The Investigation into the Death in Custody of a woman at HMP and YOI New Hall in April 2004

Report by the Prisons and Probation Ombudsman for England and Wales

July 2005

This is the report of an investigation into the death of a woman who died at HMP New Hall on 18 April 2004. I commissioned the Deputy Governor at HMP Everthorpe as the lead investigator of this enquiry. He was assisted by a Residential Governor at HMP Full Sutton. Liaison was provided by an investigator from my office. He led the investigation from October 2004 until its conclusion.

I offer my sincere condolences to the woman's family and friends and to the staff and prisoners at HMP and YOI New Hall following her tragic death.

Despite this being a distressing and difficult time for all those who knew her, or who assisted in the events surrounding her death, the enquiry team received consistent support and cooperation during its work for which I am very grateful.

I would also like to extend my gratitude to the Wakefield West Primary Care Trust and the South West Yorkshire Mental Health NHS Trust for the investigations they have undertaken.

I thank West Yorkshire Police for their assistance during the course of this investigation.

Lengthy sentencing remarks were made by the Learned Judge at Leeds Crown Court on 8 August 2003 when he sentenced the woman to life imprisonment. In his remarks he said:

''There is no doubt whatsoever in my mind that you are suffering from a personality disorder with a well-established history of impulsivity, aggression, failure to tolerate frustration and numerous episodes of attempt at deliberate self-harm … Your condition is untreatable, the prognosis is poor and you are not currently motivated to learn or change.''

In later remarks the judge said:

''I am also satisfied that your mental instability is of a kind that has not been amenable to any particular treatment. Nonetheless you and your mental state will require and receive constant supervision and assessment and monitoring.''

It is very difficult to imagine that a solitary cell in the Segregation Unit of one of her Majesty's Prisons was an appropriate location for a vulnerable and mentally unstable young woman who required constant supervision, assessment and monitoring. I fully accept that management at New Hall had already tried all the available alternatives. I am deeply troubled by the impossibly difficult role that the Prison Service is being obliged to undertake in such circumstances.

This version of my report, published on my website, has been amended to remove the name of the deceased and the names of staff and prisoners who were involved in my investigation.

Stephen Shaw CBE **July 2005**
Prisons and Probation Ombudsman

CONTENTS

SUMMARY

1. The woman was born in June 1971 in Shipley, West Yorkshire.

2. For a significant part of her life she had received care and support from mental health services. Pre-sentence reports prepared for her court appearance indicated that historically she had not responded to treatment by psychiatric services. She did however present a risk to both the public and to herself.

3. She was received into custody on 20 November 2002 on a charge of arson. A sentence of life imprisonment was passed for this offence on 8 August 2003.

4. Following sentence she was transferred from HMP and YOI New Hall firstly to HMP Durham, then to HMP and YOI Bullwood Hall, returning to New Hall on 29 March 2004.

5. Following reception she was allocated to a room in New Hall's Healthcare Centre. She remained there until 5 April 2004 when she was moved to the Segregation Unit.

6. She presented as a difficult person to manage. There is a history of impulsivity, aggressive outbursts, a failure to tolerate frustration and numerous episodes of deliberate self-harm. There were also a number of offences against Prison Rules. It is for these reasons that she was moved to the Segregation Unit.

7. On 18 April 2004 she was observed by staff on a number of occasions. During the evening a note believed to have been passed out of her room was discovered by a member of staff. Concerned by the note, staff entered her room to check that she was alright. She was, and staff left. Twenty-eight minutes later the officer on duty in the Segregation Unit opened the observation hatch of her cell and immediately saw that she had a ligature around her neck.

8. The officer sought assistance, both prison and nursing staff attended and, following an emergency call to the ambulance service, paramedics also attended. Tragically, and despite the best efforts of all concerned, she was pronounced dead by the paramedics at 19:45.

9. The cell was sealed and investigations into her sad death commenced.

BACKGROUND

10. HMP and YOI New Hall assumed its current role in 1987 as a female closed prison that services the courts. The certified normal accommodation is 327, with an operational capacity of 385.

11. When the establishment was audited against Prison Service Standards between 27 January and 14 February 2003 compliance with Suicide Prevention Self-Harm Reduction Standards was rated as Good; with an overall rating awarded to the establishment of Good.

12. Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an announced inspection of New Hall between 10 and 14 November 2003. The report was published on 28 April 2004. The prison is currently compiling its response to recommendations made by the Chief Inspector.

13. In her report HMCIP states in the introduction:

"New Hall, like other women's prisons we have recently inspected, is holding women and girls who should not be there. They include those who are seriously mentally ill, as well as some women and girls with high levels of self-harm, linked to abuse, including substance abuse. Staff at New Hall were doing their best to provide a stable and safe environment, but were unable to do more than contain the level of need of some very damaged individuals. Prison was likely to increase their vulnerability and mental disorder, in some cases with tragic consequences, and caring for them meant there was too little time to provide positive interventions for the less damaged women and girls. There is an urgent need to provide alternative, therapeutic environments where appropriate treatment and support can be offered".

14. The woman was born on 7 June 1971 and was aged 32 at the time of her death. She was born in Shipley, West Yorkshire. She stated on reception interview that she wished her father to be recorded as the next of kin.

15. She was first received into custody on 20 November 2002 from Huddersfield Magistrates' Court on a charge of arson. She returned to Huddersfield Magistrates' Court on 5 December 2002 where the case was transferred to Bradford Crown Court.

16. On 24 March 2003 she was transferred from HMP and YOI New Hall to the New Haven Unit at St Luke's Hospital, Huddersfield for psychiatric assessment. She returned to New Hall on 21 May 2003.

17. On 8 August 2003 at Leeds Crown Court she was sentenced to Life Imprisonment (Discretionary); a tariff of 18 months was set by the trial judge. On 19 August 2003 she was transferred to HMP Durham, a first stage Lifer Centre.

18. Durham transferred her to HMP and YOI Bullwood Hall on 29 January 2004. Bullwood Hall is near Southend-on-Sea in Essex.

19. On 29 March 2004 she was transferred from Bullwood Hall to New Hall where she was allocated a room in the Healthcare Centre.

20. She remained in the Healthcare Centre until 5 April 2004 when she was moved to the Segregation Unit following an adjudication and placement on Prison Rule 45 for the purposes of Good Order Or Discipline (GOOD). GOOD reviews were conducted and she remained in the Segregation Unit up to the time of her death on 18 April 2004.

21. There are no dedicated cells in the Segregation Unit, nor elsewhere in the prison for adult women, that meet the specification set by the Safer Custody Group for 'Safer Cells'.

22. She had appeared before the courts on five occasions prior to this sentence, beginning in 1996. All cases, except one conviction for arson in 1998, were disposed of by means of non-custodial sentences. A sentence of 16 weeks imprisonment was imposed on 27 August 1998 for the offence of arson.

23. She was made subject to the procedures for those thought to be at risk of suicide or self-harm on 20 November 2002. She remained subject to those procedures until her transfer to the New Haven Unit at St Luke's Hospital, Huddersfield on 24 March 2003.

24. On return to New Hall on 21 May 2003 she was again made subject to those procedures and remained on them until 2 August 2003.

25. On 13 August 2003 she was again made subject to these procedures. A form F2052SH, which documents case reviews, action plans and records interactions and interventions for those subject to these procedures, was opened. This document remained open until the time of her death.

26. Pre-sentence reports from Mental Health professionals concerning her were dated as follows:

- 24 January 2003
- 4 March 2003
- 4 April 2003
- 27 April 2003
- 23 June 2003

Having been made subject to Section 38 of the Mental Health Act she was resident at New Haven Unit, St Luke's Hospital, Huddersfield between 24 March and 21 May 2003

27. There are a considerable number of entries in both the history sheet (F2052A and B) and form F2052SH (Suicide and Self-Harm at Risk form) describing her challenging behaviour in custody.

28. On 18 April 2004 she was found in a room in the Segregation Unit with a ligature around her neck. Medical assistance was summoned (nursing staff and paramedics), but sadly she was declared dead by the paramedics who attended.

INVESTIGATION PROCESS

29. The investigation drew upon both written documentation and interviews with key witnesses and other interested parties. Members of the enquiry team interviewed Prison Staff. Staff were given the opportunity to have a work colleague or a trade union representative accompany them on interview, and a member of the local staff care team was available for staff at the end of each interview.

30. An investigator from my office visited the woman's parents soon after her death. The investigator made a note of the issues that they wished to bring to the attention of the investigation team. In January 2005 her father raised two further questions (about time in Segregation Units and anti-ligature bedding) which are dealt with at a later section of this report.

31. To ensure the accuracy of the team's recollection of the interviews, all interviews, with the consent of the staff involved, were taped using PACE recorders.

32. Documentation pertaining to the woman's custodial history was examined in detail, this included:

- Main Prison Record
- History Sheets
- F2052SH
- Life Sentence Plan
- Segregation Documentation
- Inmate Medical Records (Clinical Review by Primary Care Trust (PCT) and Local Mental Health Trust).

33. In addition, the documentation relating directly to her death was examined to ascertain the level of compliance with local and national procedures, as set down to deal with such tragic circumstances.

34. Further documentation relating to the establishment's policy on managing those thought to be at risk of self-harm and suicide was examined to establish its adequacy and the degree to which it was implemented within the establishment.

35. The enquiry team have had the opportunity to speak with the Police Investigation Team and are grateful for their cooperation and report.

36. Arrangements for a clinical review of her case were made. This review was carried out to cover two separate areas – mental health and physical health. We are grateful to the local PCT for their report on the management of her physical health. We are also grateful to South West Yorkshire Mental Health

NHS Trust for their comprehensive report concerning the provision of mental healthcare to her both prior to and during her period in custody.

37. A notice to both staff and prisoners was issued by the investigation team, extending an invitation to submit any relevant evidence concerning her death. The investigation team is grateful for the contribution made by the Chairman of the Prison Officers' Association in his presentation of the views of his branch.

The woman's father made a number of comments after seeing the report in draft. A factual error about her birthplace has been corrected. He felt that the issue of alleged bullying by two other prisoners in the Segregation Unit had not been explored sufficiently. If she was being subjected to verbal bullying by other prisoners, there was nowhere she could go in the Segregation Unit to escape from it. Staff could go home at the end of their shift but she could not.

THE INCIDENT AND EVENTS LEADING UP TO THE WOMAN'S DEATH

38. The woman was first received into custody at HMP and YOI New Hall on 20 November 2002 from Huddersfield Magistrates' Court on a charge of arson.

39. On 24 January 2003 a report was prepared by the firm of Solicitors in relation to her court appearance for the offence of arson. In this report the doctor comments that she had a long history of contact with psychiatric services and had been admitted on a number of occasions as an in-patient at St Luke's Hospital.

40. The report goes on to say she had attracted a diagnosis of emotionally unstable personality disorder, borderline type. There were recurrent attempts of self-harm, immaturity, poor judgement, lack of self-control and low tolerance to frustration associated with assaultative behaviour.

41. In the opinion and recommendation section the report states: "In the woman's case this disorder is associated with an abnormally aggressive or seriously irresponsible conduct amounting to a diagnosis of psychopathic disorder within the meaning of the Mental Health Act 1983. The pervasive drive towards self-destructive behaviour, and the tendency to act impulsively have resulted in a pattern of risk taking behaviour, as a result of which her safety and that of others has been put at risk".

42. The final sentence at point three states: "The general psychiatric services acquainted with the woman's care have expressed the view that there is little else that they can offer in terms of in-patient treatment that can alleviate or prevent deterioration in her condition".

43. On 4 February 2003 she was seen by a Professor of Psychiatry who made a declaration that, in his opinion, she was suffering from mental illness and mental impairment within the meaning of the Mental Health Act 1983. The report also stated that: "the patient has produced seriously irresponsible and dangerous conduct warranting treatment of her mental impairment and mental illness in secure conditions. A Section 37 may be in order later".

44. A psychiatric report was completed by the Professor on 4 April 2003. In that report he states: "It is known that the woman suffers from borderline, or emotionally unstable personality disorder, and this diagnostic entity contains within it a degree of mood swings and depressive behaviour. It is possible that she also suffers a bipolar affective disorder in its own right, which would make the contribution of mood disorder much greater than that normally found in the personality disorder alone".

45. The report continues: "In either case, she has already shown severe challenging behaviour within the unit. This type of behaviour does not fit in well with our more normal practice of rehabilitation psychiatry within a forensic group of patients. While we are prepared to manage this is in the initial stages, if it proved to be troublesome in the long run it is entirely counter productive, and militates against the successful use of rehabilitation strategies".

46. On 27 April 2003 a psychology report was completed by a Clinical Psychologist.

47. A further psychiatric report was prepared dated 23 June 2003 for the woman's court appearance. Under the section headed Opinion 1. Diagnosis, the report states: "She suffers from personality disorder, namely emotionally unstable (borderline) type. There is a well-established history of impulsivity, aggressive outbursts, failing to tolerate frustration and numerous episodes of deliberate self-harm". The report adds: "in my opinion her personality is damaged and severe enough to be diagnosed as psychopathic disorder. Historically, she has failed to respond in any meaningful or consistent manner to treatment/intervention with local psychiatric services. Treatment in secure care has yielded no positive outcome. More recently, while in the New Haven Unit, she again presented as disinterested, amotivated and hostile. There is no evidence to suggest that she is treatable".

48. The report continues: "The defendant is not mentally impaired. Formal assessment of her level of intellectual functioning reveals an IQ in the below average but not learning disability range. At interview it is clear she has a good grasp of language but is (more likely) an unwilling historian rather than a disabled one".

49. In addition the report states: "She does not suffer from serious mental illness such as severe depression, manic depressive psychosis or schizophrenia".

50. The Prognosis section of the psychiatric report states: "the defendant's prognosis is poor. She is now 31 years old with a well-established and lengthy history of maladaptive behaviours including aggression and self-harm. There is no evidence to suggest her condition (psychopathic disorder) had either been alleviated or is there evidence of a halt in its deterioration following treatment".

51. Under the heading of Risk the report states: "the risk of further future serious acts occurring should be understood as most likely occurring in specific context. The defendant does not tolerate frustration, does not comply with advice given and is often unwilling to delay her need for gratification. Such traits have been present for many years and in situations where these issues are relevant it is then most likely she would perpetrate acts of serious violence to members of the general public or by self-harming".

52. Finally, the report goes on to state: "she does not suffer from a form of mental disorder by which she could be detained in hospital".

53. The woman was sentenced to Life Imprisonment (Discretionary), with a tariff of 18 months set by the trial judge on 8 August 2003. When passing sentence the Learned Judge made reference to her mental state and made comment that this would require and receive constant supervision, assessment and monitoring.

54. The Department of Health has provided funding for Mental Health Services via PCTs to prison establishments. New Hall received during the period

2003/2004 a figure of £70,000 for mental health services. This is being increased to £139,000 for the period 2004/2005.

55. This enquiry has been unable to establish how the Department of Health funding was allocated to establishments; for example, another female prison in the North West was allocated £140,000 in 2003/2004. This provision is twice that allocated to HMP and YOI New Hall, even though these two prisons (allowing for some differences) perform a broadly similar role.

56. It has been evidenced that Mental Health In-Reach collaboratives are being formed in order to assist the development of mental health services within prison establishments.

57. On 19 August 2003 the woman was transferred from New Hall to the first stage lifer centre at Durham. There then followed a transfer from Durham to Bullwood Hall on 29 January 2004, and a further transfer from Bullwood Hall to New Hall on 29 March 2004.

58. She was correctly made subject to procedures for those thought to be at risk of Self-Harm or Suicide between 20 November 2002 and 24 March 2003, between 21 May 2003 and 2 August 2003 and finally from 13 August 2003 up until the day of her sad death.

59. She presented as a difficult person to manage.

60. It is noted from records that she frequently accessed the Prisoner Listener Scheme. The frequency of use would indicate she found comfort and support from this service.

61. On 4 April 2004 an entry is made in the Form F2052B (Record of Events) which states that she was intimidating other prisoners by banging and shouting abuse constantly. A further entry states she was placed on report for damaging her cell. Two further entries were made on 4 April, one records her becoming an increasing management problem, refusing to return to her room and, eventually, following location in her room, further banging on her door, disturbing other patients. As a result of this behaviour she was reviewed under the Incentives and Earned Privileges Scheme and placed on the Basic regime level. The final entry for that day records that she continued to shout abuse at other prisoners and attempted to hit a member of the Healthcare staff.

62. She was moved to the Segregation Unit on 5 April 2004 to face charges laid under Prison Rules. Following adjudication, during which she attempted to assault the adjudicating Governor, it was agreed that she should be placed on Rule 45 GOOD because of her poor behaviour at adjudication and in the Prison Healthcare Centre.

63. The behaviour of other prisoners located within the Segregation Unit towards her became a concern to staff. It is noted that on 13 April 2004 those concerns resulted in a Bullying Incident Report Form being raised by an Officer. This identified that it was suspected that another prisoner was

bullying her. The form makes comment that the other prisoner was spending time mimicking and teasing her and this was not the first reported incident of this kind of intimidation. The prisoner was warned as to her behaviour and placed on Stage 1 of Anti-Bullying Procedures. The report form used, although not the one within the establishment policy dated October 2003, did contain all relevant information.

64. Stage One of Anti-Bullying Procedures is a warning issued following investigation where suspected bullying has been confirmed. The bully is told of the consequences of further or similar acts and her behaviour is more closely monitored.

65. On 16 April 2004 two entries were made in F2052SH after ligatures were discovered. The first entry was made at 09:55 and states:

"Three Officers removed a ligature from her neck; had a chat with her and left her in better spirits".

66. At 10:45 one of the Officers made a second entry in F2052SH:

"Hiding underneath bed with ligature around her neck which was removed".

67. The next entry in F2052SH was also made by the same Officer and states at 10:50: "Given a phone call to her mother – is now in good spirits".

68. Two F2052SH case reviews were conducted at New Hall after she was transferred from Bullwood Hall on 29 March. The purpose of a case review is to share information on how a prisoner is coping and to reach team decisions on what further action needs to be taken to address underlying needs. The first review was on 30 March and the review coordinator, the Healthcare Senior Officer wrote that: ‘’ She interacted well with the review. She is happy to be here and is as settled here as she is anywhere. She likes the staff and the regime. She can have her obs. (observations) reduced to twice an hour.‘’ The second review was on 6 April and the coordinator on this occasion also recommended that her observations be reduced to “two per hour throughout”. At the end of her time at Bullwood Hall the woman had been on intermittent observation which required more frequent observation at irregular intervals throughout each hour. Scrutiny of her F2052SH reveals that after the two New Hall review meetings observations were maintained at the necessary level of two per hour until the time of her death.

18 APRIL 2004

69. The woman appeared to be asleep until about 05:10 on 18 April 2004 when she awoke and was given a light for her cigarette. She was spoken to on a number of occasions and replied on each occasion that she was OK. There follow a number of entries within the F2052SH, the salient points are:

- 09:00 the entry reads: "still kicking door and threatening staff, no evidence of self-harm"
- 10:40 She is visited by one of the establishment's Governor grades
- 11:40 She is: "eating lunch, no problems"
- 14:15 "Banging door, shouting abuse, no evidence of self-harm"
- 16:45 "Given tea, no distress noted"
- 17:45 states: "Reading Harry Potter, no distress"
- 18:15 "Asked to see a nurse'; 18:45 'Given medication"
- 19:15 entry in F2052SH "given water"
- 19:20 Final entry in F2052SH "Ligature found, phoned for assistance".

70. A CCTV system operated on a continuous record basis within the Segregation Unit (the Police seized the tape recording for 18 April). A summary of events listed by the Police is as follows (the time noted on the CCTV was one hour behind real time, real time is used in the list below):

- 17:41 an Officer seen checking the woman in her cell, and again at 18:12
- 18:31 The same Officer opened cell and the woman goes to the staff office
- 18:33 She is returned to her room by the officer who closes the room door
- 18.37 a further check is made on her
- 18:53 Two Officers check her and one recovers a piece of paper from the floor outside the room. Both Officers enter the cell where they remain for one to two minutes, leave, close the door and one returns to the office with the paper. The note reads as follows:

  "I meant to do it as I have 32 years of complete misery. Anyone who finds this note must understand it is not an accident".

- 19:21 She is checked by an Officer

- 19:23 The same Officer is joined by two further members of staff. All three enter the cell

- The police summary of events does not mention the fact that all three members of staff left the cell before the arrival of healthcare staff.

  The investigation team have studied the CCTV tape, which clearly shows this to be the case, and it is confirmed in the interviews given by the three staff named in the preceding paragraph.

  A slowed-down version of the tape was supplied by West Yorkshire Police on 1 December 2004. A further version of the tape, with precise timings, was supplied by West Yorkshire Police on 7 January 2005. This shows the three staff entering her cell at 19:23:49, then emerging from the cell at 19:24:41, closing the door behind them. A man, the Senior Officer, walks away from the cell. Two officers stand outside the cell, then at 19:25:25, approximately 44 seconds later, they re-enter the cell. Shortly afterwards they are joined by healthcare staff.

  The 7 January 2005 version of the tape shows that the first contingent of healthcare staff arrived at her cell at 19:26:57

- 19:25 (police timing) Hospital staff attend

- 19:27 (police timing) Resuscitation/first aid kit brought

- 19:32 (police timing) Additional equipment brought

- 19:44 (police timing) Paramedics arrive and leave at 20:00

- 20:01 (police timing) The cell is locked and sealed, remaining so until the Police arrive at 21:38.

71. A female Officer was the member of staff detailed to work in the Segregation Unit on the evening of 18 April 2004.

72. During interview the Officer recalled from memory the events of that evening. She stated her concerns at finding a note passed out by the woman and thought, given her history, it would be likely that she may have a ligature around her neck. Having entered the cell with another Officer to investigate the note, she awoke the woman, had a brief chat and ascertained that she was not in possession of a ligature. The second Officer was present in the unit to assist in providing hot water to the prisoners that evening.

73. On checking the woman in her room 28 minutes later, at 19:21, one of the Officers observed that she was on the floor behind the door. She asked her if she wanted to talk, attempted to gain her attention and tried to get her to stand up. The Officer believed that she was playing games. In an attempt to make her believe she had returned to the office, the Officer opened and

closed the laundry room door. On returning to the woman's room the Officer noted that she had still not moved. At this point the Officer became more concerned.

74. The Officer opened the hatch in the bottom of the door and looked in. She saw the woman was on the floor with a ligature tied around her neck. The ligature was not attached to any other object. According to the Senior Officer it was made from a piece of green bedsheet. The officer rose to her feet, returned to the unit office, and summoned assistance.

75. The Officer spoke to the Senior Officer on F wing and requested assistance in order to enter the woman's room. The Officer also requested, via a telephone call to the communications room, assistance from healthcare staff.

76. The control room log for 18 April 2004 makes no reference to an internal emergency call being made. Instructions contained in the establishment's contingency plan for life threatening medical emergency and Operational Order 29/2003 state that the member of staff should raise the alarm by UHF radio, direct line or the internal emergency telephone number. The Officer acknowledged that she knew and understood these instructions but did not consider that there was an immediate risk to life and chose not to use them. During interview the Officer confirmed that she was in possession of a UHF radio.

77. During interview with the Principal Officer (the senior manager on duty in the establishment that evening) it was established that he first became aware that something in the prison was wrong on hearing a general commotion in the Residential 1 corridor. He was then informed that something was happening in the Segregation Unit and he should attend there.

78. On arrival he observed a Nurse and an Officer performing cardio pulmonary resuscitation (CPR) on the woman. His next action was to make preparations for a hospital escort and prepare to action the Contingency Plans.

79. When asked about procedures on discovering a potential medical emergency the Principal Officer stated: "standard procedure as far as I am concerned is there should have been a blue call put across the radio (operational order 29/2003, annex 27), which is a request for medical assistance for somebody having trouble breathing, etc., or strangulation, or ligature and then I should have been informed immediately of the situation".

80. Asked if he carried a radio the Principal Officer replied: "I carry a radio, it wasn't put across the radio at all".

81. Asked if he enquired as to why, he replied no, in effect he was dealing with the incident. When asked what he would have expected to happen differently had a blue call been made, the Principal Officer pointed out that communication would have been faster and medical assistance response time may have been shorter.

82. Following the calls for assistance a Senior Officer and a male Officer from F wing arrived a few minutes later. Together with the female Officer who was working in the segregation unit that evening, they entered the woman's room. The female Officer took out her ligature knife and cut the ligature from the woman. The Senior Officer asked if she was breathing and if she was OK. The female Officer felt for a pulse and stated to the Senior Officer that she could feel the woman's pulse and had felt her breathing. The female Officer further added that it was not unusual for the woman not to respond once ligatures had been cut off.

83. The Senior Officer recalled during his interview that whilst performing duties as night orderly officer he had previous experience of being called to incidents involving the woman where she had tied ligatures to her neck.

84. During interview the Senior Officer was asked if, on finding the woman in room 10, he had any concerns that her situation was life-threatening. He replied: "At that time no". He went on to say: "I thought that her colour looked relatively normal. I knew healthcare staff had been called and were on their way. I felt that, at that stage the situation was in the process of being dealt with and it'd be appropriate for me to return to my wing".

85. At this time all three members of staff left the room expecting the woman to make a full recovery. Staff stated to the enquiry team that, on occasions, she would behave in a way designed to imply her condition was more serious than it actually was. As recently as 16 April an Officer had written in F2052SH that staff entered the woman's room in mid morning. She was hiding under her bed and they removed a ligature which was around her neck. In interview a Nurse said that she had previous experience of the woman using ligatures but the nurse said they were not serious or life-threatening. On these previous occasions when the Nurse attended, the woman took off the ligature when the nurse asked her to and the nurse described one such occasion.

''She was still conscious, walking around. She had it round her neck and she undid it and recovered immediately.''

The male Officer from F wing said he could recollect the woman ''tying a ligature and not moving on purpose.''

The female Officer was asked by the senior investigator why the woman used to use ligatures. The Officer replied that she enjoyed contact with staff.

''I think that she felt better when we were there and I think that was a way for her to get an immediate response from staff

Question: ''So this ligature making and use of ligatures, do you think that she always intended to seriously harm herself?

Female Officer: ''No, I don't.''

86. The Senior Officer returned to his wing. The two Officers remained awaiting the arrival of nursing staff.

87. After a few moments the two Officers re-entered the room. They were concerned that she was not recovering as they expected.

88. At 19:25 nursing staff arrived. A Staff Nurse entered the room and saw the woman laid on her back with her head towards the door and her feet towards the window. The Staff Nurse described her colour as quite poor. The Staff Nurse felt for a pulse, looked at the woman's eyes and then asked for medical equipment. She then commenced mouth-to-mouth resuscitation, assisted by one of the Officers who carried out cardiac compressions.

89. A Nurse explained that there was "no urgency" about the phone call received in the Healthcare Centre requesting assistance in the Segregation Unit. She was carrying the Hotel One nurse emergency radio at the time but there was no Code Blue call on her radio to indicate that a patient was having life threatening breathing difficulties. She and the Staff Nurse walked to the Segregation Unit. The Staff Nurse quickly assessed the gravity of the situation once they reached the Unit and the nurse then had to run back to the Healthcare Centre to fetch the necessary emergency equipment (defibrillator, oxygen, airways).

90. At 19:30, according to the control room occurrence sheet, a request for an ambulance was made via New Hall's control room. The occurrence sheet states that the request came from Kilo 1. Documentation from the ambulance service times the call to them at 19:28. The Staff Nurse was joined in the Segregation Unit by the Nurse (who had run back from the Healthcare Centre with the emergency bag containing oxygen and defib rillation equipment), a second Nurse and the Sister. Staff continued attempts at resuscitation until the arrival of the paramedics. They reached the prison at 19:42 and the woman's cell at 19:44. Despite the best efforts of staff at resuscitation, the paramedics pronounced life extinct at 19:45.

91. The Head of Healthcare submitted a memorandum raising concerns regarding the procedure for summoning an ambulance. These concerns are based on the need to provide medical information to the ambulance service and the possibility of delay created by all communication going via the prison communications room.

92. All staff, together with the paramedics, left the room which was then sealed pending the arrival of the police.

POST-INCIDENT RESPONSE

93. The paramedics who attended pronounced the woman dead at 19:45 as recorded in the control room incident occurrence sheet. The establishment's contingency plans for a death in custody were activated. The cell was locked and sealed awaiting the arrival of police officers. At 21:10 police and scenes of crime officers attended New Hall and began their investigation into the death of the woman. The death was notified to those persons and organisations listed within the contingency plans.

94. The Duty Governor attended the establishment, received a handover from the duty Principal Officer, and informed the Governor in charge of the establishment. The Duty Governor arranged for a hot debrief of the staff involved. During this debrief the police and the coroner's officers arrived at the establishment. A member of the Independent Monitoring Board and the Care Team were also present at the hot debrief. Staff interviewed confirmed that they were made aware of arrangements for their ongoing support and care following this tragic death. Following discussions between the Duty Governor and the Assistant Chaplain it was decided not to inform prisoners that night but a notice was placed at the gate informing on-coming staff of the woman's death.

95. The death in custody initial action checklist was completed. This form indicates that Police informed the woman's father at 00:10 on 19 April of his daughter's death. The Prison Assistant Chaplain made further contact with the family at 9:45 on 19 April. On Tuesday 20 April 2004 the prison's family liaison officer, together with the Chaplain and Assistant Chaplain, visited the family of the woman. The family were given brief details of the events surrounding the her death and informed of the subsequent Police and Prisons and Probation Ombudsman's office investigations. The family requested to visit the establishment and arrangements were made for this to take place on Friday 23 April.

96. My investigator met with the woman's parents on 26 April 2004. Issues raised by them at this time were referred to the investigation team for consideration in the investigation. At the family's request the Prison Chaplain at New Hall conducted the funeral service for the woman. A Critical Incident Debrief was held on 4 June 2004.

97. New Hall received by fax on 10 June 2004 a copy of a report sent by a specialist registrar in forensic psychiatry to the doctor at HMP and YOI Bullwood Hall regarding an interview with the woman which took place on 15 April 2004. In that report the specialist registrar stated another doctor's pre-sentence report prepared in June 2003 had concluded that the woman did not suffer from a treatable mental disorder and could not, therefore, be detained in hospital under the Mental Health Act. The specialist registrar concluded there was nothing to suggest this position had changed and did not feel it appropriate for the woman to be transferred to hospital.

ISSUES RAISED BY THE WOMAN'S PARENTS

How much time in Segregation Units?

98. The woman's father expressed to my investigator his very strong belief that she should not have been sent to prison due to the range and complexity of her mental health needs.

99. In January 2005 he asked for two further matters to be investigated. He asked how much of her sentence she had spent in Segregation Units and he asked if she should not have been issued with an anti-suicide blanket.

100. I am grateful to the Safer Custody Governor at New Hall for his assistance with her father's first question. The information from Bullwood Hall is that she spent 36 of her 59 nights there between 29 January and 29 March in the Segregation Unit. The e-mail from the Head of Operations at Bullwood Hall sets out the circumstances of the woman's residence in the Segregation Unit during that period.

101. She was then held in the Segregation Unit at New Hall from 5 April until her death on 18 April. This was for reasons of GOOD.

102. In a second e-mail the Safer Custody Governor reported that she was also held in the Segregation Unit at New Hall for a total of 16 days in June, July and August 2003. Reasons for these locations included waiting for adjudication, cellular confinement as an adjudication punishment and GOOD.

103. Information about the time she spent in the Segregation Unit at Durham is not readily available.

Reduced- Risk Bedding

104. The woman's father asked if she should not have been issued with anti-suicide bedding (her father's term) because she was on F2052 SH. PSO 2700 is the Prison Service's Order on Suicide and Self Harm Prevention

105. Chapter 4.1.3.1 of the Order states that *''Prisoners identified as being at risk of suicide or self-harm must not be placed in an unfurnished cell. …..* In the context of caring for prisoners identified as being at risk of suicide/self-injury, strip cell and strip conditions refer to bare unfurnished cells which do not contain furniture, fittings, bedding and clothing.''

106. Chapter 4.4 of the same Order is entitled Removal of Items in Possession and states:

> ''Personal items including shoelaces and belts must not be removed from at-risk prisoners as a matter of course. The reasons for the decision to remove or return items must be recorded in the prisoner's F2052SH.''

The decision by staff at New Hall not to remove her normal clothing and bedding was in compliance with both the letter and the spirit of PSO 2700. It was also a reasonable decision in the light of information recorded at the 30 March case review on her return to New Hall from Bullwood Hall:

‘’ She is happy to be here and is as settled here as she is anywhere.’’

107. I asked the Prison Service’s Safer Custody Group (SCG) if there are any initiatives to introduce bedding that is more suicide-proof. I am most grateful to the Built Environment Manager at SCG for responding to my query. He informed me that a Safer Bed Linen trial is running from November 2004 until May 2005 in three separate prisons. The objective of the trial is to assess bedding items in terms of Health and Safety, suicide prevention and some other factors. 98 knitted sheets, 50 pillow slips and 18 blankets are being tested in the three sites with the aim of providing bedding items that are more difficult to tear than standard issue items.

LEVEL OF COMPLIANCE WITH AUTHORISED PROCEDURES

Overall assessment

108. Our overall assessment of compliance with procedures appears in the Conclusions section of our report. We conclude that Segregation and Anti-bullying procedures were in line with Prison Service Orders. New Hall's Suicide and Self-Harm Policy requires minor adjustments.

Procedures for those thought to be at risk of self-harm and suicide

109. Case Reviews recorded in the F2052SH were undertaken in accordance with the relevant Prison Service Order and entries made in the Daily Supervision and Support Record demonstrated appropriate interaction between staff and the woman.

110. New Hall had in place a Suicide and Self-Harm Prevention Policy document and procedures dated October 2003.

111. Minutes of the Suicide Prevention Team meetings were kept. It was not clear from these minutes if the Anti-Bullying coordinator was a member of this team, nor if the Area Suicide Prevention Coordinator received copies of the minutes.

112. On visiting the Segregation Unit it was noticed that the Samaritans telephone number was not displayed by the telephone in that area as required. This was checked by the establishment's Suicide Prevention Coordinator, agreed to be accurate and immediately rectified.

113. The establishment's Suicide and Self-Harm Prevention Policy lists a number of risk factors in the consideration of suicidal ideation, however failure to take medication and mood swings as identified in the Prison Service Order were not listed in the establishment's policy.

114. In at least one situation of ligature making by the woman, a F213SH could not be found to record this event. The Prison Service Order specifies that: "all instances of self-harm must be recorded on an incident report form, an F213SH must also be completed". The order clarifies that this does include ligature making.

115. The Prison Service Order highlights the need to ascertain if the prisoner is being bullied. It was not clear within the establishment policy if prisoners were being routinely asked if they were being bullied or intimidated when an F2052SH was opened in order for the Anti-Bullying Coordinator to be informed.

116. Following the decision for the woman to remain in the Segregation Unit the Record of Case Review appropriately shows a member of Healthcare in attendance as required by Prison Service Order No 1700. A Segregation Safety Algorithm was also completed

117. There was no reference in the establishment's policy for a doctor or nurse to be consulted prior to unfavourable news being disclosed to any prisoner, this applies to those subject to at risk procedures who are located in the Healthcare Centre or under constant or intermittent supervision.

118. Operational Order 20/01 identifies internal systems are in place to facilitate good communication between the different locations of prisoners who are at risk, this also includes description of how prisoners subject to these measures are moved around the establishment.

119. Operational Order 08/04 reference F2052SH Quality Checks states that unit managers will carry these out at least once a month. In addition, the Suicide Prevention Coordinator will carry out random quality checks at least once per quarter. Prison Service Order 2700 Annexe B Quality Control states that a residential manager or Duty Governor must audit the quality of F2052SH entries at least twice per week, draw deficiencies to the attention of line managers, monitor the response, and record that they have made these checks.

120. Entries made in the Daily Supervision and Support Record have often been signed as stated in the policy and Operational Order 20/01. However, the Prison Service Order and the forms themselves state that the name should be printed, not signed.

121. Operational Order 50/02 is in place to set out the review procedure and the appropriate grade of the chair of the review board as specified in the Prison Service Order.

122. No evidence could be found as to whether emergency response kits were being checked monthly as required by the Prison Service Order. It was also noted that the Segregation Unit did not have an emergency response kit.

123. No evidence was provided that all open F2052SHs were reviewed within the specified period following the woman's death.

124. Operational Order 09/04 does outline the requirement for notifying outside agencies when a prisoner subject to these procedures is discharged.

125. Operational Order 16/03 outlines the review system that is in place to ensure a case review is carried out prior to a prisoner being transferred.

126. The woman's form F2052SH specifies a requirement for half-hourly checks. The record shows that these were carried out as required, with the last entry being made at 19:20.

Segregation Procedures (PSO 1700)

127. The Initial Authority for Segregation dated 5 April 2004 was appropriately made. A Segregation Safety Algorithm dated 5 April 2004 was also completed.

128. The requirement to conduct a Segregation Review was correctly undertaken on 7 April 2004 by a multi-disciplinary team which consisted of a Governor grade, prison officer, nurse and member of the Independent Monitoring Board; this occurred within the specified 72-hour period. At this review a further period of 14 days segregation under Rule 45 was approved.

Anti-bullying Procedures (PSO 1702)

129. The establishment operated an Anti-Bullying Policy in line with Prison Service Order 1702 and this policy was activated in the case of suspected bullying of the woman by another prisoner.

Contingency Plans

130. The establishment had in place contingency plans adequate for the purpose.

131. Following the declaration of death the cell was sealed pending the arrival of the police. A hot debrief was conducted by the Duty Governor for staff involved in the incident.

132. Procedures following a Death in Custody, as set out in Prison Service Order 2710, were also followed. The incident was reported as required, support for staff and prisoners was in place, and follow-up support for the family was made. The establishment continues to prepare for the inquest.

Other Procedures

133. The control room log for 18 April 2004 makes no reference to an emergency call being made. Instructions contained in the establishment's contingency plan and Operational Order 29/03 state: "raise the alarm by UHF radio, direct line or the internal emergency telephone number". An Officer acknowledged that she knew and understood these instructions but did not consider that there was an immediate risk to life and chose not to use them. The adverse consequences of this decision by the Officer are set out in the Conclusions section of this report.

REVIEW OF DEATHS IN CUSTODY AT HMP AND YOI NEW HALL 2002 TO PRESENT

134. The investigation team reviewed previous deaths in custody at New Hall from 2002 to the present time, and compiled a matrix.

135. During this period there have been six deaths in custody prior to the woman's sad death. The youngest was aged 19, the eldest being 41. The average age for the group was 26 years.

136. Of the seven deaths it is noted that six occurred during or directly before the weekend. One death occurred on Friday afternoon, one death occurred late on Friday evening. There were a further two that occurred on a Saturday and two on a Sunday. Only one of seven deaths did not occur on or directly before a weekend, this was death by natural causes.

137. Of the seven deaths one was by natural causes, of the other six a ligature was used on each occasion.

138. Four women had current F2052SH forms open on them.

139. It can be noted that three women were known to have mental health issues on reception. These women also had a history of self-harming whilst in custody.

140. The previous six women who died were known to have issues relating to drugs and/or alcohol before and during custody.

FINDINGS

141. We found that the woman had a long history of mental health problems. As a result she demonstrated aspects of behaviour which were demanding, destructive and could present as a serious risk of harm to herself and others.

142. Medical reports prepared on her indicated that she was failing to respond to treatment. As a result it was determined that she was not suitable for detention in hospital under the Mental Health Act (1983).

143. New Hall, at the time of her death, was in receipt of £70,000 from the Department of Health for the provision of Mental Health In-Reach services. The investigation team has not been able to clarify the basis upon which this funding was made and why a disparity in budget can be seen across establishments of a seemingly similar nature. Growth funding has been provided for the year 2004/2005 in the amount of £69,000. Given the size of population within New Hall, and the number of women and girls within the establishment in need of these services, the enquiry has not been able to establish whether this funding is adequate.

144. Her transfer from one prison to another clearly had an impact on the ability of healthcare services to maintain the supervision, assessment and monitoring required, as stated by the trial judge when sentencing her.

145. Throughout her period in custody she presented as a difficult person to manage. She regularly resorted to acts of damage, self-harm and assaults on others. The frequency of these types of incidents minimised the options available within prison establishments suitable for her safe accommodation.

146. The Listener Service, which operates in prison establishments, was used regularly by her.

147. At New Hall in the part of the prison that holds adult prisoners there are no cells built to the Safer Cell specification, as defined by Safer Custody Group.

148. She was subject to procedures for those thought to be at risk of self-harm or suicide when she was moved from the Healthcare Centre to the Segregation Unit. A move of this nature is permitted within the conditions specified in Prison Service Orders. Given the circumstances, and with no other suitable option available, this was the only reasonable decision available to the establishment.

149. It is clear from staff who have been directly involved in the woman's care that her behaviour influenced and, on occasions, conditioned the response by staff. Paragraph 84 includes a number of examples of previous occasions when she had been found with ligatures around her neck in situations which were not perceived as life-threatening.

150. At 18:.53 a note was found on the floor outside her room in the Segregation Unit which could be interpreted as meaning that she intended to take some serious form of action. The note was placed in the F2052SH and she was

checked because of staff's concerns that she might have a ligature, this was found not to be the case. The interview with the Officer on duty in the Segregation Unit established that this was a thorough check. The Officer was concerned that she ''would have a ligature on'' so she drew her ligature knife and went into the woman's cell with another Officer. She had a blanket over her head so the staff removed the blanket but there was no ligature. The staff had a brief chat with her and she said that she was fine. The Officer agreed with the lead investigator in interview that her worries were then diminished.

151. At 19:21, some 28 minutes after the discovery of the note, she was checked in her room and at this time she was found to have a ligature around her neck. The Officer stated to the enquiry that she did not believe, at the time, that the situation was life threatening.

152. Neither the radio nor telephone emergency procedures were utilised at this time.

153. Officers stated to the investigation team that they found her to be breathing and to have a pulse when they entered her cell. In possession of this information staff believed she would recover, as she had done on previous occasions, and so left the cell. However, recovery was not complete. There was no movement and no dialogue with her; medical staff had not yet arrived. This was an apparent failure in the staff's duty of care to her and we recommend that the Prison Service's Yorkshire and Humberside Area Manager considers setting up an investigation to decide whether disciplinary action should be taken.

154. When the Senior Officer left the Segregation Unit. the two Officers remained outside the closed door of the woman's cell for 44 seconds. One of the Officers was watching through the cell hatch and when she saw that the woman had not moved she and the other Officer went back into the cell. They felt for a pulse and checked whether she was breathing.

155. When the Staff Nurse arrived on the scene she and one of the Officers administered CPR to the woman. The Staff Nurse did mouth to mouth and the Officer did chest compressions.

156. The Officer maintained compressions for approximately two minutes then he was relieved by a Nurse once she had collected the defibrillation equipment. Further equipment to monitor the oxygen in the woman's system was brought subsequently by another Nurse.

157. Despite the best efforts of the Officer and four nursing staff, she did not recover and was declared dead by the paramedics when they arrived.

158. There are discrepancies between the timings recorded in F2052SH and those evidenced by the CCTV system. We believe that the CCTV timings were accurate, though they were one hour behind "real time".

159. The investigation found no serious failings in the local Suicide and Self-Harm Prevention Policy document; however, there were some minor omissions/errors found.

160. The investigation found no serious failings in the Segregation procedures.

161. The enquiry evidenced a policy and its use regarding suspected bullying by prisoners.

162. The enquiry team found that emergency response kits were not regularly checked as required and also that there was no emergency response kit located in the Segregation Unit.

163. There is a concern, raised by the Head of Healthcare, that the current procedure for the summoning of an ambulance may cause some minor delay.

164. The investigation found that the post-incident response was both appropriate and effective.

165. As a result of the comparison of previous deaths in custody at HMP and YOI New Hall over a short period it is noted that, where a history of mental health problems was identified, there was also a history of self-harm.

166. A comprehensive Root Cause Analysis investigation has been carried out by the Senior Project Manager and the Assistant Director of Workforce Development of South West Yorkshire Mental Health NHS Trust. We are enormously grateful for the months of effort they have devoted to this project and we also acknowledge the contribution of the Director of Clinical Risk at the Mental Health Trust.

167. Chapter 6 of the Root Cause Analysis identifies Learning Points in seven separate categories and Chapter 7 of the document makes recommendations relating to Placements, Care Planning and Management, Training, Emergency Procedures and Service Developments to meet the needs of Women Prisoners.

CONCLUSIONS

168. New Hall is doing its best to provide a stable and safe environment for women who clearly presented as difficult, vulnerable and a danger to themselves and others.

169. The investigation team highlights the opinion of Her Majesty's Chief Inspector of Prisons that: "New Hall is holding women and girls who should not be there. They include those who are seriously mentally ill, as well as some women and girls with high levels of self-harm, linked to abuse".

170. The team acknowledges the major demands on staff at New Hall who have to deal on a day-to-day basis with women who are self-harming, sometimes on multiple occasions. The very first paragraph of HMCIP's April 2004 report states: "The vulnerability and need of many of its prisoners was evident: an average of 75 suicide watch forms were opened each month; there had been 124 incidents of self-harm in the month before the inspection; all in-patients in the Healthcare Centre were severely mentally ill".

171. Current accommodation options within establishments holding female prisoners are limited. Those who present in a highly disruptive way are either confined to Healthcare or Segregation Units. No other alternatives are currently available.

172. Funding has been allocated to provide Mental Health In-Reach services. These services, even when combined with primary care, do not provide 24-hour, seven day a week cover. Therefore the question remains over the ability of the Prison Service to deliver appropriate interventions. HMCIP has highlighted the need to provide alternative, therapeutic environments where appropriate treatment and support can be offered. It is not clear on what basis the funding for Mental Health In-Reach provision has been provided to establishments.

173. Given that a ligature had been identified as being used in recent deaths, it is of concern that the establishment has not been provided with cells to the Safer Cell specification.

174. It is clear from the number of entries made in records that the woman regularly sought the services of Prisoner Listeners. The enquiry concludes, therefore, that she saw great value in being able to access Prisoner Listeners.

175. Her frequent transfers between establishments following her sentence had an impact upon the continuity of care provided by medical services. This issue is explored in detail in the Care Planning and Management sections of the Root Cause Analysis review conducted by South West Yorkshire Mental Health Trust.

176. Evidence provided to the investigation team by staff involved with the care of the woman demonstrated that exposure to her behaviour over a period of time structured their response to this incident.

177. There are no instructions as to the actions required on the discovery of such a significant note as that found by an Officer at 18:53.

178. The decision by the Officer not to use the emergency response procedures, as set out in Operational Order 29/03, was based on the fact that the order refers to there being a significant threat to life. We are concerned that, given the serious nature of the note passed out by the woman, and the discovery of the ligature just 28 minutes later, this was not deemed a significant threat to life.

179. Potentially vital time was lost because the urgency of the situation was not communicated to nursing staff (using Code Blue for an emergency related to breathing difficulties). The first nursing staff on the scene did not bring emergency equipment with them and one of the Nurses had to run back to the Healthcare Centre to obtain the necessary equipment.

180. The woman was inappropriately left alone by the Senior Officer and two Officers before the arrival of medical assistance. The three members of staff left her cell at 19:24:41 and the two Officers did not re-enter it until 19:25:25

181. An ambulance arrived at the prison within 14 minutes of being summoned. Even if the ambulance had been called slightly more quickly, it seems unlikely that the eventual outcome would have been different because New Hall's own nurses reached the woman's cell at 19:26:57. The paramedics arrived at the cell at 19:44.

182. Requests by the ambulance service for detailed patient information are currently routed via the establishment's communications room, this is of concern to the Head of Healthcare

183. The survey of seven deaths in custody immediately prior to and including that of the woman, indicated that where there was a history of mental health problems there was also a history of self-harm therefore a greater risk that death may occur through self-inflicted injury.

184. New Hall liaised fully with the woman's family following her death.

185. New Hall's Suicide and Self-Harm Prevention Policy has no serious omissions but requires minor adjustments. The Segregation Procedures were in line with Prison Service Orders. The Anti-Bullying procedures were in line with Prison Service Orders

186. Inadequate checks were made of emergency response kits and staff raised the issue with the investigation team regarding the lack of equipment in the Segregation Unit.

RECOMMENDATIONS

National

1. The Prison Service's Yorkshire and Humberside Area Manager is invited to set up an investigation to decide whether disciplinary action should be taken against any members of staff. The issues to be examined by such an investigation are:

(i) an Officer's apparent failure to use emergency response procedures;

(ii) the decision made by the Senior Officer and the two Officers to leave the woman's cell at 19:24 on 18 April 2004 before she was known to have recovered from placing a ligature around her neck and before Healthcare staff arrived in the cell.

2. Consideration should be given to the provision of alternative therapeutic environments where appropriate treatment and support can be offered to those in need.

3. The provision and resourcing of mental health services within prison establishments should be reviewed to ensure adequate care, support and interventions can be provided throughout the day and night.

4. There should be cells to the Safer Cell specification provided within the establishment.

5. Staff should not leave alone any prisoner who is failing to respond to them or who is suffering from any injury other than that of a minor nature prior to the arrival of healthcare staff.

6. Consideration should always be given to the impact upon the continuity of care of an individual prior to any transfer.

.

Local

1. The wide-ranging recommendations made at the conclusion of South West Yorkshire Mental Health NHS Trust's investigation are drawn to the attention of the Governor, Area Manager and Head of the Women's Team. A multi-disciplinary group should be invited to respond to the report and develop an implementation plan.

2. No instructions have been identified which provide guidance to staff at New Hall as to what actions are required on the discovery of potential suicide notes. Consideration should be given to providing such instruction.

3. Where there is evidence of injury, other than of a minor nature, emergency response procedures (such as the use of "urgent message" or

the internal emergency telephone lines) should always be used. Therefore a review of the current contingency plan at New Hall should be undertaken.

4. Consideration should be given to providing refresher training for staff in order to assist them in resisting the most damaging aspects of being conditioned by prisoners.

5. New Hall should review its Suicide and Self-Harm Prevention Policy given the minor omissions identified in this report. This would also afford the opportunity to incorporate the relevant operational orders into the policy.

6. There should be a review to ensure a sufficient supply of emergency response equipment in appropriate areas. There should be regular checks of the equipment and records of checks should be maintained.

7. The contingency arrangements for the summoning of an ambulance should be reviewed to take account of the additional medical information which is often now requested by the ambulance service

GOOD PRACTICE

The work of Samaritans and Prisoner Listeners within establishments was clearly of great benefit. Their work should be recognised and their use encouraged.

GLOSSARY OF TERMS

F2050	Main core record
F2052A	History sheet/general observations
F2000 IMR	Inmate Medical Record
F2052SH	Self-Harm at Risk form
Care Plan	Nursing care plan as in NHS
YOI	Young Offenders Institution
HMP	Her Majesty's Prison
Off	Prison Officer
ASO	Acting Senior Officer
SO	Senior Prison Officer
PO	Principal Prison Officer
Gov	Governor Grade
OSG	Operational Support Grade (Auxiliary)
Listener	Prison Samaritan
Nicking	A disciplinary charge
Observation Book	A general compilation of staff observations of prisoners in a particular area
PER	Prisoner Escort Record – Documentation confirming that a prisoner has been handed over, e.g. from the Prison Service to Group 4 for court appearance, etc.
Hot Debrief	A debriefing of staff immediately following an incident
IEPS	Incentives and Earned Privileges Scheme of which there are three levels: • Enhanced • Standard • Basic – this means the individual is in receipt of all statutory entitlements, but privileges are limited.