

WestminsterResearch

<http://www.westminster.ac.uk/westminsterresearch>

Suicide & Supervision: Issues for Probation Practice

Borrill, J., Cook, L.C. and Beck, A.

This is a copy of the accepted author manuscript of the following article: Borrill, J., Cook, L.C. and Beck, A. 2016. Suicide & Supervision: Issues for Probation Practice. *Probation Journal*. Published online before print November 17, 2016, doi: 10.1177/0264550516677770

Minor amendments may have been made before final publication.

The final, definitive version is available from the publisher:

<https://dx.doi.org/10.1177/0264550516677770>

The WestminsterResearch online digital archive at the University of Westminster aims to make the research output of the University available to a wider audience. Copyright and Moral Rights remain with the authors and/or copyright owners.

Whilst further distribution of specific materials from within this archive is forbidden, you may freely distribute the URL of WestminsterResearch: (<http://westminsterresearch.wmin.ac.uk/>).

In case of abuse or copyright appearing without permission e-mail repository@westminster.ac.uk

Suicide and Supervision: issues for probation practice.

Abstract

Suicides by offenders in the community have been relatively under-researched in comparison with prison suicides. This study examined in depth the events and experiences of 28 service users under probation supervision, based on continuous records from the start of their sentence to their death by suicide. The study presents novel findings through mapping suicidal behaviour onto the probation supervision process, and demonstrates the complex pathways leading to suicide in this population. Key issues identified include missed appointments, the impact of legal proceedings, changes in supervision, and the importance of recording risk.

Key Words

Deaths; suicide; supervision; probation; service users; risk; legal proceedings; training

Introduction

Suicidal behaviour by offenders under probation supervision in the community has been relatively under-researched and addressed in comparison with prison suicides, (Mackenzie, Borrill, Dewart, 2001). ~~This is despite evidence from~~ Sattar (2001) found that in England and Wales, ~~that~~ community offender suicide rates were then seven to eight times higher than the general population rates, and also slightly higher than for prisoners, while. Pratt et al (2006) ~~also~~ found that offenders ~~who had been~~ recently released from prison into the community had higher rates of suicide than the general population. More recently, King (2011) noted that 20% of suicides by people in contact with the Criminal Justice System in England and Wales within the last 12 months, were being supervised by probation. A review of deaths by offenders under

community supervision during 2009-10 reported 104 deaths by suicide (Gelsthorpe, Padfield, Philips (2012), representing 14% of probation deaths that year. It is notable that figures from the Prison & Probation Ombudsman (2015) show that self-inflicted deaths by offenders in probation Approved Premises (APs) are rare, reducing from 5 in 2011 to zero in 2014.

Regarding suicidal thoughts, Furthermore, Pluck & Brooker (2014) found that in one probation area of England more than 30% of probation service users reported having attempted suicide at some time in their life. Based on the small percentage of prisoners who appear to disclose their suicidal thoughts to professionals (Slade, Edelman, Worrall, Bray, 2014), the figures for probation service users reporting suicidal thoughts are also likely to be an underestimate. The few studies of probation service users who experienced suicidal thoughts or attempts have identified some potential risk factors, including previous self-harm (Gunter et al 2011; Wessly et al 1996) and , childhood trauma (Gunter et al 2011). Despite, the low level of suicides in approved premises, and—mental health problems have been highlighted among probation service users residing in APs approved premises (-Hatfield et al 2005; Pluck & Brooker 2014).

At the time of the current study, probation services were provided by 35 probation trusts across England and Wales. The trusts were responsible for overseeing offenders released from prison on licence and those on community sentences. Supervision on a community order, could be combined with other requirements for example, unpaid work, curfew, and certain group-work programmes. Alternatively some requirements could “stand alone” without additional supervision. Requirements could be constructive, for example, drug or alcohol treatment or restrictive, for example, prohibited activity and curfew. The role of the Offender Manager involved coordinating the sentence; assessing and managing risk (re-offending, serious harm to others and risk to self), monitoring progress; ensuring compliance and enforcing sentences.

One aspect of probation supervision involves identifying and recording risk of suicide. The Offender Assessment (OASys) system is a structured clinical assessment tool completed by the Offender Manager. It assesses the service users' risk of reoffending and harm to themselves or others over the period of supervision. The Delius case management system records all relevant case management information including supervision contacts. Individuals considered to be at risk of suicide should be identified using the Delius risk to self-register which enables suicide risk to be highlighted to all relevant staff and agencies accessing the Delius record. An individual under probation supervision is required to maintain regular contact, including attending appointments with their probation Offender Manager as well as complying with all requirements of their order. Whilst under probation supervision, service users are helped to identify the causes of their offending behaviour and ways of avoiding reoffending. Offender Managers must enforce supervision requirements according to a statutory enforcement framework. This includes issuing warning letters for failure to comply and instigating breach proceedings through the courts, within a clearly specified timeframe, in line with national requirements at the time.

The meaning and value of offender supervision has been examined in detail across a number of countries (Durnescu 2008; Shapland et al 2012), not only identifying the different aspects of supervision, but also the different perspectives of practitioners and probation service users. Folkard et al. (1966) found that good rapport between probation officers and probation service users and maintaining the same officer were related to more positive outcomes. Conversely high levels of control exercised over probation service users were related to failure. Evaluation of training developed in the UK to enhance probation staff skills in engaging with service users (the Skills for Effective Engagement, Development and Supervision (SEEDS) programme)

reported particular perceived benefits in engagement with service users with alcohol problems and those with domestic violence offences (Sorsby et al 2013). These are factors that are often associated with increased suicidal risk, demonstrating the important role that probation supervision can play in managing vulnerable offenders. Pratt et al (2010) reported that prisoners in [England & Wales](#) ~~the UK~~ who died by suicide following release into the community, had lower levels of contact with probation staff prior to their deaths. This suggests that effective supervision practice may be able to make a significant contribution to suicide prevention in probation service users.

The challenges faced by probation staff in actively engaging service users with the supervision process are important in understanding and reducing suicidal behaviour. In-depth interviews with a small sample of probation staff highlighted the challenges of supervising vulnerable probation service users who had survived a near-lethal suicide (Mackenzie, Cartwright, Beck, Borrill, 2015) and recommended mandatory suicide prevention training for all staff. Cook & Borrill (2015) analysed 38,910 client records in [England & Wales](#) ~~the UK~~, concluding that probation officers recognised the importance of previous suicidal behaviours, psychiatric treatment, depression, and current relationship problems as risk factors for suicide, but were less likely to record suicidal risk associated with alcohol misuse or loss of social support.

It is also important to understand the differences between offenders under community supervision and those in custody due to the different settings and levels of access to support. Prisons have a legal duty to protect prisoners from harm and to some extent to reduce access to specific methods of suicide, for example monitoring access to substances that could cause overdose or removing ligature points from safer cells. Due to contextual differences, the level and frequency of probation supervision and monitoring is inevitably lower [in the community](#)

[than in prisons or APs](#), and access to methods of suicide is also significantly greater in the community [than in prison](#). Probation service users have varying levels of supervision and monitoring depending primarily on an assessment of the risk of harm they pose to others and their likelihood of re-offending. Only [a a](#) small number of probation service users assessed as high risk of serious harm to others, [and](#) residing in [Probation Approved Premises \(APs\)](#) following release from custody, have access to 24 hour support and daily monitoring. Conversely, prisoners can be observed, formally or informally, at regular intervals throughout each day, with those deemed at risk of suicide assessed and monitored through the Assessment Care in Custody and Teamwork (ACCT) process.

The aim of this article was to explore the events and experiences of probation service users who died by suicide whilst under supervision, as part of a wider ongoing examination of completed suicides by probation service users. It focused on suicides which occurred whilst service users were under probation service supervision in the community in one [large urban metropolitan](#) probation trust. Understanding the pathways to a suicide requires information and assessments completed over a period of time, as suicide is best understood as a process rather than a state (O'Connor, 2011), including the development of both motivation and capacity for action (Joiner 2005). The study collated data obtained from all the recorded events and interactions between probation service users and their offender managers as well as other relevant staff. The [research overall examined a wide range of factors that emerged from the data, and which will be presented elsewhere, but the](#) specific focus of this article is to describe [and discuss those findings that are of particular relevance to the process of supervision in practice:](#) proximal events, potential warning signs, and indicators of increased risk [within the supervision process](#). These factors are also considered within the context of the probation service users' behaviours and level of engagement. The study also aimed to explore differences

in managing suicidal service users in the community compared with in custodial settings, and to discuss implications for future practice.

Method

Data collection

The research focussed on suicides of service users under supervision within one [very large](#) metropolitan probation area over a three year period. Service users who died whilst under community supervision from 2010 to 2013 were identified through local probation trust records of deaths under community supervision. Data included deaths from natural causes, deaths formally recorded as suicide, deaths which were apparently self-inflicted but not classified, and deaths where the cause of death was recorded as unknown. For the purpose of this study deaths by natural causes were excluded. All cases where a suicide was confirmed by records or coroners decisions were included. Cases which were not legally recorded as suicide but contained substantial evidence of prior suicidal behaviour and/or suicide risk were scrutinised in detail, following the criteria used in classifying prison self-inflicted deaths. For example, deaths involving drugs were classified as accidental if there was evidence of previous non-suicidal drug use but no clear evidence of suicide risk factors. If there was substantial evidence of previous suicide attempts, other risk factors, along with increased suicidal motivation or low mood they were classified as suicides. Information on the selected cases was extracted from two electronic data systems used by probation staff to record assessments and ongoing contact between probation staff and probation service users: the Offender Assessment System (OASys) records and the Delius case management system.

Data Analysis

28 cases were identified for review. Each case was examined in detail by extracting information from the OASyS and Delius systems, including assessments, information recorded by probation staff at each supervision meeting, and information recorded by any others involved in management of the case, including partnership agencies e.g. substance use services. The recorded information varied in detail and length; some offenders had attended only a few supervision sessions before their death while in other cases supervisor records spanned more than a year. Personal details that could identify the service user were removed to provide anonymity. Cases were reviewed and assessed together by the two researchers. Content analysis was used to identify key factors contributing to the suicide process, including proximal events, possible triggers, warning signs, and indicators of increased risk.

Case Demographics

26 of the 28 probation service users selected for review were male and two were female. Service users were described in the records as White British (16), White Irish (4), British Asian (3), and Black British (2). In addition, one was recorded as White Foreign National (New Zealand), one as Mixed Ethnicity, and in one case ethnicity was not recorded. The age range was from 19 to 67 years, with one service user aged 19, 19 aged 20-39, five aged 40-59, and three aged 60+. [Only one service user had been residing in approved premises at the time of his death.](#)

The index offences that led to sentencing varied considerably, including both violent and non-violent offences, with and without direct contact to victims. Violent/contact offences included 8 cases of Common Assault, 4 of which were cases of domestic violence. Other violent

offences included one malicious wounding /possession of a knife and two cases of carrying a weapon. There were two cases of Arson, one of which was a suicide attempt, and one case of sexual activity against a child. The 11 non-violent /non-contact offences included 4 driving offences, mainly minor and linked to alcohol. Other offences were theft or handling (3 cases), minor criminal damage (3 cases), and one case of Benefits Fraud. This wide range of offences shows that suicide was not limited only to service users with violent index offences and/or to high levels of risk to others.

The most frequently reported method of suicide was by hanging (11 cases), as shown in Chart 1. Information about the suicide method was missing or reported as unclear in 8 cases.

Insert here: Chart 1 Number of service users by suicide method

Results

Themes regarding the Supervision Process

The emerging themes with particular relevance to the supervision experience were as follows: missed appointments; enforcement, breach, and legal proceedings; changes in supervision or support; suicide risk recording. Additional themes, related to client vulnerability (mental health problems, alcohol, relationships, employment problems, loss of home, drug use) will be presented in subsequent research reports (in progress).

1. Missed Appointments

19 of the 28 service users (68%) were reported as having missed appointments prior to their deaths, including missing probation supervision, unpaid work, group work programmes, court hearings, mental health/drug and alcohol treatment appointments, and other requirements. The main reasons for missed appointments included work or child care commitments, personal crisis e.g. bereavement, loss of employment or accommodation, deteriorating physical or mental health, lack of money to attend appointments or having conflicting appointments.

Six probation service users missed appointments due to illness, either mental or physical. This included one case in which the missed appointments were a result of two suicide attempts. Another service user with mental health problems said that anxiety about missing appointments exacerbated his sleep problems. Five probation service users explained missed appointments as due to conflicts between attending paid or required work and appointments required under probation supervision. Maintaining paid work was made more difficult if probation service users had to take time off to attend appointments. In one case the Offender Manager subsequently arranged for an evening appointment to accommodate this need.

Three probation service users missed appointments because of appointment scheduling difficulties, such as confusion about dates or clashes with other responsibilities. For example, one client was sent messages about a change in the supervision time, which was followed by a change in date. This led to difficulty collecting his child and attending two appointments scheduled on the same day. His third appointment was cancelled by phone message but he had lost his phone so could not be contacted. Altogether he was attempting to manage multiple appointments with three different services while trying to maintain his job and provide child care.

In two cases missed attendance at programmes occurred because the service user reported personal safety concerns, for example not wishing to be seen in an area where they were 'known' to other offenders. Another service user failed to attend his community Payback session, stating that due to his religion it was not appropriate for him to work in a church. An alternative project was found however he was unable to find his way to the alternative project. He also reported that he found it difficult to get up for work due to depression.

2. Enforcement, breach and legal proceedings.

18 (64%) of the 28 cases were recorded as receiving one or more enforcement warning letters following missed appointments during the supervision period, or were returned to court for failing to meet the requirements of their sentence. Furthermore, in 15 cases (54%) the self-inflicted death took place within a month of warnings or breaches. [As shown in detail in Table 1 below,](#) eight (29%) of the self-inflicted deaths occurred within a week or less of probation service users receiving a warning, being breached, missing an appointment which would lead to breach, or missing a court appearance. One probation service user killed himself directly after his court appearance and two died the day after receiving a warning letter. In seven cases (25%) probation service users received warnings which were later withdrawn, because the reasons they provided for the missed appointments were assessed as acceptable.

[\[Insert Table 1 'Impact of Warnings, Breach, Missed Appointments.' \]](#)

In two additional cases there were other legal proceedings underway unrelated to criminal justice processes; one relating to bailiff proceedings and one to child custody issues. With regard to bailiff proceedings, the service user had been unable to read the letters he had received

from bailiffs because of dyslexia. Despite his offender manager's efforts they were not able to resolve the matter. He arrived at his next appointment distressed because he had lost his mobile telephone and therefore could not find out where and when he should attend work. He failed to attend his next supervision session, was sent a breach letter and was subsequently found dead.

3. Changes in supervision/ support:

In seven of the 28 cases (25%) the supervision records noted probation service users' difficulties in managing changes to their support or supervision arrangements prior to their deaths. These included change of offender manager/supervisor, changes to meeting dates, change of location of services or residence, change of mental health professionals, or change in supervision pattern. In five (18%) of these cases, deaths occurred a few days or weeks after the change was discussed or implemented. The records provide some evidence of supervisors attempting to support probation service users through change, but also demonstrate the difficulty and unpredictability of managing suicidal behaviour and assessing risk. For example, two service users killed themselves soon after a change in their supervision pattern. In one case the supervision was reduced from weekly to fortnightly, as an attempt to reduce stress and minimise suicide risk, because the service user reported feeling -unable to leave the house. The other service user appeared to be progressing well. His supervision was reduced from fortnightly to monthly appointments in view of his apparent reduced risk of suicide, but he died two weeks later.

In both of the suicides by women, changes in supervisors or other staff appeared to be particularly problematic. In one case the individual had already experienced a change in

offender manager. The service user subsequently died a few weeks after being informed of a planned change of psychologist. The other female probation service user was also supported through the planning of a new offender manager and a new therapist. She was due to be transferred the following day to her new offender manager but missed her first appointment with the new therapist and died that day.

4. Suicide Risk Recording

A striking finding was that in 26 (93%) of the 28 cases the offender manager had not activated the Delius risk to self-register. Offender managers may have continued to assess suicide risk throughout the supervision period, but activating the risk register is vital in ensuring that other staff engaging with the service user are aware of their level of suicide risk.

Discussion

Suicides by probation service users in the community are rarely represented in strategic developments designed to reduce suicide. The findings from this research confirm the complex pathways to suicide within this vulnerable population and demonstrate how aspects of the probation supervision process may relate to risk of suicide in vulnerable probation service users. The findings also reflect on how this information might be used to support robust suicide risk assessment by probation staff, and also identify aspects of the probation supervision process which might act as additional stressors for vulnerable service users. The data provides novel findings regarding the mapping of suicidal behaviour onto the probation supervision process, highlighting how personal vulnerabilities can impact on probation services users' ability to meet the requirements of their sentences. Also recognised are the considerable challenges for staff in supporting probation service users with multiple needs. Although the

sample size is small, each service user record provided relevant and useful information concerning the pathway to suicide over the period of supervision.

Complex needs

An important finding of this study was that probation service users who died by suicide had complex needs and vulnerabilities. They often experienced multiple inter-related stressors in the lead up to their deaths, making it unsurprising that they began to struggle to meet the legal requirements of their sentences. In line with current theory defining suicide as a process rather than a state (O'Connor, 2011), the 28 cases highlighted the interactions between multiple factors, leading often rapidly from suicidal thoughts to completed suicide. This finding ~~demonstrates~~ highlights the importance of probation staff having an awareness of suicide and associated risk factors and warning signs so they can act promptly to review risk of suicide in vulnerable service users. This further supports the call for all probation staff to receive targeted suicide prevention training. (Mackenzie et al, 2015)

Comparison with deaths in prison

Some comparisons between suicide by community offenders and prisoners were also noted in the data. Previous studies of prison suicides have utilised the Cry of Pain Model (Williams and Pollok, (2001) and subsequent Entrapment theory (Williams, Crane, Barnhofer, & Duggan, 2005) to apply the key risk factors of defeat and entrapment to a prison setting (Slade & Edelman 2014; Borrill & Taylor 2009). A sense of defeat and lack of positive future thinking appears to also match many of the experiences of the probation service users in the current sample. However, the data highlighted that in contrast with prisons, service user suicides in the community were not primarily by probation service users considered to pose a high risk of

reoffending and serious harm to others (although a number of index offences were categorised as violent). The study found that suicides in probation service users also occur in those with less serious offending histories. Therefore, assessing and monitoring risk of suicide will remain an important role for staff working in both the National Probation Service (NPS) and the Community Rehabilitation Companies (CRC).

Suicide Prevention: managing missed appointments

The study identified four key aspects of the supervision process which maybe relevant to suicide prevention practices in probation services. One prominent theme emerging from this research was the high levels of missed appointments by probation service users shortly prior to their deaths. Often these missed appointments related to the presence of underlying personal vulnerabilities, such as mental health issues, or significant changes in personal circumstances e.g. loss of accommodation or family bereavement which are relevant to future risk of suicide. Missed appointments may therefore provide an observable sign that an individual is experiencing significant difficulties in coping and meeting their responsibilities and may be at risk of future suicide. The often close proximity of missed appointments to individual service users' suicides also suggests that missed appointments could indicate imminent increased suicide risk. Practitioners should therefore be alert to the need for prompt safety and well-being checks on vulnerable service users.

In some cases individuals who missed appointments were experiencing difficulties in managing a range of competing responsibilities and priorities. Meeting family, health and/or employment commitments, alongside the legal requirements of their community sentences, appeared challenging for a number of the service users in the lead up to their deaths. Some

individuals also had a range of different requirements associated with their sentence, which involved appointments with a range of different organisations or individuals. In several cases, last minute changes to appointments appeared to reveal how an apparently small change in supervision arrangements could have a knock on effect on other commitments in service users' lives, sometimes contributing to already heightened stress. These findings suggest that probation staff need to be particularly alert to diversity in supporting vulnerable probation service users with complex needs or competing responsibilities. This would ensure that the supervision process can contribute to their difficulties, and stress can be minimised. A flexible and collaborative approach to supervision planning is likely to assist vulnerable service users in periods of crisis, including monitoring the impact of increasing or reducing the frequency of appointments, offering flexible appointments to fit around personal commitments, and responsibilities, and coordinating regular appointments between agencies to avoid clashes.

[Suicide Prevention: issues around breach and legal proceedings](#)

Another significant theme from the data was the [close proximity between link-between warning, breach action and legal proceedings events and the occurrence of the suicide, as shown in Table 1](#). Attendance at supervision and other appointments related to an individual's sentence is a legal requirement, and failure to comply with these requirements necessarily leads to a legal process involving issuing of formal warning letters. Formal breach proceedings may follow, and ultimately result in a service user being returned to court [and in some cases, to a return to prison](#). The study found that a significant number of probation service users were facing warnings, breach action and or legal proceedings for non-compliance with the conditions of their sentence at the time of their deaths. There may be similarities between deaths by probation service users soon after a warning or breach, and suicides by life sentence prisoners warned or returned to high secure conditions after breaking rules (Borrill, 2002). Therefore,

warning and breach processes may play a role as a potential stressor for suicidal action when coupled with other personal or situational vulnerabilities e.g. loss of employment, financial difficulties, accommodation or increasing use of alcohol or drugs. These considerations may be especially important when there is relatively easy access to potential suicide methods. Practitioners should therefore consider whether risk of suicide could both be more likely and imminent in those face warnings or breach proceedings, when coupled with existing personal vulnerabilities. Routinely reviewing suicide risk when instigating the warning and breach processes could have the potential to contribute to suicide prevention. Raising awareness amongst probation staff of the potential relevance of legal proceedings to suicide risk assessment would provide opportunities for staff to mitigate this risk. Strategies to mitigate the risk could then be implemented such as offering additional support and contact, and triggering urgent safety/wellbeing checks where contact cannot be made. Some supervision records did show that staff had attempted to provide timely support when warning letters or court dates were given; although the suicides were not prevented in these cases this highlights the need for staff engagement with probation service users during the breach process, to explain sentence implications and to provide assistance.

Prevention: Managing relationships and change

Alongside problems with identifying suicide risk and the negative impact of legal procedures, the data also explored possible associations between suicide and changes in supportive relationships with probation staff and staff in other agencies. The findings highlighted the importance of consistency in staff when forming positive relationships with probation service users, as a change in relationships or routines may contribute to distress. The impact of staff changes may be particularly pertinent when there is additional evidence of other multiple stressors as outlined above. Changes in personnel or routine are often inevitable, but awareness

of the potential impact of change, especially multiple changes at the same time should be considered in suicide risk assessment. This finding highlights the protective role that the supervisory relationship can play in both assessing and managing the risk of suicide in vulnerable service users. This further increases the argument for appropriate training for probation staff to ensure that they can play an informed and active role in suicide prevention.

Communicating risk

Finally, the research identified that the Delius risk of harm to self-register designed to alert all users of the shared recording system to the risk of suicide/self-harm was not being widely used by staff. This highlighted the need for further awareness-raising amongst frontline probation staff of the register and its important role in sharing crucial information about risk of suicide promptly amongst professionals working with vulnerable service users.

Conclusion

This study is based on a relatively small sample of deaths and is obviously limited by not having access to a comparative group of service users who experienced the supervision process without attempting or completing suicide. Further research is therefore needed to extend this work, including examining cases from different areas and demographics. However this preliminary study does highlight the complex association of events and experiences that may contribute towards pathways to suicide among probation service users under supervision. The challenges to supervisors in helping and supporting vulnerable clients are observed and acknowledged. The importance of suicide prevention training, in both NPS and CRC is emphasised, along with specific recommendations: alerting staff to the significance of missed appointments; providing a more flexible approach to supervision planning; routine reviewing

of suicide risk when instigating warning and breach processes; and increased awareness of the importance of risk registration.

~~4993 words (including References)~~

References

Borrill, J. (2002) Self-inflicted deaths of prisoners serving life sentences 1988-2001. British Journal of Forensic Practice, 4, 30-38 <http://dx.doi.org/10.1108/14636646200200024>

Borrill, J. & Taylor, D. (2009) 'Suicides by foreign national prisoners in England and Wales 2007: mental health and cultural issues', Journal of Forensic Psychiatry & Psychology, 20: 6, 886-905 <http://dx.doi.org/10.1080/14789940903174113>

Cook, L.C., & Borrill, J. (2015) Identifying suicide risk in a metropolitan probation trust: risk factors and staff decision-making. Legal & Criminological Psychology <http://dx.doi.org/10.1111/lcrp.12034>

Fazel, S, Benning, R., Danesh, J (2005).Suicides in male prisoners in England and Wales, 1978-2003. Lancet, 366, 1301-1302 <http://dx.doi.org/10.1192/bjp.bp.107.046490>

Fazel, S. & Benning, R. (2009). Suicides in female prisoners in England & Wales 1978-2004. British Journal of Psychiatry, RCP.

<http://dx.doi.org/10.1192/bjp.bp.107.046490>

Folkard, S., Lyon, K., Carver, M. M. and O'Leary, E. (1966). Probation research: a preliminary report. Home Office Research unit Report No. 7. London: HMSO.

[Gelsthorpe, L., Padfield, N., Phillips, J. \(2012\) Deaths on Probation. Howard League for Penal Reform.](#)

Hatfield, B., Ryan, T., Pickering, L., Downing, B., Crofts, R. (2005) Probation Journal 52 (2) 137-152

<http://dx.doi.org/10.1177/0264550505052646>

Joiner, T.E. (2005). Why do people die by suicide. Cambridge: Harvard University Press

Mackenzie, J-M., Borrill, J., Dewart, H. (2013). Researching suicide, attempted suicide and near-lethal self-harm by offenders in community settings: challenges for future research.

International Journal of Forensic Mental Health, 12, 26-32

<http://dx.doi.org/10.1080/14999013.2012.760184>

Mackenzie, J-M., Cartwright, T., Beck, A., Borrill, J (2015) Probation staff experience of managing suicidal and self-harming service users. Probation Journal.

[DOI:10.1177/0264550515571396](https://doi.org/10.1177/0264550515571396)

O'Connor, R. C. (2011). Towards an integrated motivational–volitional model of suicidal behaviour. In R. C. O'Connor, S. Platt & J. Gordon (Eds.), *International Handbook of Suicide Prevention: Research, Policy and Practice*. Chichester, UK: John Wiley.

<http://dx.doi.org/10.1002/9781119998556.ch11>

Pluck, G. & Brooker, C. (2014) Epidemiological survey of suicide ideation and acts & other [deliberate](#) self-harm among offenders in the community under supervision of the Probation Service in [England & Wales](#). *Criminal Behaviour & Mental Health*. [24 \(5\), 358-364](#).

<http://dx.doi.org/10.1002/cbm.1909>

Pratt, D., Appleby, L., Piper, M., Webb, R., Shaw, J. (2010) Suicide in recently released prisoners: a case-control study. *Psychological Medicine*. 40(5), 827-835

[Prison & Probation Ombudsman \(2015\), available from www.iapdeathsincustody.gov.uk](#)

<http://dx.doi.org/10.1017/S0033291709991048>

Sattar, G. (2001). Rates & causes of death among prisoners and offenders under community supervision. London: Home Office

Slade, K., Edelman, R., Worrall, M., Bray, D. (2014). Applying the Cry of Pain model as a predictor of deliberate self-harm in an early-stage adult male prison population. *Legal & Criminological Psychology*, 19, 131-146

<http://dx.doi.org/10.1111/j.2044-8333.2012.02065.x>

Wessley, S., Akhurst, R., Brown, I., Moss, L., & Wessely, S. (1996). Deliberate self harm & the probation service: An overlooked public health problem? *Journal of Public Health Medicine*, 18, 129–132.

<http://dx.doi.org/10.1093/oxfordjournals.pubmed.a024471>

Williams, J.M.G. & Pollock, L.,R. (2001). *The Psychology of Suicidal Behaviour*. In K Hawton & K van Heeringen (Eds). *The International handbook of suicide and attempted suicide*. pp 79–93. Wiley, Chichester,

<http://dx.doi.org/10.1093/oxfordjournals.pubmed.a024471>

Williams, J.M.G., Crane, C., Barnhofer, T., Duggan, D. (2005). *Psychology and Suicidal Behaviour: Elaborating the entrapment model*. In K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour: From science to practice*. Oxford: University Press.

Table 1 Impact of Warning, Breach, Court Appearances.

<u>Case</u>	<u>Event</u>	<u>Time to death</u>
1	Breach; court date set	8 days after breach
2	Warning letter; missed another appointment; remanded in custody; court appearance	<u>Died on day of court appearance, after receiving bail</u>
3	Warning letter; breach; did not attend court	<u>6 days after due in court</u>

<u>5</u>	<u>Breach; attended court; warned of possible return to custody; warning withdrawn due to suicide risk; further warrant issued for additional offence</u>	<u>20 days after warrant</u>
<u>6</u>	<u>Breach letter – withdrawn; court appearance, charged with additional offence;</u>	<u>10 days after charged</u>
<u>8</u>	<u>2 Warning letters, both withdrawn</u>	<u>1 month after warning</u>
<u>9</u>	<u>Warning letter – withdrawn; warning letter with possible return to court.</u>	<u>18 days after warning; 5 days after missing next appointment</u>
<u>10</u>	<u>Warning letter; two suicide attempts recorded as acceptable absence; OM noted that breach could 'tip her over the edge'. Further breach letter – revoked.</u>	<u>Approx 4mths after breach revoked</u>
<u>11</u>	<u>Breach, warning letter; second warning letter – possible return to court.</u>	<u>1 week after warning (1 day before due to discuss this with OM)</u>
<u>12</u>	<u>Warning letter after confusion of dates; failed to attend subsequent meeting (left message to OM saying he forgot)</u>	<u>3 days after warning; 1 day after missed appointment & phone message</u>
<u>13</u>	<u>Warning letter regarding prior termination of the supervision order</u>	<u>Died before letter received; 1 week after termination of order?</u>
<u>15</u>	<u>Breach (7 days added); second warning; did not attend breach hearing</u>	<u>5 days after missed hearing; 3 weeks after first warning</u>
<u>19</u>	<u>Letter indicating he would have to repeat IDAPs session</u>	<u>Breach probably initiated after his death</u>
<u>20</u>	<u>Missed supervision but no enforcement action,</u>	<u>Same day as due to attend an ETE appointment</u>
<u>21</u>	<u>Warning letter – withdrawn; warning letter withdrawn (illness); Breach Warning letter from unpaid work</u>	<u>1 day after receiving warning letter</u>
<u>22</u>	<u>Breach of IAPS requirement – taken off list</u>	<u>Approx 4 months</u>
<u>23</u>	<u>Child Custody hearing set - told of court requirements</u>	<u>11 days after set date for hearing ; 1 month before due in court</u>
<u>24</u>	<u>Letter from bailiffs; could not read (Dyslexia) ; Breach letter due to missed appointments</u>	<u>1 day after warning letter</u>
<u>25</u>	<u>Warned of return to court</u>	<u>28 days after warning</u>
<u>27</u>	<u>2 warning revoked (health problems) ; third breach also 'avoided' on medical grounds</u>	<u>2 days after revoked warning</u>

<http://dx.doi.org/10.1093/med/9780198529767.003.0005>

