INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A WOMAN AT HM PRISON SEND IN APRIL 2004

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

NOVEMBER 2005

The woman died in HMP Send on 18 April 2004. She was just 23 years old.

I offer my deepest condolences to the woman's mother and the other close relatives who have been deeply saddened by her tragic death.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. Guildford and Waverley Primary Care Trust gave clinical advice, but has not provided a written review leaving a number of unanswered questions about the woman's mental health care. I am grateful to all the investigation team and to the Governor and staff of HMP Send for their invaluable assistance.

This is a painfully sad story of a very damaged young woman. I note however, there are a number of points raised by the woman's family, regarding her clinical care, in particular mental health provision, which remain unanswered. I have therefore arranged for a supplementary clinical review to be carried out and will make this the subject of a supplementary report, when it is available. The circumstances giving rise to the woman's arrest and to her death make hers a unique tragedy.

STEPHEN SHAW CBE **NOVEMBER 2005**
PRISONS AND PROBATION OMBUDSMAN

1. SUMMARY

The young woman was deeply distressed and had spent periods compulsorily detained under the Mental Health Act. Her offence was committed at Beachy Head, where she was wont to go and tell the police of her intention to jump from the cliff and kill herself. No one knew how best to help her. She ended up in prison for want of anywhere else.

At Holloway from August 2003 until she was sentenced in March 2004, the woman was very well-known to the staff. For most of her time at Holloway she was considered at risk of suicide and self-harm and monitored through the F2052SH procedure. She often moved locations, sometimes being placed in healthcare, sometimes in a special unit for prisoners finding it hard to cope, sometimes in segregation for disciplinary reasons, sometimes on the ordinary wings. The woman cut herself and tied ligatures many times.

Throughout her time in prison, the woman was taking anti-psychotic medication which was changed from time to time.

After sentencing, the woman moved to Send on 26 March. She was not on an open F2052SH at the time and expressed enthusiasm about the move. Staff at Send were concerned about her because of her history and a fresh F2052SH file was opened.

The woman died by means of a ligature attached to the bathroom door handle in her cell on Sunday afternoon 18 April.

At the time, she should have been observed hourly but was not, and the time of the last check before she died has been changed in the record. That afternoon, one basic grade officer was responsible for supervising three wings, housing up to 120 women, while other staff were occupied with visits.

The woman was the first female to die at HMP Send. The prison has not been accustomed to caring for acutely vulnerable women but the population has changed because of pressure of numbers and the transfer of foreign national prisoners elsewhere. I question whether the prison has an adequate infrastructure for the demands now placed upon it. There are also training issues.

The report makes six recommendations.

2. MATTERS RAISED BY THE WOMAN'S FAMILY

1. When my investigators met the woman's mother and other close relatives, they said that when the woman was sent to prison they felt that at least she would be safe there and get the psychiatric care she needed. They thought there would be hospital wings and doctors and people who could sit down and talk. They said they were not trying to apportion blame and felt guilt themselves that they had not been able to meet her needs. But they raised questions which they hoped the investigation would answer.

2. They asked what had been done differently at Holloway, which had been able to protect the woman, whilst Send, though it seemed a much nicer place, did not?

3. They asked about the woman's medication. What medication was she receiving? Was it dispensed and administered as prescribed? What were the arrangements for administration of medication? Was ingestion supervised?

4. The family understood that the woman was taking Largactil. They said they could not reconcile what they had been told about her ripping up a sheet and hanging herself with their understanding of the mood-changing effects of Largactil.

5. They asked about the provision for the woman's mental health needs. What psychiatric care did she receive in prison, particularly after January 2004? If the prison could not provide appropriate care then why was she not in a mental health facility instead? They wanted to see the psychiatric reports.

6. They asked many questions about the care of prisoners at risk of suicide. Since the prison knew the woman was suicidal, why was she not given closer care? Why was she in a single cell with a bathroom with a door and handle and freestanding chair? Does the potential for CCTV to save lives outweigh the invasion of privacy, in the case of prisoners known to be at serious risk? The Wednesday before her death, the woman showed her mother she had been cutting herself again. Did the prison know this? How did they respond? Did her behaviour give no warning? How often was she being observed at the time of her death?

7. The young woman's family were appreciative of the care and concern shown towards them by the Deputy Governor. They attended a tree-planting ceremony at the prison in her memory and had valued the opportunity to talk with prisoners who had known her.

3. REPORT OF THE INVESTIGATION

Holloway prison

8. HM Prison Holloway is a closed women's prison in North London. It has the function of a local prison, primarily housing prisoners on remand from courts in London and the south-east. Its operational capacity in 2004 was 495. After sentence, women who are to remain in prison are generally transferred out of Holloway as soon as possible to release space for prisoners required to appear in the local courts.

9. The woman stayed in a number of different locations in Holloway. At the time, the healthcare unit was housed in C1. This had 25 places for medical and psychiatric patients and prisoners considered to be at very high risk of self-harm. H1 was the dedicated detox unit. Both the healthcare and detox units had nurses on duty 24 hours a day.

10. D2 was a small unit for supporting prisoners who found it difficult to cope in the general population. Small group activities such as art and drama therapy were available there and the chaplaincy offered special support. Staff were detailed to the unit consistently to provide continuity. The unit had places for 17 prisoners. The focus was to enable prisoners to move back into the general population of the prison not to provide a permanent refuge. When D2 was closed for refurbishment, alternative accommodation was provided on D3 which was otherwise the young offender's wing.

11. A1 was the segregation unit where prisoners might be located to await disciplinary hearings, for the punishment of cellular confinement, or if their behaviour was too disruptive on an ordinary wing. B4, C3 and C5 provided ordinary locations, respectively for remand, newly admitted and convicted prisoners. However, population pressures or the needs of a particular prisoner meant that the units would not always be used exclusively for prisoners of a particular status.

12. In each location except the segregation unit, there is a mix of single and shared accommodation, including dormitories housing four or five prisoners.

Send Prison

13. HM Prison Send in Surrey is a closed training prison for sentenced adult women. It has an operational capacity of 220. The living accommodation is divided into six separate wings: A, B, C, D, E and F. E and F wings are used as resettlement units. Prisoners each have single rooms with en-suite showers, except for D wing, which has used an older building and provides for up to 20 places in a dedicated drug free environment. A, B and C wings form the 'main block'. According to an inspection report by the Chief Inspector of Prisons in 2001, each wing has some cells with interconnecting doors which enable trained Listeners (prisoners trained by the Samaritans to provide a confidential service to prisoners) to be available in the adjoining room. In

February 2004, a dedicated Listeners suite was being prepared by conversion of an old staff room. All rooms have televisions installed.

14. The prison changed from a men's to a women's prison in June 1998. A variety of education and vocational training courses are offered, including hairdressing and information technology. Prisoners have the opportunity to obtain National Vocational Qualifications, and there is also scope for work placements, community work and outside education.

15. Healthcare provision at Send comprises a primary care service and visiting specialists. There are no in-patient beds and no clinical staff on the premises after 4pm on weekdays or after 2 pm at the weekend. A local GP practice provides doctors for daily surgeries. An on-call doctor service is used for medical requirements outside healthcare opening hours. On arrival at Send, prisoners are assessed by nursing staff to check that they have no medical needs requiring more intensive medical cover than Send can provide.

HMP Holloway 18 August 2003 to 26 March 2004

16. The woman was admitted to Holloway prison on remand on 18 August 2003 and remained there until 26 March 2004. This was her first time in prison. On her arrival in Holloway, in accordance with normal procedures, the First Reception Health Screen (F2169) form was used to record brief information about the woman's general health and drug and alcohol use. Her height was 5'3" and she weighed 98 kg (15 stones 4 lbs). The healthcare screening process identified that she had suffered from asthma and an under active thyroid, and had a history of both alcohol and drug misuse though said she was not currently using street drugs and drank alcohol daily but in her view not excessively. She had been treated for psychiatric illness and taken overdoses several times and slashed her wrists. She said she was currently taking prescribed Diazepam 5mg (a benzodiazepine) daily, Co-proxamol (an analgesic containing paracetamol) and 50 mg Largactil (Chlorpromazine used to treat psychotic disorders and symptoms such as hallucinations, delusions and hostility. I am told that Largactil should be used with caution if there is evidence of thyroid problems. Urine tests were positive only for benzodiazepine (consistent with Diazepam). The woman was placed in dormitory accommodation in H1, the detoxification unit, and prescribed Chlordiazepoxide, a benzodiazepine used to relieve anxiety and to control agitation caused by alcohol withdrawal. From 27 August, she was prescribed 4 mg Diazepam twice daily but as part of a programme for reducing her reliance on benzodiazepines.

17. On admission to Holloway, the woman was also placed in the F2052SH procedure of special care for prisoners thought to be at risk of suicide or self-harm. This was initially because of the circumstances of her alleged offence. The F2052SH file was opened by the escort service who received her into their custody from Eastbourne police and placed her under constant watch. It was said that police had attended Beachy Head on more than 40 occasions when

the woman had made threats to jump. Moreover, in the last few days she had tried to cut her wrists, saying this was to release tension caused by her children being taken from her. On 19 August, the record says that the woman's room-mates at Holloway told a psychologist she had been cutting herself with a fork and putting ligatures round her neck. The residential unit manager recommended that she see Psychology or a counsellor, Alcoholics Anonymous, Education and an acupuncture group. She should be reviewed three times an hour and during the night at irregular intervals.

18. The F2052SH was reviewed on 22 August by a Senior Officer. The support plan was similar to before except that observations were to be four times an hour, the woman would have access to the Listener scheme and she would not be placed in a dormitory but in single accommodation.

19. On 27 August, furniture was removed from her cell when an officer reported that she had been eating the screws and bolts from the furniture. Subsequently she was said to be "eating anything she can get her hands on". The woman said it was because she wanted to die.

20. On 28 August, the woman was moved D2, a small unit dedicated to supporting prisoners who were having difficulty coping.

21. On 3 September, staff contacted the woman's psychiatrist and social worker to confirm details of her medication and diagnosis in the community. A further review of her vulnerability was held on 6 September with a Senior Officer, an officer and the woman. The summary says she still felt suicidal but did not want to talk about it. She wanted to talk to someone from Psychology and this had already been arranged. The support plan says "Staff to monitor and supervise, access to Listeners and Chaplaincy."

22. The summary of the next review on 13 September is more detailed. An officer, an Acting Senior Officer and the woman attended. The woman still stated that she did not want to live, having nothing to live for, because she had lost her children. She said she had had a breakdown the year before and was still not considered well enough to have access to the children. She was attending an Alcoholics Anonymous course and would like to have a course of counselling. The support plan was to encourage purposeful activity, to observe at least eight times during the day and half-hourly at night, to encourage her to speak to Listeners and to use the Samaritans phones, to have access to the chaplaincy, to have access to psychology and one-to-one counselling. Entries in the record for 15 September refer to her talking to officers about wanting a blade to kill herself and turning her bed on its end so she could hang herself. She had also made superficial scratches on her leg with paint chips from the window and spoke of feeling like opening old scars on her wrist to get at a vein.

23. On 20 September, the woman said she wanted to be moved to C1 (the healthcare unit) or A1 (the segregation unit) and was placed on report for refusing to go into her room. Later that day she barricaded herself in her room

for having been put on basic regime. This followed three warnings in three days for being rude and abusive to officers, and throwing water on a nurse. The woman said she wanted to kill herself. She had thrown her mattress out of the window and was given a fresh one. The furniture was removed from her cell.

24. The next F2052H review, on 22 September, was again with one Senior Officer. The woman appeared in good spirits although said she wanted to kill herself. She said she had self-harmed in the last few days and told staff after she had done this but could not tell them before. The support plan continued.

25. On 24 September, the woman was referred to the Community Mental Health Team for assessment, at the request of her probation officer, and seen by a doctor on 10 October. At that time her medication was said to be Diazepam 2 mg, Chlorpromazine (anti-psychotic) 75 ml and Procyclidine 5 mg. Procyclidine hydrochloride is used to reduce the side effects of certain anti-psychotic medicines.

26. On 25 September, she said she was being bullied on B3 so was moved to C3 for the time being.

27. The woman's medical record says that on 28 September she "requested a tablet of death" from nurses. Whilst she said she was not currently suicidal she felt she had "no hope in life" and nothing to look forward to.

28. There was a further review of the F2052SH on 1 October when the woman had moved to B4 (normal location for remand prisoners). The medical record says that on 3 October she tied a ligature.

29. On 10 October, the doctor noted that the woman had a history of deliberate self-harm and recent acts of self-harm, one of particular concern. The woman seemed ambivalent about her drive to end her life, but her behaviour seemed impulsive so there was some risk that she might attempt self-harm again. However, she was aware that her court case was coming up soon and believed she would be released, so although she stated that hanging was better than prison she was looking forward to going back to her flat.

30. An entry in her file for 12 October says that she was very demanding of staff time and, if she was told that staff could not respond immediately, she tended to become abusive. Consequently, she was to remain on basic regime.

31. At a review on 15 October with a Senior Officer, the woman said she still had thoughts of self-harm and had last "cut up" the previous week. She stated that she regularly used the Samaritans phone and found this helpful. On 29 October there was a further multi-disciplinary review. The woman said she wanted the F2052SH closed but admitted to self-harming in the court cell that week. She was said to be settling down well on D3 (which was being used in place of D2 as the supportive unit for prisoner having difficulties) and staff arranged to meet again in a week's time with a view to closing the F2052SH.

32. The woman was convicted on 17 October of making threats to kill. Sentence was postponed for reports.

33. An entry in the file says that, although she was still on basic regime, a governor had, exceptionally, authorised her going into a dormitory because she could not cope on her own.

34. In a report dated 30 October, the doctor questioned the value of Chlorpromazine (Largactil) for the woman. He advised that if there was no evidence of it providing any significant benefit it should be stopped because of the possibility of short-term and long-term side effects.

35. On 3 November, the woman received warnings for being rude and abusive to a nurse and for throwing all her rubbish out of the dormitory window. On 5 November, at a review by a Senior Officer, the woman was said to be "disgruntled" and unhappy to be on C3, which she said was too big and cold. (C3 is a normal location primarily used for new prisoners going through induction. It houses 46 prisoners.) She had not self-harmed for nearly two weeks, the last occasion being at court, but she said that she now wanted to die and her mind was made up. The F2052SH was kept open. On 6 November, the woman was placed on report for refusing an order to go to her room.

36. The F2052SH support plan included trying to move her to a quieter unit. It is not clear where she moved, but on 13 November she was said to be "still on the 4s, but was reasonably happy", apparently with no thoughts of self-harm. The unit manager comments that he could not see the F2052SH being closed although "with some effort we can integrate her fully into the regime in the 4s. She is a pleasant talkative young lady and is making progress away from D3." It is clear that at this stage staff were working hard to try to motivate the woman through encouraging her and rewarding constructive behaviour. File entries for 16 November say she was making a big effort and had been really helpful, getting on with the other women and making the best of her time. She was moved from basic to standard regime.

37. On 24 November, at a review attended by a Senior Officer and an Officer, the woman said that she wanted the F2052SH to be closed but she was unable to say much to indicate how she was feeling. The review decided that the file should remain open, with staff support, continuing contact with the chaplaincy and activities off the unit. The review noted that she was to see someone from Psychology the next day. The woman assured an officer of her determination to be well-behaved.

38. On 2 December the woman was warned for being rude to an officer, throwing her mattress out of the window and misusing the cell bell. The review by a Senior Officer on 4 December noted that she was now on C5 (normal location for convicted prisoners), "following a spate of self-harm and/or discipline issues on other units." The support plan was for single accommodation,

befrienders, Psychology, staff support and two-hourly entries in the file during the day and half-hourly entries at night.

39. On 18 December, the woman was warned for being rude to staff, obstructing the door hatch, continuously ringing the cell bell and continuously banging the door after being told to stop. A file entry suggests that she found the structured, more intensive, supervision of D2 challenging, whereas elsewhere she said she could “do what she wants”. (D2 provided additional support for prisoners finding it hard to cope.) The record in the 2052SH file on 19 December says that the woman had tied four ligatures and barricaded twice since her court appearance the previous Monday. Later the same evening, she set fire to papers and her clothing and was moved to A1 (the segregation unit).

40. A case conference next day recorded that she said she felt like killing herself. Her need to self-harm was said to be related to anniversaries of significant events. It was her younger daughter’s birthday that week and Christmas was coming. It was agreed that the woman needed to be admitted to healthcare for a period and then to D2 after a case conference with D2 staff. She was to be observed hourly throughout the day and night and reviewed on 24 December. The review was attended by five staff including a probation officer. The support plan included contact with the proposed personal officer from D2, obtaining photographs and clothes from her stored property and sending a birthday present to her daughter.

41. An entry in the medical record for 22 December says the woman said the Chlorpromazine was helping her from hearing voices. She did not like Procyclidine because it was given in tablets. She did not like tablets and wanted only liquid medication.

42. On 23 December, in a one-to one session with a nurse, she said that she felt she wanted to barricade herself in her room again. She said she felt bored and isolated and that prisoners and staff did not like her. She had very low self-esteem.

43. The following day, the woman attempted to barricade herself in her room and refused to speak to staff. The same nurse spent time with her again. She recorded that she was unable to explain her feelings and thoughts, other than placing the blame on the way others interacted with her. They discussed how she might use more positive coping skills. The woman was not expressing any suicidal intent but remained impulsive. She was difficult to engage at times and her concentration was poor when challenged about her behaviour and interactions with others. The nurse made a referral to Psychology. On 25 December, the woman was moved to D2.

44. The next review was on 28 December. The woman was said to appear very relaxed and she was applying for work to keep her mind off self-harming. However, on 30 December she was warned for being extremely rude to staff.

45. On 1 January, the woman was warned for being verbally abusive to an officer when told she would be moving to a single cell. She was placed back on basic regime. That evening, in conversation with an officer, she acknowledged that her behaviour had been unacceptable and promised to try hard to improve.

46. The unit manager and probation officer attended the review on 6 January 2004. The summary notes that the woman was not talkative but accepted that she would stay on D2 as the safest place for her. A new personal officer had been identified and was said to have managed to get her bathed and into clean clothes. The unit manager commented, "There is always a high risk of self-harm with her but I feel that on D2 we can reduce this risk." The support plan was for the 2052SH to remain open for staff support, to continue twice-weekly contact with probation on Mondays and Fridays, the woman to be encouraged to take part in as many off wing-activities as possible, and to use Listeners as required.

47. On 7 January, the woman made superficial cuts on her leg. The medical record says she was still keen on staying on medication (Chlordiazepoxide and Chlorpromazine) but agreed to reduce them as planned.

48. On 15 January, a review was conducted by a Senior Officer. It records her progress, with behaviour and mood noted to have improved. However, the summary note says it remained to be seen whether this would be sustained and the woman said she still suffered from mood swings so the 2052SH was to remain open, with her remaining in a dormitory with support, including psychology, and hourly entries during the day and half hourly at night.

49. On 21January, the woman saw healthcare staff about galactorrhea, a condition in which the breasts lactate that can be caused by anti-psychotic drugs. The record also says that she said she had thyroid problems and was probably hypo-thyroid. On 22 January, she tied a ligature with a dressing gown cord which was removed by staff. She was admitted to C1 healthcare and remained there until 27 January. On 23 January, a doctor explained that she was probably suffering side-effects from the medication. The record says that, despite this, she wanted to continue the medications but agreed to change from Chloropromazine to 'Olanzapine'. (Olanzapine is an antipsychotic drug that was less likely to cause lactation but may cause substantial weight gain.) On 23 and 24 January, the woman tied several ligatures and refused to be assessed for adjudication.

50. The doctor saw her again on 27 January in order to prepare a report for a court hearing on 6 February. He commented that she said she wanted to be re-admitted to a psychiatric hospital where she said she had lots of friends and liked having staff available 24 hours a day. She had asked him if he could "make up" a diagnosis to get her admitted. The doctor tested the woman's IQ. The score of 75 indicated a borderline learning disability. He recalled that he had advised that her medication be reviewed. There was little evidence of her having a psychotic illness and very limited data to support the use of her

current medication in people with personality disorder. He noted that she was currently complaining of her breasts leaking milk, which was a side effect of anti-psychotic medication. The discharge summary from C1 healthcare on 27 January says that her current medication was Olanzapine 5mg nocte.

51. At the F2052SH review on 2 February, the woman said she wanted the 2052SH closed. In particular, she said she was upset that the night patrol staff kept waking her up with checks. However, she also said she still felt like tying a ligature and was worried about her court hearing the following week. Staff felt she was still vulnerable and the file was kept open. A review was scheduled for the day before the court hearing. She was to continue to see a counsellor once a week, and probation twice a week, and to be encouraged to take part in activities.

52. The medical record relates episodes of self-destructive behaviour in early February. On 7 February, the woman tied a ligature in the early hours of the morning that was cut and removed by staff. Following this she was placed on half hourly observations. She told the special watch nurse that she had come back from court and was concerned about being on B5 (normal location) and also about being assessed for "Castlefield Hospital". The next entry, still on 7 February, says she tied ligatures to her bed and self-strangulated claiming she wanted to die. She barricaded twice and wanted to go to A1, the segregation unit. At 12 noon she was warned for using offensive language towards and officer. On 8 February, she threw hot chocolate at a nurse and was abusive to officers. On 9 February, she inserted tissue paper deeply into her right ear. On 10 February, the woman tied two ligatures causing superficial redness. On 12 February, she tied a ligature but said she would not do it again and wanted to be moved "upstairs". At this point she was taking 5 mg Olanzapine once a day.

53. At a review on 12 February with a Senior Officer, Officer and Special Watch Nurse, the woman said she liked being able to talk to the Special Watch Nurse. The summary says there had been some incidents of self-harm and that she still got angry and frustrated and did not know what else to do. The summary comments that she was likely to find it difficult when the watch was reduced. She was expected to remain on H1. (H1 was the detox unit but was also used for prisoners who needed nursing supervision but for some reason could not be accommodated in healthcare.) In fact she moved to D2.

54. On 14 February, the woman threw a tablet of soap at an officer and swore. On 16 February, she was found lying under her bed having tied a ligature with a bed sheet. An officer cut the ligature. She was said to be very aggressive and demanding to go to A1 (segregation). On 17 February, she tied a ligature and flooded her room and was moved to the segregation unit.

55. On 19 February, the woman was said to be very unresponsive. She had not seen the counsellor for one-to-one counselling for a couple of weeks and wanted this to resume. She had tied a ligature two days before and said this was not because she wanted to die but because she wanted to go to A1 (the segregation unit) for time on her own.

56. On 23 February, the woman was warned for standing in front of two D2 officers constantly swearing at them. She maintained it was because she wanted to go back to segregation. She was in the segregation unit from 26 February until 1 March for disciplinary reasons.

57. On 4 March, the review noted that the woman had last self-harmed about two weeks before. The counselling had resumed and she said it helped her. The woman said she had had recent thoughts of self-harm and was worried about her children and their well-being. The review said that she was still thought to pose a danger to herself and it noted her tendency to violent mood swings. The F2052SH was to remain open until after the next court date, with a review on 18 March.

58. On 10 March, she met a consultant psychotherapist and psychoanalyst, who was to assess her for the Cassel Hospital. His report for the court is dated 15 March and recommended that she would not be suitable for the Cassel Hospital at that point. The court considered the report on 22 March.

59. On 14 March, the woman submitted a complaint that, when she had tried to talk about feeling suicidal to a member of the night staff, they had threatened disciplinary action if she did not shut up and go to sleep. A senior officer acknowledged the complaint in a letter addressed to her at Send on 7 April, apologising for delay caused by staff being on leave and saying he hoped to be able to write with a further update on 26 April. The senior officer says that he received the complaint only on 5 April and was told that the discipline office was dealing with a backlog of requests and complaints. The member of staff concerned replied on 21 April 2004 in a statement denying the woman's allegation.

60. The review on 18 March was attended by the woman, two Senior Officers, a representative of Psychology and one of the prison's Suicide Prevention Co-ordinators. At the start, the woman was distressed and kicking her door because she was missing free-flow (when prisoners move about the prison to go to activities). She was calmer after being reassured she would be taken to education after the review. According to the summary, she had not self-harmed in the last four weeks and was feeling much better. She felt able to manage on her own and wanted the F2052SH closed. The woman was assured that all the support remained there for her to use if she needed it and the F2052SH was closed. By this point, the woman said she no longer needed such a high level of support so the F2052SH had come to feel intrusive rather than supportive and the extent of observation was beginning to annoy her. There is a note in her general file advising staff that the F2052SH had been closed and she might need extra staff support, although there is no evidence of any specific support plan being put in place.

61. Next day at 8.30pm, a Senior Officer who had been present at the review, reopened the F2052SH when the woman handed him an apparent suicide note and told him she could not cope on C5 and wanted to go to segregation or hang herself. The next day, Saturday 20 March, the Unit Manager noted that the woman had said she was now fine and wanted the file to be closed. The Unit Manager was not convinced and decided it should remain open for the time being.

62. The Unit Manager spoke to my investigators about the staff's approach to opening and closing F2052SH files. He said it was important not to keep them open too long at one go because it could become simply automatic and a crutch. The aspiration was that prisoners would move on and see themselves doing so. If prisoners wanted to come off the F2052SH and staff resisted, that could be seen as the staff saying that they expected the prisoner to self-harm again. Instead, they tried to encourage prisoners by saying, for example, "You've done two weeks without self-harm. Maybe you can do three or four or five weeks." The staff on their units would continue to be vigilant. They knew that it might be necessary to open the file again but wanted to encourage prisoners to progress.

63. On Monday 22 March, the woman was sentenced. In reception, on return from court, she stated that she would cut herself, and appeared very subdued and unhappy. The health care assessment for the F2052SH was completed that evening. The nurse's assessment was, "thinks she has nothing to live for and nothing to go out for and therefore will kill herself – not actively suicidal." At 8.45pm the woman was seen by a doctor, who knew her well from her time in Holloway. The doctor's assessment was "Frustrated. Says may attempt suicide. Meantime asking for more medications. Not actively suicidal. No intention to self-harm." The records for that evening are detailed. Staff offered her hot water and biscuits when she was admitted to the wing and she was observed in the course of the evening engaging with her room-mates, showing pictures of her daughters and watching television. Staff also gave extra bedding when she said she was cold.

64. Next day the woman was said to seem in quite a happy frame of mind. At 9.35am the doctor again saw her and there were no indications of self-harm. The woman had an outstanding disciplinary charge for endangering health and safety. That was dealt with and she was given a punishment of three days cellular confinement suspended for one month. At 11:00 she was discharged to D2. Whilst on D2 wing at 12:45 the woman stated she would like to transfer out of Holloway as soon as possible and she filled in an application form to do so. It is normal practice for sentenced prisoners to be transferred from Holloway to 'training' prisons soon after sentencing. The woman appeared to be in a good frame of mind. At 3.00pm a case review was held, consisting of a nurse from the Community Mental Health Team and a Senior Officer. The summary by the nurse says that the woman stated that at times she wanted to die and at others to live. There was no clear evidence currently of suicidal ideation or thoughts of self-harm and she was feeling positive and upbeat

about being transferred to Send. The F2052SH was closed. On 25 March, healthcare staff reported the woman was fit for transfer.

65. A Senior Officer told my investigators that sentenced prisoners were usually moved out of Holloway very quickly; even three days' delay was quite a long time. He was clear that the closure of the F2052SH had no connection with the anticipated transfer. If they had felt the F2052SH should remain open she would have been transferred with an open file.

66. On 25 March, the woman submitted a further letter of complaint stating other prisoners on C5 landing were bullying her. This was submitted on a prisoner's formal complaint form serial number 151. This was not investigated.

Transfer to HMP Send

67. On admission to Send, the woman was seen by a nurse then a doctor. Entries in the medical record note that she was known to be hypothyroid and that she should be taking thyroxine but had stopped because she thought it was not working. She reported an allergy to paracetamol, which caused her to vomit. She used Salbutamol and Beclomethasone for asthma. Her height was 5'2" and weight 18st 4 lb (116 kg). She was considered fit for PE. She reported some history of mental health problems with a diagnosis of personality disorder and was currently taking 5 mg Olanzapine.

68. A nurse noted that the woman had been on an open F2052SH that had been closed a few days before, and that she sometimes felt suicidal or liable to self-harm. Considering her vulnerable, the nurse opened a new F2052SH. She recommended that she be placed in normal accommodation on a wing and supervised every three hours.

69. A doctor saw the woman after the nurse. He noted that she had a history of deliberate self-harm and suicidal ideation with cutting and overdose but had no recent wounds and reported that she had no desire to self-harm at present. He noted the diagnosis of personality disorder and depression and that she was known to be hypothyroid. He considered that the woman was not currently at high risk of deliberate self-harm and confirmed that she should be located in a normal residential unit. The doctor prescribed 5 mg Olanzapine once a day for 28 days and noted that the young woman needed to have a psychiatric review.

70. The woman was allocated to cell 12 on B -1. B wing is where all newly received prisoners are housed during the induction programme, which lasts between two and three weeks. A Senior Officer reviewed the F2052SH that evening. She noted that reception staff were concerned when the woman told them she had suicidal feelings. She instructed that residential staff should monitor her at irregular intervals. The entry in the file does not say how frequently.

71. The file records that the Senior Officer spoke to the woman on Sunday evening 28 March, after she had told an officer she wanted to hang herself.

She noted that she was worried about a number of issues including what would happen when she was released. The Senior Officer arranged for a Listener to see the woman and instructed that she should be put on hourly watch. The overnight monitoring from 22:00 to 06:00 is recorded as taking place on the hour every hour.

72. The F2052SH was reviewed by two Senior Officers with the woman in the evening on Monday 29 March. The summary says she was very down and had decided “how she would like to go”. She was uncertain about what would happen about her social worker and supported housing (which she expected to lose when her Housing Benefit ran out.). The care plan says the woman would see the Throughcare department about counselling, the visiting Psychiatrist and Probation about social work and housing issues. Residential staff should provide support and supervision, and consideration should be given to a work allocation.

73. Entries during the following week show some indications of the woman settling in at Send. As part of the standard induction programme, she visited the library and education on Tuesday and gym on Wednesday.

74. On Thursday 1 April, the F2052SH records that she had a long chat with an Officer. The woman was still expressing a wish to die, but also speaking more positively about working, and seeing Throughcare “to get answers”. She also had a long chat with the chaplain in which she talked about her tendency to depression but “seemed quite happy”. She was allocated to work in the gardens and seemed pleased with this. She had a chat with an officer at lock-up, saying she was slowly settling in and had met some familiar faces but found it hard to make friends.

75. Friday 2 April started badly, but improved. At 09:30 the woman was tearful. She was unhappy with her medication (Olanzapine), saying her tablets were not the same as at Holloway though the nurse said they were. According to the F2052SH, she told the nurse that if she were to die it would be the nurse’s fault. The medical record, apparently dated 2 April, says that the woman said she could not swallow the Olanzapine tablets, but that she was “now on Chlorpromazine”. (According to the Patientline website, Olanzapine is available in tablets to swallow or tablets that dissolve on the tongue. Other records indicate that her medication was not changed until later.)

76. On the wing, the woman declined a Listener and did not want to talk, but subsequently talked to an Officer. At 10:30 she went to induction and seemed happier. At 12:30 she was said to be “chatty and very smiley”. At 2.10pm she went to Throughcare and “seemed in good spirits”. The Officer recorded his conversation with the woman. She said she tended to get quite suicidal and felt low about her weight and appearance. She was missing her children, but left on a positive note after their chat. At 6.00pm the woman asked for a Listener to be with her at lock up and one remained with her until 9.15pm. Another Officer recorded in the file that at 9.15pm the woman asked whether dead bodies smelled. During the night the file records checks on the hour every hour.

77. The Observation Book for the main block (through which staff alert their colleagues to matters of general concern) says that the woman had been telling two other prisoners that she would kill herself and that she was jealous when those two prisoners spent time together.

78. On Saturday afternoon, the woman requested a Listener and one attended.

79. In the morning, the woman went to the wing office requesting the Avon book for ordering cosmetics. At 1.15pm she told an officer her medication was not working. She said she wanted to see a doctor the next day and that it was urgent and she was having hallucinations.

80. The Orderly Officer spoke to the woman for 15 minutes at 2.35pm. His entry in the F2052SH says:

"States she feels fed up and that medication is not as productive as she would like. Demanded to see doctor. Explained that Healthcare is not full-time. Very manipulative. Used emotional blackmail in attempt to get more medication, letters and use of computer! Reached agreement that I would discuss review of medications with Healthcare on Monday and arrange appointment with the doctor."

81. That afternoon, the woman requested a Listener, who went to her cell. At 4.00pm the woman asked to be able to call the Samaritans that evening. This was agreed. The entry also says that she was very grumpy, "constantly moaning about anything and everything". At 7.17pm she was offered the call to Samaritans but she declined, saying she was trying to sleep.

82. The woman was due to start work in the gardens but could not do so because the prison stores did not have work clothes in her size. At 10:15 she had an appointment in healthcare. She told the nurse she was hearing voices and seeing things. She said she suffered from depression and had been on Chlorpromazine (Largactil) for some years. The nurse noted as 'action taken' that she was to see the psychiatrist on Thursday 8 April. Wing staff reported that the woman came back from healthcare "all smiles". At 1.30pm she told an Officer that she felt a bit low but wanted to come off F2052SH. Shortly after this she asked the same officer how long it took for an ambulance to get to Send. Twenty minutes later she came back and apologised for being difficult, explaining that she wanted to hurt herself. That evening at 8.40pm, she is said to have been verbally abusive to an officer who came to check her in accordance with the F2052SH.

83. First thing in the morning, the woman arranged with an Officer that she would go to the stores about getting kit. However, the stores were still unable to provide what she needed so at 09:50 she was waiting to go to the library. Apparently there was also a difficulty about reconciling working in the horticultural department with the requirement in the F2052SH for her to be observed every hour by prison staff. The Prison Officer judged that, whilst she still needed supervision, the benefit of constructive activity outweighed the

requirement for hourly observation. He noted that, in consultation with the Suicide Prevention Co-ordinator, he had reduced the observation requirement to three times morning, three times afternoon, three times evening and three times overnight.

84. The Officer noted that at 12:10 the woman came to the wing office demanding he find her lost property. He explained that reception staff and Holloway would do this and she would be informed. At 2.15pm, she went to the stores for garden kit.

85. That afternoon the woman met a CARATS worker, for the first time for an initial assessment. CARATS is a staged programme for overcoming substance abuse. The CARAT worker recorded that it was very hard to get the woman to engage with her. The initial assessment normally takes about 25 minutes, but in fact took about one and a quarter hours to get very little information. At one point the CARAT worker abandoned the assessment and made the woman some hot chocolate to try to engage with her better. She told my investigators that the woman seemed completely desperate for attention and was quite concerned by her overall demeanour. The CARAT worker says the woman told her that she started using alcohol regularly from the age of six and cocaine from the age of 10. She said she had been drug free when she was pregnant because being pregnant and caring for her children had been a positive motivation.

86. On Wednesday 7 April the woman came back to the wing from work during the afternoon because she was feeling unwell. She had been talking to an Officer Support Grade about harming herself, but had also been laughing and joking. An Officer arranged for the woman to be seen in healthcare, from which she returned "seemingly miserable" and unwilling to talk. At teatime lock-up, she told the Officer she would hang herself but an hour later when unlocked seemed chatty and happy. There is no evidence that any action was taken to safe-guard her following this statement. The medical record says that the woman complained of a runny nose and headache and was signed off as unfit for work. The nurse noted that the woman was suffering "low mood" and "talking about killing herself". The record also noted that the woman's current medication was Olanzapine 5 mg, ventolin and becotide (the last two were for asthma) and that she was to see the psychiatrist next day.

87. In the morning of Thursday 8 April, the woman's F2052SH was reviewed. The case review was multi-disciplinary. The review notes that the woman was very quiet initially and said she was uncomfortable with so many people present. The woman said she was uncomfortable discussing things with men present. She said she had felt down all week and considered hanging herself but felt the "apparatus would not support her weight". She said she felt worse after lock-up and referred to the same concerns as the previous week.

88. The care plan noted that she was on a waiting list for counselling and was to see the psychiatrist that afternoon. Observations were to be increased during

lock up (the file does not specify a frequency). It was requested that male members of staff not be used in future reviews.

89. Half an hour or so after the review, the woman asked to speak to an Officer about something important. She said she had been told to speak to an officer if she felt like hurting herself. She told the officer she went to work in the gardens so she could cut her stomach and wrist “across”. She said she would harm herself, and she gave another officer a long piece of fabric which could be used as a ligature. The Officer said he could not get much conversation from the woman and she was very depressed at present. The Officer was with her for about half an hour. The file notes that, later in the morning, the woman spent time with a fellow-prisoner. After lunch she went to C wing, presumably to see another prisoner, then to healthcare to see the visiting psychiatrist.

90. There are notes in the medical record which are not signed but appear to be by the psychiatrist. He notes that the woman explained her offence by saying that she “wanted to get sectioned.” His opinion was that she was not depressed or psychotic, nor actively suicidal but suffered from a personality disorder and was a drug and alcohol abuser. The psychiatrist advised that Olanzapine should be stopped and replaced by CPZ (Chlorpromazine) 50mg BD and that he should see her again in two weeks. (CPZ is also known as Largactil and is used to treat psychotic disorders and symptoms such as hallucinations, delusions and hostility.) It appears her medication was changed that day. The F2052SH says her medication was “increased” to Chlorpromazine 50mg twice a day.

91. On Friday 9 April, the woman did not go to work and was given linctus for a cough. In the morning she had a chat with an officer who helped her with applications and arranged for her to look through the cupboard of donated clothes in reception. She then sat in with a fellow-prisoner, and was said to seem “fine”. At 6.30pm she asked an Officer to lock her in her cell. She said she was “OK” and would ring the bell if she had any problems.

92. On Saturday 10 April, the woman asked for permission to use a razor for personal hygiene. Half an hour later she cut her left arm and wrist with the razor. A prisoner alerted staff and the woman was taken to healthcare where the wounds were cleaned and dressed. She then seemed better but in the afternoon rang the cell bell having made further superficial cuts to her forearm. She then sat in with a fellow prisoner. The woman told an officer she would hang herself later but the officer records that her demeanour was that she “seemed to find it all quite amusing”. At 2.35pm she asked to use the Samaritans phone but it was found not to be working. She declined other offers of help and again said she would hang herself. The Senior Officer increased the mandatory monitoring to half-hourly observation. She and then the Deputy Governor spent time talking with the woman, who told them she had taken all her medication (four Largactil tablets issued for the weekend) that morning. At 6.30pm the woman brought to the wing office a torn sheet, a broken ashtray and half a razor blade and said she had changed her mind and would not harm herself.

93. The woman was found to have secreted a fork from the dining room when she returned from breakfast. The cuts she had made the day before were cleaned and dressed in healthcare.

94. On Monday 12 April, the “superficial cuts” to the woman’s arm were checked by healthcare. Staff were alerted in the Observation Book to a warning from another prisoner that the woman was planning a number of self-harm attempts the next day. The F2052SH records indicate that she seemed active, smiling and engaged with other prisoners, for much of Monday, though she was in bed at 4.10pm, took her tea, then asked to be locked up, was less communicative and simply turned her back when an officer wished her goodnight.

95. On Tuesday, the woman went to work in the gardens. An Officer made arrangements that staff would check every half-hour that she was all right and report back to the wing. This was done. When the woman came back to the wing at lunchtime she asked to go to healthcare where she told a nurse she had pains in the stomach, nausea and felt dizzy. The nurse noted in the medical record that the woman was taking Chlorpromazine. She was given Gaviscon and advised to drink a lot of fluids and to breathe deeply to alleviate the dizziness. According to the prescription chart, she was also given 400mg Brufen.

96. In the afternoon, the woman met a CARATS worker, for a full assessment. Her note in the F2052SH says that the woman constantly said she wanted to hang herself or cut her arms. In the CARAT workers view, she was “clearly extremely mentally ill and her needs were far in excess of what we prison could support her with.” At interview, she told the investigators the woman said she felt mentally ill, as if her mind and body were separated. She had felt better at Holloway and wanted to go back there but also said frequently that she wanted to go into residential psychiatric care. That evening, the woman asked an Officer to lend her a pen and when he could only spare a red one she verbally abused him.

97. On Wednesday, the woman seemed fine all morning at work in the gardens. Her mother visited in the afternoon. The woman’s mother says she told her she had started cutting herself again but they laughed and joked together about the treats they would have when she was released. The woman also talked about seeing the visiting psychiatrist, and said that she felt he did not listen. The woman had made a tee-shirt for her daughter at Holloway and they joked about opening an arts and crafts shop together. An officer recorded that it was a good visit. Shortly afterwards, however, the woman shouted at an officer and at 5.30pm she was said to be ripping up all her paperwork in her cell and refused to speak to staff. She went to dinner alone and at lock- up at 8.25pm told an Officer she was OK.

98. In an entry in the main observation book for Thursday 15 April, the woman is said to have asked how many officers were on duty and when asked why she wanted to know, said only, “You’ll see.” The officer took her to be implying that there would not be enough officers to cope.

99. Entries in the F2052SH say that at 09:00 the woman was "in a mood" and complaining that officers were not responding immediately to her requests. Apparently, the woman was making her displeasure with a particular officer loudly known on the wing. In particular she is said to have wanted paracetamol. On admission the woman had said she was allergic to paracetamol which made her vomit, though on admission to Holloway the woman had said she was taking co-proxamol which contains paracetamol. A multi-disciplinary case review of the F2052SH was held at 12:10. Apologies are recorded from Healthcare, although they had not been represented at any of the previous reviews nor apologies recorded. At the review, the woman was said to be "quite chatty". She expressed a wish to have an opportunity to work in a charity shop. An Officer explained how she could work towards that and had also suggested she join a 'Fine Cell' (fine needlework) class to get out in the evening and give her an interest other than watching television. A Senior Officer told my investigators that the woman was positive about the future. She wanted to lose weight before release and, at her request, the Senior Officer arranged for the gym to lift a month's ban, imposed because she had failed to turn up for two gym sessions.

100. At 5.45pm the woman told an Officer that some prisoners were "moaning at her", because she had to wear lotion for head lice which had been given by healthcare that morning. After a visit to reception and a chat with her key worker, she seemed in a more positive frame of mind. The record says that the Orderly Officer thought it might be necessary to "move one or more of her tormentors". An Officer recalled that two of the prisoners who the woman had had conflict with were moved off the wing, but she said that she could also be quite antagonistic to other prisoners herself.

101. On Friday 16 April, the woman went to work in the gardens. Another prisoner says the woman approached her in the gardens to talk, especially about her distress about her children, and said officers would not listen to her, in contrast with Holloway where she had been assigned an officer round the clock and did not have to go hunting for one. The woman also said she was being bullied on the wing – "they take my chocolate and take the mickey 'cos I'm fat". She said the only way to get an officer to listen was to harm herself. Then she began to get angry and was kicking things. She seemed very stressed and said she wanted to go to healthcare, that she would hurt herself with a plastic knife and would hurt herself badly this time.

102. The work party leader told my investigators that the woman seemed angry and frustrated, which was not unusual for her, but perhaps more so than usual. He telephoned the wing office and was asked to arrange for the woman to go to healthcare before coming back to the wing.

103. The medical record records that the woman complained of a stabbing pain in her right side and said she felt suicidal and wanted to go back to Holloway. She did not want to work and she made herself vomit after eating certain foods. The nurse's assessment was that the woman did not appear to be actively at high risk but should see the doctor again the following week. At interview, the nurse said there were always concerns about the woman

because she talked about suicide regularly but that day they had sat and chatted for a while and taken each other's blood pressure.

104. An entry in the F2052SH says that when the woman came back from healthcare she said that she had not "threatened" to hurt herself but said that she "felt like hurting herself".

105. In the evening of Friday, the woman asked a Senior Officer if she could have a razor. It was agreed she could have it for 15 minutes. When staff went to collect the razor they found she had caused superficial cuts to both wrists. These were cleaned and dressed. The Senior Officer noted that the duty Listener was called and that the woman needed to see healthcare on Saturday morning. The incident was recorded in the main block observation book to alert other staff. The F2052SH file noted that supervision was to be "hourly, throughout the night, to be reviewed in the morning." Observations during the night were recorded as at: 2040, 2200, 2315, 0005, 0100, 0200, 0300, 0400, 0500, 0600 and 0730, thus they were sometimes at intervals greater than an hour.

106. On Saturday 17 April, the woman's wounds were cleaned and dressed by healthcare. She asked for a Listener and an entry in the file says that when the Listener left she seemed in good spirits. Entries in the record indicate that she engaged with others during the day, including the prisoner in the next door cell, but was very quiet in the afternoon and in the evening said she "had had enough". She was offered a Listener but declined.

107. On Sundays, according to Send's core day, there is a handover and roll-check at 07:30. Prisoners are unlocked from 08:00. There is a roll-check at 12:15. Lunch is from 12:30 until 1.45 then prisoners are locked on the wings but not in their cells. Visits run from 2.00pm to 4.15pm.

108. Entries in the F2052SH for the early morning are at 06:00, 07:30 and 09:10, thus not adhering to hourly intervals. An Officer told the investigators that on Sunday morning the woman went to reception to look at the donated clothing because she had apparently been having some trouble on the wings about her clothing and having head lice. She stayed in reception for about 20 minutes and had a cigarette with staff there. The visit to reception is not recorded in the F2052SH. Back on the wing at 10.15, an officer has recorded that the woman seemed "cagey". At 11.45 she came to the office for a chat and said she was feeling low but was laughing at the same time.

109. Three other prisoners approached officers that morning to say that the woman had been asking them to help her cut her wrists. One prisoner spoke to the Principal Officer and said that the woman seriously needed to go to hospital, to be somewhere she could be understood and looked after. The Principal Officer explained at interview that he had heard angry shouting on the wing and had come out of his office to see what was going on. A prisoner had told him that the woman wanted her to help her kill herself. He had calmed that prisoner down and a few minutes later went to speak to the Orderly Officer.

110. Another prisoner says the woman asked her through the cell grill to slice her wrists. They had had a bit of a row two days earlier when the prisoner had told the woman off for cutting herself. The prisoner responded to her request by shouting and screaming at her outside the room. The prisoner saw the Senior Officer to tell her the woman was going to cut her wrists and that she and the woman had had a "massive row" about it. The prisoner says the woman said that kind of thing consistently and she had not felt at the time that it was different that day, though it was out of character that she did not go for her midday meal. Another prisoner says that at about 12:00 or 12:15 the woman got someone to shout up to A wing that she wanted to talk to her again. This prisoner did not come down because she was taking care of a fellow prisoner who was vulnerable and distressed. The woman did not come for lunch which was unusual,

111. At about 12:15, the Senior Officer another Officer went to see the woman about what the other prisoners had said. They were concerned for the other prisoners since the woman tended to associate with women who like her were vulnerable and on F2052SH. They found her talking to another prisoner but spoke to her in her own room. The Senior Officer checked the F2052SH and made an entry that the woman should be checked "as per the level of supervision EVERY HOUR as she is vulnerable at this time". Send has a local system of placing an adhesive form on the front of the F2052SH stating the frequency of check required. The Senior Officer placed the appropriate sticker on the front of the file giving the level of supervision as every hour, from 12.20 on 18 April. The Senior Officer told my investigators that at her management check on the file she had been concerned that the level of supervision was not clear. Another Senior Officer had indicated on the Friday that supervision was to be hourly though the night and reviewed the next morning. There were frequent entries in the file throughout Saturday but the frequency of observation had not been reviewed.

112. The prisoner the woman had been talking to that lunchtime had been at Send only four or five days. The woman would come and sit in her room and they got to know each other. The woman had wanted to go back to Holloway. At Send other prisoners were bullying her and calling her names. The woman talked about death quite a lot and that day had talked about ways of hanging herself. The prisoner had asked the woman if she was coming to lunch but she had said she was not hungry, which was unusual for her. After lunch, the prisoner said she was going to have a shower. The woman left the room and came back and gave her shampoo, hair conditioner and something else. The prisoner gave the woman a hot chocolate then took her shower. When she came out she went to knock on the woman's door but there were officers standing outside and then she heard the officers trying to resuscitate the woman. The prisoner said she did not think the woman meant to kill herself because she had not shut her door.

113. Another prisoner who was in room B1-19 said that the woman spent about quarter of an hour with her in her probably from about 1.45pm. The woman had not said much. She had been a bit tearful and said she was not having a good day. Asked if she had any particular concerns about how the woman

was treated at Send, she said that other prisoners used to single her out and "take the piss" because she was overweight.

114. In accordance with the Senior Officer's instruction, an Officer went to the woman's cell at 12:40 and recorded that she responded to his enquiry by swearing at him. The Officer normally worked on A wing but knew the woman slightly and his impression was that her mood was very changeable. He had not gone back to check on her again. This Officer was on early shift. Another Officer took over from him for the afternoon. The early shift Officer could not recall whether he had expressly briefed his relief about the immediate concerns about the woman. The next entry in the 2052SH file is recorded as being at "13:30" though the figure has apparently been changed from 14:30. The entry states that she had seen the woman at the bottom of the landing and she seemed OK. The Officer said that when she came back from treatments she had been to A wing briefly then, on her way to the main block office, she had seen the woman at the end of the corridor probably walking back to her cell.

115. At 2.55pm the woman was found by an Officer hanging on the inside of the bathroom door in her cell.

116. This Officer, who was the only Officer on the main block (A, B and C wings), which houses up to 120 prisoners, was carrying out her checks on the F2052SH prisoners. When checking on the woman, she found the cell observation panel blocked by sanitary towels. The cell door was pushed closed but not locked from the inside. She went into the room and found the woman hanging from the inside of the bathroom door. The Officer called for assistance on her personal radio and attempted to enter the bathroom area of the room, but was unable to do so because there was a chair on the other side and the woman was resting heavily against the door. After gaining partial access, the officer attempted to support the woman's body, but it was difficult because she was standing at an awkward angle and the woman's body was heavy and limp. The Officer called for urgent assistance again.

117. After hearing the second call for urgent assistance at 2.55pm on her personal radio, a Senior Officer, who was assigned to searching visitors at the gate, arrived on the scene and assisted by supporting the woman, which enabled them to attempt to release the sheet from the top of the door. When this was released she was able to lie the woman down on the floor of the shower area. Scissors were required to cut the ligature from around her neck, so the Senior Officer called for the self-harm box and the Officer left the cell to get further assistance. Staff do not carry ligature knives. There is one set of ligature scissors in the main block office and one in each of the other wings. The Senior Officer described the ligature as a sheet knotted to the outside of the toilet door and going over the top of the door to inside the bathroom.

118. Another Senior Officer and an Officer ran to the wing from the visits hall when they heard the call for assistance on the radio. The Senior Officer said that at first she could not hear the radio call properly. At the cell, the Officer was shouting for the self-harm box containing scissors. Another Officer arrived,

bringing the D wing self harm box with him. The ligature was a piece of green sheeting, double knotted very tightly and difficult to cut. The Senior Officer felt for a pulse in the woman's wrist, but was unable to find one. The staff attempted to revive the woman by performing Cardio Pulmonary Resuscitation (CPR). This was continued until the Paramedics arrived at 15:13 hours, set up equipment and then took over. The woman was taken to Royal Surrey County Hospital at 3.38pm. She was pronounced dead at 4.05pm.

119. The Duty Governor and residential PO were also present at the cell whilst the senior officers were attempting to revive the woman. They found a note written by her, describing her sense of sense of isolation and despair.

120. When the ambulance crew left, the Senior Officer bagged and sealed the ligature and the note, then sealed the cell. The Police arrived at 4.55pm hours and were taken to the scene, conducted interviews and left the establishment at 8.05pm.

121. Additional staff were called on duty to assist in supporting both the staff involved in the tragedy and to provide as near as possible a full prison regime. The prisoners at Send were later informed of the woman's death.

122. The police conducted a preliminary investigation but found no suspicious circumstances.

123. On Monday morning 19 April, the Deputy Governor, chaired a meeting where all staff involved were asked to give their account of what happened. The Deputy Governor also held a full staff meeting. The Governor was on leave and was abroad when he was told of the woman's death.

The capacity of the Prison Service to provide appropriate care

124. The account I have presented of the woman's unhappy life in Holloway and Send is shocking. People who have no reason to know what happens in women's prisons may think it uniquely shocking. Tragically, repeated self-harm and mental distress are common among women prisoners. That does not mean that prisons are necessarily equipped to provide appropriate care. The court appears to have gone to some lengths to seek an alternative for the woman. The National Probation Service's advice that they could not manage what they described as her "attention-seeking behaviour" in the community was driven at least partly by concern about resources. Prison was the place of last resort. The fact that there was nowhere else does not mean that prison was suitable.

125. In particular, I am concerned that Send lacked a sufficient infrastructure to provide adequate care. There is a contrast between the experience and resources available at Holloway and at Send. At Send at the time of the woman's death, six women out of the 120 on the main block were subject to open F2052SH files. When interviewed by the investigation team, a Senior Officer said that at Holloway there were about 60 women on open F2052SH files that day (out of a total population of about 500) and on his own unit there were nine women at risk, for whom five 2052SH files were to be reviewed that day. Holloway thus has a higher proportion of acutely vulnerable women, but its larger size allows greater diversity of provision, on-site in-patient healthcare, and a community mental health team, a refuge for prisoners finding it hard to cope, and more scope among the larger staff to specialise, and to share and rotate responsibilities.

126. At Send there was little specialist help available and the woman relied mainly on support from the uniformed staff and other prisoners, particularly Listeners. There was no Community Mental Health nursing in-reach, like that available in many prisons, though the woman saw the visiting psychiatrist. She was also on a waiting list for a counsellor. A senior officer told us prisoners might wait eight or nine weeks to see one of the two part-time counsellors. There was no in-patient healthcare or other refuge, and only single accommodation, although apparently there were linked cells available to be used as Listener suites. Nursing staff were on site only during office hours and weekend mornings, which had implications for issuing medication.

127. When the investigating team visited Send, they perceived that the culture within the establishment was positive, and there was a feeling of good staff/prisoner relationships. Entries in the F2052SH show that the woman seems to have derived support from her conversations with a number of officers at Send. There are examples of relaxed and sensitive interaction. However, there are also occasional entries in the F2052SH indicating a lack of compassion or that seem to interpret the woman's behaviour as wilfully difficult.

128. It is clear that the woman was sometimes difficult to help. The patience of members of staff can wear thin and it is to the credit of many members of staff

that they were able to sustain the woman as they did. Discipline staff are not mental health professionals. They have many duties and women to take care of, and it must be very frustrating not to know how to help, or to find one's best efforts repulsed or ineffective. The woman's behaviour towards staff was not always attractive and it must have been disconcerting for staff to find that sometimes she seemed to propose her own death light-heartedly.

129. However, characterising difficult behaviour by vulnerable women as "manipulative" or "attention-seeking" misses the point that such behaviour flows from distress. Inconsistency in the woman's own attitude towards self-harm was only to be expected and surely reflected her own struggles with herself. The woman may have seemed to demand a lot of attention from staff, but often she seems to have been following advice to tell someone when she felt like harming herself. That was probably the model she had learned in hospital care and no doubt was also encouraged at F2052SH case reviews.

130. There are other aspects of the woman's experience in prison that cause concern. There are some indications that some prisoners bullied her though she seems also to have formed some friendships. There is reference to property lost when she transferred from Holloway and I have no more details of this. The difficulty of finding suitable work clothes cannot have helped the woman's morale. I note that she gained nearly four stone in weight while she was at Holloway. However, entries in the records at both Holloway and Send suggest that the woman was at least as unhappy and apprehensive about what was to become of her when released, as she was about her experience in prison.

131. A number of people have said that they think the woman may not have intended to die. Others have noted that she wanted to be sectioned. An Officer says that essentially the woman wanted company 24 hours a day.

Healthcare and medication

132. The woman transferred to Send, the doctor prescribed a once a day 5-mg dose of Olanzepine which, latterly, the woman had been taking at Holloway. He also noted that she was hypothyroid and the medical record notes that the woman told the nurse she had stopped taking Thyroxine because she thought it was not working.

133. After a week, the woman complained that her medication was not the same as at Holloway and by Sunday 4 April she was asking to see the doctor urgently. It is conceivable this had some connection with her apparent difficulty in swallowing tablets. On Thursday, the doctor changed the medication to Chlorpromazine (Largactil) which she had taken in the past. The medication was to be taken twice daily. On Saturday 10 April, the woman said she took four tablets at once.

Arrangements for issuing medication

134. A nurse says that the woman was not given her tablets in possession, but collected them from healthcare. She recalled that the woman had been required to take her medication in sight of healthcare staff, but on reflection thought this was probably after the occasion when she said she had taken four tablets at once. She also recalled that sometimes healthcare staff would take evening medication to the Orderly Officer so it could be given at night. It would be taken to the Orderly Officer, in a sealed bag with the woman's name and the time it was to be taken clearly marked.

135. Medication was issued by nurses at Send at the healthcare centre in the mornings and afternoons during weekdays and in the mornings at weekends. When prisoners needed to take medication at times when no clinical staff were in the prison, either the treatment was given to the prisoner in advance to take later, or, where was concern that this might be unsafe – because of a risk of overdose, failure to take medication as prescribed, or the possibility of trading or bullying for medications - the only option was for medication to be issued to prisoners by non-clinical prison staff. In the past, the prison had been criticised for permitting secondary dispensing of medications by non-clinical staff. Issuing medication in a sealed package identified as for a named prisoner is not "secondary dispensing" but it raises other concerns. In particular:

- There is no protocol about the issuing of medication by officers.
- There is no dedicated secure place for storing medication to be issued by discipline staff.
- No record is made when a discipline officer issues medication to a prisoner or indeed when a prisoner fails to collect medication.
- No system is in place to record medication being returned to the Healthcare Department that has not been issued to prisoners.

136. Prison officers also issue paracetamol to prisoners on request. It is for a clinician to say whether that might pose any hazard.

137. If medical care was needed out of office hours, the prison was able to call on a locum service. At the time of the investigation, no member of staff had access to medical records when the healthcare staff were not on duty. That too seems not ideal given the vulnerability and widespread use of medications among the female prison population.

138. The Governor told the investigation team he was working on extending nursing cover to 8.00pm and to try to get the same GP five days a week instead of a different GP each day. From April 2005, healthcare would be commissioned by the local primary care trust.

The Head of Healthcare, in conjunction with the Primary Care Trust, considers clinical aspects of this report and within four weeks advises the Governor on actions required.

Compliance with F2052SH requirements

139. At 12:20 on 18 April, a Senior Officer instructed in the F2052SH file that the woman was to be supervised every hour and was particularly vulnerable at the time. She put a sticker on the front cover of the file confirming observations were to be every hour. There is an entry that an Officer spoke to the woman in her cell at 12:40.

140. Prisoners say that the woman did not go to lunch, which was unusual for her. This was not remarked by staff. The next entry in the file has been altered from 14:30 to 13:30. It is uninformative, saying only that the woman was seen on the landing, and is on similar lines to entries in other F2052 files for the same time. The time has been altered in the woman's file and the times for entries that afternoon have also been altered in other files. An Officer says that when she came back from healthcare and was walking along the top corridor to A wing and back she saw the woman at the end of B wing and recorded the fact when she went into the office. The woman was not observed every hour as the file instructed.

141. The F2052SH was not always clear about the frequency of observation required. Although mere observation at frequent intervals should not be regarded as a sufficient protection for a vulnerable prisoner, it is an important underpinning safeguard and should be observed strictly.

142. It is good practice for observation under F2052SH procedures to be expressed as a number of times within a given period (eg 12 in 12 hours) or as not less than a given frequency (eg not less than 1 in 1 hour). Many of the overnight entries are recorded as being on the hour every hour. If the records are accurate, the checks would have been predictable to a prisoner intent on self-harm.

143. I am indebted to the audit manager at HMP Downview who has advised me on compliance with F2052SH procedures at Send. It identified some shortcomings. In particular, he found that there were no lists of prisoners on F2052SH held at the gate to be distributed to all areas of the prison each day. Moreover, on the day of the woman's death, the orderly officer's report sheet used to relay information at morning staff meetings showed only three prisoners on F2052SH (including the woman) when in fact there were six.

144. At both Holloway and Send, it is notable that reviews were often not multidisciplinary but conducted only by the discipline staff. At Send there was little or no healthcare input into F2052SH processes after initial admission to the prison. Reviews were not always conducted after incidents of self-injury.

145. At the time of the investigation Send had a current action plan following deficiencies identified in an audit on suicide and self-harm prevention. The

investigation team was unable to obtain evidence of any systematic training plan at Send.

The Area Manager satisfies himself as to Send's progress on the implementation of audit recommendations relating to suicide and self-harm and in particular establishes whether targets set for October 2004 have been met.

Staffing arrangements

146. At the time of the woman's death, the main block (wings A, B and C) which houses up to 120 prisoners on two levels was staffed by only one officer. Some prisoners were at visits. We were told there were about 20 visits that day. Prisoners who were not at visits were on association which means cells were unlocked and prisoners were free to come and go between cells on their own wing. The officer on duty had to supervise all three wings. As well as exercising general oversight, this involved taking and collecting prisoners who had visits to and from the wing gates, responding to prisoners' problems and answering the phone. It also required the supervision of prisoners on open F2052SH files, of whom there were six that day, and recording observations in the file.

147. In the report on compliance with F2052SH procedures, the expectation that one member of staff was sufficient to discharge these responsibilities was not considered good practice. The officers' "detail", the deployment of basic grade staff, for 18 April is appended. Only one officer allocated to the main block during the afternoon. Four officers were on visits. One was on reception where she was dealing with property brought in or handed out during visits. There was one officer on D wing and one covering E and F wings.

148. A Principal Officer prepared the detail. He said the minimum staffing level for a weekend afternoon was 13 members of staff of various grades in addition to the Orderly Officer and Duty Governor. On 18 April there were 14: eight officers, three officer support grades, a security officer, a senior security officer and the PO. However, the staffing profile provided for higher numbers than this and in particular for there to be two officers on the main block. The shortages were caused by vacancies and sickness. There was little margin for cross deployment. The Principal Officer said that he in effect doubled as a second wing officer for the afternoon.

149. During interviews with my investigators staff frequently mentioned staffing problems at the weekend. This was particularly so amongst the staff on duty the weekend the woman died. There were three staff in the group on maternity leave at the time. There were no written procedures covering staff deployment or curtailing the regime when staffing levels were low. Staff also commented that the relatively small size of Send meant that staff shortages had a substantial impact because they were not able to redeploy staff from other areas.

150. On Sunday 18 April, the Orderly Officer, in charge of the prison for the whole 'A shift', from 07:30 until 21:00. The wing officer was also working an A shift and was detailed as A wing officer for the whole shift. A Senior Officer was on the gate. The Principal Officer was on duty for residential PO duties and was working in his office on the main block. The Duty Governor was also on the premises working in E and F wing catching up with paperwork.

151. The Wing Officer explained that in the morning there was supposed to be one officer on each of the three main block wings. She went to lunch at 1200 and went straight to healthcare at about 1.00pm to supervise treatments. When that was finished, she went back to the main block where everyone was preparing for visits. When officers and prisoners went off to visits, she was left as the only residential officer grade on the main block. The Officer understood that the staffing profile provided for a minimum of two officers but recently it had generally been one because of staffing levels. She said that the Orderly Officer and PO would tend to be moving about the prison.

152. There is a handover book on each wing. There was no entry in the B wing book about the woman and the book seemed little used. There were no entries at all from 2 April to 19 April, though for 29 and 30 March the wing handover book contained entries advising staff that particular prisoners were upset and advising about support required. The Main Block Observation Book was used more frequently for this purpose but contained no entry about the woman on 18 April. A Senior Officer explained that at the weekend, when there were fewer staff on duty than during the week, the wing diaries (the handover books) and F2052SH files were moved from the wing office to a central office. It was customary for staff to be briefed orally about prisoners on F2052SH at morning meetings and the night staff would pass on anything of note to the day staff.

153. An Officer said she spent half or three-quarters of an hour trying to arrange a compassionate call to Wandsworth for the prisoner newly placed on F2052SH who was very distraught. The Officer said she would try to get through to Wandsworth intermittently while taking care of the prisoner concerned and going to check the other prisoners at risk. It was usual for there to be a handover of F2052SH files at change of shift, but the Wing Officer said that as an A wing officer she would have been handed over the A wing people when she came on duty. When she came back from treatments, she became responsible for the main block and did a quick wander round. But everyone was gathering prisoners up for visits and there was no direct handover. No one spoke to her about the woman. The Officer said that she discovered the woman when running round the three wings to check the prisoners on F2052SH and being stopped by prisoners in between.

A Local Operating Instruction is introduced setting out the arrangements for handing over F2052SH files to ensure all relevant information is given to staff at the commencement of their responsibility. This should take account of the need to hand over to staff who are taking on additional areas of responsibility during the course of a shift.

154. My investigators asked whether there were any procedures to limit association when only one member of staff was on duty. The Wing Officer said that sometimes if there were two officers on duty they would make a request to "put the spurs on", (lock the spur gates). On the day the woman died, she said she made no request, basically because there was no one to ask. It was "the norm" for staff to be on their own at the weekends and "you just got on with it."

155. A Senior Officer said there were procedures for dealing with staff shortage during evening duties. If there were only nine staff they would lock prisoners on the spurs. If there were only eight they would lock the prisoners in their rooms. Other staff said this was an "unwritten rule". The Orderly Officer had discretion to limit association at the weekend but the staff would prefer not to do that. It was better for the women to have free movement. If the women were locked up the officer(s) on duty would be constantly responding to cell bells. The Deputy Governor said it was easier to run the prison by co-operation with the women than to bang everyone up. He expected the Duty Governor at the weekend to make a decision according to the ambience of the prison.

156. The Deputy Governor said he did not think it acceptable for a single officer to have charge of the main block and it should not have happened. He said he would have expected an officer placed in that position to consult the orderly officer or the PO. The Deputy Governor said that there should have been one officer on each of A, B and C wings to conform with minimum staffing levels. He did not consider that the presence of management grades within the prison meant that landing officer duties were being covered.

157. The Governor told the investigation team he believed Send's profiled staffing levels were low for the needs of the prisoners who were now coming to Send. In the past, as a long-term closed training prison (with a resettlement function), they had generally held women serving long sentences. However, population pressures in women's prisons and some changes to other establishments meant they were now receiving women immediately after sentence, some serving very short sentences. Also they had formerly had a high proportion of foreign national prisoners. Their needs tended to differ from the domestic prisoners and they seemed generally less prone to self-harm. Foreign national prisoners were now concentrated in another prison. In September 2004, the prison was to start working on new profiles to make the case for higher staffing levels. Recruitment problems in an affluent area of Surrey meant that the prison was carrying eight vacancies. The prison was tackling this with a recruitment campaign including links with a local college, and also seeking to make a case for public interest transfer of staff from other establishments.

158. Another problem was that a significant number of staff had been successful in gaining promotion. This meant depletion of the basic grade ranks. The Governor said it was part of the ethos of Send for staff to muck in and “act down” as necessary. The Governor acknowledged that a single officer could not be expected to cover the three wings in an afternoon with six prisoners on F2052SH. He did not think the answer lay in locking prisoners up and he made the point that women were more vulnerable in isolation. The minimum staffing level was for the whole prison. It did not specify particular deployment and it was for the Orderly Officer to determine this according to priorities at the time.

159. On the afternoon of the woman’s death, searching of visitors was being undertaken by a senior officer and an officer instead of by officer support grades. One officer was in charge of three unlocked wings. The Principal Officer was counted by some as fulfilling the role of an additional landing officer, although working in his office. Two staff were issuing instructions for managing the other prisoners while administering cardio-pulmonary resuscitation. This is not a satisfactory state of affairs.

160. The Planning Manager at HMP Downview, has kindly advised me on staffing profiles. He makes a number of useful observations.

The Area Manager, in conjunction with the Governor, undertakes a review of staffing levels and profiles and the instructions to be followed in the event of staffing levels being depleted.

Equipment

161. The Principal Officer was not carrying a radio. He said that during the week there were not enough radios to go round. The Senior Officer said that there were some areas of the prison where radio reception was poor. The Duty Governor said he was not aware of difficult areas but some of the batteries were poor.

Additional radios should be purchased and there should be a Local Operating Instruction are in place for all Prison Officer Grades to carry a radio enabling them to respond as and when required to incidents.

Thorough checks for black spots within the establishment need to be carried out, and if required, booster equipment installed.

162. Staff do not carry ligature knives. There is one set of ligature scissors in the main block office and one in each of the other wings.

The Area Manager, in conjunction with the Governor, considers whether ligature knives should be issued to all prison officer grades at Send.

6. LIST OF RECOMMENDATIONS

1. The Head of Healthcare, in conjunction with the Primary Care Trust, considers clinical aspects of this report and within four weeks advises the Governor on actions required.

***Area Managers response**: A meeting took place between the Head of Healthcare and the PCT on 1 June 2005. The following action points were identified, some of which have been implemented, with others being followed up as part of the action plan.*

***Mental Health** - Improvements have been made to the in reach services and clinical pathways. A new consultant has been recruited.*

***Medical transfer information** – A lead nurse is now responsible for all transfers, this will help to improve communications and will allow the nurse to deal with any issues that arise immediately. This will also alleviate any problems with large numbers of prisoners arriving at any one time.*

***Reception** – Where no GP information is initially available, the GPs details will be requested on reception.*

***Risk assessment tool** – HMP Send currently operates the F2052SH system the new risk assessment tool will be used in conjunction with ACCT (Assessment, Care in Custody and Teamwork). ACCT is a new process of monitoring prisoners who are at risk of self-harm and suicide. It allows staff to raise their concerns and to take action for those prisoners they identify to be at risk of suicide or self-harm. Within 24hrs of the plan being opened the at-risk prisoner will be seen by an assessor and have a case review. A care plan will be drawn up and a member of staff will be nominated as a case manager, placing greater emphasis on supporting guidance and training.*

***Mental Health Training** – The Lead Nurse in the mental health department Steve Norman will be providing a one-day training package for staff. Steve has offered to provide the training at no extra cost to the prison.*

***All 2052SH, ACCT reviews** – Healthcare staff attend all F2052SH and ACCT reviews.*

***Bullying** - A lead nurse forms part of the anti-bullying committee and attend meetings.*

***Healthcare cover** – Healthcare cover is now provided 7 days a week 07.30 to 21.00.*

***Response team** – Plans are in place to ensure team of healthcare staff receive training, which will enable them to attend emergency incidents. A defibrillator is now in the establishment.*

***Ambulance procedure** – There is an emergency protocol in place, and an agreement has been made to ensure that all prisoners go to the Royal Surrey Hospital for treatment.*

***Fish knives** – All nurses have been issued with a 'fish' knife.*

***Complex medical issues** - In order to address any complex medical issues, a nurse will be identified for staff/prisoners to contact.*

***Safe cell** – Funding has been allocated for the installation of a gated cell.*

***Zoned bed** – Consideration is being given for a medical bed for emergency transfers.*

***Medication pods** – Consideration is being given for the purchase of medication pods to hold paracetamol on the wings.*

***Drug supervision** – Send now operates a system whereby a drug round takes place four times a day to ensure medication is supervised.*

2. The Area Manager satisfies himself as to Send's progress on the implementation of audit recommendations relating to suicide and self-harm and in particular establishes whether targets set for October 2004 have been met.

***Area Managers response**: I am satisfied that all the recommendations have been implemented and are now fully compliant. Staff training is on a rolling programme and will be ongoing.*

3. A Local Operating Instruction is introduced setting out the arrangements for handing over F2052SH files to ensure all relevant information is given to staff at the commencement of their responsibility. This should take account of the need to hand over to staff who are taking on additional areas of responsibility during the course of a shift.

***Area Managers response**: A Governor's Order has been issued and distributed to all staff, which sets out clear guidelines for staff to follow to ensure they are familiar and complaint with all handover procedures.*

4. The Area Manager, in conjunction with the Governor, undertakes a review of staffing levels and profiles and the instructions to be followed in the event of staffing levels being depleted.

***Area Managers response**: A full review of staffing levels has taken place. Send now has its required staff compliment. The prison has recently undergone a re-profiling exercise, which is currently being discussed by the union.*

To allow the Orderly Officer and Duty Governor flexibility to respond to depleted staffing levels it would not be altogether feasible to commit to a set of rigid

instructions. However, it is accepted that in the event that staffing levels go down to one below the Minimum Staffing Level then association would be confined to the spurs, below that prisoners would remain in their own rooms.

5. Additional radios should be purchased and there should be a Local Operating Instruction in place for all Prison Officer Grades to carry a radio enabling them to respond as and when required to incidents. Thorough checks for black spots within the establishment need to be carried out and, if required, booster equipment installed.

***Area Managers response**: Additional radios have been purchased. Funding has been approved for the purchase of a further ten radios which will ensure all uniformed staff carry one. A Governors Order has been issued and distributed to staff which sets out clear guidelines and responsibilities for staff who collect radios. Additionally, a member of gym staff carries a radio enabling them to attend any incidents that occur.*

The report identified areas round the prison as 'black spots'. This matter has now been investigated, no black spots were found during the exercise, however this will be monitored on a regular basis.

6. The Area Manager, in conjunction with the Governor, considers whether ligature knives should be issued to all prison officer grades at Send.

***Area Managers response:** Fish knives have been issued to all Prison Officer grades and nurses.*

The Area Manager also added that:

Furthermore I wish to add that in order to improve the system of identifying prisoners on F2052SH and raise awareness for staff, a daily updated list is displayed on the Send home page of the Intranet.

With regards to the discrepancy in the Daily Supervision and Support Record where it appears that the time was amended, the Governor has commissioned an investigation. This is currently ongoing.