Independent
Advisory Panel
on Deaths
in Custody

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# Ligature deaths in prisons in England and Wales: trends and reduction strategies

2025

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*The IAPDC is an advisory non-departmental public body that provides independent advice and expertise on deaths in custody to Ministers, senior officials and the Ministerial Board on Deaths in Custody (MBDC). Along with a wide range of senior stakeholders, including Government departments, custody leaders, and charities, it is a member of the MBDC but is independent of Government.*

# Chair's Foreword

Deaths by ligature in prisons have remained too high for too long. Between 60 and 110 such deaths have occurred in prisons in England and Wales over the past decade.

This translates to an average rate of 77 ligature deaths per 100,000 prisoners – more than seven times higher than the average suicide rate across the entire population in England and Wales. These deaths continue to account for the overwhelming majority of prison suicides.

While it may not be possible to prevent every suicide in custody, we can – and must – limit the means which make these tragedies possible. Prisoners most frequently use bedding, shoelaces, and clothing – seemingly harmless objects – to cause harm to themselves. Windows, beds, and light fittings are the most used ligature points, continuing to pose serious challenges to safety within the prison environment. Although reducing access to these items can be challenging – particularly within the context of an ongoing capacity crisis – mitigating the risks they pose should not be beyond the grasp of the prison service.

As our report highlights, there is currently no cohesive national strategy for reducing ligature risks in prisons, nor consistent oversight to ensure that ligature safety standards are upheld across the prison estate. A coordinated approach is needed which combines understanding of the issue at national level with intelligence and best practice at local level to deliver a comprehensive and systematic response throughout the prison system.

I have spoken with dedicated staff and governors who have shown real commitment to addressing this issue; however, there is no straightforward solution. Ligature reduction strategies must be part of a broader, holistic, and multidisciplinary approach to identifying and managing risk effectively. Too often, staff rely on prisoners' self-presentation, custody and healthcare staff operate in silos, and there is a lack of follow-up and support following assessment, Care in Custody and Teamwork (ACCT) closures.

These gaps leave vulnerable individuals at continued risk. It is essential to facilitate research within the prison environment to better understand what works in preventing ligature and other types of deaths and to evaluate the effectiveness of these strategies. Prisons are closed institutions, which makes access to data and evaluation more challenging – but also more critical. Improved access to research is vital to ensuring Government can meet its responsibility to safeguard the lives of those under its care.

I am under no illusion about the scale of this challenge. Prisons face the incredibly difficult task of balancing safety with dignity. It is not feasible to remove every potential ligature risk – especially for those serving long sentences where maintaining humane and liveable conditions is essential. However, we can draw learning from the progress made in secure health settings and police custody suites, where ligature reduction programmes have led to a marked decrease in such deaths.

Our report seeks to bring the critical issue of ligature deaths in prisons to the forefront and provides a foundation for meaningful and lasting reform in their prevention. We urge the Government and prison leaders to act on these findings and recommendations. Finally, I would like to express my sincere thanks to Rachel Chow, researcher in forensic mental health at the University of Oxford, working under the guidance of IAPDC member Professor Seena Fazel, for the diligence and care with which she conducted the research included in this report.

Lynn Emslie

**Chair of the Independent Advisory Panel on Deaths in Custody**

# Executive summary

1. The latest statistical analysis published by the IAPDC reported trends and rates of deaths from all causes which took place in prisons, police custody, immigration detention centres, and detention under the Mental Health Act between 2017 and 2021.[1] In the report, the IAPDC called for high-quality evidence on death rates and risk factors and improved assessment of suicide and premature mortality risks for prevention of deaths among individuals in detention. This includes risks relating to the use of ligatures.

2. In support of the nationwide initiative to reduce deaths in custody and the suicide prevention strategy for England,[2] this report provides a summary of all ligature deaths in prison custody in England and Wales from 1999 to 2024 and an overview of ligature prevention strategies for prisons informed by existing frameworks, guidelines, and international research evidence.

3. The key findings and recommendations from this report are as follows:

# Findings regarding ligature death prevention in prisons

### Prevalence and patterns of ligature deaths

- Ligature deaths account for the majority (89%) of self-inflicted deaths among prisoners in England and Wales.
- There were 1,885 documented ligature deaths and an average of 73 ligature deaths per annum in prisons in England and Wales between 1999 and 2024.
- In the past 10 years, the average rate of ligature death in prisons in England and Wales was 77 per 100,000 prisoners.
- The rate of ligature deaths in prisons was disproportionately higher when compared to the rate across the entire population.
- In the 12 months up to December 2024, there were 74 ligature deaths, very slightly down from 80 in 2023.
- Most ligature deaths were by hanging, but female prisoners were more likely to die by self-strangulation.

### Methods and means

- Prisoners most frequently used bedding (73%), shoelaces (10%), and clothing (3%) as ligature means.
- The most frequently used ligature points among prisoners were windows (47%), beds (19%), and light fittings (8%).
- Prisoners may use ligatures for suicide due to limited access to other methods and their perception that it causes less physical suffering.

### Risk factors

- Potential risk factors of suicide in prison identified in international research include suicidal ideation during period in current prison, history of suicide attempt or self-harm, single-cell occupancy, psychiatric disorders, remand status, and homicide or violent crime conviction. These factors have different magnitudes of effects.
- Frustration and anxiety associated with long detention, lack of meaningful activities and interventions, and bullying among prisoners were highlighted as potential risk factors of suicide in reports from inspections of prisons in England and Wales.

### Current prevention measures

- Current efforts to reduce ligature deaths in English and Welsh prisons focus on the provision of ligature-resistant cells. Other ligature death prevention strategies include refurbishment of older cells to eliminate ligature points, constant supervision, structured risk assessment, and use of ligature knives.
- Adopting a structured approach to risk assessment supports evidence-based decision-making for interventions and the allocation of limited anti-ligature resources. A structured approach also enables identification of key risk factors throughout all stages of prisoners' incarceration.

### National Oversight and Strategic Direction

- There is a lack of national strategy and oversight in ensuring consistency in cell ligature safety standards across prison establishments.

1. IAPDC (2024). Statistical analysis of recorded deaths in custody between 2017 and 2021. IAPDC. https://cloud-platform-e218f50a4812967ba1215eaecede923f.s3.amazonaws.com/uploads/sites/21/2024/04/IAPDC-statistical-analysis-of-recorded-deaths-in-custody-between-2017-and-2021.pdf

2. Department of Health & Social Care (2023). *Suicide prevention in England: 5-year cross-sector strategy.* https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy

### Workforce training and capacity

- Poor links between prison and healthcare services, superficial and unstructured risk assessments, and lack of emergency response training could impair organisational efforts to reduce suicide deaths among prisoners.
- Prison staff should receive sufficient training in first aid and good custody recording practice for prompt response to ligature events.

### Research and evaluation

- More research in prisons is required to evaluate changes attributable to ligature death prevention and to incorporate evidence-based approach in risk assessment and interventions.

# Recommendations for ligature death prevention in prisons

### Establishing a national and coordinated approach to ligature death reduction

- Encourage cross-establishment sharing of prison audit findings to improve consistency in cell design and suicide prevention approaches between prisons, so that priorities and action plans could be identified to establish a national ligature death prevention strategy.
- Establish national “minimum expectations” in cell ligature safety standards.

### Enhancing safety through design, materials, and maintenance while preserving dignity

- Review and remove ligature points in both new-built and old cells (particularly those on windows, beds, and doors or cell gates) while maintaining an unrestrictive and humane environment, with reference to cellular accommodation design guides and checklists.
- High-priority areas should be identified to guide ongoing work addressing ligature points such as windows in older prisons, with progress reviewed regularly.
- Personnel involved in designing ligature-resistant cells should recognise that a low height of ligature point does not indicate safety.
- Explore the usability of alternative materials for ligature-resistant bedding in cells.

### Establishing structured monitoring and information sharing for ongoing risk management

- Establish criteria in the level of supervision required for ‘at risk’ prisoners to ensure prompt response to ligature use events by staff.
- Improve information sharing and communication between prison staff and other professionals, particularly with healthcare services.
- Post-incident early reviews should be conducted to identify factors, including potential ligature points in prisoners’ environment, which may have been inadequately addressed to prevent death.
- Risk assessment and intervention frameworks should be evidence-based (e.g., by considering findings from high quality research identifying risk factors).
- Improve risk assessment by incorporating findings of new evidence on role of structured approaches to support professional decision-making, particularly at the end of the ACCT process.

### Facilitating research in prisons to inform effective prevention strategies

- Encourage collaboration between prison establishments and researchers to evaluate impact of changes to policies and efficacy of existing and new suicide prevention strategies.

# Introduction

1. The risk of suicide is particularly high in prisons and ligature use – hanging or self-strangulation – is the most common method of suicide attempt across all custodial settings. A ligature or ligature means is any material that can be used for the purpose of hanging or strangulation. A ligature point is any object that could be used to attach a ligature. Prisoners are resourceful in utilising different objects within their cell to create ligature means or ligature points for suicide, which makes eliminating barriers to reducing deaths in prisons difficult.

2. **Ligature use is a highly lethal method of suicide:** around 70% of individuals who hang themselves die.[3] It presents little opportunity for intervention and resuscitation, and so prevention is key. Understanding patterns of ligature death among prisoners could assist identification of individuals at risk, supporting ongoing efforts to reduce deaths in custody in England and Wales.

3. **This report provides:**
   (i) A summary of the trends on ligature deaths in prison custody in England and Wales from 1999 to 2024
   (ii) An overview of protective measures against ligature deaths in prisons or other settings that may be adapted for use in prisons
   (iii) An overview of international research evidence on ligature deaths in prisons and how they could inform practice in HM Prison and Probation Service (HMPPS).

4. **Findings from this report will be especially informative to individuals responsible for:**
   - Assessing and managing risks of suicide among prisoners and custody detainees in need
   - Purchasing, installing, and maintaining fixtures in prison cells.

# Methodology

5. Data analysed for this report were mainly extracted from the Safety in Custody Statistics: Death annual tables most recently published by the Ministry of Justice (MoJ) (see Appendix for the full list of data sources). The historical summary data tables include all deaths of prisoners arising from incidents during prison custody in England and Wales from 1978 to 2024, including deaths of prisoners released on temporary license (ROTL) for medical reasons. Deaths which occurred during other types of ROTL were excluded. Data on ligature deaths was available by sex, ligature means, and ligature points. A literature search was performed in three scientific databases (Ovid Medline, Ovid Embase, and Ovid PsycINFO) to identify published international research on ligature deaths among prisoners. The key search terms were relevant to ligature use in the prison setting, such as 'ligature', 'asphyxia', 'hanging', 'strangulation', and 'prison'. Government statistics, reports, and guidelines related to policies on suicide prevention in prisons in England and Wales were reviewed.

3. Matsuyama, T., Okuchi, K., Seki, T., & Murao, Y. (2004). Prognostic factors in hanging injuries. *The American journal of emergency medicine, 22(3), 207–210.* https://doi.org/10.1016/j.ajem.2004.02.012

# Ligature deaths in prison custody in England and Wales in 1999-2024

6. Between 1999 and 2024, there were 1,885 documented ligature deaths and an average of 73 ligature deaths per annum among individuals in prison custody in England and Wales. Most ligature deaths were of males (94%, n = 1777). The rates of ligature death per 100,000 people in 1999-2024 is shown in Chart 1 and Table 1. In the past 10 years, the average rate of ligature death was 77 per 100,000 prisoners, which was disproportionately higher than the average age-standardised suicide rate in the entire England and Wales population (including prisoners) (10.4 per 100,000 people across 2013-2023). In 2016, ligature death in prison custody reached its highest level since 2000 (n = 111, 130 per 100,000 people), then reduced to 66 in 2017 (77 per 100,000 people), and has since remained at the range of 61 to 80 deaths (76 to 93 per 100,000 people) per annum.

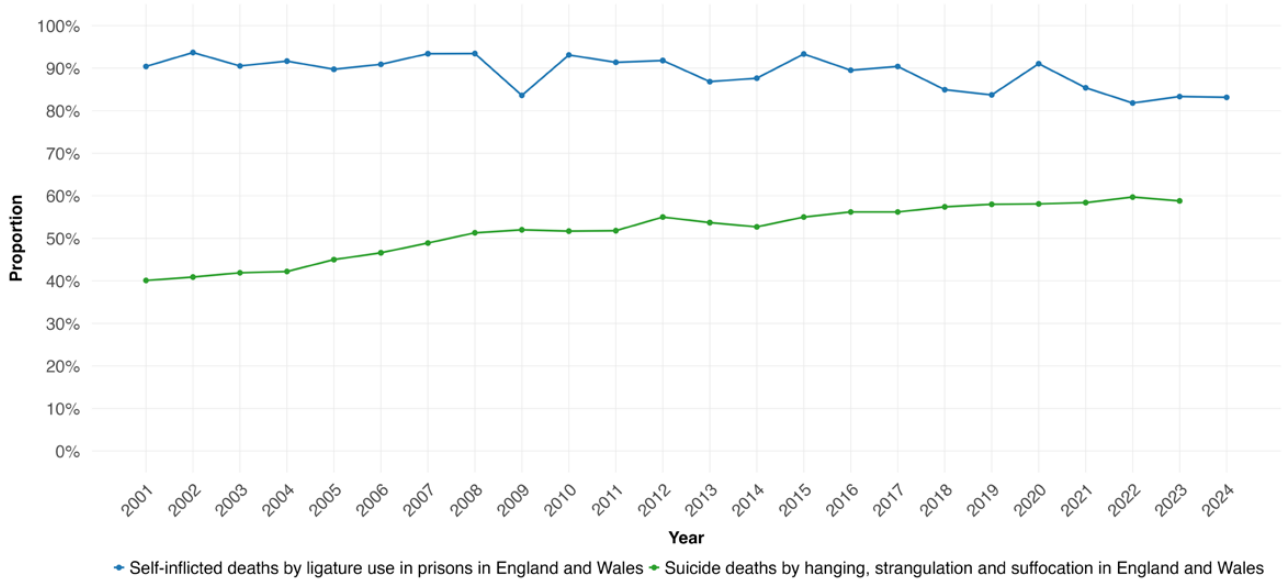
**Chart 1:** Rates of ligature deaths per 100,000 people in prison custody in England and Wales 1999-2024


**Table 1:** Ligature deaths in prison custody expressed as counts and rates per 100,000 people from 2014 to 2024

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Count** | 78 | 84 | 111 | 66 | 79 | 72 | 61 | 76 | 63 | 80 | 74 |
| **Rate** | 91 | 98 | 130 | 77 | 95 | 87 | 76 | 97 | 78 | 93 | 85 |

7. Between 1999 to 2024, ligature death accounts for 31% (25% in 2014-2024) of all deaths and 89% of self-inflicted deaths (87% in 2014-2024) in prison custody. This proportion is substantially higher than that in the overall population (including prisoners) in England and Wales, among whom the proportion of suicide deaths accounted for by hanging, strangulation, and suffocation averaged at 52% in 2001-2023 and 57% in 2013-2023 (Chart 2). To understand the psychological processes underlying suicide attempts in prison, Rivlin and colleagues at the University of Oxford (2013) interviewed 60 male prisoners in England and Wales who survived near-lethal suicide attempts.[4] They found hanging to be the most common method of suicide and noted that choice of method could be influenced by limited access to other means in the controlled environment and perception of it as being less painful than other methods. These factors may explain the high proportion of self-inflicted deaths accounted for by ligature deaths in prisons relative to the wider population.

**Chart 2:** Proportion of self-inflicted/ suicide deaths accounted for by hanging, strangulation, and suffocation in the general and prison populations




Note: 2024 data on suicide deaths by hanging, strangulation, and suffocation in England and Wales was not available.

8. An annual review by the MoJ attributed the spike of self-inflicted deaths in 2016 to "a combination of individual, custodial and environmental factors".[5] These included reduced prison workforce (2.3% reduction of full-time equivalent staff), inadequate communication and information sharing between prison and healthcare staff, and inconsistent quality of risk assessments.

9. Overcrowding has been noted as a possible risk factor of suicide, given its potential to exacerbate stress among prisoners. This is defined as when the number of prisoners held in a cell, cubicle, or room exceeds the uncrowded capacity and is a continuing issue in English and Welsh prisons. However, the overcrowded environment is unlikely to be a major contributor to the increased ligature death rate in 2015-2016, as the composition of prison population and proportion of prisoners held in crowded conditions in England and Wales remained relatively stable across 2009-2017.[6,7] Research on international data also found no clear link between overcrowding and suicide in prisoners.[8]

4. Rivlin, A., Fazel, S., Marzano, L., & Hawton, K. (2013). The suicidal process in male prisoners making near-lethal suicide attempts. *Psychology, Crime & Law*, 19(4), 305–327. https://doi.org/10.1080/1068316X.2011.631540

5. MoJ (2016). Prisons Safety and Reform [White paper]. Crown. https://assets.publishing.service.gov.uk/media/5a80aa1040f0b62302694ceb/cm-9350-prison-safety-and-reform-_web_.pdf

6. Coleman, C. (2017). Prison Overcrowding. UK Parliament. https://researchbriefings.files.parliament.uk/documents/LLN-2017-0049/LLN-2017-0049.pdf

7. Justice Data (2024, October). Offender management. https://data.justice.gov.uk/prisons/offender-management

8. 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. https://doi.org/10.1016/S2215-0366(17)30430-3

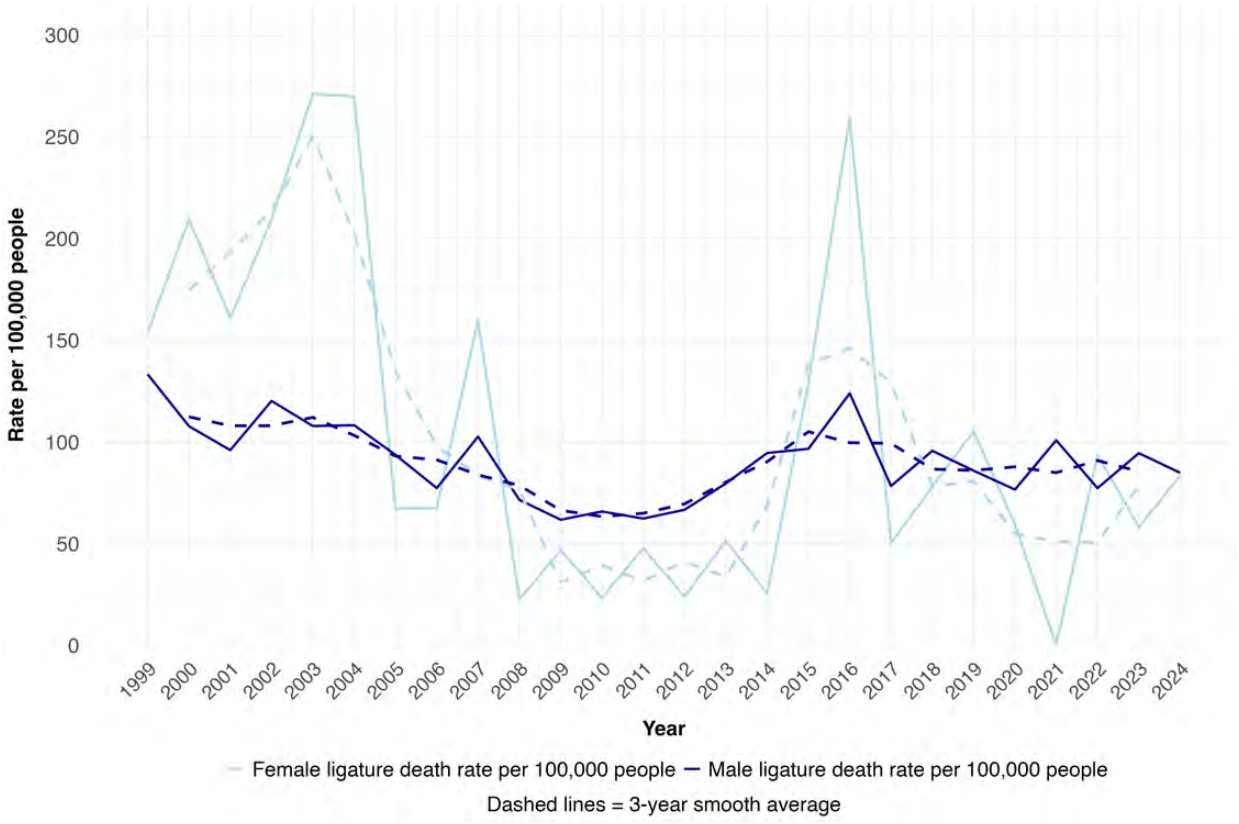
10. The subsequent decline in ligature death rate in 2017 may reflect some policy changes that took place in 2015-2017.[9,10] For example, £100 million was invested into staff retention and recruiting 2,500 new staff. In 2017, over 48,000 Assessment, Care in Custody and Teamwork (ACCT) plans were opened to closely monitor and facilitate the engagement of at-risk individuals in addressing immediate issues and long-term risks. There was also improved communication between governors and NHS England Commissioners on the management of healthcare services in English prisons. Further research is required to understand the complex interactions between factors driving changes in ligature death rates in the 2010s and 2020s.

## Ligature deaths by sex

11. The majority of ligature deaths in prison custody occurred in males, with an average annual proportion of 95% across 1999-2024. The average ligature death rate in males was 91 per 100,000 people, compared to 105 per 100,000 people in females. In 2014-2024, there were on average 92 and 86 ligature deaths per 100,000 people among males and females respectively (Table 2).

12. Among females, the rate per 100,000 people saw an increase from 26 to 129 from 2014 to 2015, which peaked at 259 in 2016 (Chart 3 and Table 2). In response to the dramatic rise in female prisoner suicide deaths in 2016, the Prisons and Probation Ombudsman (PPO) issued a bulletin on its investigations between 2013 and 2016.[11] The bulletin identified several areas for improvement, such as overreliance on subjective assessments based on presentation, lack of consideration of known triggers, lack of collaboration and communication between custodial staff and healthcare and mental health professionals, inadequate implementation of ACCT, lack of personalised ACCT process, insufficient action from staff to address bullying among prisoners, and inadequate emergency responses to suicide attempts.

**Chart 3:** Rates of ligature deaths per 100,000 people among males and females in prison custody in England and Wales between 1999 and 2024




9. MoJ (2016). Prisons Safety and Reform [White paper]. Crown. https://assets.publishing.service.gov.uk/media/5a80aa1040f0b62302694ceb/cm-9350-prison-safety-and-reform-_web_.pdf

10. MoJ (2018). A Review of Self-inflicted Deaths in Prison Custody in 2016. MoJ. https://assets.publishing.service.gov.uk/media/5bbe173ced915d7346986826/review-of-deaths-in-custody-2016.pdf

11. PPO (2017). Learning lessons bulletin - Self-inflicted deaths among female prisoners. https://s3-eu-west-2.amazonaws.com/cloud-platform-e218f50a4812967ba1215eaecede923f/uploads/sites/34/2017/03/PPO-Learning-Lessons-Bulletin_Self-inflicted-deaths-among-female-prisoners_WEB.pdf

**Table 2:** Ligature deaths in prison custody by sex expressed as counts and rates per 100,000 people from 2014 to 2024

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Male** | | | | | | | | | | | |
| **No. of deaths** | 77 | 79 | 101 | 64 | 76 | 68 | 59 | 76 | 60 | 78 | 71 |
| **Rate** | 95 | 97 | 124 | 78 | 96 | 86 | 77 | 101 | 77 | 95 | 85 |
| **Proportion** | 99% | 94% | 91% | 97% | 96% | 94% | 97% | 100% | 95% | 98% | 96% |
| **Female** | | | | | | | | | | | |
| **No. of deaths** | 1 | 5 | 10 | 2 | 3 | 4 | 2 | 0 | 3 | 2 | 3 |
| **Rate** | 26 | 129 | 259 | 50 | 78 | 105 | 59 | 0 | 94 | 58 | 83 |
| **Proportion** | 1% | 6% | 9% | 3% | 4% | 6% | 3% | 0% | 5% | 2% | 4% |
| **Total no. of deaths** | **78** | **84** | **111** | **66** | **79** | **72** | **61** | **76** | **63** | **80** | **74** |

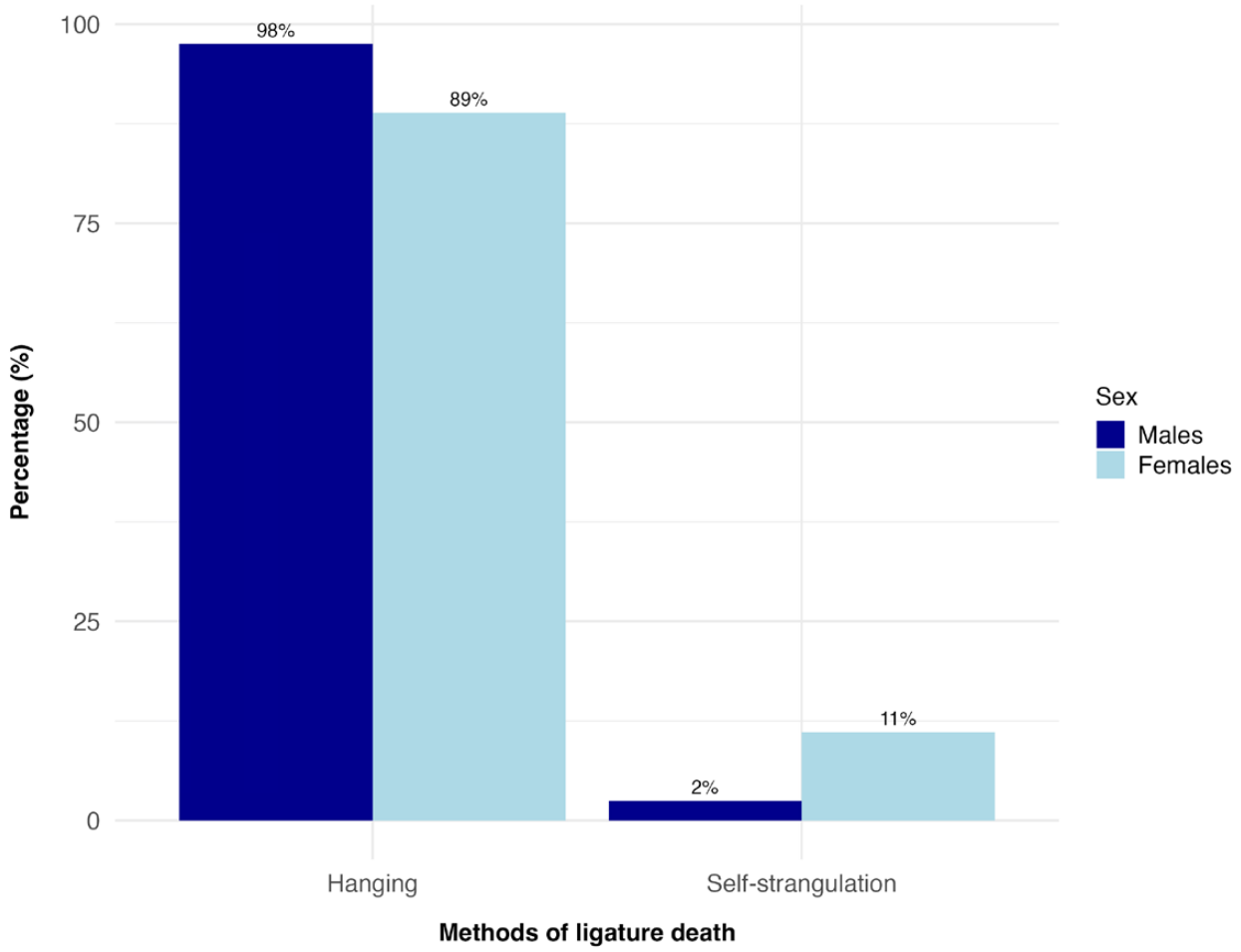
13. According to the HM Chief Inspectorate of Prisons' annual report 2022-23, inspections of adult prisons identified key factors contributing to self-harm and suicide among prisoners.[12] In male prisons, these included frustration and anxiety associated with extended lockups and lack of purposeful activities and interventions. Poor prison regime also hampered staff's ability to build supportive relationships with vulnerable prisoners. In over half of male prisons, supervision over risk measurement and care planning was poor. The report also highlighted staff's inadequate and delayed response to female prisoners with complex needs and "the most extreme mental health difficulties" (p. 8), particularly those with a history of self-harm. Female prisoners' access to meaningful regime or treatment was limited.

## Ligature deaths by methods

14. Both males and females died more frequently by hanging, which accounted for 98% and 89% of ligature deaths respectively. However, females were more likely to use self-strangulation as a method of ligature death (11%) compared to males (2%) (Chart 4).

12. HM Inspectorate of Prisons (2023). HM Chief Inspector of Prisons annual report: 2022 to 2023. HM Inspectorate of Prisons. https://assets.publishing.service.gov.uk/media/64a43d244dd8b3000c7fa479/hmip-annual-report-2022-23.pdf

**Chart 4:** Methods of ligature death in male and female prisoners




15. While data on positions of death was not available, it should be noted that not all deaths would be by complete hanging (i.e., full suspension of body with both feet off the ground), as indicated by ligature points used by prisoners such as beds and sink fittings (see Ligature deaths by ligature point).

## Ligature deaths by ligature means

16. When considering both sexes, bedding was the most used ligature means (73%, n = 1351), followed by shoelaces (10%, n = 194), and clothing (7%, n = 122). However, this mostly reflected patterns among males (Chart 5), given the much smaller number of ligature deaths recorded for females. Among females, clothing (23%, n = 24) was more frequently used as ligature means than shoelaces (18%, n = 19) (Chart 6).

**Chart 5:** Ligature means used by male prisoners

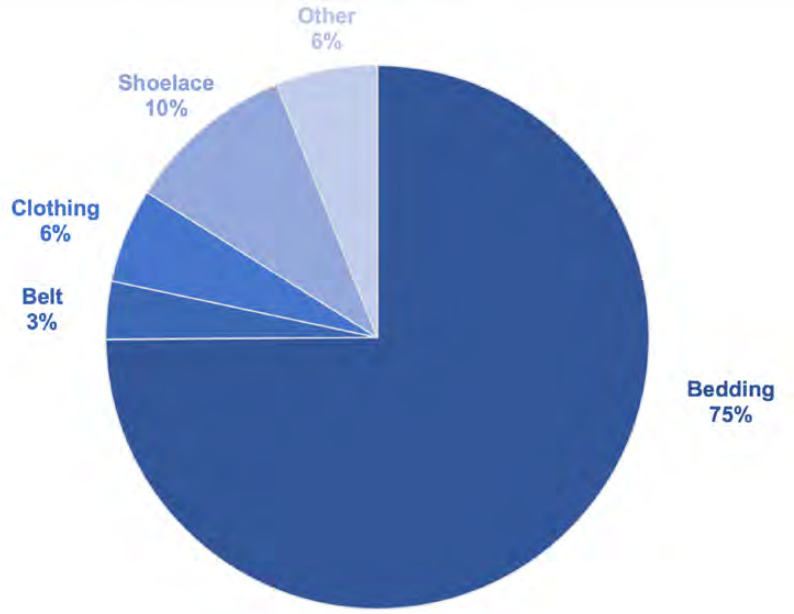
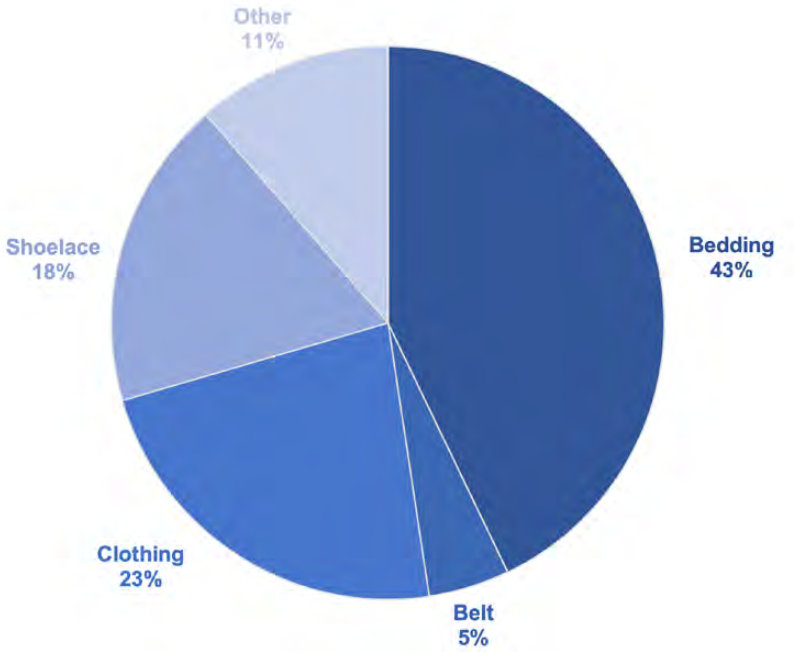



**Chart 6:** Ligature means used by female prisoners




Note for Charts 5 and 6: the 'Other' category includes cases where multiple types of ligature means were used or ligature types not easily classified in other categories.

## Ligature deaths by ligature point

17. Overall, prisoners most frequently used windows (47%), bed (19%), and light fittings (8%) as ligature points. Windows accounted for 47% of self-inflicted deaths among male prisoners (n = 820), followed by beds (19%, n = 329) and light fittings (9%, n = 153) (Chart 7). Similar to males, windows were the most frequently used ligature point in females (40%, n = 39), but doors or cell gates (18%, n = 17) and toilets or sink fixtures (14%, n = 14) were used more often than beds (13%, n = 13) (Chart 8).

**Chart 7:** Ligature points used by male prisoners

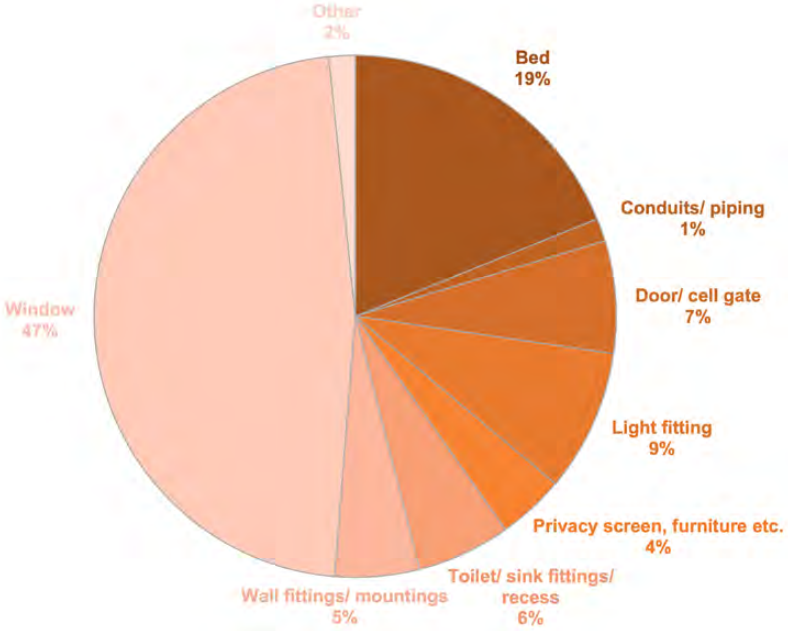
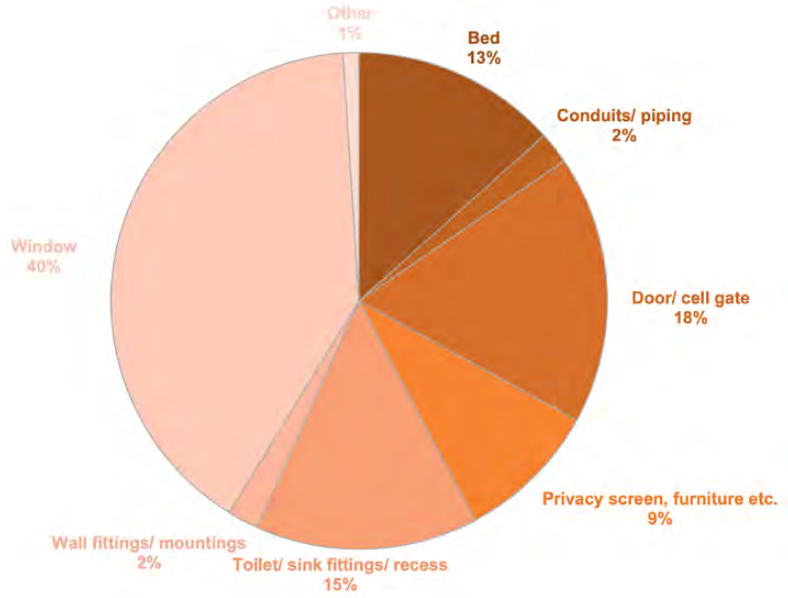



**Chart 8:** Ligatures points used by female prisoners




Note for Charts 7 and 8: the 'Other' category includes ligature types not easily classified in other categories.

## Self-inflicted deaths by time in current prison or custody, sentence type, and prison category

18. With regards to time in current prison or custody, sentence types and prison categories, there was no available data specific to ligature deaths. As data on self-inflicted deaths were used for these analyses, which accounts for around 90% of all deaths, there may be some differences when looking at ligature deaths specifically.

19. The risk of self-inflicted death increases from the day of prisoners' arrival in prison up until 3 months. Over 21% of the 2,114 self-inflicted deaths in 1999-2024 occurred between 1 and 3 months. Early days in prison are also a high-risk period, as 18% of self-inflicted deaths occurred among those who had been in their current prison for 8 to 30 days, and up to 10% for those in their current prison within the first week. In 1999-2024, nearly one-third (32%) of self-inflicted deaths occurred after individuals had been in prison custody for 1 year. The proportion of self-inflicted deaths ranged between 12% and 15% between 8 days and 1 year in prison custody. Charts 9 and 10 present the trends on self-inflicted deaths by time in current prison and custody for the past 10 years.

**Chart 9:** Number of self-inflicted deaths by time spent in current prison in English and Welsh prisons in 2014-2024

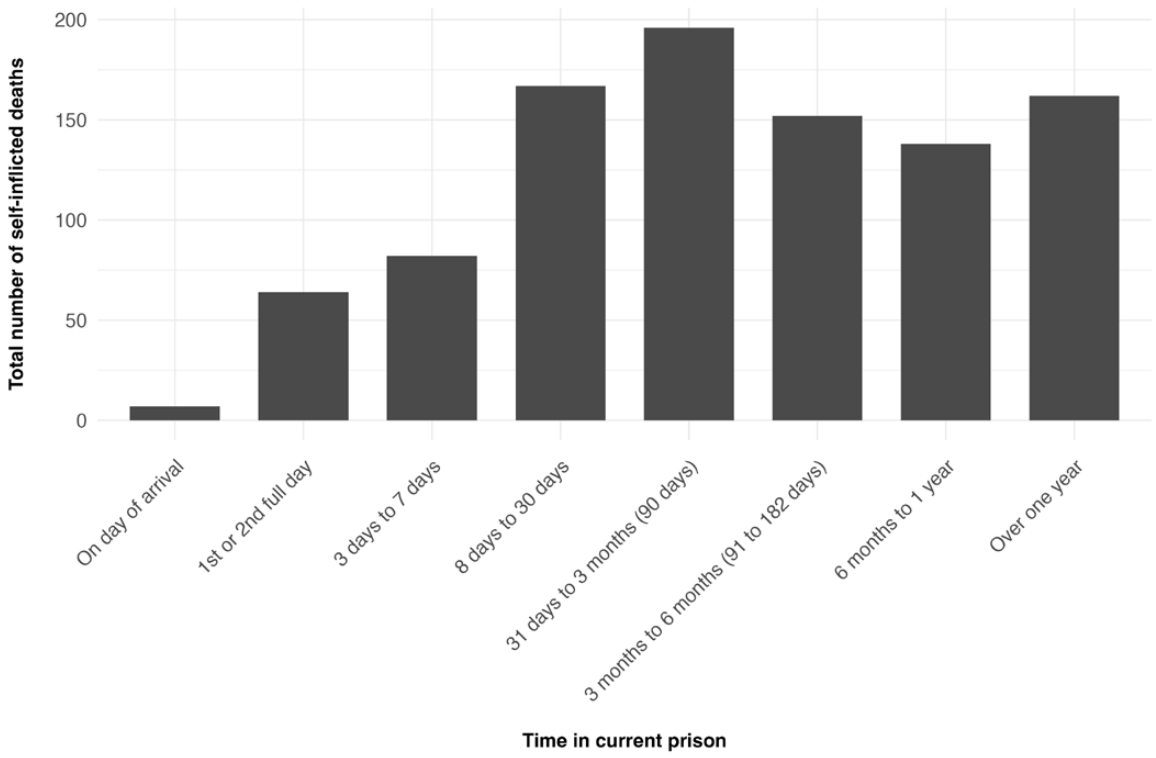
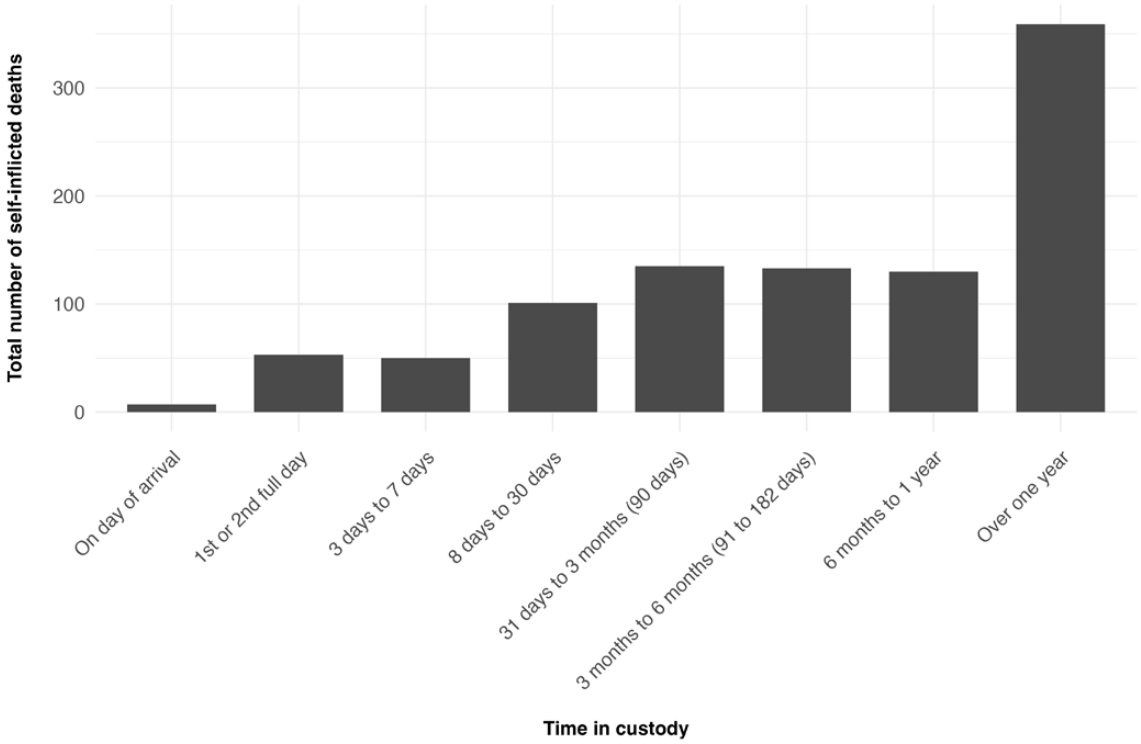


**Chart 10:** Number of self-inflicted deaths by total time in prison custody in English and Welsh prisons in 2014-2024




20. Of the 2,114 self-inflicted deaths in prison custody between 1999-2024, over half (59%, n = 1245) occurred among sentenced prisoners, 40% (n = 853) among those on remand, and 1% (n = 16) among immigration detainees. Between 2014 and 2024, the average rate of self-inflicted deaths was 85 per 100,000 among sentenced prisoners, compared to 241 per 100,000 prisoners on remand (Table 3).

**Table 3:** Number and rate of self-inflicted deaths by sentence type

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Sentenced prisoners** | | | | | | | | | | | |
| **Total number of prisoners*** | 71127 | 72892 | 73588 | 73789 | 72628 | 72353 | 65171 | 65411 | 67031 | 71042 | 67947 |
| **Number of deaths** | 61 | 53 | 90 | 48 | 65 | 62 | 47 | 54 | 50 | 66 | 59 |
| **Rate per 100,000 people** | 86 | 73 | 122 | 65 | 89 | 86 | 72 | 83 | 75 | 93 | 87 |
| **Prisoners on remand** | | | | | | | | | | | |
| **Total number of prisoners*** | 11820 | 10779 | 9251 | 9639 | 8788 | 9708 | 12066 | 12780 | 14143 | 16005 | 17023 |
| **Number of deaths** | 26 | 36 | 33 | 21 | 27 | 24 | 19 | 34 | 27 | 29 | 30 |
| **Rate per 100,000 people** | 220 | 334 | 357 | 218 | 307 | 247 | 157 | 266 | 191 | 181 | 176 |

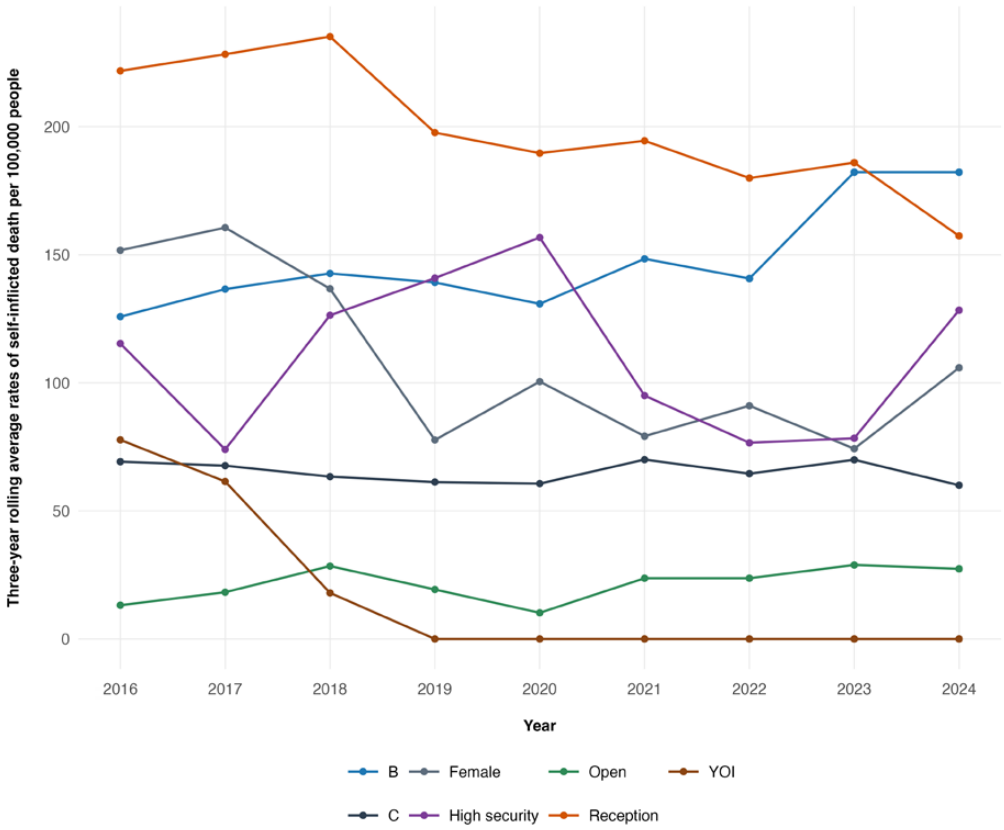
*As of data recorded in December each year in 2014-2024.

21. Over the past 10 years, reception prisons generally had the highest average rate of self-inflicted death compared to prisons with other predominant functions (Chart 11). This aligns with findings of higher self-inflicted death rates among remand prisoners. Importantly, most reception prisons are Victorian prisons and are often in poor physical condition,[10] where more ligature points may be present. The high prisoner turnover in reception prisons also makes provision of continual mental health care difficult, and time constraints on staff could hinder treatment decision-making for prisoners at risk of suicide.[13, 14]

22. In category B prisons, the rate of self-inflicted death was on average the highest during the 2021-2023 period. There has been an increase of self-inflicted death in high security prisons since 2022. MoJ's Annual Prison Performance Ratings (2023/24) found that category B and reception prisons performed poorly in the 'percentage of prisoners in purposeful activity' measure.[15, 16]

23. Data on youth offender institutions (YOI) must be interpreted with caution, as this category only includes establishments where YOI is the primary function. Many establishments serve both adult prisoners and young offenders, and so deaths of young offenders in prisons housing primarily adults were excluded from the YOI category. This means Chart 11 does not fully capture the rate of self-inflicted deaths among young offenders in England and Wales.

**Chart 11:** Three-year average rate of self-inflicted deaths per 100,000 people by prison category (predominant function) among English and Welsh prisons




Note: Data begins in 2016 as each point represents a 3-year rolling average of the current year with previous two years.

13. Liebling, A. (2002). Suicides in Prison and the Safer Prisons Agenda. *Probation Journal, 49(2)*, 140–150. https://doi.org/10.1177/026455050204900208

14. Health Services Safety Investigations Body (HSSIB) (2024). *Healthcare provision in prisons: Continuity of care. HSSIB.* https://www.hssib.org.uk/patient-safety-investigations/healthcare-provision-in-prisons/second-investigation-report/

15. Institute for Government (2025). *Inside England and Wales's prisons crisis: Which prisons do well?* https://www.instituteforgovernment.org.uk/publication/performance-tracker-local/england-and-wales-prisons/which-prisons-do-well

16. MoJ (2024). *Annual Prison Performance Ratings 2023/24*. https://www.gov.uk/government/statistics/prison-performance-ratings-2023-to-2024/annual-prison-performance-ratings-202324

# Ligature death reduction strategies in prison and other settings

24. Informed by official guidelines and frameworks in England and Wales, this section provides a summary of the preventive measures currently in place for ligature and suicide death prevention in prisons and other settings where ligature death is common (i.e., police custody, immigration removal centres, psychiatric wards, and emergency departments).

## Environment design and maintenance

25. Across all settings, routine review and removal of potential ligatures and ligature points are the prioritised prevention strategy for ligature death. In prisons, ligature-resistant cells have been developed to eliminate as many ligature points as possible, serving as an option for suicide risk mitigation in prisons. Staff are instructed to know the locations of all ligature-resistant cells within the prison, and periodic maintenance is carried out.[17]

26. Cells in new prisons and major additions such as new wings are typically built without ligature points, but many older prisons are not equipped with ligature-resistant cells. The Prisons Strategy White Paper and Suicide prevention in England noted the MoJ's plan to install new ligature-resistant cells, particularly in the highest-priority prisons, for suicide prevention among people in contact with the criminal justice system.[18,19]

27. HMPPS reviews the build standards and usability of ligature-resistant cells in supporting prisoners in crisis. Such review ensures ligature-resistant features retain build standards over time and are in full working order, while being accessible to prison staff as an option for crisis management. There has also been ongoing work to convert cells in older prisons to match the standard of new cells (e.g., by addressing windows posing ligature risk).

28. Evidence-based recommendations from a review in 2005 on prevention strategies of suicide by hanging include changing cell window frame design, removing bars, covering bars with Plexiglas, installing recessed lighting or collapsible lighting, removing clothes hooks, and replacing bunk beds with concrete sleeping benches.[20] MoJ's *Safer Cellular Accommodation* Guide (published in 2005 and consolidated in 2018) provides prisons in England and Wales with technical requirements and details for drafting project specifications and implementing ligature-resistant cell designs. The guide offers full anti-ligature designs for new-build cells as well as ways of removing ligature points from older cells. It includes the description of all cell elements (i.e., furniture, windows, ventilators, doors, lighting, heating, electrics, finishes, and sanitary fittings), with references to drawings for approved fixtures and fittings and suitable suppliers and manufacturers. Examples of the anti-ligature designs included in this guide are: WC and wash hand basin with nozzles or buttons that are recessed or levelled with the fixture body or wall; removal of external weather-shields for fitting of anti-ligature frames and glazing on windows; cornice light fittings; and fitted strips in the gap between cell doors and door frames. The descriptions are accompanied by checklists to assist assessment by prison establishments on whether their cells meet the physical standards for a ligature-resistant cell or as a self-audit form for installation checks.

17. HM Prison and Probation Service (HMPPS) (2024). *Prison Safety Policy Framework.* HMPPS. https://assets.publishing.service.gov.uk/media/6720ae033758e4604742a838/prison-safety-policy-framework.pdf

18. MoJ (2021). *Prisons Strategy* [White paper]. Crown. https://assets.publishing.service.gov.uk/media/61af18e38fa8f5037e8ccc47/prisons-strategy-white-paper.pdf

19. Department of Health & Social Care. (2023) *Suicide prevention in England: 5-year cross-sector strategy.* Department of Health & Social Care. https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy

20. Gunnell, D., Bennewith, O., Hawton, K., Simkin, S., & Kapur, N. (2005). The epidemiology and prevention of suicide by hanging: a systematic review. *International journal of epidemiology,* 34(2), 433–442. https://doi.org/10.1093/ije/dyh398

29. However, it is unclear how many cells in England and Wales currently meet the technical standards set out in the design guide and to what extent research evidence were considered in ligature point removal schemes in local prisons. There is a still lack of consensus in the implementation of ligature-resistant designs between prison establishments. For example, removing ligature points from Victorian prisons may be more difficult than from prisons built in or after the 1960/70's. The varied configurations and costs required to address different architectural constraints result in inconsistent ligature safety levels across prisons.

30. Moreover, the operational autonomy of prison governors in England and Wales results in the lack of uniform and mandatory approach for suicide prevention among prison establishments, as governors with priorities other than suicide prevention may not allocate sufficient budget or resources to implement effective practices. To reduce the overall ligature death rate and safety standard discrepancies between prison establishments in England and Wales, national strategy and oversight are required to establish 'minimum expectations' for ligature-resistant cell design.

31. In many psychiatric inpatient services, regular environmental inspections are carried out to identify high-risk ligature points of any height (including heights that have been traditionally considered as 'inaccessible') in areas where patients may be left out of sight or alone without direct supervision from staff.[21] Tools such as the Ligature Point Recording Template have been developed to support staff in identifying and recording risk points and control strategies to mitigate ligature risks associated with the built environment in mental health services. Using the template, staff could categorise risk into three tiers and determine the amount of supervision patients receive and duration of time patients are left alone in areas with potential ligature points.[22]

    In areas where ligature points are classified as tier 1, patients are typically not to be left alone for long periods of time. Ligature points classified as tier 2 are typically in open areas where patients receive minimal supervision, and patients may spend extended periods of time alone with minimal or no supervision in areas with tier 3 ligature points. Environmental, individualised, and system-related considerations are probed to assist the creation of action plans for mitigating risk of different tiers.[23] Hunt et al. (2012) found no hangings from bed curtain rails among psychiatric inpatients since the National Institute for Health and Care Excellence (NICE) recommended the removal of non-collapsible bed curtain rails from all wards.[24,25]

32. Procurement and evaluation of anti-ligature fixtures, fittings, and furniture should involve collaboration between multidisciplinary personnel and follow national standards and the manufacturers' instructions in maintenance and testing.[26] When drafting specifications, procurement staff should prioritise minimising ligature risks. Poor repair work may also result in ligature points. Repairs should be carried out as soon as practicable when a ligature point caused by damage or wear has been identified, and associated risk must be constantly tracked and managed until the cell or room is declared safe for use again. Inspection must be carried out after the repair work has been completed before the cell or room could be used again.

33. Regular individual risk assessments should be performed on each item in detainees' or patients' environment to determine the extent to which they could be used as a ligature. Staff should be aware that items of clothing (e.g., ties, belts, shoelaces, and cords) may be used as ligatures, but any decision to remove clothing should only be made after a risk assessment has been conducted. For example, damaged mattress or blankets could also be easily torn and made into a ligature, so they must be removed from use immediately once identified.

22. Care Quality Commission (2023). *Ligature point recording template.* https://www.cqc.org.uk/guidance-providers/mhforum-ligature-guidance/assessment-template

23. Hannan, M., Hearnden, I., Grace, K., & Bucke, T. (2011). *Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09.* Independent Police Complaints Commission. https://data.parliament.uk/DepositedPapers/Files/DEP2012-1687/Deaths_In_Custody_Report_0811.pdf

24. Hunt, I. M., Windfuhr, K., Shaw, J., Appleby, L., Kapur, N., & National Confidential Inquiry into Suicide and Homicide (2012). Ligature points and ligature types used by psychiatric inpatients who die by hanging: a national study. Crisis, 33(2), 87–94. https://doi.org/10.1027/0227-5910/a000117

25. NICE. (2003). *The national suicide prevention strategy for England: Annual report on progress 2003.* NICE.

26. Mental Health and Learning Disability Nurse Directors Forum & Care Quality Commission. *Reducing harm from ligatures in mental health wards and wards for people with a learning disability*. Care Quality Commission. https://www.cqc.org.uk/node/9827/book_pdf_print

34. Currently, ligature-proof bedding and clothing are used as a last resort in prisons when all other options to support detainees have been exhausted. It is not feasible to eliminate absolutely all ligature risks from inpatients and detainees. Instead, the aim should be to minimise ligature risks while keeping the environment as unrestrictive as possible. For example, police custody officers are advised to balance any identified risk with the need to treat detainees with dignity when considering removal of clothing, as increased distress may in turn increase suicide risk. In their latest published suicide prevention strategy, the Scottish Prison Service encouraged shifting away from anti-ligature clothing in favour of improving contact and support.[27] In police custody facilities, detainees deemed to be at high risk of suicide by using clothing items are under constant observation or within proximity.

## Emergency response

35. Means to sever ligatures (i.e., ligature knives, cutters, and scissors) allow staff's swift removal of ligature when they are used and have been identified as an important preventive measure against ligature deaths across all settings. For example, making ligature knives readily available to officers was found effective in preventing near-miss suicide by detainees.[28]

36. In English and Welsh prisons, there are two types of ligature tools currently authorised for use. These include the 9mm "Big Fish" safety knife and the Barrington LC1 cutter.[29] All uniformed staff in closed prisons are instructed to carry the Big Fish safety knife as a personal-issue equipment. In both closed and open prisons, every Emergency Response Kit is equipped with this tool. Every prison wing contains a Barrington LC1 cutter, which is typically used for ligatures too large or robust for the Big Fish safety knife. Staff are trained in the use and storage of these ligature tools. Any ligature tool that has been used to cut a ligature will be withdrawn from use and refitted. Custody staff should also be given regular first-aid training,[30] as 15% of people hanging are still alive after being found.[31]

## Risk assessment

37. ACCT is a care management process that prisons in England and Wales currently used to support prisoners at risk of suicide and self-harm. Staff in the Prison Service use ACCT to determine the level of risk, steps to mitigate risk, and the level of monitoring and supervision required for the concerned prisoner. However, ACCT currently does not include assessment on ligature points in the cells of prisoners with open plans. Research found little evidence of planned follow-up and support following ACCT plan closure and post-closure review of needs is unstructured and subjective, despite prisoners being at higher risk of suicide immediately after removal of close monitoring.

38. While ACCT has been in place for more than a decade, no studies have evaluated whether this process has reduced self-harm or suicide rates and how it might be improved. Research on its efficacy should be conducted independently of the prison service. Several reports criticised the poor implementation of ACCT in prisons. , Issues raised over the years included staff's failure to identify risks and triggers, lack of meaningful recorded observations, and gaps in care plans. A recent annual report by the HM Chief Inspector of Prisons for England and Wales noted that only 45% of male prisoners on ACCT said they felt cared for by staff.28 The PPO recommends assessment on risk of suicide or self-harm to be based on all known risk factors of a given prisoner instead of merely on presentations.

27. Scottish Prison Service. *Talk to me: prevention of suicide in prison strategy 2016-2021.* Scottish Prison Service. https://www.sps.gov.uk/sites/default/files/2024-02/TalkToMeStrategy_2016-2021_Strategies.pdf

28. Lindon, G., & Roe., S. (2017). *Deaths in police custody: A review of the international evidence. Research report 95.* Home Office. https://assets.publishing.service.gov.uk/media/5a822407ed915d74e3401f21/Deaths_in_police_custody_A_review_of_the_international_evidence.pdf

29. HMPPS (2024). *Prison Safety Policy Framework*. HMPPS. https://assets.publishing.service.gov.uk/media/6720ae033758e4604742a838/prison-safety-policy-framework.pdf

30. Hannan, M., Hearnden, I., Grace, K., & Bucke, T. (2011). *Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09.* Independent Police Complaints Commission. https://data.parliament.uk/DepositedPapers/Files/DEP2012-1687/Deaths_In_Custody_Report_0811.pdf

31. Cai, Z., Junus, A., Chang, Q., & Yip, P. S. F. (2022). The lethality of suicide methods: A systematic review and meta-analysis. *Journal of affective disorders*, 300, 121–129. https://doi.org/10.1016/j.jad.2021.12.054

32. 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. *Journal of Forensic Psychiatry & Psychology*, 22(1), 22–51. https://doi.org/10.1080/14789949.2010.518245

33. PPO (2017). *Learning lessons bulletin - Self-inflicted deaths among female prisoners*. PPO. https://s3-eu-west-2.amazonaws.com/cloud-platform-e218f50a4812967ba1215eaecede923f/uploads/sites/34/2017/03/PPO-Learning-Lessons-Bulletin_Self-inflicted-deaths-among-female-prisoners_WEB.pdf

34. HM Inspectorate of Prisons (2023). *HM Chief Inspector of Prisons annual report: 2022 to 2023.* HM Inspectorate of Prisons. https://assets.publishing.service.gov.uk/media/64a43d244dd8b3000c7fa479/hmip-annual-report-2022-23.pdf

35. PPO (2023). *Prisons and Probation Ombudsman Annual report 2022/23.* PPO. https://assets.publishing.service.gov.uk/media/668ffba40808eaf43b50ce16/Prisons_and_Probation_Ombudsman_2022_to_2023_Annual_Report_Updated_July.pdf

39. Evidence suggests that a reliance of needs will miss key risk factors and structured approaches can augment and support professional decision-making in risk assessments.[36,37,38] Structured approaches could be established through the use of validated and scalable risk assessment tools such as the Risk Assessment for people in Prison at risk of Self-harm and Suicide (RAPSS) tool, which identifies prisoners' risk of repeat self-harm within 3 months following ACCT plan closure.[30] The RAPSS tool was developed to complement current approaches by filling in the gap in risk management during the high-risk period when a prisoner's ACCT plan has just been closed, with implications in reducing self-inflicted deaths among prisoners (history of self-harm and suicide attempts were identified as strong risk factors of later suicide deaths in prisons).[39] Incorporating structured risk assessment tools in prison care management plans could facilitate the shift from subjective to evidence-based decision making for resource allocation, which is particularly useful in identifying prisoners with the highest need who would benefit from adding specific resources for prevention, such as moving them to ligature-resistant cells or providing anti-ligature items.

40. In the Scottish Access to Means study, researchers investigated the perceived implementability of actions to prevent suicide by hanging among individuals with lived or living experience of suicidal behaviour, health professionals, and suicide researchers.[40] They found 'establishing a system for identifying at-risk prisoners who might need accommodation in ligature-free cell' to be one of the five actions receiving the highest level of endorsement.

41. In mental health wards, education, and training for staff to improve assessment on suicide by ligature use are recommended. Issues for considerations include: (i) whether the training is appropriate and relevant; (ii) who the training is offered to and why; (iii) types of training offered on the identification of risk, behaviour, or potential triggers as indicators of ligature use; (iv) types of training offered on medical responses to ligature events; and (v) frequency of training administration, etc.[41] Advanced ligature training for senior clinical and estate team members could improve understanding of anti-ligature environments and enable safer decision-making. For example, the Mental Health Staffing Framework provides online resources to help develop leaders' awareness in the importance of, and practicalities involved in, developing local systems with appropriate skill mix and staffing levels.

36. Woodford, R., Spittal, M. J., Milner, A., McGill, K., Kapur, N., Pirkis, J., Mitchell, A., & Carter, G. (2019). Accuracy of Clinician Predictions of Future Self-Harm: A Systematic Review and Meta-Analysis of Predictive Studies. *Suicide & life-threatening behavior,* 49(1), 23-40. https://doi.org/10.1111/sltb.12395

37. Fazel, S., Heathcote, L., Farouki, L., Senior, J., Perry, A., Fanshawe, T. R., & Shaw, J. (2025). Bridging assessment and treatment for repeat suicidality in prisons: development and validation of a risk model. *BMJ Mental Health,* 28(1). https://mentalhealth.bmj.com/content/28/1/e301280.

38. Department of Health (2009). *Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services.* Department of Health. https://assets.publishing.service.gov.uk/media/5a8020a840f0b62302691adf/best-practice-managing-risk-cover-webtagged.pdf

39. 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. https://doi.org/10.1016/S2468-2667(20)30233-4

40. McClelland, H., and Platt, S. (2024). *Preventing suicide by hanging and self-poisoning in Scotland: Stage two of the Access to Means study.* Scottish Government. https://suicideresearch.info/wp-content/uploads/2024/11/mcclelland-and-platt_-reducing-access-to-means-in-scotland_stage-two-delphi-study_november-2024.pdf

41. Mental Health and Learning Disability Nurse Directors Forum & Care Quality Commission. *Reducing harm from ligatures in mental health wards and wards for people with a learning disability.* Care Quality Commission. https://www.cqc.org.uk/node/9827/book_pdf_print

### Observation and surveillance

42. Observations should be performed with the main purpose of enabling prompt response to suicide attempts by ligature. Failure to prioritise response promptness likely renders observations meaningless, as brain damage and death from hanging or self-strangulation often occur within minutes.

43. Face-to-face constant supervision should always be the default option for observation and CCTV limits the possibility of meaningful and life-saving intervention so must not be used in place of face-to-face supervision.[42] In prisons, CCTV is used as a last resort to support those at high risk of suicide and on constant supervision. Immediate intervention is key in handling emergencies related to ligature use, and so staff must consider how CCTV use may impact on their access to cells and ability to intervene promptly. Prisoners must be informed when CCTV is being used and the decision to use it should be documented in the ACCT plan.[43] When CCTV is used, it must be monitored by staff at all times for timely intervention in the event of an emergency. Staff are instructed to make attempts to communicate with the monitored prisoner (e.g., through face-to-face check-in or giving distraction activities) despite the supervision.

44. A research report of deaths in police custody notes that the reduction of deaths by hanging between 1998-1999 and 1999-2000 may be partly attributable to CCTV use in cells.[44] Prison healthcare staff identified closer supervision as a major factor that could have made suicide less likely in response to the suicides that occurred in prisons in England and Wales between 1999 and 2000.[45]

45. Good custody recording practice should be highlighted during staff training.[46] Maintaining accurate records of cell visits ensures staff accountability for monitoring frequency, which aids identification of prisoners exhibiting high-risk behaviours and prevention of ligature deaths through timely intervention.

42. MoJ & HMPPS (2021). Use of CCTV (Overt Closed-Circuit Television system) Prison Guidance. https://assets.publishing.service.gov.uk/media/619b90dd8fa8f5038358bff8/cctv-pf-prison-guidance.pdf

43. HMPPS (2024). *Prison Safety Policy Framework*. HMPPS. https://assets.publishing.service.gov.uk/media/6720ae033758e4604742a838/prison-safety-policy-framework.pdf

44. Lindon, G., & Roe., S. (2017). *Deaths in police custody: A review of the international evidence.* Research report 95. Home Office. https://assets.publishing.service.gov.uk/media/5a822407ed915d74e3401f21/Deaths_in_police_custody_A_review_of_the_international_evidence.pdf

45. National Confidential Inquiry into Suicides and Homicides by People with Mental Illness. *Safer Prisons report - A National Study of Prison Suicides 1999-2000.* https://bulger.co.uk/prison/suicide.pdf

46. Hannan, M., Hearnden, I., Grace, K., & Bucke, T. (2011). *Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09.* Independent Police Complaints Commission. https://data.parliament.uk/DepositedPapers/Files/DEP2012-1687/Deaths_In_Custody_Report_0811.pdf

# Lessons from international research

46. This section provides a summary of findings to help understand and prevent ligature deaths among prisons outside of England and Wales. References for all the research cited in this section are listed in the Appendix.

47. As in England and Wales, hanging accounts for the highest proportion of suicide deaths among prisoner cohorts studied in the United States, Australia, Canada, Italy, France, Slovenia, Switzerland, Netherlands, Germany, India, and Turkey.[47-64] Windows are typically the most frequently chosen ligature point by prisoners and prisoners tended to use bedding as their ligature means. Suicide and ligature deaths more frequently occurred among prisoners on remand. Where time in incarceration was reported, the first week or month following incarceration was identified as the high-risk period of suicide.

48. A meta-analysis of 77 studies in 27 countries identified several clinical, institutional, and criminological risk factors for suicide in prisons.[65] These included suicidal ideation during current period in prison, history of suicide attempt or self-harm, single-cell occupancy, psychiatric disorders, being in remand status, being convicted of homicide or sexual offences, and serving a life sentence. Suicide prevention and intervention strategies in prisons should particularly target prisoners "with previous suicidal behaviours, mental illness, and single-cell occupancy" (p. e172) and include provision of psychological and pharmacological treatments for psychiatric disorders. An important finding is that the magnitude of risk factors differs substantially between them.

49. Minimising ligature points in cells is a well-recognised strategy for ligature death prevention around the globe, as recommended by international research and guidelines such as the World Health Organization (WHO)'s Preventing Suicide in Jails and Prisons.[66-68] However, there is no research on how different "ligature-resistant" cell elements may individually help reduce ligature death. Gunnell (2005) suggested that even in ligature-resistant cells, at-risk prisoners require monitoring, as removing all potential ligature means is more challenging than eliminating ligature points.[66]

50. A national study on suicides in Swiss prisons found that in 72% of hanging cases, victims were found in the state of incomplete hanging, which means they were in contact with the floor or other surfaces such as the bed.[52] This finding, along with the significant proportion of prison suicides in England and Wales involving beds as ligature point, indicates that efforts in designing ligature-resistant cells and minimising ligature points should address ligature points at all heights, rather than focusing solely on those at high levels such as windows.

51. Hayes (2013) outlined the established elements of "suicide-resistant" (i.e., ligature-resistant) cells critically important in suicide prevention in correctional facilities in the United States.[69] These include tamper-proof light fixtures, smoke detectors, sprinkler heads, and protrusion-free ceiling or wall air vents. Bunk beds are moulded by fiberglass, with rounded edges and no tie-off points. Clothing hooks are collapsible. Radiator vents and sanitary fittings were modified to prevent ligature attachment. In many jurisdictions, corded telephones were replaced with cordless telephones. Additionally, heavy nylon fabric, which is difficult to tear apart, have been widely used as the material for safety clothing and bedding across correctional facilities. With regards to footwear, replacing shoelaces with Velcro fastening has been recommended.[66]

52. Hayes (2013) argued that identifying and continuously monitoring prisoners at suicide risk who are not obviously identifiable is the most important aspect of suicide prevention.[69] Risk assessment should be an ongoing process, and prisons should create as many opportunities to gather information as possible. Prisons in England and Wales should consider complementing the ACCT process, which mainly focuses on addressing immediate risk, with structured risk assessment tools for ongoing evaluation of risk after care plan closure.

53. Australia's effective approaches to prison design, particularly in safe cell technology, offers lessons in ligature death prevention policies for England and Wales.[70] An example is post-incident reviews. The HM Chief Inspector of Prisons' annual report (2023-24) noted that early learning reviews following deaths in England and Wales were often either not conducted or were of low quality.[71] In contrast, the Australian system implements rigorous post-occupancy evaluations, enabling staff to identify critical design elements effective in aiding ligature death prevention. These evaluations have shown success in national development of comprehensive design guidelines, which could benefit English and Welsh prisons.

# Recommendations for ligature death prevention in prisons

### Establishing a national and coordinated approach to ligature death reduction

- Encourage cross-establishment sharing of prison audit findings to improve consistency in cell design and suicide prevention approaches between prisons, so that priorities and action plans could be identified to establish a national ligature death prevention strategy.
- Establish national "minimum expectations" in cell ligature safety standards.

### Enhancing safety through design, materials, and maintenance while preserving dignity

- Review and remove ligature points in both new-built and old cells (particularly those on windows, beds, and doors or cell gates) while maintaining an unrestrictive and humane environment, with reference to cellular accommodation design guides and checklists.
- High-priority areas should be identified to guide ongoing work addressing ligature points such as windows in older prisons, with progress reviewed regularly.
- Personnel involved in designing ligature-resistant cells should recognise that a low height of ligature point does not indicate safety.
- Explore the usability of alternative materials for ligature-resistant bedding in cells.

### Establishing structured monitoring and information sharing for ongoing risk management

- Establish criteria in the level of supervision required for 'at risk' prisoners to ensure prompt response to ligature use events by staff.
- Improve information sharing and communication between prison staff and other professionals, particularly with healthcare services.
- Post-incident early reviews should be conducted to identify factors, including potential ligature points in prisoners' environment, which may have been inadequately addressed to prevent death.
- Risk assessment and intervention frameworks should be evidence-based (e.g., by considering findings from high quality research identifying risk factors).
- Improve risk assessment by incorporating findings of new evidence on role of structured approaches to support professional decision-making, particularly at the end of the ACCT process.

### Facilitating research in prisons to inform effective prevention strategies

- Encourage collaboration between prison establishments and researchers to evaluate impact of changes to policies and efficacy of existing and new suicide prevention strategies.

# Appendix: Data sources and references

**Data analysed in this report were extracted from the following sources:**

1. National statistics: Deaths in prison custody 1978 to 2024 (Safety in Custody Statistics: Deaths annual tables, 1978-2024) https://assets.publishing.service.gov.uk/media/6798aee0cfd3deafa04fdf09/Deaths_in_prison_custody_1978_to_2024_accessible.ods

2. MoJ: Offender management statistics quarterly (July 2014-September 2024) https://www.gov.uk/government/collections/offender-management-statistics-quarterly

3. HMPPS: The prison estate in England and Wales, including public and contracted prisons and secure training centres (January 2025) https://assets.publishing.service.gov.uk/media/679ba27d5ac7a35d1228f621/The_Prison_Estate_and_Probation_Service_Region_register_Jan25.xlsx

**References of international research cited in this report:**


47. Austin, A. E., van den Heuvel, C., & Byard, R. W. (2014). Prison Suicides in South Australia: 1996–2010. Journal of Forensic Sciences, 59(5), 1260–1262. https://doi.org/10.1111/1556-4029.12454

48. Bailo, P., Gibelli, F., Celletti, A., Caraffa, A., Sirignano, A., & Ricci, G. (2023). The contributing factors to suicide in Italian prisons: An 11-year analysis (2010–2020). Criminal Behaviour and Mental Health, 33(6), 441–454. https://doi.org/10.1002/cbm.2319

49. Chérif El Khal, M., Grill, S., Costagliola, R., Blanc, A., Savall, F., & Telmon, N. (2019). Les décès en milieu de détention dans la région de Toulouse – étude autopsique entre 2011 et 2017. La Revue de Médecine Légale, 10(2), 57–62. https://doi.org/10.1016/j.medleg.2019.02.002

50. Daniel, A. E., & Fleming, J. (2005). Serious Suicide Attempts in a State Corrrectional System and Strategies to Prevent Suicide. The Journal of Psychiatry & Law, 33(2), 227–247. https://doi.org/10.1177/009318530503300204

51. Dixon, K. J., Ertl, A. M., Leavitt, R. A., Sheats, K. J., Fowler, K. A., & Jack, S. P. D. (2020). Suicides Among Incarcerated Persons in 18 U.S. States: Findings From the National Violent Death Reporting System, 2003–2014. Journal of Correctional Health Care, 26(3), 279–291. https://doi.org/10.1177/1078345820939512

52. Gauthier, S., Reisch, T., & Bartsch, C. (2015). Swiss Prison Suicides Between 2000 and 2010. Crisis, 36(2), 110–116. https://doi.org/10.1027/0227-5910/a000302

53. Gentile, G., Nicolazzo, M., Bianchi, R., Bailo, P., Boracchi, M., Tambuzzi, S., & Zoja, R. (2021). Mortality in Prisons: The Experience of the Bureau of Legal Medicine of Milan (Italy) (1993–2017): Suicides and natural deaths in prison. Medicine, Science and the Law, 61(1_suppl), 67–76. https://doi.org/10.1177/0025802420934266

54. Green, C., Kendall, K., Andre, G., Looman, T., & Polvi, N. (1993). A study of 133 suicides among Canadian federal prisoners. Medicine, science, and the law, 33(2), 121–127. https://doi.org/10.1177/002580249303300207

55. Hurley, W. (1989). Suicides by prisoners. Medical Journal of Australia, 151(4), 188–190. https://doi.org/10.5694/j.1326-5377.1989.tb115987.x

56. Kerkhof, A. J. F. M., & Bernasco, W. (1990). Suicidal Behavior in Jails and Prisons in The Netherlands: Incidence, Characteristics, and Prevention. Suicide and Life-Threatening Behavior, 20(2), 123–137. https://doi.org/10.1111/j.1943-278X.1990.tb00095.x

57. Krell, K.-M., Heide, S., Lessig, R., & Stiller, D. (2022). Todesfälle in Sachsen-Anhalts Justizvollzugsanstalten von 1992 bis 2015. Rechtsmedizin, 32(2), 97–103. https://doi.org/10.1007/s00194-022-00556-2

58. Kuchewar, S. V., Bhosle, S. H., Shrigiriwar, M. B., & Padole, T. O. (2020). Custody-related deaths in Maharashtra state of India—Analysis of autopsies performed at a medical Teaching Institute during the period 2000–2018. Journal of Forensic and Legal Medicine, 70, 101915. https://doi.org/10.1016/j.jflm.2020.101915

59. Moron, P. (2004). Le suicide en milieu pénitentiaire. Annales Médico-Psychologiques, Revue Psychiatrique, 162(8), 672–675. https://doi.org/10.1016/j.amp.2004.07.010

60. O'Driscoll, C., Samuels, A., & Zacka, M. (2007). Suicide in New South Wales Prisons, 1995–2005: Towards a Better Understanding. Australian & New Zealand Journal of Psychiatry, 41(6), 519–524. https://doi.org/10.1080/00048670701341863

61. Pathak, A. G., Gadhari, R. K., Chaudhari, K. M., Chavan, S. S., Shejwal, D. K., & Devraj, N. A. (2016). Unnatural Deaths in Police Lockup/Prisons of North Maharashtra Region: A 15 Year Retrospective Study. Indian Journal of Forensic Medicine & Toxicology, 10(1), 74. https://doi.org/10.5958/0973-9130.2016.00017.7

62. Poštuvan, V., & Madjar, T. (2013). Ethical Issues of Mental Health Care in the Slovene Prison System. In N. Konrad, B. Völlm, & D. N. Weisstub (Eds.), Ethical Issues in Prison Psychiatry (pp. 297–314). Springer Netherlands. https://doi.org/10.1007/978-94-007-0086-4_18

63. Ünal, V., Özgün Ünal, E., Çetinkaya, Z., İmalı, M., Gürler, S., & Koç, S. (2016). Custody and prison deaths autopsied in Istanbul between 2010 and 2012. Journal of Forensic and Legal Medicine, 39, 16–21. https://doi.org/10.1016/j.jflm.2016.01.009

64. Wobeser, W. L., Datema, J., Bechard, B., & Ford, P. (2002). Causes of death among people in custody in Ontario, 1990–1999. CMAJ: Canadian Medical Association Journal, 167(10), 1109–1113.

65. 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. https://doi.org/10.1016/S2468-2667(20)30233-4

66. Gunnell, D., Bennewith, O., Hawton, K., Simkin, S., & Kapur, N. (2005). The epidemiology and prevention of suicide by hanging: a systematic review. International journal of epidemiology, 34(2), 433–442. https://doi.org/10.1093/ije/dyh398

67. Sabrinskas, R., Hamilton, B., Daniel, C., & Oliffe, J. (2022). Suicide by hanging: A scoping review. International Journal of Mental Health Nursing, 31(2), 278–294. https://doi.org/10.1111/inm.12956

68. World Health Organization. (2007). Preventing suicide in jails and prisons [Prevención Del Suicidio En Cárceles y Prisiones], 28. https://iris.who.int/bitstream/handle/10665/43678/9789241595506_eng.pdf

69. Hayes, L. M. (2013). Suicide prevention in correctional facilities: Reflections and next steps. International Journal of Law and Psychiatry, 36(3), 188–194. https://doi.org/10.1016/j.ijlp.2013.04.010

70. Grant, E., & Jewkes, Y. (2015). Finally Fit for Purpose: The Evolution of Australian Prison Architecture. The Prison Journal, 95(2), 223–243. https://doi.org/10.1177/0032885515575274

71. HM Inspectorate of Prisons (2023). HM Chief Inspector of Prisons annual report: 2022 to 2023. HM Inspectorate of Prisons. https://assets.publishing.service.gov.uk/media/64a43d244dd8b3000c7fa479/hmip-annual-report-2022-23.pdf

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# Ligature deaths in prisons in England and Wales: trends and reduction strategies