The death of a female in hospital whilst a prisoner at HMP Holloway, in April 2004

A report by the Prisons and Probation Ombudsman for England and Wales

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This is the report of an investigation into the death of a woman who died in April 2004 in the Intensive Care Unit (ICU) at a London hospital. The woman had been a prisoner at Holloway prison and two days earlier, on 15 April 2004, had been found hanging from the window bars of her cell. This report sets out my findings.

I offer my sincere condolences to the woman's family who I know were very close to her. Despite coping with her drug addiction in recent years, they always remained loyal, loving and supportive. I have great respect for the dignity they have shown; while having to deal with their own grief, they have nevertheless taken the time and effort to give their thanks and support to the prison staff at Holloway.

I also offer my sympathies to management and staff at the prison. They have to work under difficult circumstances with large numbers of very vulnerable women who are remanded or recently sentenced, and in the great majority of cases withdrawing from drugs. The number of deaths that have been prevented thanks to the care and diligence of prison staff can never be truly quantified. Yet when a death occurs, as in the case of the woman who is the subject of this report, it invariably has a profound effect on staff and they often feel personally accountable.

One of my investigators and myself led the investigation from my office. We were assisted by two Prison Service Governor grades, the Head of Security and Operations, HMP & YOI Feltham and a colleague from Prison Service Headquarters.

I am grateful too to the Detective Sergeant and Detective Constable who, in carrying out their own enquiry into the woman's death, have shared all available information and given every assistance to my investigation team.

I would also like to thank the Prison Service for seconding to me two members of Prison Service staff to assist with the enquiry. Their knowledge, commitment and hard work have been of immense value in expediting the investigation.

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PRISONS AND PROBATION OMBUDSMAN
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Summary

This is the report of an investigation into the death on 17 April 2004 of the woman.

The investigation team reviewed the woman's prison records and interviewed both prison staff and prisoners. Other reports to support the investigation were also commissioned and are referred to within.

The woman was 35-years-old, her sister describes her as being young at heart, she loved animals and kids and never really grew up. She had been at Holloway since 1 April 2004 having been convicted, but not sentenced, for theft. She was not considered to be at risk of suicide at any time during the two weeks she was in custody.

The woman had been in custody on one previous occasion; she spent six weeks, awaiting sentence, at Holloway from September to November 2003 for theft and deception. From the records available there appears to be no indication that the woman had any suicidal intentions throughout this former period in custody. She had been addicted to crack cocaine and other substances for over ten years and it is believed that she committed her offences to feed her drug habit.

The woman arrived at Holloway on the evening of 1 April 2004. She was initially admitted onto the detoxification unit where she was placed on the standard regimes for heroin detoxification (using methadone), alcohol detoxification and benzodiazepine reduction. She was then moved to the post-detoxification unit for a short time before being moved again, one week after her arrival, to a normal residential unit. There she continued to receive methadone for a further two-day period and diazepam in decreasing doses.

On the morning of 15 April 2004, the woman was seen sitting on her bed at 9.00am during a roll check. At 9.21am, while prisoners were being routinely unlocked to attend education and gym, she was found hanging from the bars of her window. Attempts to resuscitate her were made and a pulse was found.

She was subsequently taken to hospital and later transferred to the Intensive Care Unit (ICU) at another London hospital. JThe woman died at 4.10am on 17 April 2004, with her family at her side.

This report focuses on the woman's time spent in prison custody and evaluates the systems in place to establish whether they were (and are) fully effective.

The induction programme, is professional and well thought out. It encourages participation and clearly benefits new prisoners by telling them how the prison works. Unfortunately, new prisoners who come to prison and go straight onto detoxification do not always get the full programme; they undergo a short and limited induction on the unit itself, with the intention of being fully inducted on completion of their treatment. In the woman's case it was identified in the initial stages that she was of no fixed abode and therefore had housing needs. It was also recommended that she be given help to find work. The woman had also told staff that she had been previously been the victim of a rape. She also said that she was unable to have children. The result of this was a recommendation that she be referred to a rape crisis counsellor and be given help in dealing with the fact that she could not have children.

Despite finishing her detoxification programme after ten days, the woman was given no further resettlement assistance. There is no evidence to suggest a primary causal link between her not completing the full induction process and her death. However, this is a flaw in the system that needs to be rectified and which I have covered in more detail later in this report.

There is clearly a problem of drug use within the prison and at the time of the woman's death there was a particular problem on A4, the unit where she was located. Intelligence information indicated that she might have been caught up in this although there is no concrete evidence to support it. There are, however, general issues regarding the prevention and detection of drugs coming into the prison and I explore these in some detail.

I also found problems with the service provided by CARATS (the counselling, assessment, referral, advice and throughcare service). The woman was automatically referred for an assessment due to her problems with drugs. The Prison Service target for prisoners with drug problems being interviewed by CARATS is five days or less. However, Holloway has been granted a temporary non-compliance that allows 10 days. Even with this extension, many women are not being seen either within the target time or at all. These included the woman who is the subject of this report, who was on a waiting list with approximately 100 other women. As with the lack of induction, there is no evidence to suggest that the failure to provide the woman with a CARATS interview was a major contributor to her death; but again, this is a flaw that needs to be rectified.

I also explore the suggestion from various prisoners that the woman may have been bullied. The prisoners who made this claim were other drug users and suspected dealers from the woman's unit. However, other prisoners the investigators spoke to said that, although she was small, she was not easily intimidated. Officers from her unit, who knew her, did not believe she had been bullied either. Although it is possible, I do not believe bullying to be a causal factor in the woman's death.

The woman had made four previous suicide attempts, the last of which was believed to have been approximately four years ago. Three of the attempts were overdoses and one was a serious attempt at hanging. During this spell in prison (some four years later) there were no indications that she would consider taking her own life and as such she was not placed within the F2052SH system (suicide/self-harm monitoring). For this reason, the investigation team did not focus on this area. That said, the Prison service Women's Team commissioned a separate report of suicide prevention procedures within Holloway. This has highlighted deficiencies within the system and, although not directly applicable to the woman's case, it is nevertheless important in working towards improving systems and procedures within the establishment.

I also refer to a review of the woman's medical care while in prison custody, conducted on my behalf by the local Primary Care Trust. The investigation provided no direct evidence that specific problems in the provision of health care contributed to

the woman's death. However, the report concludes that there is scope for improvement in the assessment and management of patients with mental health problems, and for more client centred management of drug detoxification.

The report also sets out some statistics and analysis relating to self-harm and suicide by female prisoners and looks at the woman's profile in relation to this.

Actions taken by staff following the discovery of the woman hanging in her cell are described in detail within the report. All staff concerned reacted quickly and made every effort to revive her. However, when the call for urgent assistance was made over the radio net, staff, and in particular medical professionals, were unclear as to what type of emergency they were being asked to attend. Potentially, this could have had a delaying effect for any subsequent treatment if, for instance, the wrong type of equipment was taken to the scene. Senior management at the prison are aware and are looking at a system used by other prisons, whereby a code is given over the radio net alerting staff as to the type of emergency they will be attending. I recommend that this be expidited.

The report also looks at events that occurred after the woman's had been taken to hospital. There was a dispute between the police and prison management at Holloway over what investigating authority the police had. This arose because the woman was alive when found. At the time, the police were in the process of securing evidence, as they would with any apparent self- inflicted death in custody. This was inconsistent with the manner in which the prison was managing the incident. I have recommended that a joint protocol be agreed between the prison and police for deaths in custody and that it should also address serious cases like this, where death is not immediate, but clearly imminent. This will help avoid any further such disputes.

A senior manager at Holloway, was appointed as the Family Liaison Officer (FLO). The Prison FLO made contact with the woman's two sisters and brother-in-law at the hospital shortly before she was moved to the ICU at the other London hospital. The immediate aftermath of a death or near-death of a loved one is a confusing and painful experience for the family. The job of liaison officer is therefore critical in minimising the trauma suffered by families in these circumstances. The Prison FLO

established a strong relationship with the woman's family very early on and carried out this difficult role with honesty and compassion that I know has been greatly appreciated by the family. I commend her actions.

The report also looks at specific issues that might have triggered the woman into carrying out this act of self-harm. She was on her own in a single cell and there is no suggestion that anyone other than the woman was responsible for the act itself; however, *did she take intend to take her own life?* The evidence would suggest that she did, but nevertheless it is not fully conclusive. The woman hanged herself at a time when she knew staff would shortly be coming to her door as part of the unlocking routine. This routine had been delayed and it is not inconceivable that she had planned to be found before it was too late but had misjudged the timings.

The woman was an intelligent and literate woman who was close to her family yet did not leave a suicide note. She had written to her mother over a three-day period from 11 to 13 April, but that letter was never posted. There was no indication from this letter that she intended to take her own life. However, we know from a recording of a phone call made to her mother on the day she arrived at Holloway that she became distressed when learning of the death of her dog.

The woman had also been ill with nausea and stomach pains almost continuously for the previous 24 hours. She was upset at being refused a bath only an hour or so before she hanged herself (baths eased her nausea and discomfort).

Also, prior to coming into prison, the woman had been prescribed anti-depressant medication by her General Practitioner (GP). This had been effectively withdrawn from the time she arrived in prison. Stopping her medication could possibly have affected her state of mind some two weeks later when she hanged herself.

All these factors, or a combination of them, make it possible, if not likely, that hanging herself was a spontaneous act brought about by an overwhelming sense of despair. However this is conjecture, and I can only conclude that while there were systemic errors made during the woman's two weeks in custody, from the evidence I have found, her death could not have been predicted nor prevented.

The report makes 11 recommendations.

Holloway prison

Originally a mid-19th century prison for men and women, Holloway became an all-female prison in the early 20th century. It was subsequently rebuilt in the 1970s and 1980s and designed as a secure hospital. Cells are located in a maze of corridors and spurs. Poorly designed for the observation of prisoners on the units.

Located in North London, Holloway is a local prison that serves the courts throughout the South East of England. At the end of March 2004, Holloway had a population of 460 female prisoners with 293 staff in post.

Holloway is a prison with many diverse functions. Its main role is to hold women on remand or waiting sentence. However, it also has a Mother and Baby unit and a Young Offender unit that holds girls and young women between 15 and 21 years old. Many women awaiting deportation often remain at Holloway following the end of their sentence, rather than being moved to an Immigration Removal Centre. In addition, the majority of women arriving at Holloway suffer from alcohol or drug addiction and require detoxification. Many are mothers with young children and up to 35% of the population at Holloway are foreign nationals. High numbers of the female prisoners suffer from mental health problems (80 to 90% nationally) and large numbers have had very limited schooling and education.

Holloway has a very transient population with only one in four women still at the prison six weeks after their initial reception. In 2003/04 Holloway accepted 6,500 new prisoners.

In 2002, following critical reports by the Chief Inspector of Prisons, the Board of Visitors and the Prison Service, the Governor and Senior Management Team were replaced by a completely new team.

The last death in custody at Holloway prison prior to the woman who is the subject of this report, was in August 2002. Since the woman's death, there have been two further serious incidents, one resulting in death and the other causing a young woman, to require intensive care in hospital.

Investigation outline

I appointed an investigator from my office to lead the investigation. We were assisted by two Prison Service Governor grades, the Head of Security and Operations, HMP & YOI Feltham and a colleague from Prison Service Headquarters.

A protocol was agreed and liaison maintained throughout the enquiry with detectives from the police department who were carrying out their own investigation, independent of my own.

The investigation made contact with the Coroner, the Chair of the Independent Monitoring Board (IMB) and the Branch Secretary of the Prison Officers Association (POA).

At the outset, the team issued a Notice to Prisoners and Staff at Holloway inviting anyone with information in relation to the woman's death to make contact with the enquiry team. This invitation was not taken up, although during the course of the enquiry the investigators spoke to two prisoners: The last person to speak to the woman before she hanged herself, and the cleaner on the woman's unit. The team endeavoured to speak to other women they felt would have contributed to the enquiry, but found that they had subsequently been released and were unable to be contacted.

The investigators listened to a recording of the one phone call the woman made whilst in custody, which was to her mother.

They interviewed a number of staff who had been involved in the attempt to revive the woman and in the immediate period thereafter. They also spoke to other staff likely to be able to provide background information and information relating to the management systems and regimes in place at Holloway.

The investigators reviewed the woman's prison files and other pertinent documentation to establish a chronology of events. They also reviewed her file from when she was previously in custody at Holloway in 2003.

Contact was made with her family and information relating to her background is based on the description given by the woman's sister.

A doctor with the local Primary Care Trust, was commissioned to conduct a clinical review of the woman's medical care whilst in prison custody. Additionally, a member of the Prison Service Women's Team carried out an audit of suicide prevention procedures at Holloway. This audit was commissioned as part of an investigation into the death of another prisoner, which occurred at Holloway shortly after the woman died. Although the woman was not deemed to be at risk of suicide, and was not therefore part of the monitoring system at Holloway, the report carried out by the Prison Service Women's Team has been incorporated in to this enquiry.

The woman – Background

The woman was born in 1969 and was the youngest of four children.

She was one year old when her family emigrated to Australia in 1970. The family returned to England in 1979 and the woman stayed with her parents until she left home at nineteen.

She worked as a machinist and then as an estate agent after completing a switchboard/telephonist course. Soon afterwards, she became Personal Assistant to a surveyor, having bought her own car and a flat.

Another of the woman's sisters' moved into the flat with her, but shortly afterwards the woman sold the flat and they both left their jobs to travel and work abroad. Unfortunately, this did not work out and they returned to live with their parents. Her sister was offered her old job back and moved out, but the woman remained unemployed having been replaced at work. As a result she became very depressed and began experimenting with drugs, age 23.

The woman continued to live at home with her parents but, as her drug addiction took hold, life became very difficult and she later moved in with her boyfriend, a financial advisor, who lived in North London.

In 1994 the woman's mother and father separated and her mother moved to Bexhill. She gave the woman a young dog. The woman became very attached to the dog and would not go anywhere without it.

In 1996 the woman and her boyfriend also moved to Bexhill to be near her mother who was suffering from ill health. The woman became a full-time carer to her mother over the next three to four years, despite both the woman and her boyfriend being addicted to crack cocaine. It was during her time at Bexhill that the woman attempted suicide on four occasions: three overdoses and one attempted hanging. At one stage she also attended counselling sessions, but never finished them.

By 1999 the relationship between the woman and her boyfriend had broken down, and things went downhill for her from then on. Her addiction continued and was also not eating properly. The woman's mother moved back to London, but she remained in Bexhill.

Her family hoped that the woman might straighten herself out now that she did not have to care for her mother. She became involved with a new boyfriend and began taking heroin in addition to crack cocaine. They both ended up homeless, sleeping in beach shacks and moving from one drug addict's house to another.

In the summer of 2002, the woman and her boyfriend attended a drug treatment project and got a room in a house together. She obtained work as a part-time hotel receptionist but could not manage to stay in the job. She and her boyfriend also lost the room they had. They then moved into a Bed and Breakfast in Hastings but when this did not work out they began squatting.

On a visit from her family, the woman gave up her dog to be looked after, as it was clear, even to herself, that she was in no fit state to look after it. This was heart wrenching for her as she had cared her dog for the past eight years. After this visit and on their way home, her sister and her sister's husband felt they might never see her again.

In October 2003, the woman was in contact with her family, having been taken into custody at Holloway. She had been convicted of a number of charges, including theft and deception. While in Holloway, she underwent detoxification and had to be treated for an abscess on her hand.

On 12 November 2003, having demonstrated her willingness to stay drug-free, she was bailed and went to stay with her sister whom she had lived with previously, and then with her mother. On 10 December 2003, the woman returned to Crown Court for sentencing where she received an 18-month Drug Treatment and Training Order (DTTO). The woman went to stay with her sister whom she had previously lived with, and her family, and attended various appointments as part of the DTTO. On 18 December 2003, she attended an appointment with a Housing Officer where oral fluid tests carried out the previous day indicated a positive reading for cocaine.

The woman did not stay with her family and it is believed she moved to Hastings. She did not keep her next medical assessment appointment on 6 January 2004 nor her first court review at Crown Court on 7 January 2004. It was later learned that she had been arrested in Sussex on 2 January 2004 and again on 7 January 2004, and brought before Sussex Magistrates Court on 8 January 2004. The court did not enquire into what was happening on her DTTO and merely dealt with her case by way of a one-year conditional discharge.

On 1 April 2004, the woman appeared at the Magistrates Court where she was convicted of theft and remanded to HMP & YOI Holloway, awaiting sentence.

Holloway,

1 April 2004 to 14 April 2004

At 6.05pm on 1 April 2004, the woman arrived at HMP & YOI Holloway. While in Reception, a member of staff conducted an initial Cell Sharing Risk Assessment that showed that she was a heroin and crack cocaine addict and had attempted suicide four years previously. The woman was assessed as being of 'low risk', which means she was deemed suitable to share a cell with other prisoners.

The woman was then given a full search, had her property (personal items) checked, and was photographed and issued with an Identity card and canteen pack. Whilst in Reception she attempted to telephone her sister, but got a wrong number. She then rang her mother and spoke for ten minutes and eight seconds. It was during this phone call that the woman learned that her dog had died.

The woman was given a Healthcare Screening in reception where she disclosed her drug and alcohol habit and was admitted onto the detoxification unit of the Healthcare Centre.

On admission to the detoxification unit, a Care Plan was opened. The plan indicated that she had self-harmed four years previously and that she was at risk of self-harm due to depression. However, no F2052SH was opened and the question 'F2052SH Yes/No' on the front sheet of the Care Plan was left unanswered. She was initiated onto three detoxification regimes: Methadone detoxification for her heroin habit, chlordiazepoxide for her alcohol abuse and decreasing doses of diazepam for a benzodiazepine habit.

On 2 April 2004 whilst on the detoxification unit, an initial induction was carried out. The interviewing officer's comments state that the woman was of No Fixed Abode and had been previously living with a friend, but would rather not go back due to the friend being on drugs. Other comments were that the woman was previously a Registered Carer, had been raped aged 14, and that she had made three previous suicide attempts. Comments made under the "Immediate Follow-Up Action" section recommended that she be referred for housing advice and given help to find work

(even voluntary) having been a carer. It was also recommended that she be referred to Rape Crisis and given help with the fact that she was unable to have children.

On the evening of 3 April 2004, the woman became threatening and abusive and threw a sandwich and an apple at nurses. She was relocated to a single cell where she settled for the night.

On the evening of 4 April 2004, the woman again became argumentative, this time with other patients as well as staff, but settled around midnight.

On 5 April 2004, she was moved to the post-detoxification unit.

On 6 April 2004, the woman spent £2.49 on a pack of tobacco and a lolly. A Visiting Order was also issued and she sent this to her sister, whom she had previously lived with.

On 8 April 2004, the woman was moved from the post-detoxification unit to A4, a residential unit. She asked for, and was given, a single cell.

On Sunday 11 April 2004, the woman began writing a letter to her mother. She wrote about how she was struggling to "get to grips" and accept that her dog had actually "gone" (died). She wrote that she hadn't cried and did not understand why.

She wrote about "guilt" and all the "should ofs" and "could ofs". She continued the letter on Monday 12 April 2004, and wrote about feeling envious of one of the girls on the landing who was pregnant, which led to her thinking about her dog.

The woman described a film she saw about a little boy and his dog, which made her "cry and cry". She then wrote about how she chatted with a nurse who gave her Valium and 'a sleeper' to calm her down. She wrote about an altercation that occurred shortly after this between two other girls who visited her cell and which she had to calm down.

On Tuesday morning on 13 April 2004 the woman was seen by a nurse and given medication for an abscess in her mouth. She then continued the letter to her mother with a view to getting it posted later in the day. She wrote about feeling a lot better and "pigging out big-time again". She wrote about gaining weight and playing it safe by sticking to "veggie food". She wrote about her dog and of the good memories she had. She finished the letter by thanking her mother and asking that she send in pictures. The letter was never sent, and it was found in her cell on 15 April 2004, after she had been taken to hospital. Why it was never posted is unclear.

On 14 April 2004 the woman was ill throughout the day, vomiting and clearly uncomfortable. According to the officer, who was on duty on A4 during the daytime, the nurse was called on three occasions. However, the only record of any medical intervention was at 02.20am on 15 April 2004, when the woman was given an injection of prochlorperazine (an anti-emetic).

According to the Night Orderly Officer, the woman looked "thoroughly washed out", presumably from having been sick throughout the day.

Earlier in the day, at about 4pm, the woman had requested, and was given, a five-minute bath; this apparently eased her "belly ache". She asked for another bath on two further occasions but was refused. On the first of these occasions at about 7pm, she became upset when another prisoner was allowed a shower on her return from court, yet she was not allowed a bath to ease her discomfort. At about 8.15pm, on the second occasion that she asked for (and was refused) a bath, a nurse was on the unit. The officer on duty on A4 asked the nurse about the woman. The nurse apparently said she just had "belly ache". When asked by the officer on duty in A4 if there was a medical reason why the woman should be allowed a bath, the nurse allegedly replied "No, of course not". The officer on duty on A4 went on to make a long entry in the unit Observation Book, describing how the woman had been continually asking for a bath throughout the evening and for staff to be aware. She made further comments to the effect that it would be fine if she was grateful for the one bath (the five-minute bath given earlier at 4pm), but more than that was greedy and selfish, considering there was no association and the other women were not allowed a bath.

15 April 2004 to 17 April 2004

Despite the woman complaining of feeling ill throughout the evening, it would appear that it was only on the intervention of the Night Orderly Officer at about 2am the following morning, 15 April 2004, that she was given any medical treatment. However, this seems to have had limited value, as we know that the woman was requesting a further bath just a few hours later at 8am. We also know from another prisoner, that the woman had been sick again that morning on 15 April 2004 shortly before she hanged herself.

At 7.30am, two officers commenced duty, both detailed to A4 unit. Also around this time, the woman was given her medication of 2mg of diazepam. One of the officer's, as part of the daily routine, counted all the prisoners on the unit. The woman was in her cell.

At just after 8am, when being unlocked, the woman asked the officer who did the counting of prisoners if she could have a bath. The officer replied no, because exercise would be commencing shortly and the other officer on duty on A4 would be left alone on the unit. The woman then approached the other officer in the unit office and asked the same question, but received the same answer. The woman was unhappy about this. According to the officer on duty on A4 she said "bloody hell" and stormed off into another prisoners cell. The other prisoner told us that the woman was angry, calling the officer on duty on A4 "such a bitch". According to the other prisoner, the woman had said to the officer, "look at me, I've got sick all over me, I need a bath". The woman told the other prisoner that the officer on duty on A4 had replied "you will have to aim a bit better next time". The officer on duty on A4 told the investigation she did not notice any vomit down the woman's front and that she did not make the comment attributed to her.

At about 8.15am, those prisoners who wanted to go outside on exercise waited in the TV room until ready to move. All other prisoners, including the woman, were locked in their cells. Exercise commenced at about 8.30am.

At 8.40am there was a fight between two prisoners outside, resulting in the exercise area being cleared and a stand fast roll check being called by the Orderly Officer, at 8.50am. At about 9am, all prisoners from A4, the woman's unit, were returned and locked up. The routine when carrying out a roll check is that all prisoners are counted to ensure they have not gone missing. In this case, the officer who carried out the first prisoner count, counted one side of the unit and the officer on duty on A4, the other. The officer on duty on A4 clearly remembers seeing the woman sitting on her bed leaning against her pillows on the wall with her feet up on the bed and knees up to her chest.

At 9.20am the Control Room reported the roll as correct. The officers then started to unlock the unit for prisoners to attend Gym or Education. Both officers, as was the custom, started unlocking at the far end of the unit. During the unlock, one of prisoners began demanding to be unlocked to attend the Gym. However, she was on the basic regime of the Incentive and Earned Privileges scheme and was not therefore permitted to go. In order not to delay unlocking the rest of the prisoners, the officer who conducted the first prisoner count stayed to sort out the issue with the prisoner and the officer on duty on A4 continued on her own.

When the officer on duty on A4 got to the woman's cell she opened the observation hatch and saw her hanging from the bars of her window. She shouted for the officer who did the first prisoner count and then used her radio to call for urgent medical assistance. The call was registered in the Control Room at 9.29am. The officer on duty on A4 then screamed at one of the wing cleaners to go and get the officer who did the first prisoner count. The wing cleaner did not respond. The officer on duty on A4 went into the cell and tried to support the woman's legs by lifting them up. The officer was joined by the wing cleaner and another prisoner, who helped support the woman's body. The officer tried to cut the ligature with a 'fish knife', a specialist knife designed for this purpose, with which every officer is issued. Having heard the radio call, the officer who did the first prisoner count ran to the woman's cell and took over from the officer on duty on A4 in trying to cut the ligature, which had formed very tightly around the woman's neck. The officer on duty on A4 told one of the prisoners to press the (general) alarm bell in order to gain further assistance.

The alarm was registered in the Control Room as being received at 9.30am. The officer who did the first prisoner count, after a great deal of effort, was able to cut the ligature away and the woman was then placed in the recovery position. At this point two other officers, having responded to the alarm bell, escorted the officer who did the first prisoner count and the officer on duty on A4, who were understandably distressed, away from the scene as other staff arrived to take over.

A nurse heard the call for urgent medical assistance whilst issuing medication to prisoners on C wing. He responded immediately to the call and ran to the woman's cell. When he arrived he attended to the woman by first checking her airway and then her pulse, which he was unable to find. At this point the Orderly Officer arrived at the scene and requested an ambulance via his radio. The Senior Nursing Sister arrived simultaneously and took over from the Nurse. She instructed him to get an oxygen cylinder and resuscitation bag. The Senior Nursing Sister began mouth-to-mouth whilst the Orderly Officer did corresponding chest compressions.

Other officers arrived and proceeded to clear the cell of furniture in order to make room. The Orderly Officer was relieved by a clinical practitioner, who continued with the chest compressions. The Doctor then arrived and endeavoured to establish intravenous access. By this time, the woman's veins had collapsed and the Doctor found this procedure very difficult. However, on the third attempt, he managed to find access at the woman's elbow and administered a saline solution.

The paramedics then arrived on the scene and took over from the Doctor and the nursing staff. The ambulance was registered in the Control Room as having arrived at 9.40am. The Deputy Head of Security, arrived at the scene and took charge. At 10am a pulse was found and the woman was moved to the ambulance. This was a difficult procedure; the woman had to be immobilised, put on a stretcher and transported down each landing to the ambulance. The Deputy Head of Security then instructed staff to open all the intervening gates and sent a message over the radio net to arrange for the vehicle gates to be opened so the ambulance could make a quick exit. The ambulance left the prison for the hospital at 10.18am. Two prison officers went with the woman in the ambulance.

The Duty Governor when the incident occurred, in accordance with procedure, went to the Control Room to manage the incident. The Head of Residence, and the Deputy Governor, assisted him shortly after his arrival. The following were all contacted in accordance with the establishment's contingency plans:

- The Deputy Suicide Prevention Co-ordinator (who arranged for a review of all prisoners on an open F2052SH, and for Listeners to attend the scene to offer support);
- The Staff Care Team;
- The Chaplain;
- Police (to inform the next of kin);
- The Press Office;
- The Area Office;
- The Magistrates Court (to inform them that the woman would not be attending court the next day);
- The National Operations Unit;
- The Independent Monitoring Board.

At 11am, the Deputy Head of Security conducted a 'hot debrief' in the boardroom with all the staff who had been involved in the incident. Various issues relating to the incident were discussed and minutes of the meeting were taken.

The Head of Holloway's Performance Management and Development Unit, was appointed the prison Family Liaison Officer (FLO). The prison FLO left the prison at 10.50am to attend the hospital. At 12.55pm, the woman's sisters arrived with her brother-in-law. They were given a brief overview of events by the prison FLO and then taken to see the woman.

After undergoing a scan, the woman was transferred to the Intensive Care Unit of another hospital, arriving at 2.35pm.

The next day, 16 April 2004, the woman's condition took a turn for the worse. Her sister and her brother in law, arrived at the hospital later that morning and were informed that the woman would not pull through.

At 4.10am on 17 April 2004, with her family at her bedside, the woman passed away.

<u>Examination of the issues</u>

Induction

While the transient population at Holloway does not lend itself to long-term release planning, those within the Senior Management Team at Holloway do endeavour to address the key areas of concern to those held in their care. They utilise the various partnership agencies that operate at Holloway and provide advice and support as necessary, in order to ensure that prisoners, as far as possible, can be released into a stable environment better equipped to cope with their situation without recourse to crime.

The induction process is a key part of Holloway's resettlement strategy. The aim is to assist and support prisoners' integration into the establishment and to begin the assessment process, enabling them to make best use of their time and to prepare for a law-abiding life after release.

The induction process begins in Reception when a prisoner first arrives at the prison. The 'First Night in Custody' team interview all women who have never been in prison before. This is where all urgent needs are routinely identified and acted upon. For all other newly received prisoners (or 'Receptions'), the Orderly Officer or Duty Governor arranges any crisis intervention on an ad hoc basis.

The woman's first time in custody had been in 2003 and so she was therefore excluded from this First Night in Custody process. This is unfortunate, as I believe it might have benefited her. However, I do not believe that her exclusion from the process had any bearing in relation to her subsequent death.
Although too late in the woman's case, I am pleased to report that this process now incorporates <u>all</u> new receptions to Holloway, irrespective of whether it is their first time in custody or not. This is a welcome change, as a newly arrived prisoner may have issues that are not always easily identified by busy reception staff dealing with large numbers of women returning from court.

The formal induction programme begins the morning after reception. In a classroom setting, prisoners are told how the prison operates, how they are expected to behave and what they can expect in return from Holloway. Throughout the course of the day, all new receptions are offered one-to-one interviews with a variety of specialist staff. These range from bail information, legal services or housing officers through to officers from Probation or Resettlement, members of the drugs counselling team CARATS, a representative from the chaplaincy, as well as education staff.

This induction process is an excellent programme that unfortunately does not apply to women who have been referred for detoxification. At Holloway, it is felt that these women are unsuitable for group work because of their chaotic lifestyles and that, in the majority of cases, they would not be coherent enough to fully participate in the programme. The Resettlement team endeavour to induct these women once they have completed the 10-day detoxification programme. However there is no mechanism in place within Healthcare to inform the Resettlement group when a prisoner has actually finished her detoxification.

Reliance is placed on periodic Local Inmate Database system (LIDs) checks by induction staff to see if these prisoners have moved from the detoxification unit to normal residential location. An appointment is then made for them to be seen at the earliest opportunity. In the interim, detoxification staff carry out a limited version of the induction programme on the detoxification unit itself. Any urgent issues are referred to the Resettlement team to be dealt with on a one-to-one basis.

In the woman's case, it was recommended that she was immediately offered advice on housing and employment, rape counselling, and counselling addressing her inability to bear children. Yet none of these needs were ever addressed and she was never given the full and proper induction. There is no explanation for this and I have not ascertained whether this was a one-off, or whether many others like the woman miss out on this essential requirement. The pressures upon staff at Holloway, and the systems currently in place, suggest that many other women who have undergone detoxification have been (or are likely to have been) missed.

The Resettlement Manager informed the investigators that as an alternative, his team were putting together an induction pack for all new Receptions that will include information on what services prisoners can access if they are feeling depressed or suicidal.

Whilst I recognise the potential difficulties involved in inducting prisoners undergoing detoxification, I do not believe these are insurmountable. We should not automatically assume that these women are unable to partake in the process until at least 10 days later. They may be physically ill, but they will still know what their needs are. I also believe that women on detoxification could be interviewed, and any referrals made to the appropriate agencies, on a daily basis. However, irrespective of details, it is essential that a needs analysis and subsequent implementation plan is put in place to address this issue.

Bullying

Shortly after the woman hanged herself, officers reported prisoners' allegations that she had been bullied. None of the reports were specific and only one prisoner was mentioned. Subsequent enquiries have shown it is unlikely that this prisoner was in fact bullying the woman. Indeed, the last person to speak to her before she hanged herself, was adamant that the woman was not being bullied. The last person to speak to the woman was friendly with her and believed that the prisoner alleged to be the bully had 'attached' herself to the woman. She added that the woman was irritated by the close attention from the alleged bully, and that the woman was relieved when she was moved from the unit.

The last person to speak to her was in no doubt that the woman was tough, that she could look after herself, and had not been bullied or intimidated by anyone. Another wing cleaner, confirmed that the woman and the alleged bully were friends and said she did not believe there was any bullying on the unit at that time. The officer that did the first prison count and the officer on duty on A4 did not believe the woman was being bullied either. The alleged bully was subsequently released from custody and

our efforts to locate her were unsuccessful. However, with the evidence available, I do not believe she, or any other prisoner, was being bullied.

Holloway has a Principal Officer anti-bullying co-ordinator and a comprehensive anti-bullying policy and system in place. Each unit has two anti-bullying Liaison Officers and, from the observations of the investigation team, the system appears to be working adequately. Four months previously, 70 prisoners were interviewed just prior to release, using ‘exit questionnaires’. The majority of respondents said they felt safe but some problems, as might be expected, were identified. The most common place for bullies to be active was on residential units, primarily in dormitories. The units shown to have the biggest problems were H1, D1 and C1. H1 and D1 are the detoxification units and C1 is the mental health unit. However, Holloway has a very transient population and the information gained from these questionnaires is not necessarily a true reflection of the woman’s time in custody.

Personal Officer scheme

In 2003, a Governor’s Notice to Staff was issued relaunching the Personal Officer scheme. The notice stated that staff are allocated to prisoners by cell number, which is then recorded on the unit roll board. A Personal Officer allocation form is given to each prisoner and the officer responsible recorded in the prisoner’s history sheet. This is to happen within 48 hours of reception. Unit officers are to make themselves known to their allocated prisoners and should record this and any subsequent meetings or dealings on the prisoner’s history sheet. Each Personal Officer is expected to make an entry at least weekly. Senior Officers are to check 10% of history sheets weekly. Similarly, checks should be carried out fortnightly by a Principal Officer and monthly by a Governor.

The investigation team confirmed that the unit roll board on the woman’s unit (A4) was marked up with Personal Officers’ allocated prisoners. However, this appeared to be the extent of the scheme in practice. The team could find no evidence of a personal officer allocation form on the woman’s history sheet or any evidence of any meetings or management checks by any grade. Indeed, her history sheet had minimal entries made within it.

For the week the woman was on A4 unit, the only entry was made when she arrived there on 8 April 2004. It stated simply: "*Rec'd onto A4, placed into single on request".* This entry was made by the officer who did the first prisoner count. When interviewed, both the officer who did the first prisoner count and the officer on duty on A4 were scathing of the scheme; The officer who did the first prisoner count was honest enough to admit that she did not know who she was Personal Officer to. Her argument was that she would deal with a prisoner's problems, requests or questions regardless of whether she was that prisoner's Personal Officer or not. With no management checks being made, this argument is likely to go unchallenged.

It is a basic requirement for prison officers to deal with prisoners' issues as they arise. The Personal Officer scheme provides prisoners with the opportunity to develop a continuous *personal* relationship within the establishment with someone who knows them as an individual, and is aware of their needs. It also helps develop positive staff / prisoner relationships, reduce tension and improve security. Many local prisons have problems implementing a personal officer scheme with prisoners who stay with them for such a short time. However the effort is worthwhile, and I recommend that the Governor relaunches the scheme once again.

Drugs

It was suggested that the woman's illness on 14 April 2004 was due to her having taken 'bad crack'. A Governor told us that the police had reported that a woman who had recently been at Holloway had been found virtually dead with a needle in her groin. Because of this, the police indicated that there might be some bad drugs within the prison.

The wing cleaner, told us that other prisoners had told her that the woman was in debt having traded her medication for drugs. The wing cleaner told the investigation team there were a lot of drugs on the landing (A4) and named a kitchen worker who was allegedly dealing drugs on the wing. At the time of our investigation, the prisoner had been released from custody and could not be located. However the last person

to spreak to the woman, did not believe the woman was dealing or taking illicit drugs. She told the investigators that she had “nothing to trade”.

A toxicology report completed on blood taken from the woman on her admittance to hospital at 10.58am on 15 April 2004 highlighted that tests for opiate drugs, cocaine, methadone, amphetamine and cannabis were all negative and that she had, therefore, not taken these drugs recently. However, the report did state that a ‘normal’ single abuse amount of crack cocaine could be eliminated from the blood stream in about 18 hours. Theoretically, it is possible that the woman’s illness *was* caused by having taken crack cocaine (bad or otherwise). However, we know that she was still ill *after* the cut-off time of 6pm on 14 April 2004, when any drugs she might have taken would have been eliminated from her blood. On balance, the likelihood is that her illness was not caused by having taken an illicit drug. The cause therefore remains unknown.

Holloway has not been meeting the mandatory drug testing targets set by the Prison Service and clearly faces a challange in containing the issue of drug dealing amongst its prisoners. It was evident to the investigation team that the Drug Strategy Team at Holloway is under resourced. However, I am led to believe that this issue is likely to be addressed now that Holloway is being managed as a London prison rather than one from the Women’s Estate.

There are some positive aspects. The detoxification provision is well resourced and is referred to by senior management at Holloway as being probably the best in the country. Unfortunately, this good work is undermined by the relative ease with which prisoners are able to obtain illicit drugs. For the year 2003/04, Holloway randomly tested 4.8% of the prison population for drugs. Of those, 19.9% tested positive. Holloway’s target was to achieve less than 10%.

I recommend that an independent review of Holloway’s Drug Strategy is undertaken, and that it should examine whether the security measures and demand reduction services could be improved, and so reduce the availability of drugs within the prison.

There are also problems with the service provided by CARATS (the counselling, assessment, referral, advice and throughcare service). The woman was automatically referred for an assessment due to her drug problem. The Prison Service target for CARATS referrals to be interviewed is within five days, although Holloway has been granted a temporary non-compliance that allows 10 days. However, even with this extension, many women are not being seen in time. These included the woman, who was on a waiting list with approximately 100 other women. Again, there is a resource issue. The CARATS manager at Holloway told the investigators that the complement of drug workers needed to be increased from seven to 10 to be effective.

Additionally, prisoners referred to CARATS from any one of 25 boroughs that are included as part of the Government Criminal Justice Intervention Programme (CJIP) initiative will receive priority. The woman was not in one of the identified areas, and so was effectively ‘leap-frogged’ by a prisoner from Southwark. Ultimately, all areas throughout the country will have a CJIP team and this system of prioritising will therefore eventually disappear. It is unfortunate that in the meantime, a ‘queue-jumping’ system exists which favours prisoners from certain areas.

The team spoke to a CARATS area manager, who felt that the specific complexities of Holloway were not understood and not altogether comparable with male prisons. The CARATS area manager advocated a pilot analysis be undertaken at Holloway with a view to establishing a seamless service that would include a number of different agencies carrying out case reviews on prisoners together, as opposed to agencies working independently of each other and often duplicating each other’s work. I endorse the CARATS area manager’s view and support the recommendation that an analysis be undertaken.

Suicide Prevention

Although the woman had a history of suicide attempts, she had not made an attempt for about four years.

The woman was asked a set of risk assessment questions by a nurse when she arrived at Holloway on 1 April 2004. These included: “Do you feel like hurting yourself at the moment?” to which she answered “No”; and “Are you feeling suicidal?” to which she also answered “No”. A further question, “Does the prisoner seem excessively withdrawn or depressed?” was also marked “No”. The team’s findings support this initial assessment.

We were unable to find any indications throughout the woman’s period in custody that she intended to harm herself or, indeed, take her own life. A short time after being interviewed by the nurse on Reception, the woman was admitted to the detoxification unit where she *was* assessed as being at risk of self-harm. Depression was given as the reason. However, no F2052SH was opened and the question “F2052SH yes/no” on the front of the Care Plan was unmarked.

We can only surmise that because it was known that the woman had in the past been treated for depression, she was therefore seen as having the potential to self-harm, but not actually considered as high risk. This view was subsequently, albeit poorly, reflected in the assessment notes by being marked up as merely ‘at risk’. It seems likely that an F2052SH was not opened because of this relative lack of serious concern, which was corroborated by other perceived signs. Had the woman been on the F2052SH self-harm monitoring system, it is more likely (although far from certain) that her death would have been prevented.

Following the woman’s death, and that of another woman at Holloway, a review of Holloway’s suicide prevention procedures was carried out by an advisor for the Women’s Estate. The review highlighted 28 recommendations for improvements. However, it cannot be concluded that the woman who is the subject of this report, would still be alive today had these recommendations already been in place, as she gave no indication that she intended to harm herself.

Medical Care

The woman was admitted to Holloway on the evening of 1 April 2004, where a nurse questioned her on reception. The nurse was from a nursing agency who had been

contracted to work at the prison for over a year. The reception questionnaire included around 50 questions and would have taken about 15 minutes to administer. In response to the nurse's questions, the woman disclosed that she had seen her GP recently for depression; she was positive for hepatitis A; she suffered from irritable bowel syndrome. She also said she was taking anti-depressants, but could not remember their name. She was also noted to be allergic to aspirin and stated that she had had surgery on her knee 10 years previously during which she had had a "plate" inserted.

The woman disclosed her drugs habit and said she used heroin (£60-£100 per day, smoked or injected), crack and Valium (diazepam). She smoked 20-30 cigarettes per day and habitually drank 4 pints of beer per day. On specific questioning about self-harm in a later part of the assessment, she informed the nurse that she had attempted suicide by taking an overdose of analgesics four years earlier.

She was noted to weigh 45kg and her vital signs were also documented.

A routine chemicalurinary drugs screen was positive for cocaine, THC, morphine and benzodiazepines.

Entries were made by a member of the medical staff onto a standardised medical record sheet, which explores detoxification regimes for people with substance abuse problems. This locally developed "Brief Medical Screening at Reception" allows the medical officer to record which drugs have been abused by the patient, whether she is depressed, and to authorise detoxification regimes for alcohol, heroin and benzodiazepine misuse. It also allows the clinician to indicate whether night sedation will be prescribed. In the woman's case, it was indicated that Zopriclone would be prescribed, however it appears that Zolpidem was instead prescribed on 1 April 2004.

The sheet does not provide any template or prompts for recording details of past medical history or examination. It is not clear from the record whether the information on it was obtained from the woman, or whether it was lifted directly from the reception assessment questionnaire. There was no record of any communication with her

general practitioner with regard to her recent consultation regarding depression or her anti-depressant medication.

The person who completed the medical record was a locum doctor who had worked at the prison for a few months.

Three detoxification regimes were selected for the woman: methadone detoxification for her heroin habit; chlordiazepoxide for her alcohol misuse, and reducing regime of diazepam for benzodiazepine misuse. The woman stayed in the detoxification unit (HI) until 5 April 2004, when she was moved to the post-detoxification unit (D1), and finally onto a residential unit (A4) on 8 April 2004. The last dose of chlordiazepoxide was administered on 8 April 2004, and the last dose of methadone on 10 April 2004. The benzodiazepine withdrawal programme is a 5-week regime and was ongoing.

The nursing records indicate that the woman slept all night on 1 April 2004, and was comfortable throughout the next day, until the evening of 3 April 2004, when she became threatening and abusive. She settled when she was relocated to a single room. Again, on the evening of 4 April 2004, she became very argumentative. No further entries were made after she was moved to the post-detoxification unit on 5 April 2004.

The Care Plan is structured around general issues and also specific issues relating to individual detoxification regimes. On the woman's care plan, a tick indicates that she was encouraged to participate in a therapeutic programme while undergoing detoxification, but no details are provided as to what psychological or rehabilitative support was actually offered.

In respect of complications and future health, there is no record of referral to the Women's Health Clinic for advice or screening, and although the 'review by MO' (Medical Officer) is ticked, there is no indication in any record of any assessment by a Medical Officer. The statement "additional symptomatic relief if required" is also marked (another tick), but no evidence of drugs having been administered was entered on the Drug Sheet during the period 1-8 April 2004. None of the entries in the Care Plan was signed.

The woman was moved to normal accommodation on 8 April 2004, where she requested and was given a single cell. Her methadone regime came to an end on 10 April 2004, and she was treated for a dental abscess on 13 April 2004.

On 14 April 2004, the woman said she was suffering from abdominal pain. She was allowed to use the bath, but continued to complain of abdominal pain and to ask for a further bath. She asked to see the nurse at 1.30am on 14 April 2004, and at 2.20am she was given an injection of prochlorperazine (an anti-emetic). At 8.00am on 15 April 2004, she once more requested a bath, which was declined. A routine check was made at 9.00am to ensure that prisoners were in their cells. At 9.21am she was found hanging in her cell.

The reception-screening questionnaire is a standardised procedure conducted by nursing staff. A clinical review was conducted on my behalf and raised concerns as to its sensitivity as an instrument for detecting intention to self-harm. It is important that nursing staff understand the limitations of the questionnaire and that its use is complemented by a careful medical assessment of prisoners, many of whom have complex needs.

There are many difficulties in accessing records from GPs and community services. In the woman's case, the nursing and medical staff at Holloway did not know potentially important information. It could not be ascertained from the written records whether any attempt had been made to contact the relevant GP and community services. It is important to identify whether this is an isolated instance or a systemic issue that needs to be addressed.

The discrepancies between the risk assessment from the reception–screening questionnaire and the Care Plan are of some concern. Equally, the failure to open an F2052SH having identified a risk of self-harm due to depression is worrying from a procedural viewpoint. Written evidence from the reception screening suggested that opening an F2052SH was not necessary, however these indications should have been reflected in the Care Plan, or at least reference made to them.

Such discrepancies highlight the need for clear and consistent criteria that can be referred to by staff when considering whether or not to open up an F2052SH.

The Detoxification Unit Care Plan is a potentially useful guide to acceptable standards of care. However when incomplete, unsigned and without written comment, it provides no assurance that care is provided or to the expected standards. It is important to ensure that adjunctive pharmacological treatment and psychological support are available to prisoners undergoing detoxification, and that these prisoners are referred for rehabilitation advice, health promotion and relevant infectious-disease screening.

There was no evidence of any involvement by medical staff in the work of the detoxification unit once the standardised records and medication charts had been signed off. While accepting that the units may be nurse-led, medical staff could usefully support the nursing staff and work with them to ensure continuous improvement in the standard of healthcare services for prisoner/patients.

Prisoner compliance with the detoxification prescribing regimes was high and should be commended. Nevertheless, the regimes did and do lack flexibility, and it would also be useful to review the regimes currently adopted in NHS environments and reflect on the likely strengths and limitations of using same model in custodial settings. (The figures for April, May and June indicate good flexibility in prescribing regimes.)

No further medical issues emerged in the course of the investigation, but given the dependence on agency nurses and locum doctors, it would be wise to review the induction, training and supervisory arrangements for such staff.

Emergency Medical Assistance

The woman was found hanging in her cell at 9.21am on 15 April 2004. The events surrounding this, and the emergency medical assistance provided, were described in detail earlier in this report. It should be pointed out that the summary of events is based on various reports written by those involved in the incident, as well as

evidence given by staff who were interviewed as part of the investigation. As expected, given the intensity of the situation, not all details correspond exactly. However the account given is, I believe, an accurate reflection of what happened.

The response was immediate once the alarm was raised. Medical professionals were administering emergency assistance within five minutes of the woman having been found hanging. It is to the credit of all concerned that every effort was made to revive her. The arrival of the London Ambulance Service approximately 10 minutes later is also impressive.

The woman's pulse was found some 35 to 40 minutes after the officer on duty on A4 opened the cell door to find her hanging. Unfortunately this was too little, too late. The woman was blue when found, indicating that she had been hypoxic for some time. As a result of this the Doctor, who was at the scene, believed the woman had been hanging for nothing less than five minutes, maybe 10 minutes, possibly longer. Given this, it seems unlikely that she could have been saved. However, I would recommend that a number of Holloway's medical staff be trained in Advanced Trauma Life Support (ATLS) techniques in addition to basic life support procedures.

Consideration should also be given to the practice of emergency medical responses. When the call for urgent assistance was made over the radio net, staff, and in particular medical professionals, were unclear as to what type of emergency they were running to. This could have had a delaying effect for any subsequent treatment if, for instance, the wrong type of equipment had been taken to the scene. Senior management at the prison have recognised this and are looking at systems that other prisons have whereby a code is given over the radio net alerting staff as to the type of emergency they will be attending. However, this has apparently been under consideration since a previous death-in-custody at Holloway in August 2002. I recommend that a system to address this issue be expedited.

The Deputy Head of Security, held a 'hot debrief' at 11am with all staff involved with the incident. A number of issues were raised, including problems with: the effectiveness of 'fish knives', insufficient radios, defective radio batteries, ascertaining which medical staff should attend, and problems with having too many users on the

radio net. It was also suggested that there should be an ‘in-room’ co-ordinator for the medical issues and the same for non-medical issues. This was a useful exercise that contributed to an action plan to address these and other issues raised.

Post-Incident

Procedures were followed in line with contingency plans whereby the various offices and individuals were informed of events as required.

At 11am a ‘hot debrief’ was held (see previous section) and an establishment action plan initiated.

A senior manager at Holloway, was appointed as the prison Family Liaison Officer (FLO). The prison FLO played a vitally important role in keeping the woman’s family informed of events and helping them come to terms with what had happened. I commend her. She made herself available to the woman’s family by being only a telephone call away. She was practical, honest and compassionate and I know the woman’s family have recognised this and are grateful for her efforts.

The prison FLO was critical of Management at the hospital who (mis) informed the woman’s sister, on two occasions as to when the life support machine would be turned off. Ultimately, the hospital made the decision to allow the woman to die naturally.

There was a dispute between the Police and prison management at Holloway as to what investigating authority the Police had. This arose because the woman was still alive when found. In a report given to the investigating team the Detective Sergeant states that, Holloway’s Head of Security accused the Police of being pre-emptive and premature in their approach, which obstructed senior prison staff from completing their own enquiries.

This disparity of understanding clearly needs resolving in order to prevent any such disputes in the future. I recommend that a joint protocol be agreed locally between Senior Management at both Holloway prison and the relevant Police/Prison Liaison

Unit outlining the actions and authorities required when a death-in-custody occurs. This would also address exceptional cases like the woman's, where the death is not immediate, but subsequently occurs in hospital. Consideration should also be given to extending such a protocol throughout the London area, and possibly to all prisons. It is likely that a standard template could be used and adjusted accordingly to suit local arrangements.

Analysis of Self-Harm Statistics and Self-Inflicted Deaths

Statistics are compiled by the Psychology department at Holloway who then produce monthly reports for senior management. I have referred to some of these statistics within this report, which I have taken at face value and assumed to be correct. However, I note that in the period 26 March 2004 to 25 April 2004, the report made no reference to the woman's death.

At the time of her death, Holloway had a population of approximately 460 women. Many of these women have difficult issues to contend with and during any given month up to 100 (and sometimes even more) F2052SH forms are opened on women deemed to be at risk of self-harm.

In 2003, a total of 809 incidents of self-harm were reported at Holloway, compared to 902 reported incidents in 2002. In the reporting period 21 December 2003 to 25 April 2004, there have been a total of 338 reported incidents of self-harm, including attempted suicides.

The summary report for 2003 shows that Friday represented the highest risk for self-harm and Sunday the lowest. However, this statistic has little predictive value. In January 2004, most incidents occurred on Wednesday and Thursday and the least on Monday and Tuesday. In February 2004, most incidents occurred on Monday and Saturday and the fewest on Friday. In March 2004, there was no significant difference between the numbers of incidents occurring on each day of the week. In April 2004, self-harm was highest at the weekend and lowest on Monday and Tuesday.

The most frequently occurring method of self-harm is cutting followed by strangulation. In 2003, nearly half of all incidents occurred between 4pm and 12pm, which coincides with evening lock-up time. There were many fewer incidents between midnight and 12pm. The majority of incidents occur on the Healthcare unit. The woman hanged herself at approximately 9.10am on a Thursday whilst on a residential unit.

From 1998 until the woman's death on 17 April 2004, there were 49 deaths-in-custody within the women's estate. The average age was 28; the woman was 35. Also, during this period, the most common offence for women who have died in custody is Theft and Handling followed by Violence Against The Person.

The number of self-inflicted deaths in prisons in England and Wales (since 1988) is shown in the following table. As illustrated, the number of deaths among women has increased markedly in recent years.

Self-inflicted deaths in Custody*

Year	Female	Male	Total
1988	0	37	37
1989	2	46	48
1990	1	49	50
1991	0	42	42
1992	2	39	41
1993	1	46	47
1994	1	60	61
1995	2	57	59
1996	2	62	64
1997	3	65	68
1998	3	81	84
1999	5	86	91
2000	8	73	81
2001	6	67	73

Year	Female	Male	Total
2002	9	86	95
2003	14	80	94
2004 to 6 July	9	41	50

*Safer Custody Group

In all of the last five years, the *rate* of female self-inflicted deaths, i.e. the number of deaths expressed as a proportion of the total population of women prisoners, has been higher than the rate for males.

The number of reported self-harm incidents in prisons in England and Wales for 1998 to 2003 is shown in the following table:

Self-Harm incidents in Custody*

	1998	1999	2000	2001	2002	2003#
Male	2923	3120	4196	5406	5664	8815
Female	211	505	933	2034	2493	7408
TOTAL	3134	3625	5129	7440	8157	16223

*Safer Custody Group

Note: These figures cover all acts of self-harm, however serious. The figures provided are the number of incidents of self-harm, not number of individuals. Data on self-harm was not available in this format before 1998.

#In December 2002, a new form for reporting self-injury (F213SH) was introduced across the prisons estate in England and Wales, which is known to have improved reporting practices. It should be noted therefore that much of the increase in reported self-harm in 2003 may be as a result of the change in reporting procedures rather than reflecting an actual increase in incidence of self-harm. Given that women prisoners account for only 6% of the prison population, the above figures show that women prisoners self-harm at a rate far higher than male prisoners.

Consideration

The investigation team was unable to be certain whether the woman meant to take her own life or whether the act was a cry for help that was mistimed and which subsequently went tragically wrong. However the following key facts remain true:

- The woman, who had been a regular drug user for many years, had just finished a period of detoxification when she took her own life.
- The woman's (prescribed) anti-depressant medication was withdrawn when she arrived at Holloway.
- On arriving at prison, after a telephone call to her mother, the woman learned of the death of her dog. She was clearly upset, and later wrote to her mother expressing her regrets.
- The woman told staff that she had been raped when aged 14.
- The woman was unable to have children and was envious of another prisoner on her unit who was pregnant.
- Two days before she took her life, the woman wrote to her mother saying how she was 'pigging out' and putting on weight. She also asked her mother to send in some pictures.
- The woman had been ill in the preceding 24 hours.
- At approximately 8am on 15 April 2004, the woman asked for, and was refused, a bath. She was upset and angry as a result.
- At 9am, 15 April 2004, the woman was seen sitting on her bed.
- At 9.21am, 15 April 2004, the woman was found hanging from the bars on her window. She was blue, and had been hypoxic for some time, indicating that she had been hanging for maybe 10 minutes, possibly longer.
- The woman had been on A4 residential unit for a week and was familiar with the morning unlocking routine. On 15 April 2004, the routine had been delayed.

No one, prisoners or staff alike, had any idea that the woman would hang herself. 'Pigging out', putting on weight, and asking her mother to send in photographs does not present a picture of someone intending to fatally harm themselves, and despite being close to her family, a suicide note has not been found.

However, by the same token, she had just finished detoxification; she was no longer on anti-depressants; she was distraught and feeling guilty at the death of her dog; she had been ill for the previous 20 hours or more and was frustrated and upset at not being allowed a bath. It would appear that hanging herself was, if intended, a spontaneous act.

From the time the woman was seen sitting on her bed at 9am, there would have been only a few minutes for her to make a ligature from her sheet, tie it to the bars of her window, tie it around her neck and then hang herself.

If the morning unlocking routine had not been delayed, the woman would, in all likelihood, have been found in time. If she was unaware of the delay in the routine, then it might be reasonable to conclude, *on the balance of probabilities*, that she meant to be found in time and was not, therefore, intending to take her own life. However, she would almost certainly have both heard and seen the disturbance on the exercise yard (her cell window looked out on it) and might have reasonably concluded that the regime that morning would be delayed, thereby giving her (just) enough time to hang herself.

The investigation team looked at whether the woman's death could have been prevented.

We know that staff at Holloway deal with large numbers of disturbed women at risk of self-harm or suicide on a daily basis. The fact that the woman was not placed on the F2052SH self-harm monitoring system indicates that there were no visibly obvious signs of intent to self-harm. The investigation team was also unable to find any evidence to suggest that she should have been on an F2052SH.

Under the previous section, Examination of the Issues, I looked at a number of areas including: Induction, Drugs, Personal Officer scheme and Medical Care.

The woman did not receive a proper induction. She told staff very soon after arriving at prison that she had been raped when she was 14. Although it was recommended that she be referred for rape counselling, this never happened. It was the woman

who raised the issue of the rape with staff; it is not a standard question asked as a matter of course. The rape occurred over 20 years previously and we could not possibly know if it had any bearing at all on her subsequent death. However, research tells us that the experience of physical and sexual abuse in a woman's past impacts on almost everything else they do. The Head of Residence at Holloway is also the Child Protection Co-ordinator. She told the investigation team that she would have expected to see a report on the woman's alleged rape but was unaware of the issue.

All new receptions are offered one-to-one interviews with a variety of specialist staff, ranging from bail information, legal services or housing officers through to officers from Probation or Resettlement officers, members of the drugs counselling team CARATS, a representative from the chaplaincy, as well as education staff. The woman was not given access to these services.

The availability of illicit drugs within Holloway is a big problem. Drug dealing was certainly occurring on A4, the woman's unit. Whether the woman was involved in any way is uncertain, although she was certainly exposed to it. Drugs within prison are an unfortunate fact of life. However I believe more could be done to reduce the availability of illicit drugs within Holloway and have made recommendations to this effect. Whether the drug culture on A4 was a contributory factor in the woman's death could not be established. However the fact that it may have been highlights the need for stronger controls in this area.

The woman should have been seen by a CARATS worker to assess her needs and to provide an ongoing care plan in respect of her substance abuse. Because of resource issues, this never took place. Had it done so, it is likely to have had a positive effect.

The Personal Officer scheme was not in force at the time of the woman's death. These schemes are prone to failure in prisons like Holloway where the turnaround of prisoners is rapid (on average less than a month). However, if there had been an officer who the woman knew she could turn to, she might have sought their help.

The review of medical care carried out highlights a number of issues that need to be looked at and addressed. I would like to see a more robust screening system and greater flexibility within the detoxification regimes.

It is debatable whether the decision to deny the woman more than one bath had any bearing on the outcome. The officer on duty on A4 was acting within prison rules by not allowing the woman further baths when requested. However, another officer might have relaxed the rules to meet her needs. Given the vulnerability of the women in their care, staff must be alert to the complexity of issues that face them, when managing the health and social care needs of female offenders.

Women prisoners have a different set of needs to their male counterparts. Prison Officer training, however, does not reflect these differences and, as a result, the care provided is unlikely to be as sensitive and effective as it might be. A direct comparison can be made with the juvenile estate, where specialised training is a requirement for staff working with children.

Conclusions

The woman died having hanged herself. Whether her intention was to die is for the Inquest to decide.

With the systems in place at the time, her death could not have been predicted nor prevented. However, it is reasonable to conclude that if the woman:

- had received a full and proper induction,
- had not been subjected to the drug culture on her unit,
- had been seen by CARATS,
- had been given the attention of a Personal Officer,
- had received a more comprehensive reception-screening,

and

- if the detoxification regimes were more flexible,
- if the officers caring for the woman had been trained to meet her needs,

The woman would have been less likely to hang herself, irrespective of whether she intended to die or not.

Recommendations

Director General of the Prison Service

I recommend that the Director General of the Prison Service commissions a needs analysis of Prison Officer training in respect of women prisoners.

London Prisons Area Manager

I recommend that the London Prisons Area Manager commissions the following:

- A review of Holloway's induction procedures to examine the needs of women undergoing detoxification.
- A Needs Analysis to review whether the resources available to Holloway's Drug Strategy Team, including CARATS staff, are adequate to meet the requirements of Prison Service Standards.
- A review of Holloway's drug strategy to examine whether security measures and demand reduction services could be improved in order to reduce the availability of drugs within the prison.
- A review to assess the efficacy of the different agencies that operate at Holloway. Is there duplication of each other's work? Is it feasible for case reviews of prisoners to be carried out jointly (either full or in part) between each of the agencies working at Holloway?
- A review of procedures undertaken when screening for the risk of self-harm, and
- A review of the quality of care provided during detoxification.

Governor of Holloway

I recommend that the Governor of Holloway:

- Relaunches the Personal Officer scheme, ensuring it is managed consistently and effectively.
- Reviews the induction, training, supervisory and support arrangements (including Staff Care and Welfare) for agency nurses and locum doctors.
- Has medical staff trained in Advanced Trauma Life Support techniques.

- Agrees and documents a joint protocol between Holloway prison and Islington Police/Prison Liaison Unit outlining the actions and authorities required when a death-in-custody occurs. The protocol should address exceptional cases like the woman's, where the death is not immediate, but subsequently occurs in hospital.

A number of in-house issues were raised at the hot debrief held by the Deputy Head of Security. These resulted in various recommendations being made that were subsequently incorporated within an establishment action plan. It is not my intention to repeat those recommendations here, as I trust they have already been, or will be, acted upon.

The one exception I will make, however, is to stress to the Governor the importance of expediting an emergency coding system, via the radio net, to alert staff as to the type of incident they will be responding to.

Good Practice

The devoted actions of the prison Family Liaison Officer in helping the family in this difficult time should not be underestimated. She deserves specific recognition.

STEPHEN SHAW
PRISONS AND PROBATION OMBUDSMAN