# INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A WOMAN AT BROCKHILL PRISON ON 3 APRIL 2004

PRISONS AND PROBATION OMBUDSMAN

FEBRUARY 2005

This is the report of an investigation into the circumstances of the death of a woman at HMP/YOI Brockhill on 3 April 2004.

We would like to offer our most sincere condolences to the parents, family and friends of the woman. I am in no doubt as to the extent of their loss and sadness. Indeed, I also know that those feelings are shared by many prisoners, the management and staff of Brockhill.

The woman was well known to be at risk. She had said to many people that she would kill herself if she received a long sentence. On the day of her sentence many staff and prisoners extended support but were convinced, wrongly, that she was ready to look to the future. The investigation identifies failures to communicate warnings that might have made a difference.

This investigation was conducted on my behalf by two Prison Service investigators and other members of Prison Service staff who assisted on particular parts of the investigation. I am indebted to them for their thorough and painstaking work. I am also grateful to the Acting Director of Public Health at the Redditch and Bromsgrove Primary Care Trust, who undertook the review of the woman's clinical care.

I hope that in combination their work may help both to explain what happened to the woman and offer ways of reducing the incidence of self-inflicted deaths in the future.

**STEPHEN SHAW CBE**
**PRISONS AND PROBATION OMBUDSMAN**

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## SUMMARY

This is a report of an investigation commissioned by Stephen Shaw, the Prisons and Probation Ombudsman (PPO), into the death in custody of a woman at HM Prison Brockhill on 3 April 2004.

She spent two periods in custody at HMP Brockhill, the first from 30 July 2003 to 6 August 2003. This was followed by a further period of custody from 13 February 2004 to 3 April 2004.

She appeared at Leicester Magistrates Court on 30 July 2003 and was remanded in custody to appear at Leicester Crown Court on 6 August 2003. On arrival at HMP Brockhill the woman was placed on an F2052SH self-harm booklet on which she remained throughout this period of custody. She was released on bail from Leicester Crown Court on 6 August 2003.

The woman was received into police custody on 12 February 2004 at Leicester Crown Court. During the evening she required medical attention and was taken to Leicester Royal Infirmary. She was discharged from hospital later that night and remained in police custody. During the night it is recorded that the woman made two attempts to strangle herself and was seen by the police surgeon.

The following day, the court staff placed her on constant observations. Shortly after she was convicted, staff found her with a pair of socks tied around her neck. She arrived at Brockhill later that day. Following a risk assessment it was identified that she was vulnerable to suicide/self harm and she was placed on a F2052SH with a frequency of observations of 96 times daily.

She remained on an open F2052SH from 13 February until 19 March. During this period the woman frequently took advantage of the Listener Scheme and her vulnerability was formally reviewed on seven occasions.

On 2 April 2004 the woman appeared at Leicester Crown Court for sentencing. On arrival at court she was placed on constant supervision by the court staff. Later that day she was sentenced to nine years. On returning to Brockhill she was seen by both reception and health care staff. She was not placed on an F2052SH.

On the morning of 3 April the woman was found in her cell suspended by a ligature. Staff immediately attended the scene and attempted resuscitation. Paramedics also attended. It was clear that she had been hanging for some time and she was certified dead by the police doctor at 11:00.

The investigation has focussed on the woman's treatment whilst in custody, specifically the management of her vulnerability, how this was communicated amongst prison staff and external agencies, and the assessment of risk following her sentence. The report records her time in custody, her family's concerns as expressed to the investigating team, the findings of the general

investigation and its conclusions and recommendations, the report of the clinical review, also with conclusions and investigations, and finally the Ombudsman's overview.  The report makes 42 recommendations.

## MATTERS RAISED BY THE WOMAN'S FAMILY

My investigators met the woman's family on two occasions. The first meeting was at the prison on 7 April. The Governor and her staff had invited the family to visit the prison, to meet staff and ask questions, to see her room and to pray in the multi-faith chapel. The investigators then visited her parents at their home on 27 April.

The woman's family's overriding question on both occasions was why her death was not prevented. They said that if prison could not safeguard her life then she ought not to have been incarcerated.

The family also wanted to understand exactly what had happened and how. They had many questions about the physical environment of the prison, the relationships between staff and prisoners and the woman's relationships with other prisoners, and about her medical care. They asked why she was left with the means to take her own life and why the cell had a clothes rail strong enough to bear her weight instead of just having drawers for clothes. They wanted to know what the woman used as a ligature and how she acquired it. They were sceptical of the explanation they were given that it was made from socks because she did not like to wear socks and the description did not correspond with the only type she wore. They asked about the system for locking and unlocking cells. They wanted to know who had access to her cell, the circumstances of the discovery of her death and why she was not found earlier.

The family said that when the woman first went into prison she was not eating or drinking. She was a fussy eater at home too, but part of the problem in prison was that the woman, who was accustomed to spicy food, found the prison vegetarian food unpalatable. The family were grateful to the Visiting Hindu Minister for arranging to take extra fruit but he was not allowed to take spicy food. The family said the woman pursued her religion in prison. The Hindu Minister provided pictures of gods and goddesses for her. She fasted on Fridays and prayed in her cell. On C wing she would get up early to bath before breakfast. She told her parents that on two or three occasions officers objected to this and she felt intimidated.

The family said it was hard to book visits. It was supposed to be possible to phone from 10 to 12 every weekday morning but it was often hard to get through on the phone. When the woman first went into prison they tried to book a visit but could only get the answerphone. Eventually they arranged a visit through a voluntary organisation, the Prisoners' Families Helpline. On the Saturday of the woman's death, the family could not get through to the prison on the telephone. They called the Helpline who rang back to say that they could have a special visit and the prison would telephone. From 10:00 to 13:00 they were waiting for the prison to telephone them. Then the police arrived to tell them of her death. They learned later that the Helpline had known of her death when they rang the family back but had agreed not to break the news.

The woman's parents said that the day before her death she had been taken from the prison in a cellular vehicle at 07:00 and taken from the court at 13:00 but she had not arrived back until about 17:00. At court she was not listening during the sentencing but waving her hands about and crying. The family had wanted five minutes to see her and for the priest to bless her but the solicitor had told them it would not be allowed. She made two telephone calls to the family between 18:00 and 19:00 and was very distressed, though calmed a little during the conversations. The family felt powerless because they could not embrace her and could only assure her of their support and that they would visit the following day. She had always given the same message about killing herself if she was sentenced to prison. They believed her solicitors had warned the prison. They wanted to know what care and support the woman was given during the night.

## THE WOMAN'S TIME IN PRISON AND EVENTS IN THE PERIOD LEADING UP TO HER DEATH

## HER FIRST PERIOD IN PRISON: 30 JULY TO 6 AUGUST 2003

1. On leaving Leicester Magistrates Court on 30 July 2003, the woman was placed on the cellular vehicle at 17:00 and at 17:15 stated that she could not breathe and was feeling claustrophobic. She was observed every five minutes until her arrival at Brockhill at 18:20. Between 18:25 and 19:20 both reception and health care staff assessed her. The cell sharing risk assessment form records that she wanted to be on her own and said she would refuse to share a cell. She was described as agitated, stating that this was her first time in prison and that she felt like killing herself. She also said that her grandmother was ill and this was a concern to her, she did not want to be there and she was tearful. During interview, the woman stated that she had previously self-harmed and did not want to eat or drink at present.

2. The assessment on the first reception health screen form describes the woman as weighing 40kg and her height as 5ft. The mental health screen notes that she said that she had suffered from depression but had never needed treatment and had not been prescribed psychiatric medication. It is recorded that, a few weeks prior to appearing at court, she cut her wrists but stated that these injuries were not treated. She again stated that she felt like killing herself but did not know how to and that she was stressed due to her grandmother's illness. At 19:20 the woman was placed on an F2052SH self harm at risk form.

3. She was located on C wing, C2 landing at 20:00. C2 landing was used for prisoners who were thought to be vulnerable and need higher levels of support and care.

4. On 31 July, the prison doctor saw the woman. Her Inmate Medical Record (IMR) recorded anaemia, poor diet, vegetarian, anxiety and depression and panic attacks. A further entry that day describes the woman as being very sullen, having cut her wrists before, and that she had not eaten over the last few days due to stress. The record says she was encouraged to eat and drink.

5. A case review of the woman's vulnerability was held the same day. The doctor, a senior officer, a staff nurse and the woman attended. It is recorded that she had previously self-harmed, this was her first time in custody and she was nervous and intended to contact her solicitor in the hope of bringing her case forward. The support plan outlined the following action:

    - maintain regular observations of no less than 24 times daily at unpredictable times

- offer Listeners
- maintain current location and review on 4 August

6. During the first 24 hours it is recorded that the woman did not sleep well and that she requested additional bedding.

7. On 1 August she asked for a Listener, who stayed with her from 21:00 to 22:40. On 2 August, at the woman's request, Listeners stayed with her from 19:15 to 23:20. She asked for a Listener again in the evening of 5 August but none was available.

8. There was no case review on 4 August but the F2052SH file remained open. She attended healthcare that day. Her IMR records that she refused to have her blood taken and stated that she felt paranoid at times. She was listed to see a mental health nurse. Her wing file records that she attended for meals.

9. On 5 August the woman was required to attend Wigston police station, Leicester. The following day, she appeared at Leicester Crown Court and was granted bail.

## SECOND PERIOD IN PRISON: 12 FEBRUARY TO 2 APRIL 2004

### The woman was convicted and remanded to prison to await sentencing

10. On 12 February the woman was received into custody at Leicester Crown Court. The dock officer at the court raised a suicide/self harm warning form. The PER form (Prisoner Escort Record) says that she was claustrophobic, anaemic and having palpitations. The box marked suicide/self harm was ticked. The PER form records that between 18:00 and 22:56 she required medical attention. At 18:00 she was found to be hyperventilating and was taken by ambulance to Leicester Royal Infirmary. Following assessments and tests, she was discharged at 22:56 and lodged in police custody, where she remained overnight because she was due in court next morning. The PER form records that at 01:55 the woman tried to strangle herself with a pair of foam slippers. At 02:10 she tried to strangle herself with a paper suit and was seen by the police surgeon at 04:30.

11. On 13 February, at court, the woman was placed under constant observation. At 12:50 she was convicted and remanded in custody to appear at a later date for sentencing. The court staff contacted Brockhill to say that she would be coming to them later that afternoon. At 13:00 court staff found her with a pair of socks tied around her neck. These were taken from her and disposed of. She left Leicester Crown Court at 14:40 arriving at Brockhill at 16:05.

## Reception and induction at Brockhill

12. Cell sharing risk assessment and first reception health screen forms were completed as part of the reception process. The cell sharing risk assessment form identified that the woman had been in custody in August 2003.

13. A nurse conducted the health assessment. She noted that the woman suffered from anorexia, anxiety, claustrophobia and palpitations. She said she did not use drugs or drink alcohol but smoked 10 cigarettes daily. She said she was taking anti-depressants but no medication was identified. She said she had tried to self-harm by strangulation, cutting her wrists and taking an overdose. She said she was trying to kill herself but nobody believed her. She said she did not expect to be in prison and, although she expected to be in contact with her family, she felt suicidal. The reception nurse considered the woman to be at high risk of self-harm and opened an F2052SH file. She was to be observed at a frequency of 96 times daily.

14. The woman's weight is recorded as 40kg and her height as 1.52m. On the section of the first health screen form titled 'Additional Information' the address of her next of kin is recorded, and her dietary needs and religion.

15. In the F2052SH, it is recorded that the woman had a past history of self-harm and that she felt she should be in a hospital and see a psychiatrist. The care plan specified that she should be allowed access to the Listeners, be observed 96 times daily and supported by wing staff (C Wing), healthcare staff and Listeners. The daily supervision and support record states that at 21:50 on 13 February she requested the support of a Listener and that one was allowed into her cell at 22:17, leaving at 23:10.

16. Next day the woman saw a second prison doctor. Her entry in the inmate medical record (IMR) confirms the information in the first Reception Health Screen Form and, additionally, the doctor referred her to see the psychiatrist. She was unable to remember the name of her GP or surgery or the name of the medication she had previously been prescribed. The doctor made a note that her family would be asked to provide this information. The doctor stated that the woman should remain on an open F2052SH with a frequency of observations of 96 times in 24 hours.

17. The same day a principal officer, the reception nurse, the second doctor and the woman met for the first review of the F2052SH. The review recommended continuing the actions identified on 13 February and, additionally, that she is to be assessed by the Registered Mental Nurses (RMNs) at Brockhill.

18. The woman's history sheet (F2052A) records that she was issued with a £6 canteen pack and £1 of credit for the pin phone system.

19. On 15 February, the woman was given a phone call to her grandmother to confirm the name of the medication she had been prescribed before coming into custody. The same day she submitted an application to see her Probation Officer and was subsequently seen on 19 February.

20. On 16 February, the Resettlement Team saw the woman as part of the induction process. The induction programme informs prisoners about the opportunities for work, education and other activities in the prison, introduces the support services, including the prison's Listener scheme (Samaritan trained prisoners) probation staff, the chaplaincy team, healthcare staff and drug and alcohol workers, and explains about visits, letters and phone calls. This information is summarised in a booklet entitled "Welcome to Brockhill" (Document 15). On the same day a review of the woman's F2052SH was held. No changes were deemed necessary and the next review was planned for 18 February.

**17 February to 19 March: the period until the F2052SH was closed**

21. Between 17 February until the woman's death on 3 April she was in regular contact with her legal representatives. Her first letter received by them on 17 February (Document 19) expresses her anxiety whilst in prison and confusion about legal proceedings. The woman also reiterated her concerns through several telephone calls, the first recorded as received on 17 February. A letter of that date was written by her legal advisors to the prison's healthcare department asking that she be seen by the psychiatrist and stating that the solicitors were concerned about her.

22. An entry in the IMR dated 18 February records that the woman had been taking Cipramil for seven months. This information had been obtained from her family. (Cipramil is an anti-depressant of the type called SSRI - selective serotonin re-uptake inhibitor.) The IMR entry also says that she was low in mood and not coping very well. The entry records that she was to see the doctor to be prescribed anti-depressants.

23. A review of the woman's F2052SH support was held on 18 February. At this meeting it was decided to reduce the frequency of observations to 24 times during the day and 48 times during the night. The review records that she was not very talkative but said she was getting on with her peers on C2 landing. Although the woman said she had no thoughts of self-harm at the time, it was still felt that she was at risk. It is recorded that she was aware of available help. There is an indication that the woman may have been bored and efforts would be made to place her on an educational course. She was encouraged to speak to staff and it was generally felt that she was slowly settling in at Brockhill.

24. On 19 February, the woman saw one of the prison RMNs (Registered Mental Nurse). Her entry in the IMR records that the woman was concerned that she needed to see a psychiatrist to have a report completed for her forthcoming court appearance. This was discussed at some length and the woman understood that this matter was being dealt with. They also discussed her poor sleeping pattern and her dietary and medication needs. It was agreed that the woman would see a psychologist regularly, have daily contact with the RMN team and re-start her anti-depressant medication. It is also recorded that she stated that when confined to small spaces like a prison van she suffered panic attacks.

25. The IMR records that the woman was assessed by the doctor as being depressed and should be on Cipramil. The entry records that she had poor concentration, felt slow, paranoid, hearing noises, voices and murmuring in the background. She stated that these feelings were new to her. It is also recorded that the woman continued to feel vulnerable, at risk of self-harm, tearful and morose and was not sleeping well. She was referred to see the psychiatrist the following day.

26. The prescription and administration record chart shows that on 19 February the woman was prescribed Citalopram (a brand name for Cipramil) at 20mg daily for her depression. The chart records that she attended for her medication on 21 and 23 February and thereafter daily until 25 March. The record chart records DNA (Did Not Attend) for dates 26 March to 2 April.

27. On the afternoon of 22 February it is recorded on the F2052SH that the woman's mother visited her. It is also recorded on the same day within the induction record that the woman enquired about the process for appealing against her conviction. It was explained that this could only be pursued following her sentence and that she should discuss this with her legal representatives.

28. On 20 February, the RMN visited the woman on C wing. There is a record of the visit in the IMR. In summary, the RMN found her to be low in mood and not sleeping well. It is also recorded that the woman was starting a course of anti-depressant medication that day but was not happy about it. The RMN records that the woman stated she did not

wish to see the psychiatrist that day and that her dietary intake was poor (stating the food was horrible). The RMN summarises ongoing action as: to encourage the woman to eat and drink and take her medication as prescribed; continue to observe and re-evaluate regularly.

29. On 22 February, a member of the healthcare staff visited the woman. It is recorded in the IMR that she felt slightly weak, stating that she was not eating much and that she had eating problems. It is recorded that she was to be referred for further RMN assessment regarding her eating problems. She was advised to submit an application for supplementary drinks (weight gain products) and to attend the gymnasium for weight training.

30. On 23 February, the woman was again seen by the RMN to discuss vegetarian dietary options and to ensure adequate menu choice. The RMN visited the kitchen to pursue this matter and also talked with the woman about maintaining a diary recording her food and fluid intake. She was also seen that day by a Consultant Clinical Psychologist, who described her as quiet, non verbal, hearing voices, though giving a poor description of these and seeming to raise them as an afterthought. There was also some discussion about her view of events leading up to custody. The psychologist recorded that he would see the woman again if asked.

31. On 23 February, a representative of the woman's legal representatives spoke to the RMN and discussed the woman's demeanour and current health issues.

32. On 24 February, the F2052SH was reviewed again. In attendance were the woman, a different senior officer, the RMN and an officer. It is recorded that, although the woman was quiet, she took part in the review. There had been no attempts or incidents of self-harm since the last review and the review team decided to reduce the frequency of observations to 24 times in 24 hours. The support plan also recorded use of Samaritans phone and Listeners; that she was to be allowed meals in her cell (this is also recorded on the wing record); she was to continue to work with healthcare staff; and the next review would be on 2 March.

33. On 27 February, the woman saw the visiting psychiatrist.

34. On 1 March, the woman was seen on C wing by induction staff, as they were concerned that arrangements had not been made for her probation officer to see her to prepare a Pre-Sentence Report (PSR). The induction staff continued to pursue arrangements for completion of the PSR and psychiatric report. A probation officer visited on 2 March.

35. On 3 March, a further case review was held, with the woman, a different senior officer, officer and staff nurse. The summary records that the

woman felt “strange at the moment”. She said she was focussing on her impending court date. The frequency of observations was reduced to four times during the daytime but remained at once an hour during the night. The support plan reflected these changes and comments and provided for continued support by wing staff and listeners.

36. The same day a second nurse recorded in the F2052SH that the woman’s mood seemed to be settled and she denied any current thoughts of self-harm but had stated that if she received a custodial sentence she would kill herself. The nurse’s entry records “I believe she [the woman] will be an increased risk at the time of sentencing.”

37. On 3 March, the woman’s probation officer contacted her legal representatives and informed them that the woman was not being realistic in dealing with the possibility that she would receive a substantial sentence and had said she would kill herself if she was to be in prison for years. On the same date her solicitors instructed the psychiatrist to complete a psychiatric report on the woman.

**Pre-Sentence Report**

38. The Pre Sentence Report (PSR) was completed on 4 March. In the report, the probation officer outlines the woman’s denial of her involvement in the offence. The report informs the court that this was her first offence and that at the time she was in full time employment and resided with her grandmother in Leicester. It records that she considered herself to be the “backbone” of the family and that they would struggle to cope without her. There is also mention of recent ill health among family members. The report states that the woman was diagnosed with depression in August 2003 after her first period in custody (this is also confirmed in the GP’s clinical record and the psychiatric report) and was currently being treated for depression at Brockhill and was considered at risk of suicide.

39. Paragraph 3.4 of the PSR records that the woman reported that she had attempted to kill herself on four occasions and she was certain that she could not cope with a long prison sentence. If this was imposed she stated that she would commit suicide rather than be separated from her family.

40. The PSR was received at Brockhill on 7 April 2004, four days after the woman’s death. The probation officer also completed a Briefing Form to accompany the PSR for the information of her colleagues at court. The briefing forms stated that in the event of custody the woman would be at immediate suicide risk and Court security staff, escort staff and the prison should be informed accordingly.

41. On 5 March, the woman saw the visiting psychiatrist again. On 7 March, she was seen by the RMN who records in the IMR that she identified that the woman’s eating pattern was still a problem. Her

weight was recorded as 40kgs on 13 February and 38kgs on 3 March. The RMN also recorded that the woman was to be weighed weekly and that she had referred the issue of her diet to both the doctor and the catering manager. On 15 March the IMR records the woman's weight as 37.5kgs.

42. The woman, a third nurse, senior officer and officer attended a case review on 9 March, together with a seconded probation officer. The summary record states that the woman said she was all right and in a positive frame of mind. It also records that she said she had no thoughts of self-harm but that the nights were hard for her. It is recorded that she talked openly and appeared quite cheerful. The report indicated that the woman was still not eating enough, but the risk of self-harm had diminished. The support plan records: to continue to keep busy, reduce the frequency of observations to four times daily at irregular intervals, continue with staff/Listener support and to be encouraged to eat more.

43. The same day, the woman saw the visiting psychiatrist again because he had been commissioned by her solicitors to prepare a psychiatric report for presentation at court.

44. The next case review was on 12 March. The woman, the second senior officer and officer attended with a fourth nurse. The summary states that the woman was talkative, that she had experienced some problems with her prayers as these coincided with her education classes and that she did not require observations during the day, only at night. The support plan records: the frequency of observations reduced to four times nightly, to continue to attend education classes, to alter her morning routine to ensure that this did not impact on prayers.

45. The woman, a different nurse, a fifth senior officer and the first officer attended the next case review on 19 March. The summary record states that the woman was much more positive in presentation, she was still feeling down, but had no current thought of suicide or self-harm. There has been no incidents of self-harm since she arrived at Brockhill and she had actively used the Listeners scheme. She had a good rapport with the staff and could talk to them if necessary, as well as the Listeners. She was positive about getting enhanced status on the Incentives and Earned Privileges Scheme (IEP) and moving to F wing. The review team agreed that the F2052SH should be closed and the SO signed the document to this effect.

**Comments from staff and prisoners about the woman's manner during this period**

46. One of the Listeners at Brockhill had regular contact with the woman during her time on C wing. (Due to Listener confidentiality, the Listener was only able to provide limited and non-specific comment regarding her relationship with the woman. In accordance with Prison Service and

Samaritans policy, the Listener was supported by a member of the Samaritans during the interview.) The Listener describes the woman as not coping very well in prison but a nice and very honest person. The Listener identified some of the difficulties that she was experiencing with her diet particularly whilst on C wing. The Listener was also aware that the woman had been on an open F2052SH since her arrival in the prison.

47. A prisoner at HMP Brockhill had known the woman for approximately one month, particularly during the time that she spent on C2 landing. In her statement after her death, the prisoner said that she knew that the woman was going to commit suicide if she received a custodial sentence. When asked when she had been told this, the prisoner said that on various occasions when they were both on C wing the woman had told her that she could not cope with a custodial sentence because she loved her grandmother and in the event of her grandmother's death she would have to attend the event in handcuffs.

48. The prisoner also recalled that when she first met the woman she was really bright and bubbly. When asked if the woman remained bright and bubbly the prisoner said "Yes, but as I got to know her I realised it was a show for the Officers". She goes on to say that staff took her off her supervision watch (F2052SH). The prisoner stated that on the day they took the woman off the watch she came to her cell and said, "They think I'm all right but that's what I want them to think". When the prisoner was asked if she was aware of how the woman planned to take her life she stated that she had said that she was going to hang herself. The prisoner went on to say that the woman had planned it, recalling that it was her intention to hang herself from the shower rail in the bathroom. The prisoner had said to her that if she were to do this at night one of the prisoners would find her. The prisoner then said that the woman indicated that she could use the rail inside the wall-mounted wardrobe in her cell. The prisoner said that the woman had actually been into her wardrobe and managed to shut the door. The prisoner said that the woman was so slightly built she demonstrated that she could climb into the wardrobe and shut the door.

49. The prisoner also stated that she would save her crisps and breakfast cereal for the woman as she was a vegetarian and disliked the food she was being given. The prisoner recalls the woman having her diet changed but that this was not maintained and that this had made her feel worse.

50. The RMN outlined the referral scheme at Brockhill. In summary, prisoners can be referred to an RMN if they are deemed to require this additional support. Following an assessment, a prisoner will be allocated to an individual RMN who will develop a care plan and manage that plan closely with the prisoner until their release or until the point where support is no longer deemed necessary. The RMN managed the woman's care plan throughout her time at Brockhill.

51. The RMN described the woman in the early stages of her second period in custody as being very petite and looking either undernourished or underweight. She goes on to describe her as pale, low in mood and said that officers had shown concern because she did not appear to be eating well. The RMN was involved in trying to address her dietary issues, liaising with both the doctor and the Catering Manager to try and ensure an adequate and appropriate diet was provided.

52. The RMN states that during the early stages the woman was very tearful, low in mood, spending most of her day on her bed and not willing to engage in the regime. The RMN would see her every day that she was on duty and recalls that throughout the following weeks she started to socialise with other girls, attended education, took a greater pride in her appearance and visited the hairdresser. The RMN also said that the woman became quite talkative and chatty with her and she thought that she had come to trust her.

53. During this period, the RMN was in contact with the woman's solicitor. The RMN recollects that the solicitor informed her that the woman had tried to self-harm whilst in police custody, which was prior to her first period in custody. The RMN recalls that she overheard staff discussing that if the woman received a custodial sentence she was going to kill herself. The RMN also mentioned that this factor was included in the psychiatric report. The RMN states that the woman always denied this when she asked her if it was true. The RMN states that the woman thought she was going to get off lightly and indeed walk out of court. The RMN states that she spoke to her solicitor and it was quite obvious that this was not going to happen and the indications were that she would get a few years at least.

54. The RMN said that she was not surprised that the woman was taken off the F2052SH on 19 March. The RMN said that if girls did not show any signs of self-harm then the staff would try to take them off it gradually.

55. During the period 13 February to 19 March, whilst the F2052SH was open, the woman made use of the Listener scheme on 11 occasions, was seen by healthcare staff frequently and the F2052SH was reviewed on seven occasions.

**19 MARCH TO 2 APRIL 2004**

**Letters to the woman's solicitors**

56. On 23 March, a four-page letter was received by the woman's legal advisers. In the letter, she stated that she had attempted suicide four times since being convicted but now accepted it was wise to wait until 2 April in case she went home from court. She went on to say that she cannot put her family "through this prison crap." She said that if she were to be in prison she might as well be dead and if she could not be

at home she should “simply not be at all”. In the final paragraph of the letter, she said she was having suicidal thoughts and had planned ways in which to do it and do it well. Enclosed with the letter was a typed letter to the judge setting out her mitigation. The letter is dated 22 March and had attached to it a copy of the mental health assessment compiled by the RMN the same day. This identifies various issues and states that the woman’s mood seemed lower and that she was not sleeping well. The woman wrote a further letter to her solicitors dated 29 March, and recorded as being received on 5 April. In this letter she expressed her concerns and fears as her court date approaches. She also says that she has told both probation and RMN staff that if she returned to prison on Friday she would hang herself.

**Psychiatric report**

57. The psychiatric report was completed on 30 March and sent to the woman’s legal advisors the following day by fax in readiness for her court appearance on 2 April 2004. The report was prepared by the Women’s Forensic Mental Health Services at Ardenleigh, Birmingham.

58. The psychiatrist interviewed the woman on 9 March and had also seen her twice previously during weekly visits to Brockhill. Additionally, the psychiatrist assessed documentation supplied by the legal advisors, her medical records from her GP and her inmate medical record (IMR). The psychiatrist also had a short discussion with the woman’s probation officer.

59. The psychiatric report records the woman’s past and current family history and that she was not aware of any mental illness or criminality within the family. The psychiatrist records her personal history through childhood until prior to the offence; there are no incidents of note. The woman informed the psychiatrist that she had only one relationship within the last five years. This had been her first relationship and her boyfriend had been supportive during her court case. She described herself as a determined and hardworking person who was a key supportive figure within the family unit. She also stated that she was Hindu and her religion and vegetarian diet were important to her. There is no record of alcohol or drug abuse. She stated that she smoked fewer than 10 cigarettes a day.

60. Under the heading ‘past psychiatric history’, the psychiatrist records that the woman saw her GP in August 2003 following her previous period in custody. The notes record “viral illness, depression – tearful, also wanting treatment”. Her GP prescribed Citalopram antidepressant medication. The report records that she had self-harmed during her childhood through an overdose of paracetamol tablets and by cutting her arms. These incidents happened several years previously. She also told the psychiatrist of her attempts to strangle herself whilst awaiting the jury’s verdict on 12 February and on 13 February whilst in police custody. The psychiatrist discussed her weight loss and the

concerns shown by healthcare staff at Brockhill. The psychiatrist described the woman as being particular about what she ate but did not suggest she had a formal eating disorder. The psychiatrist records that, during her interview with the woman on 27 February, she had expressed suicidal thoughts but also stated that she was not going to act on these until she knew the outcome of her case. Within the section of the report entitled current symptoms, the psychiatrist records that the woman stated that she was a fussy eater who hardly ever ate at regular meal times. It is also recorded that she was not decreasing her food intake to lose weight.

61. The psychiatrist records on page 10 of her report that the woman stated emphatically that she felt unable to cope with prison life to the extent that she was certain she would attempt suicide if she received a custodial sentence. This fact is again raised by the psychiatrist on page 13 where she records "in particular I would suggest that (her) risk of suicide would increase substantially if she were to receive a custodial sentence, and she would be likely to require a suicide watch from the outset."

62. The woman's medical notes obtained from her GP confirm that on the 15 August following her release from her first period in custody she saw her GP and the consultation was as outlined in the psychiatrist's report. The notes record the details of that consultation as outlined in the report.

**The woman moves to F wing and returns to court for sentencing**

63. On 1 April the woman was moved to F wing, the wing for prisoners on the enhanced band of the Incentives and Earned Privileges Scheme. Another prisoner, had a conversation with her when she first arrived on F wing. The prisoner stated that the woman said, "Why have they moved me up here? Are they trying to tell me I'm staying?" The prisoner said that the woman made a point of telling several prisoners on Thursday 1 April that this time next day she would be ecstatically happy, or dead. In addition, the woman had told the prisoner and others that she had climbed into the wall mounted cupboard in her cell whilst she was on C2 landing. The prisoner said that the woman had told another prisoner that she was rehearsing an opportunity to hang herself.

64. On 2 April the woman attended Leicester Crown Court for sentence. The prisoner described her behaviour prior to going to court as wandering up and down the landing. The woman left the prison at 08:35 and arrived at Leicester Crown Court at 09:55. On the PER form the box indicating suicide/self-harm risk was ticked and a note added to say that F2052SH had been closed on 19 March. She was searched and at 10:06 was seen by a member of her legal team. At 10:22 another member of her legal team visited the woman for about 18 minutes. After the meeting, the woman was located in an interview

room and placed on a constant watch. No reason for this is recorded on then the PER form. A custody officer stated at interview that the reason was because the woman was known to staff and they were aware of her previous incidents of self-harm. Because of this, she was located in the interview room opposite the staff control room. The interview room has large viewing panels that offer greater visibility and is therefore more appropriate for constant watch arrangements.

65. At court the woman was sentenced to a total of nine years imprisonment. She was returned to the cell area at 12:10. The custody officer stated that she did not react when sentenced, appearing to be in shock. The Court Service phoned Brockhill to inform them of the sentence and that she would be returning to the prison later that day. The woman met with her legal team at 12:30 for approximately half an hour. They took notes of the events at court. These record the proceedings, including the woman's mitigation, and appeal procedures, as explained in the meeting that followed. There is no note of her demeanour at the time.

66. A Probation Support Officer at Leicester Crown Court outlined the procedures for gaining information about a prisoner's vulnerability: "All pre-sentence reports would be researched for identifiable risk. These are always read prior to the prisoner appearing in court". The PSO also said that they would ask the custody officers who work in the court if they have any knowledge or experience that would lead them to believe there was a risk of self-harm or suicide. The PSO pointed out that there was a strong indication of self-harm risk within paragraph 4 of the Pre Sentence Report (PSR) and the briefing form contained at the end of the PSR. The court required these documents on the day prior to sentencing. Following sentencing the PSR and the briefing report would have been sent by post to the prison. Probation staff would have completed a post sentence interview form that is normally faxed through to the prison the same day and additionally a copy will be sent along with the PSR by post.

67. The PSO could not confirm that the PSR and briefing sheet were faxed to the prison on 2 April. He went on to explain that the Lord Chancellor's Department have an agreed protocol that the PSRs are provided to the Custody Officers so that the PSR accompanies the prisoner on leaving the court. When interviewed, the court custody staff said that this rarely happened. The PSR was written a month prior to the woman's appearance at court for sentencing. The Senior Probation Officer for the court probation team was asked whether it might have been appropriate to forward the report to the prison in advance of her appearance. She stated that this would not normally be done because the documents were for the court and passed on to the prison after sentence.

68. At 13:50 the woman was placed on the cellular vehicle and taken to Leicester Magistrates Court (en route to Brockhill) arriving at 13.55.

The custody officer (Document 34) stated that she had tried to arrange her return quickly and that she did not know that the cellular vehicle was going to go to the magistrates' court before returning to Brockhill. On arrival at the magistrates' court the woman was placed in an observation cell. A prison custody officer (Document 35) recalls that she had been told that the woman had received a nine-year sentence, that she was on a constant watch and there was a need to keep an eye on her. She recalls that the woman was located in an observation cell at the magistrates' court when it became clear that the escort was unable to leave immediately. The prison custody officer stated that the woman was fine but had been crying on the van and that she had tried to reassure her. She was placed in the observation cell with another female prisoner and she continued to be upset. She did not want to be alone and a member of staff remained with her at all times talking to her. The prison custody officer recalls that they took it in turns. She also recalls (Document 35) that the woman wanted to telephone her grandmother and that they talked about how she might appeal and that she might be transferred to Foston Hall prison. The custody officer states that the woman was angry with her solicitor who she said had advised she would get between three and four years imprisonment.

69. Normal procedures require staff to raise the At Risk of Self Harm Form following a risk assessment at the court. Court staff did not raise this form although a record of placing the woman on a constant watch and the frequency of observations is recorded on the PER form. In the custody officer's statement she explained that no visits were allowed on Fridays due to time constraints. She stated that court staff can make allowances but she did not know that the family wanted to see the woman, and such requests would normally go through Counsel. The prison custody officer recalls that the escort left Leicester Magistrates' Court at approximately 15:45 and arrived at Brockhill at approximately 17:10.

**Reception at Brockhill**

70. In her statement, the prison custody officer recalls that there was only one member of staff in reception at Brockhill so the woman could not get off the van until about 17:30. The prison custody officer recalls that she informed the reception officer that the woman was on a constant watch. The prison custody officer says they did not give the reception officer the new At Risk of Self-Harm Form because she understood that that Brockhill staff had previously had the woman on an open F2052SH and that they knew her. The prison custody officer acknowledged that the new form should have been raised.

71. Working in Brockhill reception that evening were three officers and a senior officer (SO)'s duties included oversight of Reception that evening. However the SO was supervising the issue of prisoners' medication at the time of the woman's arrival so was not present in reception. The only reception trained member of staff on duty in

reception that evening was the first officer. The officer recalled that reception was particularly busy, having received approximately 20 prisoners from court. The officer did not recall being told that the woman was on a constant watch, however she signed the PER form formally receiving her into Brockhill's custody. The relevant page of the PER form signed by the reception officer states that the woman was on a constant watch and the checks on her are clearly recorded on the form.

72. The reception officer recalled the woman coming into Reception and going through the reception process. She described her manner at the time as calm, stating she said she was "fine". The second officer in reception remembers searching the woman in the Reception area. She says she did not know her and describes her as being quiet but her manner did not raise any concerns. The officer recalls issuing her with a tea pack (containing beverages and also breakfast for the following day) and then relocating her to F wing along with three other prisoners.

73. The reception officer states that the first part of the reception procedure was to find out what happened at court that day. Prisoners are assessed to establish whether they have any injuries or if they are upset, if there are any mental health issues and also to establish the sentence length. The officer explained that sometimes reception staff have prior knowledge of the sentence length, having been warned by custody or probation staff at the court that day. She confirmed that the prison had been informed by the court that the woman had received nine years, although she could not recall who received the telephone call. The procedures for receiving a prisoner returning from court differed from those for new prisoners. Neither the cell sharing risk assessment or the First Reception Health Screen is undertaken from women returning to Brockhill from court. Instead, they are seen initially by Reception staff, who assess the demeanour of the prisoner at the time. This assessment is based on how the prisoner presents in relation to the sentence length or court procedures that day. Additionally, Reception staff review the accompanying documentation and specifically the PER form. The reception officer said that there is information on the PER form but that the reception officers did not always read it because the Senior Officer normally checks prisoners in. On the evening in question the Senior Officer was not available and the reception officer was carrying out the reception checks on prisoners returning from court.

74. During interview, the reception officer said that Premier escort staff did not tell her that the woman had been on constant watch. The prison custody officer escorting her says that she did inform the Reception officer that she was on a constant watch. The reception officer says that although she was aware that the woman had just received nine years she presented as being calm and was not tearful whilst being interviewed at the reception desk. The PER form records that the woman was placed on a constant watch that morning and that the

frequency of observations is clearly recorded. The third page of the PER form records 'Constant watch' at the top of the third page, followed by details of the observations from 14:12 and every 10 minutes thereafter until 17:10 when the escort arrived at Brockhill. Below the last entry made by the prison custody officer at 17:10 is an entry made at 17:20 by the reception officer where she signed to receive the woman into the custody of Brockhill prison. At interview, the third officer in reception said she saw the woman enter Reception having just come off the cellular vehicle and that she seemed calm and did not seem stressed at all. The officer said that she asked her how she was and the woman stated that she was fine. Once the woman had been booked in, two officers carried out a strip search prior to putting her in the holding cell. When asked if there were any concerns at this time the third officer said, "Nothing at all, in fact she was bubbly if anything. There were no concerns". Later the officer saw the woman making a phone call in the holding room. She described her as being tearful after the phone call but then said that she perked up almost straightaway and that she was asking to get back to her friends and kept saying, "Can I go, can I go?" A prisoner was working in reception as an Orderly that evening. She recalls the woman being in the holding room and making a phone call. The prisoner also recalls that she was upset, stating that she was curled up in a ball, looking upset and appeared to be crying.

75. On interview, when asked if there was anything on the PER from that was of concern to her, the reception officer responded, "I didn't remember anything but I was very busy". When asked if she had read the PER form the officer said, "I would have read it". It was explained that the PER form had indicated that the woman was on constant supervision and as such would this have given an indication of risk. The reception officer responded "Not necessarily" and went on to say that Premier Court Services (PCS) place a lot of prisoners on constant observations and that they have different criteria to the prison. The reception officer suggested that PCS would have placed the woman on a constant watch based on her sentence length and not through knowledge of her or her current demeanour. It is clear from the statements of both the custody officer and the prison custody officer they had made the decision to place the woman on a constant watch based on their knowledge of her previous attempts to commit suicide whilst in police custody and her demeanour on the day, as she was placed on the watch prior to being sentenced. When it was reiterated to the reception officer that the woman had been placed on a constant watch and given a nine year sentence, she responded by stating that she judged each case at the time based on the prisoner's demeanour and went on to say that if there were any concerns these would have been passed on to the nurse.

76. During the interview, the contents of the PER form were shown to the reception officer and when asked to confirm whether she thought the woman was at risk, she responded "What I am saying is, it was a very busy Friday evening. I was on my own with one other officer who isn't

Reception trained and at the time I would have done the appropriate thing but I can't remember". When asked if she could remember what was on the PER form the reception officer responded "No, I booked in 20 inmates that night, 20 prisoners that night, I can't remember what was on every PER form". When asked if the information should have been passed onto the nurse, the reception officer responded "I would have explained to the nurse that the prisoner had been given nine years and obviously that's a long time. Whether I specifically said to her she's been under a constant watch on the transport, I can't remember whether I did or not."

77. A Senior Officer has managerial responsibility for the reception at Brockhill. On the day in question he was detailed to work in Reception but also had other relief duties within the prison. The SO relieved the Orderly Officer for his tea break between 16:45 and 17:30. He was due to return to Reception at 17:40 but was diverted to D wing to help out because of staff shortages. The SO arrived in Reception at around 18:30-18:45.

78. The SO explained that he normally conducts the initial reception interviews but, in his/her absence, the reception officer would do it. The initial interview includes a check of the warrant and the PER Form and completion of the Cell Sharing Risk Assessment Form. The reception officer normally checks property and complete the associated paperwork. When asked if the escort services regularly communicated any concerns they had about a prisoner to reception staff, the SO said this happened occasionally, also that the court staff often communicated any risks by telephone. The SO was shown the PER Form that was used for Sheena on 2 April and on being given the information contained on the front sheet alone. He was asked if he would pass these concerns on, to which he replied "Absolutely, yes". It was explained to him that the woman had been on a constant watch since 10:30 that morning and that the frequency of observations were clearly outlined on the PER Form. He said, "I would like to have thought that the reception officer would have informed Health Care staff. I do know that Health Care staff did interview the woman at length that evening prior to her being located onto the wings. But I would have expected that the reception officer would tell Health Care staff." When asked if he thought that being placed on a constant watch by the escort services was a significant piece of information, the SO said, "It is a significant piece of information which would lead to her being interviewed by both reception and nursing staff". The reception officer did not place the woman on an F2052SH, nor did she communicate to a member of the Health Care staff that she had been on a constant watch since 10:40 that morning. The Health Care member of staff would therefore be making a judgement regarding her vulnerability based on her demeanour at the time alone without any supporting documentation. When asked for his view, the SO said, "Yes, it's a lack of communication, probably lack of training". When asked why he thought

the reception officer might not have communicated this information he replied, “He felt that it was probably due to pressure of work”.

79. A nurse saw the woman when she arrived in reception on the evening of 2 April. The reception nurse recalls that she saw her enter Reception and reception staff checking her in prior to going into the holding room. The nurse went to the holding room to collect the woman but she was on the phone at the time and she noted that she was crying. At this point the nurse saw another prisoner, giving the woman time to finish her phone call.

80. The nurse then took the woman to the healthcare office where she spent approximately 15 minutes to half an hour talking to her. The nurse states that the woman said, “What am I going to do?” and that she was quite distraught, having just come off the phone. The nurse said that she and the woman talked and discussed whether or not she was going to appeal against the sentence and about her going back onto anti-depressant medication. The nurse said that the woman had stopped taking her medication because she felt it had affected the impression she gave in court. The nurse said that she would get her a leaflet about Cipramil for her to send to her solicitor as this might contribute to the appeal process. The nurse said that they discussed that the woman would probably not have to do the whole of her sentence and it would be normal for a prisoner to do half or perhaps two thirds, depending on parole and other factors. The nurse states that they were looking positively about the future and that the woman said she would write to her if she moved onto another establishment. Although the woman was worried about what her family would think about her being in prison, she did seem to calm down. The nurse states that throughout the time she was in discussion with the woman, she kept asking whether she felt like harming herself, to which she replied “No”. The nurse also asked if she would like to be placed on an F2052SH for extra support to which she again replied “No”. The nurse recalls that she looked her in the eye and promised she was not going to do anything to herself. The nurse states that she believed her because during the time she had got to know her she felt she was both trustworthy and honest with her. The nurse said that she believed her when she said she would not do anything to harm herself. The nurse recalls that the woman asked if she could see the doctor the next day because she wanted to start on a different anti-depressant, saying that she needed anti-depressants and she disliked the ones she had been on. The nurse booked her down to see the doctor the next day. During the discussion, the nurse recalls that the woman said that the judge had not looked at the psychiatrist report and that this had upset her. She had said that she did not want to go back to C wing as she felt this was a retrograde step. The nurse had offered this to help her get over the shock, as the level of support would perhaps have been greater on C wing. The woman’s response was that she had worked hard to get to F wing and as an enhanced wing there were more privileges and better accommodation.

81. The reception nurse was asked if she thought her decision not to place the woman on an F2052SH was a correct one. The nurse based her decision on the fact that the woman had quickly calmed down and was talking about appealing against the sentence, changing her medication and was generally forward looking in her attitude. The nurse explained that, prior to the woman arriving back at Brockhill, she had been informed that she had received a nine-year sentence and that in discussion with a nursing colleague felt that she would probably have to place her on an F2052SH. The nurse said that she had already prepared a care plan in readiness for the woman's return as she assumed that she would be placing her on an F2052SH. However, based on the way she presented during the interview, the nurse decided not to place her on an F2052SH and was confident that she made the right decision.

82. The PER form is not shown to healthcare staff as a matter of course. Both the reception officer and the reception SO have stated that if there were areas of concern identified on the PER form these would be passed on to the healthcare staff. The woman's PER form clearly indicated that she had been placed on a constant watch. When the reception nurse was carrying out her assessment interview with the woman she was not aware of this fact, nor had she been informed that she had been on a constant watch since 10:40 that day. When asked if this would have influenced her decision, the nurse said, "It's a difficult question, really". It is clear that the nurse's assessment was based on the facts available to her at the time. She was aware that the woman had previously said if she got a custodial sentence she would kill herself. She also knew that she had just received a nine-year sentence. The overriding factor, however, was the way that the woman presented herself during the interview assessment. When again asked if she had been in receipt of all the information, and whether this would have influenced her decision, the nurse responded, "I would have questioned it and I would have thought why? And it's possible I would have carried it on".

**On F wing**

83. The Listener who had met the woman previously had contact with her again during the short time she was on F wing. The Listener recalls that when the woman returned from court on Friday 2 April, she came directly to see her. The Listener states that the woman was crying and really upset, she related what had happened at court that day and the fact that she had received a nine-year sentence. The Listener felt that she would need support and suggested that they move into the "Daffodil Suite" that night. The Daffodil Suite has two beds and is used to provide Listener support for vulnerable prisoners. The Listener states that the woman declined this offer. The Listener stated at interview that she did not feel that the woman needed it and that she gave the impression that she did not. She was talking about lodging an appeal

against her sentence. The Listener also recalls that she told the woman that she was there for her if needed.

84. The woman arrived on F wing at approximately 19:00. Another prisoner, who also knew the woman previously, states that, when the woman arrived onto F wing that evening, she and two other women went into her cell to see her. The prisoner describes the woman as being very quiet. Later in the interview the prisoner describes the woman as being very, very shaken that night. She goes on to say that the woman stated that she thought the judge had not read her psychiatric report. The prisoner left the room but the other two prisoners remained with her. The prisoner states that a wing officer was quite concerned for the woman. She explains that the concerns were not about self-harm or suicide but more related to trying to help or advise her with regard to her appeal. The prisoner said that later that evening the officer asked her if she would like to sit with the woman. The prisoner states that she is also a Listener but the woman had not approached her directly in that capacity. The prisoner did sit with the woman and described her as being very, very shaken. However due to Listener confidentiality the prisoner was unable to divulge the content of the conversation. The prisoner recalls remaining with the woman until approximately 21:00.

85. On the evening of 2 April, the wing officer was detailed to supervise F wing. On interview (Document 48), the officer stated that although he knew the woman by name he had had no previous contact or involvement with her previous F2052SH procedures. During the evening, the officer was initially involved in supervising the distribution of medication, between approximately 18:00 and 19:00. The officer recalls a reception officer returning the woman to F wing at approximately 19:00 and that the reception SO let them onto the landing. The reception officer told the wing officer that the woman had received a nine-year sentence and the wing officer recalls that the SO also made reference to this. The wing officer decided to lock up the wing earlier that evening at 19:40 instead of 19:45 so that he could spend some time talking to the woman. At 19:40 the officer left the office and noted that the woman was on the telephone. The officer thought that she was speaking to her father. The officer went upstairs to lock up the upper landing of the wing, giving her more time on the telephone. He then proceeded to lock up the bottom landing, the woman being the last prisoner to be locked in her cell on completion of her phone call.

86. The wing officer states that he then went into the woman's cell and sat talking to her. The discussion was about her sentence length in relation to the offence and about how she might now wish to pursue the appeal process. The officer informed her that he would contact the Legal Support Officer that evening, who would come to see her the next morning. The wing officer described the woman as not upset or crying and that at the time she was drinking coffee and was focussed on how to appeal. The officer said, "I didn't have any concerns at that point and

I was trying to look for them, that's why I went back to see whether I could see any concerns". The officer recalls that the woman stated that she was having a visit from her parents the following day. He also recalls that he asked her if she would like to speak to a Listener and allowed the prisoner into her cell. The officer remained with them for a further 10 minutes. On leaving the cell, the officer placed a note on the office notice board informing the night staff that the prisoner was in the woman's cell. During the evening, the officer spent approximately 25 minutes with the woman, either on his own or with the prisoner present. The officer stated that he was still, "rooting for a problem". The wing officer recalls that another officer came onto F wing during the evening and that she informed him that she was going to see the woman as she had heard that she had received a nine-year sentence. The wing officer recalls this being at some time between 19:00 and 20:00 and that the second officer gave him no feedback of her conversation with the woman before she left the wing. Later that evening, the wing officer told the Legal Support Officer that the woman would like to see him in the morning with regard to her appeal. The Legal Support Officer stated that he was already anticipating this because he was aware of her sentence.

87. During interview, a second prisoner stated, "I heard the people say she tell many people if she get four years she will kill herself because she think it too long." The second prisoner had onto F wing the day before the woman and had limited contact during that period and although she saw her on the night of 2 April she did not speak to her.

88. On the evening of 2 April, a third prisoner returned to F wing from working in the kitchen and heard from other prisoners that the woman had received a nine-year sentence. During interview, the third prisoner said that when seeking the woman that evening, "Actually to me she was calm, really, really calm, because I thought she would have been like hysterical crying and everything but she was really calm". When asked if she had ever heard the woman talking about committing suicide the prisoner said, "No never. Apparently she said it to other people but she never said it to me."

89. A fourth prisoner spoke with the woman on 1 April. The woman told her, "This time tomorrow it might be one of two things, either ecstatically happy or dead." When asked what she thought the woman meant by that the prisoner said, "She was going to commit suicide, but when she came back from court she was talking about her appeal and everything". On the evening of 2 April, the prisoner recalls that the woman returned from reception and went straight upstairs to see the Listener. "When the woman came back downstairs and we were all asking her what she got, she said she got nine years. She was upset but coping with it, she was talking about appealing." Later that night, about 21:15, the fourth prisoner came out on the night sanitation system and checked on the woman. The prisoner said that she was watching the television, so she assumed she was all right.

90. A fifth prisoner recalls that on Friday evening she was not aware that the woman had returned from court. She asked the second officer whether she was back and the officer said she would find out for her. Later, the officer came back to the prisoner and said that she had heard that the woman was back from court and that she had received a nine-year sentence. The prisoner recalls that this was about 19:15 in the evening and remembers bursting into tears because she knew that nine years was an awfully long sentence for the woman and she knew how she would react. The prisoner states that the officer said that she would go and see the woman and make sure that she was OK. Later the officer returned to see the prisoner and said that she had seen the woman with Listeners, confirmed that she did get nine years but stated that she was all right and that they were aware of what the prisoner had told her. The officer confirms this and recalled that she only met the woman for the first time on the night of 2 April. The officer confirms that the prisoner had told her that evening that the woman would kill herself if she received a custodial sentence.

91. The same officer recalled going to F wing to see the woman and on arrival noted that the wing officer was in the wing office. The officer went to see the woman in her cell. She was sitting on the bed and another prisoner had her arm around her. The officer also sat on the bed and the woman told her that she was OK. The officer said they talked about appealing against the sentence and speaking to her legal advisors. The officer informed the woman that they could start the appeal process on Monday. The officer stated that she discussed the woman with the reception SO with regard to placing her on a F2052SH. The officer and SO decided, in light of her behaviour, not to place her on a F2052SH.

92. The Night Orderly Officer (NOO) on the night of 2 April came on duty at 20:40 and was informed by the reception SO that there was a Listener in with the woman. The SO informed the NOO that the woman had received a nine-year sentence that day. The NOO said he did not really know the woman and had had little or no contact with her. The NOO does not recall what time the Listener came out or indeed who she was. However, he does recall that the woman and the Listener came out of her cell together and that they were laughing. At the time, the NOO and another officer were together and he recalls that the Listener said that the woman was OK. He thought this was around 23:00. The NOO recalls that the woman used the toilet before going back into her cell and he also remembers taking the Listener to C wing to see another prisoner.

93. The first prisoner stated that she stayed with the woman for approximately 40 minutes until approximately 21:00. The prisoner stated that approximately an hour later (22:00) she looked through her door and the lights were off. The prisoner was on Listeners' duties during the night of 2/3 April. She recalls that in the early hours she moved her chair whilst watching television. That made a scraping noise. She states that she heard a similar noise coming from the

woman's cell (next door) but it was not as heavy. The prisoner then said, "I could feel somebody standing outside my door so I turned my telly down" because she thought it was the woman and she might want to talk to her. The prisoner then said that she pressed her call bell to come out of her cell on the night sanitation system. On exiting her cell she went to look in the woman's cell and found it was in darkness.

94. EI-WHS is a private company that have been involved in the installation and maintenance of Night Sanitation Systems in prisons. EI-WHS has provided an independent analysis of the use of the night sanitation system on F1 and 2 landings on the night of 2/3 April. Prisoners cannot move in between landings. The investigation has therefore focussed on movements on F1 only.

95. On the evening/night of 2 April and the morning of 3 April, the woman's cell (103) was unlocked at 21:02, which allowed the other prisoner to enter, and locked again at 21:06 with both prisoners inside. The cell had its Night Sanitation restriction removed at 21:15 to allow the prisoner out. At 22:56 the woman's cell door was unlocked to enable her to use the toilet and was locked again at 22:59. The woman did not leave her cell at any other time during this period.

96. The NOO recalls that on the night of 2 April, with the exception of a minor incident on D wing, there were no incidents of note or concern. He explained that during the night the Senior Officer has four Officers and three Operational Support Grades who make up the night staff complement. During the night, those prisoners who are on F2052SHs will be supervised in accordance with the required frequency of observations and additionally all landings within the prison will be visited and pegged (the visit recorded electronically) every hour. The NOO handed over to another SO on her arrival at the prison on the morning of 3 April.

97. A fourth officer was on duty of the night of 2 April. He recalls that he had prior knowledge of the woman from the time she had spent on C wing. The officer recalls being asked to let a Listener out of her cell but he cannot remember at what time or who the Listener was. The officer stated that at the roll check at the handover from day staff to night staff they get a response from all the prisoners. He stated that there is no routine procedure for checking anyone who is not on an F2052SH. When questioned, the officer stated that he was not sure whether staff always required a response from prisoners when checking the roll before handing over to the next shift.

98. The first day officer came on duty on 3 April at 07:30. He was detailed to carry out roll checks on C and F wings. He completed the roll checks and noted nothing untoward. The officer explained that the roll is signed for in the centre and the night staff go off when the roll is confirmed as correct. He stated that he did not recall any information about the woman's cell other than there was a note in the office which said that

the prisoner, also a Listener, was in her cell. He said that he knew this was wrong. It is believed that this note was to alert the night staff coming onto duty the previous evening to the fact that the woman had a Listener in with her at that time. The day officer said he understood the roll check procedure to mean that he could see someone in the cell. He was asked if he would get a response when someone was apparently asleep but could not actually be seen. He stated, "In general no. Not unless there is any reason. If they are on a F2052SH then yes, but generally no. Unless I can't see them in bed at all." When it was suggested that somebody could place a dummy in the bed and either escape or self-harm, the officer replied, "That's right". He stated that he could not recollect what he saw when he looked into the woman's cell. When asked what his actions would have been if he had seen nothing in the bed, he said he would have entered the cell if he could not get a response. The officer recalls that whilst he was on C wing at approximately 09:40 there was an alarm bell. A female officer attended the alarm bell and the first day officer remained on the wing. When asked if the officer was aware of any local Operational Instructions about roll check procedures, he responded, "I've got a vague recollection but I can't be sure. Something about don't disturb prisoners, but I don't know if that's a fact". It was explained to the officer that the establishment's Operational Instructions said that staff should get a response from prisoners.

99. A seventh prisoner stated that, on the morning of 3 April 2004, she went to work in the kitchen at 07:30 and returned to the wing at around 10:00. The prisoner stated that she first looked through the flap in the woman's cell door and thought that she was in bed asleep. The prisoner went on to say that there was something on the bed, which gave the impression that somebody was in it. She entered the cell and said to the woman, "Are you still asleep?" but did not receive an answer. The prisoner goes on to say that she looked at the bed and then spun around to leave the room. As she turned, she saw the woman hanging from the clothes rail in the wall-mounted wardrobe to the left hand side of the door. The prisoner recalls that she panicked and started screaming and ran out of the cell.

100. The prisoner/ Listener states that she came out of her cell at some point early in the morning. She said that the woman's curtains were open and it looked as if she was in bed. The prisoner said there was a blue duvet on the bed with what looked like a body underneath but the cover was pulled up quite high. The prisoner said that at about 09:30 the kitchen girls returned to the wing. The seventh prisoner looked through the woman's door then opened it and went inside. The prisoner/ Listener said that she saw the other prisoner walk over to the woman's bed and heard her say something but was not sure what. The prisoner then turned, screamed and ran out of the cell. The prisoner/ Listener ran to get the officers and, once they arrived, she looked after the prisoner. The officers cut down the woman and the prisoner/ Listener remembers seeing her on the floor.

101. A third day officer arrived on duty at 08:30 and reported to F wing to assist with the issue of prisoner's medication. A fourth officer was also present at this time. The third officer recalls that the issuing of medication was completed at approximately 0930-0945. The officer recalls that at approximately 09:40 prisoners on the bottom landing of F wing started to shout, "It's xxxxx", using the woman's name. She goes on to say that they ran up to the landing and went into the wrong cell, entering 104 instead of 103. The officer recalls being the first to enter cell 103 and she saw the woman hanging from the wall-mounted wardrobe in the right hand corner of the cell as one faces inwards through the door. The officer also states that the woman could not be seen from the entrance to the cell as the door opened to the right obscuring the view. The officer states that the woman was hanging by a piece of material that was suspended from the hanging rail in the wardrobe. The first on scene officer took her weight and the fourth officer (the second on scene) cut the ligature. The first on scene officer remembers shouting for the SO to call for an ambulance. They laid the woman on the floor, placing her on her back. The officer recalls that nurses arrived quickly and that she left the cell to assist with the management of F wing prisoners.

102. The second on scene officer recalls that on the morning of 3 April she and the other officer had just finished issuing medication and were about to call for exercise. The SO and both officers stood outside the office and they heard prisoners screaming on the bottom landing of F wing, shouting the woman's name and "Come quick." The second on scene officer said that she and the other officers ran onto the bottom landing. She goes on to say that she did not know that the woman's first name: "I didn't know her first name because I didn't know her". The officer said that because of the state of panic it was confusing. She ran first into cell 104 and it was only when she came back out that prisoners told her that it was cell 103. The officer recalls that the first on scene officer went in first and that she followed her into the cell. The woman was hanging in the corner of the cell and the first on scene officer supported her body and asked for the second on scene officer's cutter, which she had on her belt. The second officer cut the ligature, they laid the woman on the floor and the nurses arrived. Once the nurses arrived, the second officer left the cell. On interview, the officer was asked if there was any noticeable stiffness in the woman's body, and she stated that there was and that the stiffness related to her whole body.

103. The SO recalled that she arrived for duty at approximately 08:10 on the morning of 3 April. She led the morning meeting and then commenced the issue of medication at approximately 08:40, assisted by the two officers mentioned before. At approximately 09:40 she recalls a commotion on the bottom landing of F wing. The SO stated that she ran to the cell. Prisoners were hysterical, shouting "xxxxx's cell." The SO goes on to say that the woman was found hanging, the alarm bell had been pressed and that she called Code Blue over the radio net.

The SO recalls that the first on scene officer took the woman's weight and that the second on scene officer cut the ligature. The SO says that she assisted them in getting the woman's body to the floor. The SO said that Health Care staff arrived within seconds and that she summoned an ambulance. With Health Care staff, a Principal Officer and the Duty Governor in attendance, the SO left the cell and assisted with the management of F wing prisoners. She recalls the ligature being made of red or orange and blue material twisted together. The SO went on to say that there was some evidence of rigor mortis.

104. A Registered General Nurse (RGN) recalled that the woman had stopped taking her medication about two weeks previously. The RGN recalls on the morning of 3 April that she arrived for work at 07:15 and that at about 08:30 was involved in the issuing of medication that was distributed from a room close to F wing. The RGN goes on to say that the issue of medication was completed at about 09:45, at which point an alarm bell sounded on F wing. She also recalls that a Code Blue was called over the radio. A prisoner was with another nurse at the time and recalls that she went directly to the scene and the nurse went to get the emergency bag containing resuscitation equipment. The RGN entered cell 103 and saw the woman lying on the floor. She turned her onto her back and shouted to the nurse for the equipment she needed. The second nurse states that there were no signs of life and that in her opinion the woman had been dead for some time, probably several hours. The nurse covered the woman with a quilt and went to see if the prisoners who found her were alright.

105. On the morning of 3 April, the wing officer came on duty with the fourth day officer. The wing officer explained that he briefed the other officer about the previous night and the woman's sentence length, wish to appeal and the planned visit with her family that day as the other officer was working on F wing that morning.

106. The wing officer states that later there was an alarm bell and a Code Blue announced over the radio net. He ran to F wing and on arrival described the scene as absolute pandemonium. He went to the woman's cell where she was on the floor with nurses in attendance. The officer recalls that her arms were sticking up.

107. The Orderly Officer (OO) on the morning of 3 April recalls that she went to the centre to check the handover sheet from the night staff and noted that the woman had received nine years at court the previous day. The OO recalls that there was an alarm bell on F wing that she attended and recollects that the SO, and three officers, along with Health Care staff, were present. The OO states that in her opinion the woman was dead and that rigor mortis had set in. The OO states that the ambulance service and police surgeon were all called and attended. The incident was managed in accordance with the establishment's contingency plan, overseen by the Duty Governor on the day.

108. The Duty Governor on the morning of 3 April responded to the alarm bell and attended F wing. On arrival, he was informed that rigor mortis had set in and it seemed that the woman had been dead for quite some time. The Duty Governor did not enter the cell but instead went to the communications room and started to work his way through the contingency plans. He explained that there was some confusion over which doctor should attend. The establishment doctor felt that this was an issue for the police but the police felt that it was not their responsibility. Eventually the police surgeon arrived and at approximately 11:00 pronounced the woman dead. The cell had been sealed earlier and evidence retained for the Scenes Of Crime Officer (SOCO).

109. The Duty Governor was asked to give an explanation of how roll checks in the evening and the morning were carried out at Brockhill. He explained that the oncoming night patrol would carry out a roll check in the evening prior to the day staff going off and that the day staff would repeat this process in the morning prior to the night staff going off. When asked if the local Operational Instruction required the member of staff carrying out the roll check to get a response from the occupant of the cell, the Duty Governor said that seeing the person through the observation panel would indicate that the prisoner was there. On the morning of the woman's death there would have been a roll check at around 0800 to 08:30, yet she was found hanging in her cell at approximately 09:45. When it was put to the Duty Governor that the roll check procedure was flawed he replied, "I wouldn't suggest it was flawed, I would suggest that the roll check was completed as it was every night on Foxtrot wing". He continued, "I think there was an issue of actually a member of staff perhaps going round and checking the doors and opening them to find out if the prisoners were OK". The Duty Governor went on to explain that when a wing requested a group unlock all doors are unlocked. When asked if this meant that staff did not go round to check that everybody was OK, he replied, "I would suggest that staff didn't do it". When it was suggested to the Duty Governor that if somebody placed clothing in a bed or made a dummy the prisoner's absence might not be detected at roll check, he agreed that this indeed could be the case.

FINDINGS

**F1** The woman had previously self harmed in her childhood by a paracetamol overdose and cutting her arms.

**F2** She was first received into custody on 3 July 2003 having been remanded to appear at court on 6 August. She presented herself as being vulnerable and informed staff she had previously self-harmed. She was placed on an open F2052SH until her release on bail on 6 August. There were no incidents of self-harm during this period.

**F3** The woman had attempted to self-harm/commit suicide whilst in police custody on the night of 12 February 2004 prior to her court appearance on 13 February.

**F4** On arrival at Brockhill on 13 February, she was identified as being at risk of self-harm and was placed on an open F2052SH. She remained on an F2052SH until 19 March. During this period, it is recorded that she requested support from Listeners on at least 11 occasions and that F2052SH arrangements were formally reviewed on seven occasions. There were no recorded/reported incidents or attempts to self-harm during this period.

**F5** There is evidence to suggest that the woman had rehearsed suicide. A prisoner stated that she had planned suicide, actually rehearsing it. She states that the woman had considered using the shower rail in the bathroom and by using the rail within her wardrobe, stating she had climbed into her wall-mounted wardrobe in her cell. This is also confirmed by another prisoner who was a Listener.

**F6** During interview, the prisoner states that the woman had convinced the review panel that she was no longer at risk. The prisoner states that the woman said, “They think I’m alright but that’s what I want them to think.”

**F7** During her second period in custody the woman had raised issues regarding her dietary needs. The RMN had attempted to resolve these issues through discussion with both the doctor and the Catering Manager.

**F8** During her second period in custody the woman was referred to the RMNs at Brockhill. The RMN developed a care plan with her and provided high levels of support and care. The RMN was in contact with the psychiatrist who completed the woman’s psychiatric report and also with her legal advisors.

**F9** On 19 February, the woman was prescribed Citalopram 20mg daily for depression. She attended for her medication on 21 and 23 February and thereafter until 25 March. It is recorded that she did not attend for her medication from 26 March to 2 April.

**F10** There is evidence that the woman intended to commit suicide if she were to receive a custodial sentence. This is confirmed by Prison Health Care staff, prisoners, the psychiatrist, probation officer and her legal advisors.

**F11** The Pre-Sentence Report (PSR) was completed on 4 March. The report identified risk of suicide. However the report was not received at the prison until 7 April, four days after the woman's death.

**F12** The psychiatric report was completed on 30 March and clearly identified the risk of suicide. This report was requested by the woman's legal advisor in readiness for her court appearance on 2 April. The report was not made available to the Prison Service.

**F13** The woman was located on C wing, landing C2 from 13 February to 1 April. Evidence suggests that she gradually engaged with the establishment's regime, attending the education department and hairdressers. She only associated with prisoners on C2 landing although she did attend the communal dining room. C2 landing at the time was used to locate prisoners deemed to be vulnerable. Prisoners who had previously lived on C2 described the environment as safe and supportive. When interviewed, both staff and prisoners indicated that the perceptions of other prisoners differed from this view and the terms 'slashers wing' and 'fraggles' were common.

**F14** The woman was moved to F wing on 1 April. F wing is an enhanced wing, which allows prisoners an increase in privileges, greater freedom of movement and a more relaxed regime. Although the woman was not yet an enhanced prisoner, her good behaviour indicated that she would gain enhanced status at the next review. The prisoner/ Listener indicated that the woman was suspicious of the reasons she had been moved to F wing, stating that she said, "Why have they moved me up here, are they trying to tell me I'm staying?" She was due to appear in court the following day and was hoping for a non-custodial sentence.

**F15** On arrival at Leicester Crown Court on the morning of 2 April, the woman was placed on a constant watch. The Senior Custody Officer stated that this decision was based on previous knowledge of her attempts to self-harm. She remained on constant watch throughout the day. The PER form records the arrangements, comments and observations.

**F16** Whilst the woman was at court, her Pre-Sentence Report (PSR) was read by court probation staff. The Probation Support Officer identified that a strong risk was evident both within the PSR and briefing report. He explained that these would normally be faxed through to the prison the same day. There is no evidence to confirm this took place.

**F17** The Probation Service Officer stated that the Lord Chancellor's Department based at the Crown Court have an agreed protocol that Pre-Sentence Reports are made available to custody staff on the day of sentence so they can accompany the prisoner to prison. When interviewed, the Senior Custody Officer said that this rarely happens. The woman's PSR did not accompany her to Brockhill on 2 April.

**F18** The 'At Risk of Self Harm' form was introduced in the early part of 2004 (prior to April). The new procedures require court staff and or Escort Services to raise this form if risk is identified. Although the PER form clearly identified that she was at risk and on a constant watch, the 'At Risk of Self Harm' form was not raised. When interviewed, the Custody Officer who was responsible for escorting the woman back to Brockhill, stated that the form was not raised because she had previously been on a F2052SH and as such Brockhill staff knew her.

**F19** The reception officer signed the PER form accepting custody of the woman from the Escort Service. The PER form clearly identifies that she was on a constant watch. The record of observations is clearly recorded above the point where the officer signed. The officer stated that she was the only trained member of reception staff on duty at the time and they had received 20 prisoners during the course of the late afternoon and early evening. There was no senior officer working in reception. A prison custody officer stated that she told the reception officer that the woman was on a constant watch. The reception officer does not recall being told that she was on a constant watch. The reception officer said she would have read the PER form and made a judgment but did not recall doing so. She was aware of the woman's sentence but described her demeanour as calm. The officer said she would not necessarily have opened an F2052SH file just because the escort service considered the woman at risk. She did not place her on an F2052SH.

**F20** The reception officer did not pass on the PER form to the RMN who was in Reception that evening to assess prisoners as they returned from court. The officer stated that she would have passed on information to the nurse. The RMN stated that she did not have sight of the PER form and had not been told that the woman was on a constant watch. The RMN was aware that the woman had received a nine-year sentence.

**F21** The 'First Reception Health Care Screen Form' is completed during the prisoner's first reception and not when returned to the establishment from court. At Brockhill, a nurse is on duty to assess prisoners returning from court. There is no requirement for prisoners to see the nurse in the interview room. The nurse will ask each prisoner if they are OK and record in their Inmate Medical Record how they present at the time. If a prisoner wishes to speak to the nurse, this will be facilitated. On the evening of 2 April, the RMN was on duty in Brockhill reception.

**F22** The RMN recalls that she saw the woman enter Reception and later saw her on the phone crying. Following this, she saw her for approximately 15 minutes in the Health Care interview room. The RMN stated that the woman was quite distraught, having just come off the phone. The RMN stated that she calmed down and became more forward looking, discussing how to appeal against sentence and that she wanted to go back onto medication the next day. The RMN stated that she asked her on several occasions if she felt like harming herself to which she responded "No". The RMN stated that when she had heard that the woman had received nine years she had thought that she would probably be placing her on an F2052SH and that she had already prepared a care plan for her return from court. The RMN stated that in light of the way the woman presented she was confident she had made the right decision not to place her on an F2052SH. When it was explained to the RMN that the woman had been on a constant watch since 10:40 that morning, she made it clear that she had not been informed of this. When asked if this fact would have influenced her decision not to place her on an F2052SH, the RMN said, "It's a difficult question really". The RMN was aware that the woman had previously said that if she received a lengthy custodial sentence she would kill herself. She was not aware that she had been on a constant watch throughout the day and stated that, "I would have questioned it and I would have thought why and it's possible I would have carried it on".

**F23** The RMN stated that, when she asked the woman if she wanted to go onto an F2052SH, she said, "No". It is also recorded that when asked if she wanted to go back to C wing she again said, "No". During the investigation, evidence has emerged that although prisoners are placed on F2052SH across all wings there has been a tendency over time to place those on F2052SH on C wing (C2 landing) as the levels of support tend to be better. There is also evidence from both staff and prisoners that those who were located on C2 were perceived by other prisoners (and occasionally staff) as mentally ill or suicidal. Both groups reported the use of derogatory/inappropriate language. Such perceptions and behaviour may well influence a prisoner not to return to C2 when in need of greater support. There is no firm evidence to suggest the woman was influenced by the findings in relation to C2 landing but managers must be made aware of such possibilities.

**F24** During the evening of 2 April, the woman was on F wing. She was seen by Listeners, other prisoners and staff and, although there was prior knowledge that she had previously stated she would kill herself if she received a lengthy custodial sentence, all felt the woman was thinking positively and considering appealing against sentence. The first prison Listener, recalls that initially the woman presented as being upset and that she asked her if she would like to use the Daffodil Suite, a two bedded care suite facility for those at risk of self harm. She recalls that the offer was declined and that in her opinion at the time the woman did not need that level of support. The second prison Listener

recalls that the woman was shaken but she was not concerned about her risk from a suicide or self harm point of view, but in relation to the advice she would get concerning her appeal. The second Listener stayed with her in her cell until approximately 21:00. She described her as shaken, but due to Listener confidentiality could not divulge the content of the conversation. The wing officer recalls the woman making a telephone call at approximately 19:40. Following this, the officer spent some time with her. He said she was not upset or crying, she was drinking coffee and focussed on her appeal. The officer stated, "I didn't have any concerns at that point and I was trying to look for them, that's why I went back to see whether I could see any concerns". A second officer from C wing had been informed by a prisoner that the woman had previously told her that she would kill herself if she received a long sentence. This officer recalls that she acted on this information and went to see her on F wing. The officer stated that she sat on her bed and that the woman talked about her appeal and instructing her solicitors. The officer states that she did discuss placing the woman on an F2052SH with the SO but they decided in light of her behaviour not to do so. Two more prisoners recall her as being calm and talking about her appeal. The evidence indicates that all who had contact with the woman that night were convinced that she was forward planning and quite positive and that the risk of suicide and self-harm was not evident.

**F25** A night sanitation system is in operation at Brockhill. At 22:56 the woman's cell was unlocked for three minutes to enable access to the toilet. She did not leave her cell at any other point during the night.

**F26** The SO reported that there were no incidents of note within the establishment on the night of 2 April. The woman was not on an F2052SH and therefore there would not have been a requirement to check her through the night. All landings were visited during the night.

**F27** At approximately 07:30 an officer completed the roll check on F wing and noted nothing untoward. The officer could not recall what he had seen when he looked into the woman's cell. When asked what he would do if he found no-one in the bed, he stated he would have entered the cell to investigate. The officer believed that the local instruction for roll checks did not require him to get a response.

**F28** Another prisoner entered the woman's cell when she returned from the kitchen at approximately 09:40. She recalled that there was something in the bed which gave the impression that somebody was in it. On entering the cell she said, "Are you asleep?" but did not receive an answer. On turning to leave the cell, she saw the woman hanging by a ligature from the clothes rail inside the wall mounted wardrobe. The prisoner said she screamed and ran out the cell.

**F29** Two officers responded to the noise and entered the cell. The first officer on scene took the woman's weight and the second officer cut

the ligature. They laid her on the floor. Two nurses arrived on the scene. They turned the woman from the recovery position onto her back. One nurse states there was no sign of life and that in her opinion she had been dead for some time. No attempt was made at resuscitation. Several staff and prisoners interviewed indicated that rigor mortis had set in. The nurse covered her with a quilt cover. Other members of staff arrived and the contingency plans were enacted.

**F30** The ambulance service attended the scene, no attempt of resuscitation was made. They were not authorised to pronounce death. There was some confusion over which doctor to summon. The establishment doctor did not attend and it was necessary to request that the police surgeon attend. The police surgeon attended and at approximately 11:00 pronounced death. The cell had been sealed earlier and evidence retained for the Police Scenes of Crime Officer (SOCO).

**F31** It is important that the woman's care and support is considered, not only in isolation, but also considering the whole prison environment in relation to the management of the risks presented by vulnerable prisoners. The following figures refer to Brockhill in the calendar year 2003.

- 670 incidents of self-harm
- 114 prisoners attempted self-harm
- 47 prisoners required resuscitation at the scene
- 14 prisoners required outside hospital treatment.
- 243 incidents of attempted self strangulation
- 211 incidents of women cutting themselves
- 68 attempted hangings
- 26 instances in which prisoners aggravated existing wounds
- 14 occasions of prisoners burning themselves
- 14 instances of attempted self suffocation
- 35 incidents of injury through head butting/wall punching
- 505 F2052SHs were opened, of which 441 were closed
- the crisis suite was used on 29 occasions
- 46 constant watches.
- 1 death

**F32** Only 15 staff at Brockhill received training in Suicide Prevention during the year, 2003/2004.

**F33** In the region of 50% of First Reception Health Screen Forms were completed incorrectly.

## CONCLUSIONS

**C1 The level of care given to the woman whilst subject to F2052SH procedures during both periods in custody was good and compliant with national guidelines.**

The woman was placed on an F2052SH during her first period in custody 30 July to 6 August (seven days). She was again placed on an F2052SH during the first 36 days (13. February to 19 Marc) of her second period in custody. The decision to place her on an F2052SH and to locate her on C2 landing was based on the knowledge that she had previously attempted to take her own life whilst in police custody on the night of 12 February and the way she presented during her reception at HMP Brockhill on 13 February. During these periods her care was managed well. Evidence indicates that she was well supported through the Registered Mental Nurse (RMN) referral system, C wing staff and the prison's Listener Scheme. During these periods there is no evidence to suggest that she self harmed.

**C2 The decision to take the woman off the F2052SH procedures was based on perceptions that she was more settled, engaged in the prison regime and that there was no indication of self harm or intent to self harm. There is however evidence to suggest that she may well have intentionally presented herself in such a way to influence this decision.**

It is recorded that the woman discussed, practised and indeed demonstrated methods by which she might take her own life. It is also recorded that, after the final F2052SH was closed, she said "They think I'm alright, but that's what I want them to think". This evidence indicates that there was a degree of manipulation on her part to influence the review panel's decision.

**C3 The woman's dietary needs were identified but not addressed in a timely or satisfactory way.**

During the woman's second period in custody she raised issues regarding her dietary needs. Attempts were made to address these but the process was lengthy and reached no satisfactory conclusion. Evidence indicates that she continued to suffer weight loss during this period.

**C4 On 19 February 2004 the woman was prescribed Citalopram 20mg daily for her depression. It is recorded that she attended for her medication between 21 February and 25 March 2004. She did not attend after this date. There is no evidence to indicate that this was investigated or alternatives considered.**

At the time of the woman's court appearance and death she was not receiving medication for her diagnosed depression.

**C5 Throughout the woman's second period of custody there were indicators that should she receive a custodial sentence she would attempt to take her own life. It is of concern that these indicators were not communicated and or co-ordinated in such a way to influence decisions regarding the level of post sentence care.**

The Pre-Sentence Report completed by the woman's Probation Officer clearly indicated such risks. The PSR is commissioned by the court and does not become available to the prison until after sentencing. The report was completed on 4 March 2004 but was not received at HMP Brockhill until 7 April – four days after her death. The psychiatric report was commissioned by her legal advisors and completed on 30 March 2004 in readiness for her appearance at court on 2 April 2004. The report clearly identifies risk but there is no evidence to suggest that this information was formally communicated to the prison. It also became evident during the investigation that prisoners were aware of the risks should the woman receive a custodial sentence. These were not communicated either because of Listener confidentiality or, in the case of non-Listeners, due to prison culture. On the evening of 2 April 2004, one prisoner did inform an officer of her concerns.

**C6 It is of concern that during the investigation evidence emerged that prisoners sometimes refer to those who reside on C2 landing as 'lunatics, slashers and fraggles'.**

There are obvious concerns regarding the potential adverse impact of such labelling on C2 residents and the staff team. There are also concerns that there may be a reluctance for prisoners to reside or return to C2 should they need the higher level of support or care provided there. At the time of the investigation a high percentage of those on C2 were on F2052SH procedures. Again there are concerns that prisoners may avoid being placed on an F2052SH if they believe they would be located on C2. On the evening of 2 April, the woman was asked if she would like to return to C2. She declined this offer on the grounds it would be a backward step. There is no evidence to suggest her decision was based on prisoners' perceptions of C2 but this may have been a consideration.

**C7 There is evidence that bullying does take place at HMP Brockhill.**

This is usually in the form of 'window calling' or at cell doors during the night sanitation. There is no evidence to suggest the woman was subject to bullying whilst at HMP Brockhill.

**C8 The levels of risk identified on 2 April were not effectively communicated and this affected the level of post sentence care given to the woman.**

On arrival at court on 2 April the woman was placed on a constant watch by the court custody staff. This decision and the frequency of observations were clearly recorded on the PER form. The 'At Risk of Self Harm Form' was not raised by the Court or Escort staff. On her arrival at HMP Brockhill, Reception staff signed the PER form. The member of staff concerned had no recollection of the constant watch, no action was taken and the PER form was not passed to the nurse for consideration during her assessment. Reception and Health Care staff were aware that the woman had received a nine year sentence. The nurse carrying out the assessment had anticipated placing her on an F2052SH on being informed of the sentence length. The nurse did observe the woman in a distressed state whilst in reception. During an interview of some 20 minutes, she presented herself as quite positive and forward thinking and gave assurances she would not harm herself and as a result the nurse decided not to place her on an F2052SH. The nurse was not aware that she had already been on a constant watch throughout the day.

**C9 There is a belief by Reception staff at HMP Brockhill that the Court and Escort Services place prisoners on constant watch as a matter of course.**

We have uncovered no evidence to suggest that Court or Escort staff place prisoners unnecessarily on F2052SHs. It is however a concern that this is the perception of prison staff as this will devalue the support procedures and possibly lead to poor decisions being made.

**C10 There is evidence to suggest that the woman behaved in such a way to convince both staff and prisoners that she was not at risk of self harm or suicide.**

On the evening and during the night of 2 April the woman was seen by both prisoners and staff. She was described as tearful and shocked at her sentence length. She was offered the support of C2 landing, an open F2052SH and to share the Care Suite overnight with a Listener. She declined all such offers. During conversations with several prisoners and two members of staff she presented herself as quite positive, forward thinking and planning to appeal against her sentence. The woman was seen by a Listener but this conversation is subject to confidentiality rules. Based on the way she presented and other evidence available she was not placed on an F2052SH by wing staff or the Orderly Officer. Neither were aware that she had been on a constant watch throughout the day as this had not been communicated by the Reception Officer.

**C11 There is evidence to suggest that the woman planned to take her own life and took action to avoid detection.**

On the night of 2 April, the woman took her own life having suspended herself from a ligature tied to the clothes rail in her wall mounted wardrobe. As previously mentioned there is evidence to suggest she had previously rehearsed this. The wall mounted wardrobe is located to the right of the cell door and cannot be seen from the observation panel. She placed items of clothing in her bed and a hat on the pillow. This appears to have been quite convincing as in the morning prisoners did initially think she was still in bed. Earlier, during the evening of 2 April she had declined the opportunity to spend the night in the Care Suite (twin bedded) with a Listener. She had also stated that she did not need to be placed on an F2052SH. It should be noted that in the circumstances outlined above any frequency of observations other than a constant watch might not have prevented her attempts.

**C12 The roll check procedures on the morning of 3 April 2004 did not discover the woman's death.**

On checking the woman's cell on the morning of 3 April the officer did not gain a response. Her body was discovered by prisoners some two hours later. On confirming the roll the officer should assure him/herself that all prisoners are in their cells and this requires a response either verbally or physically. There is no evidence to suggest that had the woman been discovered some two hours earlier that this would have prevented death or aided resuscitation as rigor mortis appears to have been quite advanced.

## OMBUDSMAN'S OBSERVATIONS

The clinical reviewers and their colleagues who have conducted this investigation on my behalf have made detailed observations and recommendations which flow from their study of the circumstances of this woman's tragic death.

In this section I make some observations on the messages that I draw from the investigation.

### Knowledge of the woman's vulnerability

The woman's parents asked me to find out whether their daughter's solicitors warned the prison about her condition on the day she was sentenced. They did not and I understand did not judge at the time that she was so acutely vulnerable that they needed to. That said, there was no lack of information about her vulnerability. The woman herself told many people she would take her life rather than serve a sentence in prison.

The first time she was admitted to prison, the woman said she had cut her wrists some time previously and felt like killing herself. She was also in a distressed state on the cellular vehicle, suffering from claustrophobia and breathlessness. This may have been put down to the initial shock experienced by someone who had no previous contact with the criminal justice system but, when she was taken back into custody in February, she appeared to attempt self-strangulation twice in a police cell. At court the same day she was placed under constant observation and in the afternoon was found to have tied socks round her neck. When she arrived at Brockhill, she again spoke of wanting to kill herself. She was placed on the F2052SH procedure with four observations an hour.

Over the next five weeks, the woman appeared to settle to some extent. She began to take up occupation and engage with prisoners and staff. Until her death she had never self-harmed in prison save that she ate little and lost weight. The intensive observation and support was gradually reduced and the F2052SH was closed on 19 March.

The F2052SH was closed two weeks before the woman was due to be sentenced. On 3 March, a nurse had recorded in the F2052SH that the woman had stated that if she received a custodial sentence she would kill herself. The nurse also recorded her own view that she believed the woman would be at increased risk at time of sentencing. There is no reference to the nurse's entry, nor any reference to the forthcoming sentencing hearing, in any of the case reviews.

The clinical reviewer has drawn attention to the variety of personnel who attended the woman's 2052SH reviews and she recommends that the named nurse (the RMN) should always attend. In fact the RMN attended only one of the reviews. Shift work means that it will not always be possible to have the same people attending reviews and the numbers and range of disciplines of

staff attending is to be commended, but I agree that greater consistency of attendance is desirable. It is also necessary to ensure that reviews are informed by a reading of all the entries since the previous review and that any special concerns about future dates are carried forward.

The nurse's entry of 3 March is the only reference in the F2052SH file to the woman's attitude to her forthcoming sentencing. Yet it was widely recognised that she would be at most acute risk if she received a custodial sentence, especially a long one. Until then, she seems to have harboured some hope that she might be released, despite the gravity of the offences of which she was convicted.

- The probation officer recorded in the Pre-Sentence Report that the woman had told her on 4 March that she would commit suicide rather than be separated from her family. The probation officer added in a briefing note for probation colleagues at court that, in her opinion, the woman would be at immediate suicide risk if sentenced to prison and that Court, escort and prison staff should be informed accordingly.

- In a letter of 23 March, the woman told her solicitor of past suicide attempts, that she was having suicidal thoughts, but would wait until the hearing in case she went home from court. In a letter dated 29 March but not received until after her death, she said she had told probation and mental health nursing staff that she would hang herself.

- The reception nurse recalls the woman's solicitor telling her that she had tried to self-harm in police custody and that she had heard staff say that she was going to kill herself if she received a custodial sentence.

- The psychiatric report was completed on 30 March. In it he expressed the view that the woman's risk of suicide would increase substantially if she were to receive a custodial sentence and would be likely to require a suicide watch from the outset.

None of this information found its way into the F2052SH processes.

The woman also shared her intentions with fellow-prisoners

- A prisoner on C wing, states that the woman told her several times that she would commit suicide if she received a custodial sentence, that she spoke of how she would do this, and that she was putting up a front to conceal her intentions from prison staff. The prisoner told an officer of her concern the evening that the woman returned from sentencing.

- The woman moved to F wing on 1 April. A second prisoner/ Listener says that she told her and others that she had rehearsed a means of hanging herself and indicated that if she was given a custodial sentence she would take her own life.

The prisoner escort record sent with the woman to court stated that the F2052SH had been closed on 19 March. Escort staff at court placed her under constant watch from 10:40 apparently because staff remembered previous incidents. She was sentenced about noon.

**How was this knowledge communicated?**

**The Pre-Sentence Report**

The substantive Pre-Sentence Report and a briefing note for court probation staff stated that the woman would be at risk if sentenced to custody and asked for all the staff in charge of her care to be informed.

The information about her vulnerability in the Pre-Sentence Report and accompanying Briefing Form was not shared with Brockhill when the report was prepared on 4 March. One of the important values of the F2052SH system is that everyone working in prison who comes into contact with a prisoner considered to be vulnerable should contribute relevant information. That seems to me to apply not just to prison service staff but to other criminal justice professionals. If a probation officer has reason to believe a prisoner is vulnerable I would expect the officer to share that information without delay with colleagues in the prison charged with her care.

Had that information been shared at the time, it might have encouraged the case review panel that closed the 2052SH on 19 March to prepare a care plan to support her at the time of sentencing.

Pre-Sentence Reports are posted to the prison where the prisoner is to be sent. It seems that there are also arrangements for post-sentence interview forms to be faxed to prisons on the day of sentencing and apparently for Pre-Sentence Reports to be handed to custody officers to accompany prisoners. It was not clear that these arrangements were well-understood or consistently followed. Moreover documents faxed to a prison office number after office hours are unlikely to be read until the next day.

Interviewees pointed out that the woman might well not have returned to Brockhill from court but gone to another prison. The Prisoner Escort Record is the critical document that passes from one agency to another accompanying the prisoner. Where the pre-sentence report includes a briefing to colleagues at court in connection with any risk this is information likely to be needed by court custody, escort and prison staff. I recommend that means are found to ensure that such information is routinely transferred to the PER.

**The PER and the absence of an At Risk Form**

The clinical reviewer has pointed out that escort staff did not complete an At Risk of Self Harm form. Previously escort staff were instructed to open an F2052SH if they considered a prisoner to be at risk. The value of the special form is that it is a distinct document that unmistakably draws attention to the Escort Service's concern and contains the reasons for it.

In this case the escort officers relied on the PER form, information passed orally to the reception officer which is disputed, and what they believed to be Brockhill's prior knowledge of the woman.

The psychiatric report was prepared for the woman's legal advisers for submission to the court. Prison staff were not aware of its contents. As part of her review of clinical care, the reviewer learned that in the afternoon of 2 April the psychiatrist was in the prison and expressed her concern for the woman to a nurse. The nurse trusted the procedural safeguards to operate to protect the woman if she returned to Brockhill, she was busy and she did not pass on the psychiatrist's concern.

**Reception**

There were serious deficiencies in the reception process. We are told that resources were stretched and neither of the senior officers with reception responsibilities was available. However, it seems that proper consideration was not given to the fact that custody officers at court had thought it necessary to place the woman on a constant watch all day at court. However, this was perhaps less significant than the lack of the other information about what was known about her probable vulnerability if she were given any custodial sentence, never mind one which was longer than she had contemplated.

**Adequacy of decision-making tools**

The nurse who spoke with the woman at length when she returned to Brockhill was perhaps the staff member who knew her best. It is possible, but not certain, that more information about the concerns expressed by others that day would have altered her assessment that evening.

The reception nurse's responsibility was an unenviable one. She drew on her knowledge of the woman and her own experience and judgment. The clinical reviewer refers to the need for a validated suicide and mental health assessment tool to provide a baseline for identifying changes in risk. Sadly, there is no absolute litmus test for suicidal intent but it is manifest that self-reporting is an insufficient indicator. There is evidence that the woman at times intended to mislead staff, though the extent to which she disclosed this suggests at least an ambivalence.

**Action to support the woman**

There was no lack of concern for the woman when she returned to the wing. Staff and prisoners were aware that she would be badly affected by the sentence and they worked together to try to support her.

One Listener suggested they move into the double care suite for the night. The woman declined and the Listener was convinced that she need not press her to change her mind. A second Listener and two other prisoners sat with

her in her cell. The C wing officer came to F wing to see the woman because of concerns expressed by a C wing prisoner. The officer and SO discussed whether to open an F2052SH but decided it was not necessary. The wing officer was told that the woman had received a nine-year sentence and spent time with her, mainly talking about how to appeal. He arranged for the second Listener to sit with her after lock-up.

The woman's demeanour that evening has been described as, at different times, distraught, very shaken, crying, but also as calm. I do not think there is necessarily any contradiction here. Many people told the investigators that they believed the woman would be all right because she was talking about the future. But, with the benefit of hindsight, it seems remarkable that no one opened a 2052SH.

A 2052SH is not a guarantee. It is a file, that can be opened by any member of staff and which starts a process. Decisions are made about the nature of protection required and how intensive it should be. Observation is part of the protection and during the night mere observation at specified but irregular intervals is often all that can be given, but other fundamental elements are interaction and systematic care planning and review

My investigator ends the account of his investigation by placing the woman's death in the context of the high incidence of self-harm which Brockhill staff face – 670 instances and 505 F2052SH files opened in the calendar year 2003. Prison staff save many lives. I say this not to belittle the tragedy of this woman's death but to achieve a fair and realistic understanding in which to judge whether more might reasonably have been expected. This report isolates the facts about her time in custody but it has to be remembered that she was one among many vulnerable women. For the staff who have their care, distinguishing between degrees of vulnerability to identify the women most acutely at risk and responding successfully is an unenviable responsibility and a challenge which must sometimes seem hopeless.

But in the context of that challenging responsibility, I have been surprised to learn that only 15 staff at Brockhill received training in Suicide Prevention during the year 2003/2004. When staff are caring for such a vulnerable population they need to be skilled and knowledgeable about how best to help.

However, even with appropriate training, staff can only make reasoned decisions on the basis of the information before them. One can never know if this death was preventable, but it followed serious failures to share information about her vulnerability and stated intentions.

RECOMMENDATIONS

**Local**

**R1** That all Health Care staff are trained in completing the First Reception Health Screen Form.

**R2** Procedures must be put in place to identify prisoners' dietary needs on their first day in custody and methodology established to address these needs in a timely manner.

**R3** The Governor should ensure the role of C2 landing is clearly and positively communicated to all staff and prisoners.

**R4** The Governor should ensure that during Reception procedures, including reception of prisoners returning from Court, the PER form will be passed by Reception staff to the Health Care member of staff carrying out assessments on all occasions.

**R5** The Governor carries out a review of bullying incidents and prisoners' perceptions of safety.

**R6** The Governor investigates the actions of the reception officer on the evening of 2 April 2004.

**R7** The Governor should arrange to facilitate a meeting with key managers from the Prison and the Escort and Court Contractors to raise the issue of perceptions (of prison staff) regarding the alleged over use of constant watches. The Governor should report the findings and develop joint improvement objectives.

**R8** The establishment's operational instructions for carrying out roll checks should be reviewed. The instruction should be issued to ensure that staff gain a response from prisoners at both the last (pm) and first (am) roll checks.

**R9** The Governor reviews the establishment's training programme and ensures that adequate numbers of staff are trained in Suicide Prevention each year.

**National**

**R10** When a prisoner does not attend for their medication this should be followed up by Health Care staff. The reason for declining medication and or alternative arrangements should be recorded.

**R11** It is accepted that Pre-Sentence Reports (PSRs) are written by the field probation officer for the court. It is recommended that these accompany the prisoner to prison and any risks be communicated by the courts prior to transfer.

**R12** The Court and Escort Services must use the 'At Risk of Self Harm' form where there is evidence of risk. This form should be used in conjunction with the PER form, which must log events. Additionally staff must alert the receiving staff (either prison or escort) orally in person to such risks and record this on the PER form before handover.

**R13** Governors should be advised that, when possible, wall mounted fittings (cupboards/wardrobes) should be relocated within the cell to ensure these are within the line of vision from the cell observation panel.

**R14** Prisoners identified by healthcare as requiring dietary supplements for clinical reasons should have these prescribed and not be required to apply for them.

## SUMMARY OF RECOMMENDATIONS FROM THE CLINICAL REVIEW

**CR1** The prison should adopt a validated suicide and mental health assessment tool.

**CR2** The named nurse system is good practice and should be maintained. However there should be a system in place to ensure review of caseloads of individual nurses.

**CR3** When referrals are made for mental health assessment a system should be in place that monitors the importance and degree of urgency of the referral and that allocation is formalised.

**CR4** Formalised validated assessment processes and documentation (including care-planning) should be made at all times whilst prisoners are receiving healthcare intervention.

**CR5** Every effort should be made to understand the cultural and religious basis of special diets.

**CR6** Where possible the named nurse should be involved in the review of the F2052SH.

**CR7** In light of the fact that the psychiatrist may see many prisoners as a one off and they may well move onto other prisons a summary of findings and actions should be recorded at the end of each consultation.

**CR8** Where independent reports are commissioned that highlight a cause for concern these should be routinely shared with prison staff.

**CR9** That safeguards are put in place to ensure that if reports of this nature are faxed to prisons then staff are aware they are being sent and appropriate person receives them and distributes as appropriate.

**CR10** A standard formal approach should be adopted which allows a series of decision-making stages to be carried out before any final decision about whether a prisoner should be placed on F2052SH observation. The approach should allow input from all parties concerned with the care and/or treatment of the prisoner and should consider all relevant correspondence relating to the prisoner's current psychological condition.

**CR11** Consideration should be given to adopting a routine procedure that places all prisoners returning from such a lengthy sentencing on a 15-minute observation for the first 24 hours. I understand this is in place for ten years plus, however this should not mean that anything under ten should not be treated in the same way. Following this initial period a team could then meet to consider whether it is necessary to continue

the process or whether it can be closed in consultation with the wing officer.

**CR12** If concerns of such a nature are raised with other health professionals then they have a duty of care to ensure that that information is passed on to the appropriate person. Even if the woman were not being returned to Brockhill it would have been appropriate practice to let the receiving prison know the psychiatrist's concerns in relation to her immediate suicide risk. In light of the fact that she was returned to Brockhill the nurse in reception should have been notified of concerns, failing that they should have raised their concerns with the wing officers.

**CR13** Clarity must be established regarding responsibilities to certify deaths at all times.

**CR14** Records must be audited against set guidelines, on a regular basis

**CR15** Prisoner's inmate medical records need to be the key means of communicating between healthcare providers. They therefore must be used with this in mind, with accurate and appropriate assessment and action planning.

**CR16** Where the nature of the information received has a significant impact on the individual's management, this is required to be communicated in an appropriate and timely manner

**CR17** A review of the current induction procedure should be mapped against the new guidance, and developed accordingly.

**CR18** Specific educational opportunities should be provided for prison healthcare staff in relation to assessing suicide risk and undertaking suicide prevention interventions.

**CR19** All healthcare staff should have access to clinical supervision/ mentoring sessions – this can be developed in partnership with the Primary Care Trust.

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**ANNEX 1**

## GLOSSARY OF TERMS

| | |
|---|---|
| IMB | Independent Monitoring Board |
| ECR | Emergency Control Room |
| F2050 | Prisoner's Main Core Record |
| F2050A | Prisoner's Wing History Sheet |
| F2052SH | At Risk of Self-Harm Booklet |
| F2169 | First Reception Health Screen Form |
| F2000 | Inmate Medical Record (IMR) |
| PER | Prisoner's Escort Record |
| Care Plan | Nursing Care Plan (as in NHS) |
| Code Blue | A radio call sign for urgent assistance |
| MO | Medical Officer (resident doctor) |
| GP | General Practitioner (visiting doctor) |
| Gov | Governor (Senior Manager) |
| PO | Principal Officer |
| SO | Senior Officer |
| Off | Officer |
| SCO | Senior Custody Officer |
| PCO | Prison Custody Officer |
| RGN | Registered General Nurse |
| RMN | Registered Mental Nurse |
| CPN | Community Psychiatric Nurse |
| Duty Governor | Duty Senior Manager (operationally in charge) |

| | |
|---|---|
| Orderly Officer | PO (days) or SO (nights) operational responsibility |
| Obs Book | Wing or Establishment Observation Book |
| HMP | Her Majesty's Prison |
| HMCIP | Her Majesty's Chief Inspector of Prisons |
| PPO | Prisons and Probation Ombudsman |
| POA | Prison Officers' Association |
| SAU | Standards Audit Unit (Prison Service Auditors) |
| SIR | Security Information Report |
| LIDs | Local Inmate Database |
| Remand | Period in Custody prior to conviction/sentence |
| Pegging | Electronic record of supervision at night |
| Night San | Electronic record of time out of cell at night, access to use the toilet. |
| VO | Visiting Order |
| SPC | Suicide Prevention Co-ordinator |
| Listeners | Prisoners trained by the Samaritans |
| PIN Phones | Wing phones for prisoners, PIN number access |
| Insiders | Peer support scheme |
| Action Plans | Improvement plans following an audit, inspection or investigation |
| Induction | Information giving and acclimatisation period following first time in custody |
| ABS | Anti-bullying Scheme |
| Detail | Staff on duty for that day/night |
| SPAR | Record of attendance and allocated work |
| Contingency Plans | Plans to manage serious incidents |

| | |
|---|---|
| Daily Log Sheet | Daily log of incidents or occurrences in the prison |
| NTS | Notice to Staff |
| NTP | Notice to Prisoners |
| Operating Instruction | Local instructions for specific tasks/duties |
| LCC | Leicester Crown Court |
| PSO 1301 | Prison Service Order – Investigating Deaths in Custody |
| PSO 1300 | Prison Service Order – Investigations |
| PSO 2710 | Prison Service Order – Follow up to Deaths in Custody |
| HCC | Health Care Centre |