

Perrie Lecture - Newbold Revel 15 June 2001

# *Every Suicide is Somebody's Child*

*The impact of suicide in prison upon the family*

Erin Pizzey, founder of the Chiswick Women's Refuge, and grandmother of Keita, who died in Wandsworth in January 2000.

On Monday, 31 January 2000, I was two days out of the hospital recovering from a major cancer operation when my daughter came to visit me and told me that Keita, my 22 year old grandson had been sent to Wandsworth prison. This was the first I heard of a series of events that had taken place over the last two days. Six months before his death, Keita had been finally diagnosed as a schizophrenic. For many years, like so many families in this country, we were shuttled between psychiatrists, doctors, health clinics and social workers in a desperate attempt to get help for this beautiful, fragile child of our family.

While I was in hospital, unable to move off my bed, I heard the station nurses speaking to Keita who telephoned to ask how I was. 'Tell him I'm fine and I'll be home in the next few days. Tell him I love him and not to worry about me', I said. I should have struggled out of bed to talk to him. Maybe, if I had talked to him, he could have told me that his dysfunctional girlfriend had thrown him out for the last time. He could have explained to me why he ran down the road from her flat and snatched a handbag from a woman who crossed the road in front of him. A passer-by tried to stop him and Keita punched him and ran back to his flat near-by and waited for the police to come and collect him.

'It was a cry for help,' I said hugging my anxious daughter, his mother, on the Tuesday night that he died. 'Don't worry,' I said. 'He's in the safest possible place. We can sleep tonight.' My daughter spent the evening telling me how Keita had become suicidal in the cells at Richmond Magistrates' Court. How his social worker had refused to section him so that he could be admitted into a locked ward in a psychiatric hospital and how eventually, the magistrates decided that because Richmond did not have a court-based diversion, Keita would have to wait to appear on Wednesday in Wimbledon. I still feel that the magistrates' decision to send Keita (who had no criminal record) to jail rather than let him stay with a member of the family was largely based on the fact that he was schizophrenic and black. There is a dangerous and automatic assumption that schizophrenics are all

Jviolent when in fact very few commit violent offences.

At eight fifteen on Wednesday morning, I telephoned my daughter to tell her that I would be praying for Keita during the hearing at the Wimbledon court. His Godmother answered the telephone. I could hear my daughter crying in the background. 'Keita is dead', his Godmother said. 'The Lord giveth and the Lord taketh away, blessed be' the name of the Lord,' is all I could say. 'How?' I asked. 'They gave him back his trainer-laces', she said. An image of those long black laces always undone because it meant that Keita was a 'cool dude', flashed through my mind. From that moment on my life was irrevocably changed. Not just my life of course, but the lives of our whole extended family. For parents to lose a child is probably the greatest of all human tragedies. For grandparents to watch their sons carry their grandchild to a grave causes unimaginable anguish.

I discovered a well of rage and anger that I did not believe could possibly exist in one human being. I am no stranger to prisons or to suicides. In the last 30 years I have worked with violent and dysfunctional human beings all over the world. In Chiswick the first women's refuge in the world, I was aware that at any time at least a third of the women living there had attempted suicide. Many of the women had criminal records and I had to design a programme where violent behaviour and suicide was not a possibility and in my time, there were no suicides in the 12 years I ran my refuge and very few violent incidents.

We were lucky that the new Governor of Wandsworth was a sympathetic man. However much he could empathise with our grief, the situation between the Prison Service and the families of suicides is one of almost total negligence. The first and foremost need for any family is to find out how their child died. The second is to be given full and factual information about what is to happen in the future and the third, and in many ways the most vital, is what sort of retribution is available. It is cruel for a desperate family believing that their beloved child whom they last saw alive and well, is now to be returned to them as a corpse and that the life of the child is only worth the price of a coffin.

From the beginning we were able to have as much

information as we needed from the prison but this is rare and not representative of the case for most families. I only learned of the existence of 'Inquest' an organisation that specialises in advice and help through the Internet. One of the biggest hurdles for the family is the fact that at the inquest they stand alone unless they have money because no legal aid is available for inquests. The prison governor and the staff, as far as the family is concerned, are guilty of the death of their child. The prison and the staff will be represented at the inquest by a barrister and a solicitor paid for by the taxpayer. This epitomises in my opinion the whole ethos of the prison versus the family.

Keita was only 22 years old. He was unmarried and had no children and as far as the Home Office is concerned his life was considered worthless. The fact that he was musically gifted and could follow in his famous father's footsteps and eventually become a world-class musician was ignored. By insisting that bereavement damages, if they are awarded at all, might just cover the cost of a pitiful funeral, leaves the family with a sense of outrage.

How can the Prison Service say that Keita had no dependants? His mother is a single parent; he has a very young brother and a sister. They all depended upon Keita as the loving though fragile older brother and his mother's first son. In the future, Keita like most sons would most certainly have been responsible both emotionally and financially for his mother. Schizophrenics these days, once they are medically stabilised can go on to lead productive and emotionally and professionally successful and satisfying lives. Why should those who commit suicide in prison be deemed invisible by the authorities? Partly because we now live in a society where families are not recognised and respected. Also, I think if the families can be expunged from the suicide, there is less risk of financial retribution and probing enquiries into the reasons for the suicide. Most of the families that contacted me expressed very strong feelings that they came up against an iron-clad barrier that excluded them as far as possible from any information or knowledge of what had happened to their child. In many cases the Prison Service closed their portcullis and left the family outside bereft, paranoid and alone. Only when listening to the evidence at the inquest did many families hear, details that shocked and outraged them but by the time they filed out of the Coroner's court, the inquest was over and their questions remained unanswered.

It took weeks; even months to get Keita's clothes back from the police. Even his little personal items that he kept in his pockets were unnecessarily withheld. His big black leather jacket finally came back to his family. This unnecessary cruelty is what so many families suffer, and again the prison system treats its prisoners as if they are divorced from all family connections. At the end of all the attempts by the Prison Service, some really well meant and sympathetic, there is a real need to rewrite the whole concept of how desperate,

mentally ill people end up in prison when it is palpably obvious to the families and to the Prison Service that they should never have been there in the first place.

I know, from my own experience that in some cases anyone determined to commit suicide in a prison setting will probably succeed. In Keita's case, he had already begged for help in Richmond Magistrates' Court. He acknowledged his suicidal impulse and asked that he be protected from himself. He arrived at the prison with three reports from agencies warning the prison of his suicidal frame of mind and an F2052 form accompanied him warning the staff of his condition. The fact that his trainer-laces were returned to him was, as far as I am concerned, the deciding factor in his decision to commit suicide. Keita, like so many schizophrenics that I know suffered from frequent and torturing voices in his head. These voices defiled him, abused him and distorted his thinking. He was due for his dipixol shot on the day he died but it was never given to him. We knew, that once he received his injection even though it took several days to still the voices, the soporific effects upon Keita were almost immediate. Within a few hours he became drowsy and fell asleep. These were the facts that made his death such a nightmare for this family.

Almost immediately, I was contacted by other families who had suffered from the same sense of outrage and disbelief in the prison system as we did. Many of the people who telephoned said it was the lack of information that made them so desperate. One woman told me that her son had been 'ghosted' from one prison to another after a prison riot. He hanged himself from the window bars. He wrote 'I love you mum' on his hand with a biro before he died. 'Why was I not told that he had been moved?' she asked the prison governor. 'Because he was moved as an example to the other prisoners,' he replied. She feels sure that if she had been able to visit him when he was moved, she could have saved his life. Why is it not possible when a prisoner on remand is suicidal that a member of the family is not awarded a visit within the first 24 hours, of incarceration?

The effects of a suicide in prison stay with the family for life. The overriding feeling for a parent or a grandparent is that you failed your child in the greatest hour of their need. You were not there to help them.

They died alone and afraid in terrifying circumstances. The sense of despair that caused the child to take its own life stays with us all forever. I know that a suicide in the prison affects both the governors and the staff and the prisoners badly. I know that there have been suicides amongst the staff in prison as a result of the stress of these terrible events but no other event that I can think of in a prison leaves the family outcast and helpless. The prisoner may well commit suicide for whatever reason but that suicide leaves the family in a permanent state of breakdown.

A mother whispered down the telephone one night, 'Please don't think I am mad. I just want to go

down to the grave and dig him up just once, to look at him one more time.' 'You're not mad,' I told her. 'Most of us want to do that just to apologise for not being there.' We all feel a huge burden of guilt because we were parents and grandparents and we were not there to fulfil our natural duty to our child. Somehow, whatever the event, we failed to protect our beloved children. Nobody warned us, nobody told us, we just hear a knock on the door and two strangers from the local police inform us that our child is dead. I was walking on a march to Downing Street organised by the families that lost their loved ones in institutional care beside a mother who lost her son in prison. 'My husband died three weeks ago,' she said. 'It was too much for him. He had a heart attack.' I can believe it. The damage of those suicides in prison leaves deep holes in the parents and the children of the family that are left behind. I found that many of the children from those families suffer from the guilty feeling that they are the survivors. An 11 year old threatened to jump from his bedroom window when he was angry with his mother. 'Then you will cry for me,' he ranted. I talk to families who years after the event are still as driven and damaged as if the death had only just taken place. The family is imprisoned in that moment of horror and tragedy. For many, their only recourse is endless litigation to alleviate the pain of the injustice. The pain and the sorrow become cyclical as they move from lawyers' offices to courts and back again.

'Move on,' well-wishers tell them. How can they move on? The few lucky families will have genuinely sympathetic, understanding governors and staff at the

prisons but far too many face nothing more than the huge barred door of the prison. The injustice and in some cases, the appalling neglect and carelessness that allowed the prisoner to take his or her life, leave the family scarred and embittered. At least 5,000 seriously mentally ill people are incarcerated in our prisons at anyone time. Prison is disastrous for the mentally ill and grossly unfair for the over worked and underpaid staff. Why can't we call upon prison governors unanimously to refuse to accept people with proven mental illnesses into their prisons? We all know that prisons have always been used as a dumping ground for the mentally ill. Apart from anything else it is far cheaper to keep the mentally ill in prison than in mental hospitals where they belong. The role of prison governors in our prisons is really akin to that of Pontius Pilate. The washing and the wringing of hands is the only recourse that they have to the tragedies that occur in their prisons. The chilling fact is that historically when men are herded together and isolated from the rest of humanity, the herders soon lose their sense of compassion and the herded become debased and dehumanised and the result is concentration camps,

I leave you with Keita's last words in his suicide note. 'I truly love and can't live without the people I have mentioned, therefore I am committing suicide. No more horrible cells no more boring court and no more suffering. Please forgive me and I love you all.' When will the Prison Service stop excluding the families of the children who died in their prisons and begin a meaningful dialogue to end these tragedies?

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# *Suicide —from Awareness to Prevention*

**Ingrid Posen, Head of the Prison Service's Safer Custody Group.**

I feel honoured to be presenting the opening Perrie lecture. I am also privileged to be following in the footsteps of a former shadow Home Secretary, Tony Blair, who gave this Lecture in 1993.

My subject is Suicide - from awareness to prevention. From all I have heard and read of Bill Perrie's style in governing establishments and handling people, he would have been sympathetic to the approaches I believe necessary to making prisons safer places in which to live and work. He put a strong emphasis on the accessibility of staff to prisoners and staff to himself. I understand, for example, that at Long Lartin in the 1970s - there were no suicides during his five years there and much anguish when one occurred

about a year after he left - he and his assistant governors had 'open door' policies before the phrase became common-place, in his case with the boardroom as his office so as to encourage all his staff to visit as they wished.

We all recognise that the number of people who have died in prison over the years represents a terrible waste of life, each death an individual tragedy. Providing prisoners with a safe and decent environment, and looking after them with humanity are primary objectives for the Prison Service; the preservation of human life is fundamental to our duty of care. In the course of this lecture, I hope to persuade you that our duty of care requires us to move on from

awareness and adopt a rigorous suicide prevention strategy; and that this stance is consistent with both social policy and the current legal context.

The attitude of any society to suicide reflects much wider social, cultural and ethical norms. Alvarez, in his seminal book *(The Savage God)* quotes two examples which illustrate wide contrasts in attitudes to self-inflicted death.

**1 860 - Nicholas Ogarev writing to his mistress Mary Sutherland, with news from the London papers:**

*A man was hanged who had cut his throat, but who had been brought back to life. They hanged him for suicide. The doctor had warned them that it was impossible to hang him as the throat would burst open and he would breathe through the aperture. They did not listen to his advice and hanged their man. The wound in his neck immediately opened and the man came back to life again although he was hanged. It took time to convoke the aldermen to decide the question of what was to be done. At length aldermen assembled and bound up the neck below the wound until he died. Oh my Mary, what a crazy society and what a stupid civilization.*

**Fifth century BC - Court statute from Athenian and Athenian colonies:**

*Whoever no longer wishes to live shall state his reasons to the Senate, and after having received permission shall abandon life. If your existence is hateful to you, die: if you are overwhelmed by fate, drink the hemlock. If you are bowed with grief; abandon life. Let the unhappy man recount his misfortune, let the magistrate supply him with the remedy, and his wretchedness will come to an end.*

These responses to suicide reflect two contrasting views of man's place in the universe. In classical Greece, philosophers discussed suicide as a rational act, a reasonable response to intolerable circumstances such as unbearable pain or starvation. The Stoics moved the argument on to grounds of the quality and dignity of one's life. If inner compulsions became too great, the question was how one could kill oneself with style, demonstrating in one's manner of death, bravery and dignity.

The nineteenth century London aldermen were heirs to a long tradition of church and state which regarded suicide as a wicked act. Suicide was the ultimate sin which denied God's grace, so it had to be punished to demonstrate its wickedness and to deter others. Across Europe the bodies of suicides were subject to indignities dragged through the street, hung upside down, buried at a cross-roads with a stake

through the heart.

The state strongly supported the attitude of the church, not just because of shared moral values, but through greed. The property of the suicide reverted to the crown, and the laws of confiscation were not changed until 1870. The crime of attempted suicide, an imprisonable offence was not repealed in England and Wales until the passage of the Suicide Act in 1961 and self-harm remained a prison disciplinary offence even later.

Where does our society stand in relation to these two world views? I would speculate that we are probably somewhat closer to the Greek view. We normally see suicide as a sad response to internal or external pressures which make life intolerable. But society's tolerance has limits. The Greek Court kept a supply of hemlock made available to successful applicants - but English Law construes assisted suicide as a crime. This was illustrated again in the recent tragic case of a father who assisted his chronically depressed daughter to die. Despite uncontested evidence that the daughter wanted to die, that is, it was assisted suicide, and the clear sympathy of the court, the verdict was manslaughter (whilst the balance of his mind was disturbed) with a two year suspended sentence.

Although there are individuals whose religious faith leads them to perceive suicide as sinful, that cannot form part of our response as public servants. Suicide is not illegal, and it is no part of our responsibility to punish or make a public example of those who attempt to end their lives.

There are indeed limits to the medical action which can be taken to stop a prisoner intent on suicide. In the case of Secretary of State for the Home Department v Robb [1995] it was held that the Home Secretary was under no duty to prolong the prisoner's life by force-feeding. The prisoner was entitled to refuse medical treatment and starve himself to death (in law, providing nutrition and hydration by artificial means is considered to be medical treatment) as part of his right to self-determination. Only patients who do not have the capacity, within the terms of the Mental Health Act, can be medically treated against their will.

So in pursuing our duty of care for prisoners the Prison Service must adhere to the following principles:

we must not assist a prisoner to commit suicide;  
we must not punish a prisoner for attempting suicide; and,  
we must not breach a prisoner's right to self-determination through non-consensual medical treatment.

These, as you will notice, are all negative principles. But it is equally clear that Article 2 of the European Convention on Human Rights places a positive obligation on public bodies to take steps to safeguard the lives of those in their care. In a recent

judgement (*Keenan v the United Kingdom*) the European Court carefully considered the extent of that obligation. It said that the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. For a positive obligation to arise, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual; and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.

In the context of prisoners, and risk of self harm, the Court said that 'The prison authorities must discharge their duties in a manner compatible with the rights and freedoms of the individual concerned. There are general measures and precautions which will be available to diminish the opportunities for self-harm, without infringing personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case.'

In due course, definitions of what constitutes reasonableness and proportionality in particular circumstances will be defined as the courts review individual cases. And the remarks that follow are my personal interpretation of the judgement, and cannot of course anticipate the views of the courts. But I believe that to our previous principles, we can now add:

- we must take general measures and precautions to diminish the opportunities for self-harm (without infringing personal autonomy); and, on a case by case basis, we must decide whether it is reasonable to apply more stringent measures.

And these measures should be guided by what we know or ought to know about risk. Taken together, these principles provide a powerful framework to guide our strategy on reducing death in custody. First, they require us to take active steps to understand and respond to the risk presented by prisoners in general, and to the risk presented by individual prisoners on a case by case basis.

This risk-based approach lies at the heart of the new Prison Service Suicide Prevention Strategy. Large numbers of research papers, and the evidence of our own statistics, clarifies where risks are highest. At a global level, we know for example: when prisoners are most at risk, where prisoners are most at risk and which prisoners are most at risk

### When?

In 1880, the Medical Inspector of Prisons noted that newly received prisoners were at heightened risk of

suicide. One of the most consistent and robust findings in prison suicide research is that suicides are most likely to occur in earlier phases of custody. The new strategy is therefore focusing on several initiatives to reduce stress and anxiety in the early days of custody. This starts with treatment at court, the availability of court diversion schemes, the conditions and length of time involved in the transfer from court to prison.

We are piloting new arrangements at five large local prisons to achieve major improvements in how prisoners are received into prisons. We want to ensure that:

- receptions are open long enough to receive prisoners properly when they arrive from court;
- there are first night centres where prisoners have time to make a phone call, speak to staff, receive a welcome pack;
- there are informative and supportive induction programmes;
- there is easy access to Listeners on reception and induction; and
- that staff working in reception, first night and induction units receive additional training, particularly in mental health issues.

In general we are adopting a precautionary approach, so that prisons across the country recognise that all prisoners are more vulnerable during their first days in custody. We are already seeing the emergence of excellent first night centres and much improved induction schemes.

### Where?

Location is a significant factor in assessing risk. The majority of self-inflicted deaths occur in local prisons, overwhelmingly 'in single cells, and disproportionately in health care centres and segregation units. Over 90 per cent of all deaths are by hanging. We are using this information to focus significant investment (some £8 million this year alone) in improving the support available, and the environmental safety of high risk locations in local prisons.

We are funding full-time suicide prevention co-ordinators in the 30 highest risk local prisons. These enthusiastic staff, who have just participated in a three day seminar, are making sure that all aspects of suicide prevention policy are delivered to the highest possible standard in their prisons. Their work will be reinforced and good practice spread by newly appointed area suicide prevention co-ordinators.

We are also working in close partnership with the Samaritans to enhance the role of peer support in high risk prisons. We have secured matched funding which enables the Samaritans to provide the training, support and supervision for an additional 450 listeners each year. Additionally, we want to make full use of

environmental safety, whilst still adhering to the principle that we should not punish suicidal prisoners. That means that we eschew the use of strip cells, and rule out shackling prisoners to beds as a forcible means of preventing suicide.

Instead we are developing a series of building standards which will improve the ambience of prisons, with light and reassuring design. At the forefront is the new safer cell. This cell is designed to be as ligature-free as possible, whilst having a reassuring and domestic style of furnishing. Safer cells are significantly more expensive than traditional cells, but they are becoming the norm for all new building. We are also installing safer cells in the five pilot sites in high risk locations, such as induction, detoxification units, healthcare centres and segregation units. We are also developing design standards for care suites and gated cells. This is part of a wider programme which will seek to incorporate safety on the same basis as security in our building standards.

### Who?

Extensive research literature has elucidated the social, personality and health characteristics of those who commit suicide. Many are present in high concentrations in our prisoner population - but it is worth mentioning three groups in particular: substance abusers; those with mental health problems and the socially vulnerable.

#### Substance abusers

The role of alcohol and other drug misuse in suicide is well established. The 1997 ONS survey analysis of substance misuse among prisoners in England and Wales confirmed facts well recognised by the Prison Service. Very high rates of drug use and dependence prior to coming to prison were found. Around 60 per cent of men and 38 per cent of women reported hazardous drinking. Between 30 and 40 per cent of men reported severe drug dependence, and 47 per cent of women. Particularly amongst younger prisoners, multiple substance abuse, was found to be prevalent.

Prisoners are particularly high risk during the period of withdrawal. Until recently the main objective was to achieve a safe chemical detoxification - and this of course is very important. But once the physical detoxification is over, some prisoners are left with serious psychological problems which can lead to self-harming behaviour. The latest healthcare standard on detoxification recommends a range of other rehabilitative measures which can help prisoners through this difficult period.

In the five pilot sites, we are going a step further and setting up dedicated detoxification and post detoxification centres, which we intend to staff jointly by prison and nursing staff. We believe that these units can play a significant role in reducing the risk of self-

harm and suicide amongst serious substance abusers.

#### Mental Health Problems

Psychological autopsy studies have shown that over 90 per cent of those who commit suicide have been suffering from mental illness, and between ten per cent and 15 per cent of people with severe mental illness eventually kill themselves.

ONS has published a series of surveys on the mental health of prisoners, reporting very high levels of psychiatric morbidity. Twenty three per cent of male unsentenced prisoners, 14 per cent of male sentenced prisoners and 20 per cent of female prisoners were diagnosed as suffering from borderline personality disorder. The prevalence in the community is around 1.8 per cent. Rates of functional psychoses ranged from 7-14 per cent. The rates of neurotic disorder were generally very high, with remanded women reporting 76 per cent incidence.

Looking at previous suicidal actions and ideation, over a quarter of the sample of male remand prisoners had attempted suicide in their lifetime, and one sixth within the previous year. Nearly one half of female prisoners had attempted suicide in their lifetime, and over a quarter in the past year. Psychiatric illness was more common amongst those who had attempted suicide - for example the prevalence of psychosis rose to between a quarter and a half of those who had attempted suicide in the past year. Overall, the suicidal group were four or five times more likely to have several categories of disorder simultaneously compared with those who had not tried to kill themselves.

These levels of risk require us to make the identification and care of mentally ill prisoners a central plank in our preventive policy. The first requirement is that we improve our level of identification of those at risk.

All new prisoners receive healthcare screening, which includes questions on mental health and suicidal intent. But a study by Professor Don Grubin found that the current screening missed large numbers of prisoners with mental health problems. He has developed and trialled a more effective screening instrument, which will be piloted in ten prisons this year. The pilot prisons will also develop protocols for the treatment of prisoners found to be at high risk, and more detailed clinical assessments will be carried out during the induction period. We hope that this new screening will identify, and address the problems of more prisoners who are at risk of self-harm in their earliest days in custody.

Additionally we must ensure that there is adequate provision of mental health service in prisons. New partnerships between the NHS and local prisons are being promoted. Funding has been secured for an additional 300 qualified staff to help provide comprehensive mental health services in prisons. Some of these services are already in place, and mental health nurses are involved in a full assessment of prisoners at

risk of self-harm, in drawing up their care plans, and supporting wingstaff in the delivery of the plans. We are not seeking to medicalise self-harm and suicide, but there is no question that some prisoners urgently need specialised mental health or psychological support, and we believe that they should receive it.

#### Socially vulnerable prisoners

In our prison population we find a concentration of social risk factors associated with elevated risk of suicidal behaviour, such as family breakdown, sexual abuse, frequent and severe experience of violence, periods in local authority care, poor educational achievement and truancy. Such prisoners tend to be socially isolated both outside and inside prison.

Staff have a critical role in respect of this population, and many are very sensitive to the needs of isolated prisoners. Prisoner peer group support can also reach out to prisoners who may be on the edge of a crisis, which is why we are paying so much attention to the training and supervision of listeners and other prisoner carers.

Self-harm cannot just be ascribed to the actions of an individual vulnerable prisoner. The institutional setting can exacerbate or reduce the risk. That is why we have established a Safer Custody Group, which embraces suicide prevention. But the Group also looks wider. It is charged with developing a range of measures to make prisons safer places in which to live and work. For example, it will develop a violence reduction strategy, and enhance existing anti-bullying policies.

### **Conclusion**

I have spoken about some of the ways in which our new suicide prevention strategy is based on the fundamental principles of our duty of care. The duty actively to seek out knowledge about where risks lie with the general population, and with individual high risk prisoners. The duty to take positive steps to tackle risk on the broadest possible front, through excellent staff-prisoner relationships, good mental health services, a safer physical environment, sound systems to identify and deliver care plans for the most vulnerable, and by expanding peer support schemes.

We also have a duty to expand our knowledge base - and we are developing a long term research strategy to provide a better evidential basis for our interventions.

We must take all these measures in a way which respects the autonomy of prisoners and does not add punishing attitudes to existing suffering. This is a huge challenge, but one to which the prison community can, and thankfully already is rising. Suicide appears to be on a downward trend - but awareness is not enough - (prevention must be our goal).

We must work within the boundaries marked by forbidden assistance at one end, and forbidden

punishment and force at the other. For let there be no mistake, the Prison Service has the strongest possible duty of care to vulnerable prisoners. The European Convention on Human Rights, incorporated under the Human Rights Act (which came into effect on 2 October 2000) places a positive obligation on public authorities to protect life (other than in a limited number of defined circumstances). Article 2, the right to life, is an absolute right. As the pre-condition to enjoyment of all other rights, it is seen as fundamental.

Article 3, prohibition of torture, also has an important bearing on the conduct of our suicide prevention policy. This means that no-one shall be subjected to torture or to inhuman or degrading treatment or punishment.

In pursuit of our duty of care, in relation to suicide prevention we therefore have the following principles to protect life:

- we must not assist a prisoner to commit suicide;
- we must not punish a prisoner for attempting to commit suicide;
- we must not breach a prisoner's right to self-determination through non-consensual medical treatment;
- we must take general measures and precautions to diminish the opportunities for self-harm; and
- on a case to case basis, we must decide whether it is reasonable to-apply more stringent measures.