all relevant staff contribute to the assessment, care planning and review of detainees who might be vulnerable to self-harm, and enhance the skills and competence of all staff involved in that work. (7.5.6)

To Ministerial Board on Deaths in Custody

9.11 The Ministerial Board on Deaths in Custody should commission work to develop the coverage of courts by mental health diversion teams, and to strengthen joint working between court and prison mental health services. (7.5.6)

To NOMS and all police forces

9.12 Staff training should encourage police, court custody and escort staff to talk with detainees, particularly when concerns have been identified, as part of the process of actively monitoring their mood. It should equip staff to recognise and ask about any significant evidence of increased risk of self-harm, record it and note it on the PER, and it should provide staff with basic awareness of how information about risk of self-harm is used. (7.5.8)

Appendix I: Person escort record/custody file analysis template

Reference number: Custody suite: Juvenile?

1. Whole form	**Yes**	**No**
1.1 Are all relevant sections of the PER completed?		
1.2 If not, what sections are incomplete?		
1.3 Are all entries legible?		
1.4 Does the PER contain all necessary signatures, names, dates etc?		
1.5 Who is the originator of the form?	**Police**	**Prison**

2. Risk indicator page	**Yes**	**No**
2.1 Are any risks of suicide or self-harm identified? (If none identified, check 'escort handover details' page and 'history and events' pages for consistency)		
2.2 If risks are identified, are details of what happened and when it happened specified?		
2.3 Does the information about risks identified fit in the category of risk under which it has been recorded?*		
2.4 Is the source of the information about self-harm recorded?		
2.5 To what extent are the risks identified consistent with any risks described in the custody record risk assessment?	Not at all Partly Fully	
2.6 If 'risk has changed' is initialled, has an entry been made on the 'history and events' page?		
2.7 If a new PER form has been completed, is the previous form attached to it?		
2.8 If a care plan is required, is it attached?		

2.9 If risk of self-harm is indicated, is a self-harm warning form attached?		
2.10 If the prison has originated the form and there is an ACCT in place, is information from the ACCT attached?		

*For example, if the person is identified as having a history of self-harm, is this information recorded under the correct heading 'suicide and self-harm'?

3. Escort handover details page	**Yes**	**No**
3.1 Are phone numbers given as instructed?		
3.2 Are details in the 'forms enclosed' section properly completed?		
4. History and record of detention and events forms	**Yes**	**No**
4.1 If the risk has changed (see 'risk indicator page') has information been given about it here?		
4.2 Has any new risk of self-harm been identified?		
4.3 If new risks are identified, are they clearly described with information about the context?		
4.4 Do you consider the information given is adequate to help the receiving prison /YOI manage the risks?		

Further information or comments:

Useful case example material:

HM Inspectorate of Prisons is a member of the UK's National Preventive Mechanism, a group of organisations which independently monitor all places of detention to meet the requirements of international human rights law.