Investigation into the circumstances surrounding the death of a woman at HMP Foston Hall in April 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is the report of an investigation into the death by hanging of a woman at HMP Foston Hall on 18 April 2007. The woman was 32 and serving her first custodial sentence: three years' imprisonment for supplying drugs.

A key part of the investigation was to ensure that the woman's parents and family had the opportunity to raise any concerns they had about her death. One of my Family Liaison Officers was in contact with the woman's mother who had spoken to her daughter the very night before her death. I offer my profound condolences to the woman's family and friends for their loss.

The investigation was undertaken by two of my investigators. I commissioned a clinical review from Derbyshire Primary Care Trust (PCT) of which I am most grateful. I also thank the Detective Superintendent of Derbyshire Police and his team for their assistance to my investigators.

I am also particularly indebted to the Governor and staff of Foston Hall for the help and active co-operation that my investigators received throughout their inquiry.

I took over responsibility for investigating deaths in prison custody in April 2004. This was the first apparently self-inflicted death that I have investigated at Foston Hall. I refer in my report to some excellent practice at Foston Hall, including an impressively detailed, speedy and caring response to the woman's death.

The woman died within 24 hours of being located in Foston Hall's segregation unit. Given the circumstances obtaining at the time, I do not criticise the decision to separate the woman from other prisoners. Once more, however, I must draw attention to the special vulnerability of prisoners held in segregation.

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Prisons and Probation Ombudsman
July 2008

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SUMMARY

The woman was born in September 1974. She was 32 years old when staff discovered her in the segregation unit at Foston Hall during the morning of 18 April 2007. She was suspended from a ligature made from her belt that was attached to the cell window frame. Staff acted promptly in cutting her down and attempting resuscitation. The woman was taken to Derby Royal Infirmary where her death was formally pronounced.

The woman had been received at Foston Hall on 21 January 2007. She had been transferred from Low Newton where she had been the subject of special self-harm monitoring and support measures since being sentenced at Newcastle Crown Court. She was eligible for release in August 2007. Since arriving at Foston Hall, the woman had been put on a self harm monitoring and support measures on three occasions.

On 17 April 2007, the woman was taken to the segregation unit after she assaulted another prisoner. The healthcare nurse noticed that she was carrying razor blades, which the woman had removed from prison-issued disposable razors. The Governor who was head of remand, and prison officers persuaded the woman to hand over the blades. In return she was allowed to telephone her mother. When the woman reached the segregation unit, she initially refused to be strip searched in accordance with prison procedure, but staff persuaded her to cooperate and she allowed officers to search her. The woman was assessed by a nurse who noted that she had previously been on an open self harm form but was suitable for segregation. The duty governor also knew that the woman had been on a self harm form, but authorised her segregation, deciding that there was no alternative location.

She was then placed in cell two, and subsequently a risk of self harm document was opened when the woman told a nurse that she had attempted self harm earlier.

On the morning of her death, the woman was seen by staff who noted their interactions in her personal history folder, her self harm form, and her medical records. A nurse arranged for a doctor to see her later in the day to look at an injury to the woman's left wrist which she had caused previously. The woman attended an adjudication hearing concerning the assault on another prisoner. This was adjourned for a police investigation and the woman walked back to her room in the segregation unit. Officers then arranged for the woman's belongings to be brought to her so that she could shower. Within 20 minutes of last being seen, the woman was found hanging. Staff responded immediately and commenced resuscitation. Sadly, this was unsuccessful.

I have nothing but praise for the response of staff who found the woman. They acted promptly and professionally and I am satisfied that everything possible was done to try to save her life. Systems for giving the ambulance access to and egress from the prison also worked well. Finally, I commend

staff at the prison for the way they initially engaged with the woman’s family after her death.

THE INVESTIGATION PROCESS

1. This investigation was conducted by two of my investigators. They first visited Foston Hall on 23 April 2007, three working days after the woman's death. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity to participate. To date, no prisoners or staff have asked to speak to my investigators. My investigators also spoke to the safer custody manager and the governor grade with responsibility for self harm and suicide prevention.

2. My investigators examined the cell where the woman was found hanging. They also visited the cell where she lived prior to being taken to the segregation unit. My investigators obtained copies of documentation relating to the woman's imprisonment.

3. An extensive Fatal Incident Investigation was conducted by Derbyshire Police who took statements from prisoners and staff who had significant contact with the woman. I am very grateful for the assistance my investigators received from the Detective Superintendent, who led the investigation into the woman's death for Derbyshire Police, and his team. In accordance with the memorandum of understanding between the Association of Chief Police Officers (ACPO) and the Prisons and Probation Ombudsman (PPO), the Detective Superintendent allowed my investigators unrestricted access to all the statements taken by police in the course of their investigation. This has prevented unnecessary duplication of interviews.

4. My investigators have also had access to PPO reports following two deaths at Foston Hall due to natural causes.

5. One of my Family Liaison Officers spoke to the woman's mother in May 2007. The woman's mother has raised some concerns that she would like our investigation to consider.

   - She had heard that the woman had been fighting with another female prisoner and had been waving a chair around. After this the woman was moved to the segregation unit. The woman's mother asked for our investigation to consider this and explain what happened.

   - The woman's mother also asked why her daughter was being checked every 30 minutes if she was not on an open suicide watch. She asked us to clarify whether her daughter was on any extra watch and if so why.

   - The woman's mother knew the hardest question to answer would be why her daughter had decided to take her own life. However, she hoped that our investigation would give a full account of what was going on for her daughter in prison, as this might help to shed some light on how she was feeling.

- The woman's mother asked the investigation to consider an incident she had heard about, namely that her daughter had cut her wrist with a razor blade and was then returned to the blood stained cell with the blade still in her possession. The woman's mother has serious concerns that her daughter was not looked after appropriately after the incident and that the prison failed in its duty of care towards her.

6. The first PPO draft report was issued to all interested parties in October 2007. After its circulation, the principal investigator and family liaison officer met the woman's mother and her solicitor in January 2008. At that meeting my investigator was asked to consider:

- The woman's mother was unaware that a note had been found in her daughter's room after her death until reading the first PPO draft report. Had the woman's mother known about this at the time of her daughter's death it would have reduced the torment she had gone through over the months following the death. The family have serious concerns that they were not made aware of this by the prison.

- A governor acted as the prison FLO. There is concern that he was not aware of the note left by the woman and did not share this. He had also told the woman's mother that the woman had not cut her wrist on 5 April. The woman's mother is upset that he gave her incorrect information. If he had not known he should have found out.

- The prison FLO last spoke to the woman's mother in November 2007, when he asked her when the court case would be and offered to visit her. The woman's mother agreed but he has not been in touch since.

- The family were concerned that the PPO investigation had not been as rigorous as other PPO investigations relying on police witness statements and requested specific issues put to members of staff involved. As a result, some staff were subsequently formally interviewed and transcripts of their PPO interviews are attached as an annex.

- HM Chief Inspector of Prisons inspected Foston Hall two weeks after the woman died and reported in September 2007. The key issues raised in the report had not been mentioned in the PPO report. My investigator agreed to include them in the reissue of the draft.

- The Foston Hall policy document for suicide prevention refers to F2052SH and not the new ACCT procedures. The family asked whether this would mean staff would be referring to an old and out

of date policy? The family would also like this issue raised in the PPO report and the governor in charge of safer custody interviewed regarding their policy and ACCT training.

- The family requested that the staff be interviewed by the PPO as well as consideration being given to interviewing the head of healthcare. The family's solicitors wanted the staff interviewed about their training in suicide and self harm.

- The family requested that my investigator interview the prison FLO to establish what he knew about the note the woman left. They believe refusal of home detention curfew was a trigger in the woman being depressed. They would like the prison FLO to be asked about how the woman was informed that it had been refused. Why was the woman's mother told her daughter had not cut her wrists? What is the extent of the prison FLO's knowledge of Prison Service Order 2710 follow up to deaths in custody. A copy of the prison FLO's PPO interview is attached as an annex to this report.

- The Foston Hall 2006 suicide prevention policy mentions those at risk having items that they could harm themselves with. On page 19 it mentions the removal of items in possession, which should not be removed unless it is a razor. The woman had access to a razor. It also states that it may be necessary to remove items if the person is high risk. The family solicitor asked why this was not applied to the woman regarding the belt as arguably the woman was in a highly suicidal state and there should at least be evidence of the staff considering removing the belt.

- Communication between discipline staff and healthcare. Was the woman's medical record available to medical staff on the segregation unit?

7. I have done my best to address the matters raised by the woman's mother, and I hope that my report answers any further questions that she may have.

8. An independent clinical review of the medical care the woman received whilst in prison. The clinical reviewers were appointed by the Derbyshire County Primary Care Trust (PCT) and worked to terms of reference agreed with my investigators.

HMP FOSTON HALL

9. HMP Foston Hall is a small training prison for women in Derbyshire. The present hall was built in 1863, but the estate is 14th century and many parts of the 17th century house remain. The Prison Service acquired the hall and grounds in 1953. In 1996, it was closed for major refurbishment before being reopened on 31 July 1997.

10. The prison has eight wings, A, B, D, E, F Remand 1, Remand 2 and Toscana Unit, which accommodate up to 283 women. A, and B wings each hold 41 prisoners. Remand 1 holds 39 prisoners and Remand 2 holds 41 prisoners. The cells are referred to as rooms, and each has an integrated toilet and shower. D wing is the induction wing where the accommodation is a mixture of multi-occupancy rooms ranging from two to five beds, with a total of 44 prisoners. E wing comprises nine rooms/dormitories with a range of single, two, three and four bedded rooms holding a total of 19 prisoners. The wing is for enhanced prisoners who require minimal supervision. F wing, which holds 40 prisoners is the Voluntary Testing Unit (VTU). The Toscana Unit is a dedicated 16-bed unit for 17 year old young women.

11. Safer cells are designed to minimise the risk to prisoners by removing ligature points. There were no such cells at Foston Hall at the time of the woman's death.

Healthcare

12. The prison has a healthcare centre with three sites: one for remand prisoners, one for sentenced prisoners, and one for the Juvenile Unit. There is 24 hour nursing staff on duty, and Derbyshire Health United provides doctor cover. There is an inpatient facility on the sentenced side with three beds in two rooms (one single and one double). The beds are largely reserved for prisoners with mental health problems and tend to be used as single occupancy rooms. At the time of the woman's death the inpatient facility was closed for refurbishment.

13. In addition to the nurses who are on duty, there are 25 members of the prison's discipline staff who have up to date first aid qualifications.

Segregation unit

14. There are five cells in the segregation unit. The unit is not purpose built and is not ideally designed. The sight lines are very poor for some smaller cells, and the design makes it difficult for staff to observe the prisoners. The prison has attempted to ensure that women are not held in segregation unnecessarily. Although prisoners are rarely held in the unit for long, it has been used in the past for some who have proved particularly difficult to manage. In such cases, I am told that

every effort has been made to provide a suitable regime and involve prisoners in the outside routines of the prison wherever possible.

15. Prisoners must be assessed by a nurse or doctor as fit to be segregated and a governor must confirm their location. Their decisions are recorded on the segregation safety algorithm.

16. Prison Service Order (PSO) 2700 on Suicide and Self Harm Prevention contains advice on segregation. The PSO states that prisoners who are at risk of suicide or self harm must not be routinely held in a segregation unit unless they present such a risk to themselves or others that no other location is appropriate.

17. Such prisoners must only be placed in a segregation unit in exceptional circumstances, or where all other options have been tried but considered inappropriate. If the decision is taken to locate prisoners at risk of self harm within the segregation unit, it must be for as short a period of time as possible, and the temporary nature must be reflected in the prisoner's care plan.

Counselling, Assessment, Referral and Throughcare (CARAT)

18. Every prisoner who is identified as having a drug problem is assessed, given advice about their misuse and referred to the most appropriate drug service. CARAT workers give basic information about drugs and their effects, and may offer some counselling and group work to those who want to give up or reduce their misuse.

Assessment, Care in Custody and Teamwork (ACCT)

19. Assessment, Care in Custody and Teamwork (ACCT) has been introduced at Foston Hall to monitor and support prisoners assessed to be at risk of suicide or self harm. (The previous system was known as the F2052SH.) Once placed on ACCT, the prisoner is observed at pre-determined intervals according to their perceived level of risk.

20. Each prisoner must also be assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the prisoner and the people who know them or who are involved in their care. The key questions for each review are listed as:

- Have the problems that caused the ACCT plan to be opened now been resolved?
- If not, what needs to be done to resolve them?
- Have any further problems arisen that are now causing distress and more risk?
- If so, what action can be taken to address these?
- Is the person at risk now in contact with friends, family or other support?

- Does the person at risk now have something in their life that they feel good about?
- If not, how can this be improved?

21. Over time, the reviews should also consider such other factors as:

- Distress – has anything changed to make the person at risk more or less desperate?
- Resources – has anything changed that makes the person at risk now feel more or less alone?
- Previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
- Suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
- Pattern of self harm – is self harm becoming more or less frequent?

22. Amongst other things, the ACCT guidance says that prisoners should be cared for in a safe environment and that it is for their review team to decide the most appropriate place to locate an individual prisoner.

23. Foston Hall recognises that being sent to prison can be a traumatic and often distressing experience for many women, particularly those in custody for the first time. There is a peer support scheme which is run specifically by prisoners for prisoners. It aims to contribute to suicide prevention by helping to create a safe, decent and healthy environment. The intention is to establish positive prisoner to prisoner and staff to prisoner relationships, in which problems can be voiced and addressed and anxieties alleviated.

24. Samaritans are available 24 hours a day to offer emotional support. If a prisoner wants to see a Samaritan, they can ask a member of staff to arrange a visit or use one of the dedicated phones which provides access to Samaritans 24 hours a day throughout the year. Alternatively, prisoners may call their local Samaritans branch at any time of the day through their phone. Prisoners' conversations with the Samaritans are completely confidential and will not be discussed with prison staff. The Samaritans' main activity is to select train and support volunteer prisoners called Listeners, who also provide confidential emotional support.

Suicide Prevention Policy HMP Foston Hall 2006

25. At the time of the woman's death, the Suicide and Prevention Policy that underpinned the safer custody of prisoners at Foston Hall was dated 2006, and referred to form F2052SH. However, the ACCT document was in use at Foston Hall at the time of the woman's death.

26. The safer custody governor has said a new safer custody policy for Foston Hall referring to ACCT should be published in April 2008. Since the woman's death the management checks of ACCT documents have

become more robust. There is a separate log sheet in all the wing diaries where residential managers must check the quality of all ACCT documents for the day. Concerns must be identified and addressed.

27. A senior officer will be a dedicated safer custody manager assisted by two support officers from April 2008. The senior officer is currently responsible for implementing all of the ACCT training at Foston Hall.

28. The safer custody governor was asked if the prison had received any additional support from Prison Service Headquarters in relation to ACCT training. He said that the senior officer (safer custody manager) attends safer custody meetings. They receive Prison Service Orders (PSOs) and Prison Service Instructions (PSIs), and support and guidance from the area safer custody manager.

29. The safer custody governor said that a definition of a near miss would be when a prisoner, as a result of self harming, goes to outside hospital, to internal healthcare, or is resuscitated with oxygen.

Removal of items in possession

30. The Foston Hall policy states that:

"Prisoners identified as being at risk of self harm or suicide will not have items removed from their possession, or cell to reduce their opportunity to self harm. Except for a razor which will be removed from the room, but the prisoner will have access to it via the office at times when they require it e.g. showering etc. Other than this they will be treated in the same way as other prisoners. This means they are allowed items according to their regime status and behaviour.

"Prisoners will not be punished for acts of self harm. If a breach of prison rules has occurred in order for the prisoner to self harm i.e. ripping a sheet to tie a ligature, or if sink breaks when trying to break a cup to cut with, they cannot be placed on report. Neither is it assumed that they are keeping items with the intention of self harm.

"In cases where the prisoner is violent or refractory, or highly suicidal, it may be necessary to remove items from their room. This will be when all other options have been exhausted i.e. a review of the care plan is carried out peer support tried or suggested etc.

"The removal of items can only be authorised by the duty governor in consultation with the review team, and documented as such. If items are removed then form F2323 must be raised and the prisoner placed on the minimum of four observations an hour. The items should be returned to the prisoner as soon as possible after their behaviour has become more settled."

Incentives and Earned Privileges (IEP)

31. Prison Rules require every prison to provide a system of privileges which can be granted to prisoners in addition to the minimum entitlements under the Rules, subject to their reaching and maintaining specified standards of conduct and performance. The National Policy Framework applies to all prisons, and the national aims are:

- to encourage responsible behaviour by prisoners
- to encourage effort and achievement in work and other constructive activity by prisoners
- to encourage sentenced prisoners to engage in sentence planning and benefit from activities designed to reduce re-offending
- to create a more disciplined, better-controlled and safer environment for prisoners and staff.

32. The aims are achieved by ensuring that privileges above the minimum are earned by prisoners' good behaviour and performance, and are removed if they fail to maintain acceptable standards. The IEP scheme is intended to encourage prisoners to behave responsibly, to participate in constructive activity, and to progress through the system.

33. Governors may tailor their individual IEP schemes by including incentives and privileges available locally that are likely to prove attractive to their particular prisoners.

Basic Level

34. Prisoners are placed on the basic IEP level because they have failed to meet local criteria for admission to standard and enhanced levels. Their position is different from prisoners in the segregation unit who have been removed from association under Prison Rules. All prisoners on basic level continue to receive the entitlements laid down in Prison/YOI Rules and other instructions in relation to visits, letters, telephone calls, provision of food and clothing, and any other minimum facilities provided locally for all prisoners, apart from those in segregation. They continue to participate in normal activities, including work, education, treatment programmes and religious services, and are allowed access to the prison shop, exercise and association, and to attend offending behaviour programmes as necessary. Prisoners on basic IEP level are reviewed every seven days.

Standard Level

35. Prisoners on standard level will be provided with a greater volume of the basic allowances and facilities, plus additional privileges which are available locally. Typically, these include more frequent visits, more time for association and the provision of in-cell television. Standard level prisoners are also eligible for higher rates of pay for work, subject to those on the enhanced level being considered first for particular

jobs, and a higher allowance of private cash.

Enhanced Level

36. Prisoners on enhanced level receive the same privileges as those on standard level but in greater volume, with additional visits, time for association (subject to local resources), more private cash, and priority consideration for higher rates of pay.

Violence Reduction

37. The Prison Service has a specific policy on reducing violence which also incorporates policy on dealing with bullying. Everyone has the right to feel safe and free from physical, emotional or psychological intimidation. All prisons are required to have in place a local Violence Reduction Strategy, which must make clear that violent and intimidating behaviour is unacceptable and will not be tolerated.

38. If a prisoner is bullied, or they know someone who is being bullied, they can report it in confidence to an officer or another member of staff who will take action in accordance with their local strategy. This should be to support the victim and challenge and monitor the alleged bully's behaviour.

HM Inspectorate of Prisons Report Foston Hall 10-14 May 2004

39. HM Chief Inspector of Prisons (HCMIP) conducted her most recent announced inspection of Foston Hall in 2004. In almost all respects she found that Foston Hall was a fundamentally safe establishment. Neither bullying nor self harm was a significant problem and drug use was very low. Staff were aware of the needs of the women and intervened appropriately, often informally, to maintain a quiet, calm and ordered prison.

40. Staff/prisoner relationships at Foston Hall were said to be as good as anywhere in the women's estate and this, combined with generally excellent accommodation and external environment, ensured a positive atmosphere. Overall, Foston Hall was a mutually respectful establishment for both staff and prisoners. There was plenty of time out of the cell, sufficient purposeful activity and good provision of education and training.

41. The HMCIP inspection report noted that a large percentage of the prisoners at Foston Hall had a history of drug abuse, self harming and psychiatric problems. My investigators too found that self harming is a regular occurrence. It is common for a number of ACCT plans to be opened at any one time, and for prisoners to be observed constantly when the risk of self harm is heightened. In the four months before the woman's death, 121 ACCT plans were opened.

HM Inspectorate of Prisons Report Foston Hall 1-3 May 2007

42. HMCIP conducted an unannounced follow up inspection of Foston Hall between 1 and 3 May 2007. The inspection found that the prison was significantly different from the one they had reported on last time. Foston Hall had been a training prison for sentenced women, with a relatively settled and stable population. Because of changes in the women's estate, including the change of role of some other women's prisons, it had become a local prison, receiving women directly from

court. Indeed, at the time of this inspection, over a quarter of the population were women on remand - a much more vulnerable and volatile group.

43. According to the Chief Inspector, “The inspection found that the prison had not yet come to terms with its new role and population. Suicide and self harm procedures, and reception processes, were not robust enough to deal with the levels of self-harm and vulnerability among remand women. Use of force had increased significantly, often to remove ligatures from self harming women. Procedures to ensure that it was safe to segregate such women were weak. Contrary to our recommendations in the last report, remanded women had been received before there were safe detoxification procedures, though this had now been remedied and a good service was in place. Nevertheless, Foston Hall remained overall a reasonably safe place.”

44. The inspection report notes, “…the ACCT system had been introduced in November 2006. This was considerably later than planned and some training needed to be refreshed. Fourteen staff, including a member of the psychology, healthcare and chaplaincy teams, had been trained as assessors, 18 case managers and 168 staff had received foundation training.” She added:

   “The quality of ACCTS was variable. Some forms were mechanistic and based on brief observations rather than recording engagement with prisoners. Some entries were simply a staff signature with no further comment. There was little evidence that actions identified in care plans were followed up and responsibilities were not always attributed to named staff. Management checks were perfunctory.

   “The number of open ACCTs and incidents of self harm had increased since the opening of the remand unit. Compared to 41 incidents the previous year, there had been 99 incidents of self harm in April 2007, although 28 of these involved one woman. Incidents were monitored for time, location and whether the prisoner involved was on an open ACCT, which most of them were. Thirty-seven prisoners were currently on open ACCTs. Two of these were on constant watch and both were on the remand unit …

   “Safer custody was managed by a committed senior officer but this post was not full time and staff shortage meant that she had to provide residential cover, manage the enhanced wing and cope with external demands. The volume of paperwork involved in collating and monitoring ACCT documentation left little time to take an overview of the key issues and act as a champion of good practice. There was no deputy safer custody manager. Despite this, individual women appeared to receive good quality care.”

45. The Chief Inspector made the following recommendations in relation to ACCT procedures:

- Staff signatures should not be used on ACCT documents in place of proper observations of prisoners at risk.

- Actions identified in ACCT documents should be attributed to named staff, followed up and properly documented.

- Managers should carry out routine daily quality checks of ACCT documents and identify staff in need of refresher training.

- The safer custody manager should be given additional support to complete administrative tasks and free up more time to provide help. Advice and guidance to residential staff.

Independent Monitoring Board (IMB) Report December 2006 to November 2007

Segregation

46. The IMB reported that, "…the segregation unit, located in the main prison is used for both sentenced and remand prisoners. The unit staff are very patient and understanding of the problems experienced by women in their charge and whilst exercising the necessary control, offer admirable support and care for them.

47. Its report continued:

"Staff make documentation available to, and willingly share their knowledge of prisoners in the cells with, IMB members, one of whom attends meetings of the Segregation Monitoring and Review Group.

"Due to concerns that the IMB was not always informed when prisoners were placed in segregation or when reviews were to be held, the Board established a new system whereby one member of the IMB is now designated to co-ordinate the attendance of IMB members at reviews, and that member is the contact for segregation unit and staff. Subsequently, the situation has improved, but some segregations and reviews still take place without the IMB being notified.

"Reviews that have been observed by IMB members have been attended by appropriate members of staff, and have been conducted in a formal but positive manner, always with the intention, which is usually realised, of providing appropriate support for the prisoners involved, as well as necessary protection for staff and other prisoners.

"In common with all IMB's, Foston Hall continues to express its serious concern that there is inadequate provision in the nation's penal systems for prisoners with serious personality disorders, with the result that, because of their often uncontrollable behaviour, they are frequently confined for long periods in segregation units, as has

happened at Foston Hall, to the inevitable long term disadvantage of such prisoners, despite the professional care and understanding they receive from staff."

Safer Custody

48. In respect of safer custody, the IMB wrote as follows:

"The ethos in Foston Hall creates a friendly and sociable environment to which the majority of prisoners make a very positive contribution.

"The regime in Foston Hall is intended to encourage prisoners, through appropriate discipline, guidance, support and freedom to become independent and self-disciplined individuals, in the hope that this will stand them in good stead when they are released, to their benefit and to the benefit of the communities in which they live.

"Inevitably, as in any group of people, forced without choice to be in each other's company, there are disagreements, some serious, a few occasionally violent, but these are rare in Foston Hall, and generally, the women behave very well and in a very supportive way to each other.

"There are occasional instances of bullying, but these are dealt with promptly by staff and appropriate action taken after investigation.

"The more volatile nature of society in general, and the greater number of prisoners at risk of self-harming, is reflected in Foston Hall, and an increasing number of ACCT forms were opened, these being monitored by two members of the IMB. The IMB recognises that, in the praiseworthy desire not to risk the safety of anyone, erring on the side of caution can, at times lead to inconsistencies in the opening of ACCT forms on prisoners.

"Prisoners generally feel able to discuss problems with members of staff and to seek solutions in recognised ways, and very rarely do applications or verbal comments to IMB members indicate lack of confidence in staff ability or willingness to deal with issues of concern to prisoners.

"Offender management and drugs counselling staff initiate programmes which can link with agencies in the outside community to support prisoners after release."

49. The Board's report also referred expressly to the circumstances of the woman's death. They wrote as follows:

"On 18 April 2007, a prisoner [The woman] in the segregation unit died by means of a ligature. The prison authorities immediately contacted all necessary persons and agencies, including the Chairman of the

IMB, who went into the prison as soon as alerted and spent some time there. All correct procedures were followed, including over the next several days, sensitive and supportive visits by the Governor, members of the senior management team, and a chaplain to the woman's family in the North of England, and subsequent attendance at the funeral. The family appreciated the thoughtfulness shown to its members. Many of the prisoners were greatly distressed, but were very well cared for by staff, including chaplains who arranged several services in the chapel, which provided comfort for, and were appreciated, by the many prisoners and staff who attended them. Subsequently an official of the Prisons and Probation Ombudsman's office spent time in the prison to enquire into the procedures followed both before and after the incident and the report is awaited.

"It is inevitable that the suicide of a prisoner attracts publicity, but considerable credit is due to staff, and at other times other prisoners, who on numerous occasions have saved prisoners from what could have been the fatal consequences of their own actions against themselves."

50. The IMB Report also discussed a range of other issues relating to safer custody:

"A prison that claims to be totally free of illegal substances is deluding itself, but based on the evidence of mandatory drug testing the presence of drugs in Foston Hall is minimal and prisoners are frequently willing to co-operate in locating and removing them.

"An area over which Foston Hall has no control, but which causes considerable concern to Foston Hall staff and IMB members, is that on occasions, young women arrive at the juvenile unit late at night, having been transported very long distances across England and Wales. At times, they have to return those long distances early next morning to appear in court. There are also instances of women arriving very late in the remand centre, having been transported from distant courts. Foston Hall staff are commended for doing what they can to feed the late arrivals and to settle them down after doing their long journeys, but the IMB deplores that these situations ever arise.

"The Board is aware that some detainees arrive at the remand centre claiming to be unsure of reasons for which they have been remanded in custody. Whether the fault is theirs, or of court officials, it means that remand centre staff spend time explaining the legal system to them.

"Indirectly related to safer custody is safer transportation, and the IMB, for long concerned about the vehicles used by independent contractors employed by the national Prison Escort Service for carrying prisoners between prisons and courts and from one prison to another, and the long distances often involved, is now more concerned that the escort

services vehicles are not required to carry tachographs. The Board also deplores that female and male prisoners are still conveyed in the same vehicles, with constant verbal abuse.

"Also indirectly related to safer custody is the welfare of prisoners' families when visiting, and the IMB would like to see a visitors centre provided at Foston Hall, where those traveling from a distance or arriving early, can wait in comfort before being admitted to the visits room. Better provision for young children visiting their prisoner mothers is also desirable."

Physical and Mental Health Care

51. Finally, the IMB Report had this to say on physical and mental health issues:

"Provision is by Derbyshire County Primary Care Trust. The medical centre can accommodate three resident patients in two ensuite rooms. During much of 2007, the centre was closed for refurbishment to provide additional space for administration, storage, treatment and fit for purpose pharmacy and dispensing. During the refurbishment the centre continued to dispense medication at appropriate times each day to those in need of it. There is 24 hour nurse cover, and there are regular attendances by chiropodist, counselors, dentist, optician, psychiatrist and psychologist.

"Like most prison establishments Foston Hall does not have either the facilities or the expertise to care for prisoners with severe personality disorders or psychiatric needs who are on long term sentences. This is a problem which can only be solved through joint action by national health and penal authorities, with Government support. Meanwhile women with this need are denied appropriate help, and have to be confined to the segregation unit, where the great care and kindness they receive from staff, cannot compensate for the lack of appropriate mental health attention."

KEY FINDINGS

52. On 13 February 2006, at Newcastle Crown Court, the woman was sentenced to four years imprisonment for supplying controlled drugs. (The sentence was subsequently reduced to three years on appeal.) She was to be taken to HMP Low Newton but, whilst at court awaiting transfer, she threatened to kill herself as she did not feel that she could go through with the sentence. A suicide / self harm warning marker was completed and accompanied her to prison.

53. Upon the woman's arrival at Low Newton, a first health screen was completed, with the second completed the following day. The woman was a known drug user who smoked heroin and she was experiencing withdrawal symptoms. She was admitted to the detoxification unit and detoxification monitoring forms were completed.

54. A mental health assessment was carried out the following day and a CARAT form was completed. The woman was prescribed a detoxification programme. The screening process identified a number of other health concerns. The woman said that she had had a heart attack when she was 17 years old whilst trying to 'come off speed,' and currently had deep vein thrombosis (DVT) in her left leg. Her medical history was checked to confirm its accuracy. The local accident and emergency department (A&E) confirmed that the woman had attended on 11 February 2006 regarding the DVT symptoms, but took her own discharge before she was diagnosed. Her doctor's practice was also contacted but confirmed that the woman had no recorded history of a heart attack. The practice also stated that the woman had a history of frequent attendance at A&E with different symptoms, and that there was a note in their records that she was not always truthful.

55. Also on 14 February, staff opened an ACCT document as the woman told them that she was more distressed than usual by being in prison for the first time. She said that she had felt very depressed since June when her boyfriend had been murdered. The woman also said that she was missing her children who were being looked after by her mother. She said that she had been prescribed anti-depressant medication before coming into prison. The woman was described as tearful and going through detoxification for drugs. It was decided that she should be observed frequently, and she was allowed full access to Samaritans phones and the Listeners.

56. The woman said that 15 years earlier she had self harmed by taking tablets and cutting her arms. She had also thought about killing herself before going to court, as she could not cope with going to jail. She said she had thought about self harming the previous day as she was very down. She thought that her children would be better off without a mother than with one in prison. She said she wanted to walk in front of a car but could not do it. The woman said she had suicidal thoughts and wanted to be dead. She could see no end to being in prison, and

thought that she could not cope with being locked in and missing her children.

57. The woman said she had some support from her family, but was too upset to think about anything. She felt like she was by herself on the wing and needed something to do to keep her busy. She wanted to move and be with older prisoners, and have a job or equivalent to keep her mind off her worries.

58. The mental health referral form for 16 February reports a history of psychotic episodes in 2005 after the woman witnessed the murder of her partner. She said she had depression and flashbacks to the incident, but was described as rational, calm and collected. It was felt that no further Registered Mental Nurse (RMN) input or referral to mental health services was necessary. The woman had some insight as to why she felt low at times and was again advised about support from Listeners, the chaplaincy and healthcare.

59. The woman left the detoxification unit and transferred to normal location two days later on 18 February.

60. An ACCT review was held on 28 February 2006 which the woman attended. She told those present that she was okay, no longer wanted to die or to harm herself. She said she was settling down into a routine and knew quite a few people in the establishment. She no longer had any concerns about her children being looked after by her mother. The woman said that she would like to be taken off the ACCT plan. It was agreed to reduce the level of ACCT observations but to keep the document open.

61. On 3 March, the woman's sentence was reduced on appeal to three years. On 7 March, the woman told her next ACCT review meeting that she was pleased about the news and also that her cell mate was supporting her. The review decided to close the ACCT plan and schedule a post closure review for 14 March.

62. The woman then appeared to settle into prison life, other than an occasion on 12 July when she fractured her left hand by punching the wall after a telephone call. Her hand was reviewed regularly by healthcare staff but the ACCT document was not re-opened.

63. On 2 August, the woman's medical record states that she needed to be reviewed and this took place on 9 August. She was reported as have taken mirtazapine for six months and feeling that it was no longer effective as she was stressed.

64. Later in the month, on 13 August, an anti-bullying form was opened as another prisoner alleged that the woman was intimidating her. The woman told staff that she was not a bully, but did not wish to appeal

against the procedures. She was monitored for a month in accordance with the bullying policy and then the booklet was closed.

65. A medical review took place on 15 September when the woman was reportedly as not sleeping, and as stressed and irritable with staff. She was described as overactive in the evening. There was a suggestion that her mood was due to excessive caffeine intake, but the explanation was rejected. The woman was next seen by a RMN on 25 November when she was moved to the segregation unit at Low Newton. The woman told the nurse that her mental health was stable.

66. On 21 January 2007, the woman was transferred to Foston Hall for a fresh start after being involved in incidents of bullying and aggressive behaviour at Low Newton. When the woman arrived she was seen in reception and taken through the initial reception procedures before being seen on healthcare centre, which is the normal process for all prisoners transferring to Foston Hall. Staff recorded that the woman had no problems, although she asked to see a doctor for a repeat prescription. (The clinical review conducted as part of this investigation has highlighted that the reception health screen form was inaccurate as it said that the woman had no history of self harm or mental health problems. The clinical reviewers feel that reliance was put upon the woman’s self reporting and no obvious reference was made to her records.) The next day she was seen by a prison doctor.

67. Soon after arriving at Foston Hall, the woman formed a close relationship with another prisoner whom she referred to as her partner. They lived on the same wing and worked together in the kitchen. They would often write letters and cards to each other and spend time together.

68. A prison officer issued a verbal warning to the woman on 8 March after she was found on D wing without permission. On 19 March, the woman was refused Home Detention Curfew (HDC) because of her history of breaching community orders. Although there is an appeal process, the woman did not use it. In an interview with the PPO investigator, the prison FLO was asked about an allegation that he turned the woman down for HDC in front of other people. He remembered discussing the woman’s HDC with her but could not recall the exact conversation and denied turning her down in front of others. Soon afterwards, the woman told Acting Senior Officer (ASO) that she was stressed and asked if she could move to a different wing. The acting senior officer arranged for the woman to move to D wing, which he considered to be a quieter part of the prison, but later learnt that she refused to move.

69. On 2 April, the prison officer issued a verbal warning to the woman after she showed a poor attitude and swore at the officer.

5 - 11 April

70. Three days later, on 5 April, the woman had an altercation with a second prisoner in the kitchen and threatened to throw a chair over her. The woman was returned to her room, pending a disciplinary adjudication for her threatening behaviour. She became angry and stormed out of her room. Later that day, another anti-bullying form was opened.

71. That afternoon at 2.25pm, the prison officer opened an ACCT document as the woman had cut her left wrist with her own razor. She refused to explain why she had cut herself; in interview, the prison officer described her as very angry. The woman was assessed by a member of healthcare who described the wound as one and half to two inches long. The wound was cleaned and sutured. It was decided that the woman should remain in a single cell and have hourly observations and conversations with staff. It was noted on the ACCT plan that the woman knew how to access the Samaritans' phone and the Listeners.

72. The woman was seen later that day by a nurse as she had removed the sutures from her wrist. Her wound was cleaned and re-dressed.

73. The next day (6 April), an ACCT interview assessment took place at 11.30am between the woman and a trained ACCT assessor. The woman said she felt a little depressed because staff kept asking her if her partner, was beating her up. When asked about self harm, the woman said she felt really depressed, and was upset that their relationship had not been going well. The woman said that she had wanted to commit suicide, but did not cut herself deeply enough. She added that, in her current state of mind, she felt silly about harming herself and did not want to be on the ACCT document. The woman said she got on well with most people. She felt this would help her cope and prevent her from self harming again. It was agreed that the woman would be referred to the community psychiatric nurse (CPN). The ACCT assessor has said she emailed a member of healthcare requesting CPN input for the woman (that email has apparently now been deleted).

74. The ACCT document was closed on 6 April. A post-closure ACCT review was scheduled for 11 April 2007, although my investigators can find no evidence that it took place. (Foston Hall now has annual refresher training that should ensure all ACCT Managers, ACCT Assessors and staff carrying out observations fully understand their responsibilities.) The woman telephoned her mother on 10 April. She spoke to her children, but did not mention her recent self harm.

12 - 16 April 2007

75. On 12 April, the woman had an argument with her partner and during lock down at approximately 6.45pm (when prisoners are locked behind their doors) she asked staff to allow her to speak to her. The request

was refused and the woman smashed a chair into her cell door. The prison officer checked the woman and found her with an open razor which she believed the woman was going to use to harm herself. The woman said that her partner had harmed herself previously when she said she did not want to be with her.

76. The woman initially refused to hand over the razor blade, and was seen again by the nurse who described her as very angry. The woman said she was really fed up, that she was not sleeping and had relationship issues. She was due for release in August 2007 after serving 18 months. She described her feelings as muddled, but denied any further intention to self harm. The woman was offered reassurance and an ACCT plan was opened again. The immediate ACCT action plan was for the woman to remain on the wing in her own room. She was to be observed every two hours and staff were to engage her in conversation at least once a day. The woman was reminded of the availability of the Samaritans phone and Listener access.

77. The next day (13 April), 9.45am it is recorded in the woman's adjudication record that the she demanded to speak to a Principal Officer and referred to her as a "dick head." When challenged the woman continued to be abusive and said, "I suppose you are going to nick me for that. You wait until I kick off you have not seen that yet". She was placed on a disciplinary charge for smashing her chair the previous day and being abusive to an officer after she had breached the rules by associating with another prisoner in a room with the door shut. The woman was given a warning about her behaviour and was also placed on the anti bullying procedure.

78. On 14 April she appeared before a governor for her adjudication. It was adjourned to 2 May 2007 for an independent adjudicator (District Judge).

79. The Health Care Assistant (HCA) said in an interview with my investigators that she was a ACCT trained assessor and had received a week's training at Foston Hall. She described the woman as a "very sparky girl, very loud raucous, a very tough girl who wouldn't share her business easily and she would rather fight than cry, she was a tough chick." She recalled that the woman worked in the kitchens; she had previously met her when working at the medication hatch. The healthcare assistant liked the woman because she was a character but said they had a professional relationship. She felt that the woman did not trust people very easily although there were members of staff that she could go to.

80. The healthcare assistant carried out an ACCT assessment interview on the woman. She noted on the ACCT document that the woman was distressed due to her partner having self harmed and being unable to talk to her. The woman felt her partner had hurt herself because she

had said she did not want to be with her. The woman was upset about being placed on bullying report. She was considered a low risk of self harming, but the document was left open. My investigators were unable to find any evidence of an ACCT care map being completed. Three days later, on 16 April, an ACCT case review was conducted by a second senior officer and a second prison officer and the woman. The woman said she had support on the wing. She was angry because she was not allowed to see her partner. The woman denied any plans to harm herself and the ACCT document was closed. She was allowed to keep all her belongings including a razor.

17 April

81. At 9.05am, the woman went to the healthcare centre and complained to the healthcare assistant that another kitchen worker, the second prisoner, was tormenting her. The woman told the healthcare assistant that she was in danger of losing her temper. The healthcare assistant listened to the woman's concerns for approximately 20 minutes and advised her to speak to the kitchen manager. The healthcare assistant also spoke to the kitchen manager and completed a Security Information Report (SIR) outlining the woman's allegation. (An SIR is completed when staff believe that the good order and discipline of the prison could be compromised.) The healthcare assistant made a note of the conversation in the woman's medical records

82. Later in the morning, a second senior officer was on A wing when she was told by kitchen staff that the woman was being sent back to the wing after being placed on disciplinary report for threatening the prisoner. The second senior officer informed other staff that the woman was to be locked in her room. However, the woman refused to go to her room, shouting that the staff would have to put her there.

83. The second senior officer invited the woman to her office to discuss her concerns and the woman said she was finding it hard in the kitchen that morning. She felt that the second prisoner was taking advantage and was not doing her share of the work. The woman also told the second senior officer that the prisoner was trying to provoke her. The woman felt that it was unfair if she was placed on report because she voiced her feelings. She told the second senior officer that she had no plans to assault the prisoner. She explained that she had gone to speak to the healthcare assistant for a chat and to calm down.

84. The second senior officer told the woman that she would investigate what had happened and that the woman should ask to change her job if she was unhappy working in the kitchen. She told the woman that she had to go to her room as she had returned from work early, but that she could come out at 11.30am when everyone else returned.

85. The second senior officer went to the kitchen and discussed the woman with the kitchen manager. They agreed that it would be

beneficial to keep the woman off work until Friday 20 April with full pay, and ensure that she attended the labour board on Friday. (A labour board allocates all work placements for prisoners.) The second senior officer returned to the wing to explain to the woman why she was on a disciplinary charge and that she should speak to the Governor. The second senior officer also told her to complete a labour application form to ask to change her job.

86. Later that morning, the second senior officer sat on the IEP board and discussed the woman's behaviour with her. She was told that she would be put on the basic regime. As the second senior officer thought it was inappropriate for the woman to be locked in her room all day and evening, it was agreed that she could be unlocked until the labour board.

87. During the afternoon, a third prisoner went to the wing office and told the second senior officer that there was a fight in the second prisoner's room. The woman and her partner were in the second prisoner's room and the second prisoner was on the landing with the prisoner who reported the alleged fight. The second senior officer told the woman to leave the room, but she refused to follow the order. The woman shouted at her partner to get out. She eventually did so returning to her own room, with the woman following. The woman refused the second senior officer's request to leave her partner's room. Her partner was ordered outside and eventually the second senior officer persuaded the woman to go to the office.

88. The woman told the second senior officer that she and her partner had been arguing. The reports from the prisoners present at the time suggest that her partner had gone to the second prisoner's room to tell her not to speak to her any more. While she was standing in the doorway, the woman pushed past and grabbed second prisoner around the neck. The second prisoner retaliated and grabbed the woman's hair, and they continued to struggle with each other. The woman told the second senior officer that she could not guarantee that she would not attack the second prisoner again, and asked to be taken to the segregation unit.

89. The second senior officer told the woman to return to her room, but she started shouting that she was not going and staff would have to take her out. The second senior officer described the woman as aggressive and said that she started wandering around the wing. The second senior officer telephoned her line manager a principal officer, at 2.30pm to discuss the woman's behaviour. The principal officer advised the second senior officer to lock off parts of the wing to limit the woman's movements. He said that the woman should go to the segregation unit and arranged for staff to take her there. He also went to the wing, accompanied by a third senior officer and a governor.

90. Several staff arrived on the wing to give assistance. The second senior officer told them that the woman had returned to her room, but was now refusing to go to the segregation unit. She had razor blades in her hand.

91. The governor spoke to the woman at length and offered a telephone call to encourage her to go to the segregation unit and hand over the razor blades. The second senior officer returned to the woman's room and took her without force to the segregation unit, escorted by a second principal officer and the third senior officer.

92. When they reached the D wing dining hall, the woman handed over the razor blades to the second principal officer, and then made a telephone call to her mother. Her mother told us that the woman told her that she had been fighting and was going to the segregation unit. Her mother also said that her daughter started to cry and said that she had had enough. The woman then spoke to her child before the telephone was disconnected.

93. The woman arrived in the segregation unit and initially refused to be searched. Eventually, she allowed the second senior officer and a female prison officer to search her. At 4.00pm, the female prison officer began the segregation safety algorithm and decided that the woman was fit to be segregated. A registered general nurse recorded on the form that she knew that the woman had previously been on an ACCT document. He nurse wrote that she did not think that the woman's mental health would deteriorate significantly if she was segregated. The governor signed the safety algorithm at 4.55pm, thus authorising the woman's segregation to be appropriate.

94. The registered general nurse also examined the woman's head, which had been banged against the door during the fight. The nurse noted that the woman's head was swollen, but she refused a cold compress. The registered general nurse had no other concerns about the woman's health or her location.

95. Between 6.30pm and 7.00pm, the nurse was in the segregation unit giving medication to the prisoners. She was asked to speak to the woman and went to her cell. The woman was upset and tearful, and spoke about her relationship with her partner. She told the nurse that she could not cope and it was "a matter of time and finding the right method". The nurse noticed a mark on the woman's neck, which she described as being about two inches in length. When the nurse asked about the mark, the woman said she had been scratching her neck. She told the nurse that there was nothing in the cell to use as a ligature. The nurse remained with the woman for about ten minutes, but was unable to console her.

96. The nurse passed her concerns to the acting senior officer who was in the segregation unit on a routine visit. In interview, he said that the

nurse had said she had spoken to the woman at that time and that she was very low and struggling to cope. She had commented that she had noticed some red marks on the woman's neck. He was concerned enough to open an ACCT knowing that the woman had previously been on ACCT documents. The acting senior officer also recorded the information in the segregation observation book, and decided that the woman should remain in her cell. She was to be observed twice every hour and have access to the Samaritans phone and the Listeners whenever required. In hindsight, it does not appear that staff considered whether or not to remove any items from the woman or her cell that she could have used to self harm. Nor does it appear that consideration was given to completing a further segregation safety algorithm in view of the change of circumstances.

97. The nurse also spoke to the second principal officer and reported that she considered the woman to be at risk of self harm or suicide. The nurse offered to swap her duties with the healthcare assistant (as noted above, the healthcare assistant is a trained ACCT assessor) so that the woman could be interviewed as soon as possible. The principal officer agreed to the proposal.

98. At 7.45pm, the healthcare assistant interviewed the woman as part of her ACCT plan. In interview, she said that she sat next to the woman on her bed in the cell and could see that she was very distressed. The woman spoke of unhappy relationships in her life and that nothing seemed to go right for her. She spoke about her childhood, and drugs. She felt there was not much point in going on. The healthcare assistant tried to engage the woman in thinking positive thoughts. The woman said nothing ever went right for her and she felt she wanted to die. She said she had tried it earlier and that the ligature had snapped. The healthcare assistant could see reddish marks on the woman's neck. They talked about the Samaritans, church, and the woman's children. The woman spoke about her partner wanting her children back and she felt that would not happen if they were partners because of her history. The healthcare assistant could not get anything positive from the woman. The woman then asked her to stop, thanked her for listening and said, "It's my mountain and I've climbed it." It was noted on her ACCT document, 'she hears voices to harm herself that have become worse.'

99. The healthcare assistant also said that the woman was calm when she was talking to her. She had not been when she first walked in and would normally react with anger rather than distress. The healthcare assistant was alarmed because the woman was so calm and told the segregation staff that she wanted to speak with the senior officer to share her concerns before she went off duty. The acting senior officer was telephoned by the segregation staff who told him that the healthcare assistant was very worried that the woman could commit suicide. The healthcare assistant spoke to the acting senior officer and told him she was very worried about the woman. The acting senior

officer said he would attend the segregation unit and the healthcare assistant continued with her duties before going off duty.

100. The acting senior officer said he spoke on the telephone to segregation staff about the healthcare assistant's concerns but did not have a face to face meeting with her. He returned to the segregation unit at approximately 8.50pm. He spoke with staff on duty and asked how the woman was. He was told that she had seemed to calm down a little, appeared a little more content, and at that point was writing some letters within her room. He did not speak to the woman but notified the principal officer what he had done. The acting senior officer believed the level of observation was sufficient. At that time there were no cells in the segregation unit designed as safer cells.

101. In interview with the PPO investigator, the acting senior officer said that he did not consider removing items from the woman that she might have harmed herself with. Neither was consideration given to completing a further segregation algorithm once the woman was placed on an open ACCT document.

102. It was agreed that the woman would be referred to the mental health in reach team and to the doctor to request anti-depressants. The ACCT documentation records the trigger for the woman's self harming behaviour as when she was angry and upset. Her mental state was recorded as tearful and very low in mood. The woman described her feelings as being like climbing a mountain and falling off.

103. It is not clear from the documentation that the woman was observed twice every hour throughout the night in accordance with the ACCT plan. Some of the entries indicate that checks were carried out every hour, although from 8.05am onwards there was some interaction every half hour.

104. On 18 April, The ACCT assessor and the female prison officer took over their duty in the segregation unit. There were six prisoners in the unit that morning, four of whom (including the woman) were awaiting adjudications.

105. The female prison officer saw the woman at 8.05am when she was sitting on her bed. The officer gave the woman the notice of report. This detailed the charges as using threatening, abusive or insulting words or behaviour the previous morning. The female prison officer then gave the woman her breakfast at 8.20am. At 9.10am, the woman asked for a light for a cigarette, which was given to her, and she was offered a shower. However, as she only had the clothes she was wearing, the officers arranged for more clothing to be collected from her room.

106. At 9:30am, the woman was seen by a nurse as part of the daily segregation healthcare rounds. The nurse was aware that the woman

was on an open ACCT document. The woman complained of a headache. The nurse gave her some paracetamol. In the medical record, the nurse noted that the woman also complained that her left wrist was painful and she was worried that it had become infected. The nurse explained that the doctor would see her later to assess her wound. The nurse did not record any concerns raised regarding the woman's mental health or the events of the previous evening. She returned to the healthcare centre and made an entry on the woman's medical record. In an interview with the PPO, the nurse said that she had planned to return to see the woman with the doctor after her GP clinic at approximately 11.30am.

107. The nurse said the woman seemed quite okay; she just complained about her headache and a pain to her left wrist. She seemed like the normal person that she knew. However, she was aware that the woman was on an ACCT and had been taken to the segregation unit the day before. The nurse was asked whether she spent any more time with the woman because she knew she was on an ACCT. She replied that at that time she did not, "I just asked her if she needed anything and she just needed a paracetamol and asked to see the doctor."

108. The deputy governor was on duty and responsible for carrying out the adjudications on prisoners who had been accused of breaching prison rules. The deputy governor discussed the woman's case with another governor and they decided that it should be adjourned, pending a police criminal investigation of assault.

109. The woman attended her adjudication hearing at approximately 10.45am and it was formally opened. The deputy governor explained the adjudication process and said that the hearing would be adjourned until a police investigation had been completed. He noted in his statement that the woman confirmed she understood the decision, and did not indicate any signs of distress, anger or frustration. In hindsight, owing to the change in the woman's circumstances (she was attending an adjudication whilst on an open ACCT), consideration should have been given to reviewing her ACCT status. At the conclusion of the hearing, the deputy governor returned to his other duties and the woman was escorted back to her room in the segregation unit by the female prison officer and ACCT assessor. At 11.10am, the female prison officer spoke to the woman through the observation panel. The woman was listening to the radio and the female prison officer told her that her belongings were being brought over from the wing.

110. At 11.15am, an officer on A wing was telephoned by the ACCT assessor who asked him to collect some clothing from the woman's room and deliver it to the segregation unit.

111. Approximately 20 minutes after the previous check, at 11.30am, the female prison officer checked the woman again. The officer looked

through the observation panel in the cell door and saw her suspended from the window. The female prison officer described the woman as being in a sitting position, with her head leaning to the left side and her tongue sticking out. The woman was dressed in her vest, jeans and socks and the officer could see that she had urinated. The female prison officer wrote in her statement to the police that she was shocked and shaking, and so was unable to use her radio. She shouted to the ACCT assessor who pressed the alarm bell for immediate assistance. Both officers then entered the cell.

112. The woman had used her belt as a ligature. The ACCT assessor lifted her to take her body weight whilst the female prison officer used her anti-ligature knife to cut the belt. Together they laid the woman on the bed on her back. The female prison officer tilted the woman's head back to try to open her airway, and heard a rush of air which sounded like an intake of breath. The female prison officer also felt for a pulse in the woman's neck, but could not find one. Nor could she hear any breathing.

113. At approximately 11.30am, the officer from A wing was on his way to the segregation unit with the woman's belongings when he heard a radio call for staff assistance. He arrived in the unit and saw the ACCT assessor and the female prison officer in the cell, with the woman lying face upwards on the bed. The officer from A wing noticed that the two officers were in a state of shock. Two other officers also arrived and the second of the officers instructed that an ambulance be called. The ACCT assessor and the female prison officer went out of the cell.

114. The officer from A wing also felt for a pulse in the woman's neck but could not find one. He was joined by a principal officer. The officer from A wing commenced mouth to mouth resuscitation and the principal officer commenced chest compressions. The principal officer described the woman's appearance as blue. They were quickly relieved by other officers and nursing staff, and another officer and a nurse took over the resuscitation attempts. The prison doctor arrived soon afterwards and the officers left the cell whilst the nurses continued resuscitation.

115. The acting principal officer was in the security department where he heard the prison alarm bell over the radio at 11.36am. In accordance with the prison contingency plans, the acting principal officer went into the communications room to supervise events and ensure that the emergency services had unrestricted access and egress to the prison.

116. The deputy governor heard the general alarm announced over his radio concerning an incident in the segregation unit, followed by a request for medical assistance. He went to the unit and saw the two officers attempting to resuscitate the woman. They were quickly joined by healthcare staff who continued resuscitation. The deputy governor

confirmed that an ambulance had been called and remained in the segregation unit, overseeing the response.

117. The paramedics arrived and took over the resuscitation attempts from the nursing staff. After approximately 20 minutes, the woman was taken to Derby Royal Infirmary with two officers escorting her. The deputy governor gave permission that she should not be restrained in any way. The woman arrived at Derbyshire Royal Infirmary at 12.40pm and her death was pronounced at 12.48pm.

118. After the woman left the segregation unit, her cell was sealed until the arrival of the police. The acting principal officer handed over all documentary evidence to the police. A governor called a meeting with her senior managers to decide how to inform staff of the events concerning the woman. During the meeting, at approximately 12.55pm, the Governor was told that the woman had sadly passed away.

Events after the woman's death

119. At 1.30pm, after the woman's death was pronounced, the governor called a meeting for all available staff to pass the information to them. Individual managers were given responsibility for informing the prisoners in their care, and each manager was assigned a psychologist to support them. Available nursing staff were deployed to the wings to give further support to prisoners.

120. Because of the distance to the woman's family home, the governor sought the assistance of the local police to break the news of her death. Sending a member of the prison staff would have unnecessarily delayed notification. However, the governor spoke to the woman's mother later that day, and arranged for the Family Liaison Officer (FLO) to meet family members the following day. In interview, the prison FLO said he met the woman's family at their home the following day. He said that they were very welcoming but there was some understandable anger from some members of the family. The woman's mother had asked him if her daughter had left a note and he said he did not know. He was also unaware that the woman had previously cut her wrist. He did know that the woman had used a ligature. The prison FLO facilitated a visit for the woman's mother to the Chapel of Rest to see her daughter. He subsequently attended the woman's funeral.

121. The prison FLO said he subsequently became aware of a note left by the woman, but did not mention it on the advice of the prison police liaison officer. However, he said he did tell the woman's mother about the note at some point. He was aware of Prison Service Order 2710 concerning follow up to deaths in custody. In interview with the PPO investigator, the prison FLO said he had not attended a family liaison course.

122. A third principal officer was tasked with informing the residents of A wing that the woman had died. A prisoner who had worked in the kitchen with the woman, told the third principal officer that the woman had not been "right" for a couple of weeks, and had talked to her about killing herself. The prisoner had suggested to the woman that she looked at a picture of her children as a comfort, and the woman told her that the children would be alright with their grandmother. The prisoner remarked that prisoners had guessed that the woman had harmed herself when they heard the ambulance.

123. The third principal officer also spoke to the prisoner whose room was next to the woman's. The prisoner said that she had heard the woman and her partner arguing and that the woman had said that she was going to do it for real this time (referring to killing herself). Her partner replied that if she did, then she would be following her. Another prisoner also said that the woman had not been right for a while, and had been going to the office asking for help for the past couple of

weeks. (My investigators have been unable to find any other evidence that the woman had sought help from staff.)

124. At 4.15pm, the governor held a managers meeting to discuss the potential risk to vulnerable prisoners and the contingencies for responding to increased numbers of self harm incidents. Additional staff were brought in for the evening night duty and arrangements were made to brief those who were not on duty that day. The governor took personal responsibility for informing the staff arriving for night duty.

125. On Thursday 19 April, at 11.38am, the governor formally identified the woman's body to the Detective Inspector at Derby Royal Infirmary.

126. A 'Remembering the woman' service was held on 3 May in the prison chapel at the same time as her funeral was taking place. The prison FLO, together with the police prison liaison officer attended the funeral.

127. The woman's room on A wing was sealed and cleared of property by the police investigators. A letter was found on top of the wardrobe. It indicated her state of mind, but it is unclear when it was written.

Post Mortem

128. A Home Office pathologist carried out the post mortem on the woman on 19 April at Derbyshire Royal Infirmary. He commented and concluded:

    1. "My examination shows no established natural disease which may have caused or contributed to her death.

    2. "She has some marks on her neck consistent with the presence of a ligature which has been used to suspend her body from her cell window. There are a small number of petechial haemorrhages in and around her face but it is my opinion death has occurred fairly rapidly probably through the mechanism of vagal nerve outflow stopping the heart.

    3. "Toxicological analysis indicates that she was not under the influence of alcohol or drugs at the time of her death.

    4. "The linear scars on her left forearm are highly suggestive of a self inflicted injury at an earlier date. The cuts passing through the tattooed word on her right ankle are also in keeping with self-inflicted of some days old.

    5. "There are a number of other minor injuries on her body, largely confined to her limbs. Several are of some days old whilst the more recent are probably the result of her body being moved and handled during the resuscitation procedure. All injuries are

superficial and would not have caused or contributed to her death.

6. “There is no injury on her body to suggest that another person(s) was involved in her death.”

156. The pathologist gave the woman’s cause of death as hanging.

ISSUES

Documentation /Standards of Record Keeping

157. The clinical reviewer found that the healthcare records were generally of an acceptable standard, although some entries were dated but not timed. The records were stored chronologically and appeared to have been made contemporaneously. The language used was appropriate, with little jargon or abbreviations.

158. The records were transferred to Foston Hall at the same time as the woman, and should have been available to reception staff. However, when the reception form was completed, it appears that the records were not consulted as the section on mental health appears to rely solely on the woman's self reporting. The evidence gained at Low Newton regarding the woman's tendency to be untruthful about her medical history gives further weight to the weakness of self reporting as means of assessment.

     Reception staff should make sure that they refer to all available information and not just to the prisoner's own report.

ACCT

159. Whilst the woman was at Newcastle Crown Court, the escort staff completed a Prisoner Escort Record highlighting that she had threatened to kill herself as she did not think that she could survive the experience of being sent to prison. The form accompanied her to Low Newton and an ACCT plan was opened the next day and closed three weeks later.

160. The following year, after the woman moved to Foston Hall, she was found with a self inflicted wound on her wrist. This was stitched and an ACCT form was opened. The woman was also to be referred to the mental health in reach team for a review of her medication. Subsequently, the woman removed the stitches and the wound was dressed again. This incident was not considered as a further example of self harming behaviour and the ACCT was closed the following day.

161. There is no evidence that the woman's medication had been reviewed or of a mental health review. Neither is there any indication that the significance of the refusal of Home Detention Curfew was recognised. The woman reportedly said that she did not want to be on ACCT, and it was closed on the basis of her statement that she was not likely to self harm again. The rapid closure of the ACCT is at odds with the ACCT guidance which states that closure should be prepared for over a period of time.

162. Six days after the ACCT document was closed, the woman was angry and deliberately broke a chair. She reported being very fed up and not

sleeping, but later denied that either was a problem and explained that she had relationship problems. It was also recorded that she had broken a razor, but denied any intent to harm herself. An ACCT was opened again and two hourly observations begun. The document states that the woman denied any history of self harm or suicidal thoughts; this appears to have been taken at face value despite the wound on her wrist.

163. An ACCT review took place the next day which the woman refused to attend. Her risk of self harm was assessed as low. She did go to the next review three days later, and was said to be angry about being forbidden from seeing her partner who had also self harmed. The woman said that she had neither the intention to self harm nor any suicidal thoughts, and again the ACCT was closed.

164. Although a third ACCT document was opened four days later, there is no evidence of a psychiatric assessment. The woman was assessed by a trained ACCT assessor whose main employment was in healthcare and who had lengthy experience of working in mental health and a prison environment. Neither the ligature marks, the woman's alleged increased intensity of auditory hallucinations, or her worsening mental health state were referred for further assessment.

165. The ACCT process lists the triggers for the woman's self harm and details the actions to be taken by prison and healthcare staff. However, it seems that these actions may have been carried out less than adequately. For example, the woman was to be observed twice every hour, but the documentation suggests that she was actually observed once per hour.

166. Attending the disciplinary adjudication may well have been a trigger for the woman's self harm, but in hindsight it does not appear that it was considered a reason to review her ACCT document immediately after the adjudication.

167. The day after the ACCT was opened again, the woman complained to healthcare staff that she had a headache and was worried that the self inflicted wound on her wrist was infected. She was told that the doctor would see her later, but sadly she died before she was seen.

The Governor and Primary Care Trust should review communication between healthcare and prison staff.

The Primary Care Trust should review communication between healthcare staff when prisoners express suicidal thoughts.

The Primary Care Trust should ensure that referrals to healthcare take place as requested.

The Governor should remind staff that, where a decision has been made to open an ACCT, consideration is given to recording the rationale for removing or not removing property from the person or cell that can be used to self harm.

The woman's location in the segregation unit

168. I believe that the woman's disruptive behaviour on the wing left staff with no alternative but to take her to the segregation unit. At the time, the prison had no safer cells and the healthcare ward was closed for refurbishment. Her removal was properly decided by the appropriate prison managers and the situation was defused so that no force was needed to move her. An ACCT document was opened after the woman had been assessed fit for segregation. A short time after her arrival in the segregation unit, an ACCT document was opened and it was judged that segregation was still an appropriate location for her. The woman attended the adjudication the following morning and was found hanging a short time later. She had died within 24 hours of being placed on an open ACCT and before the next ACCT review or consideration had been given to holding a further review. However, there is no evidence to suggest that consideration was given to reviewing the ACCT in the light of the adjudication, although it constituted a change of circumstances.

The Governor should ensure that, when a prisoner on an ACCT has a change of circumstances such as an adjudication, consideration should be given to conducting a review as soon as practicable.

Immediate response to finding the woman

169. Staff acted quickly and efficiently when they found the woman hanging in her cell. They cut the ligature and began to attempt to resuscitate her. They initially put the woman on her bed, rather than a hard surface, such as the floor. Whilst I make no formal recommendation, the Governor may wish to remind staff to place the prisoner on a hard surface when carrying out resuscitation.

170. Staff used their radios to summon healthcare staff and an ambulance, all of whom arrived without delay. Their records are detailed and indicate that the necessary treatment was given. They had ready access to all the equipment they needed, including the defibrillator.

Prison Family Liaison

171. At a post incident meeting, the prison FLO was given the role, although he had no specific family liaison training.

The Governor should ensure that he has properly trained staff to fulfil the role of Family Liaison Officer.

CONCLUSION

172. When the woman was sentenced, she told escort officers that she would kill herself as she could not survive her sentence which was her first time in prison. At Low Newton she was correctly identified as at risk of self harm or suicide and an ACCT document was opened. Her anxieties were managed through the ACCT process until she was no longer thought to be at risk of self harm.

173. The woman was transferred to Foston Hall in January 2007, and she denied any previous mental illness or thoughts of self harm. She formed a close relationship with another prisoner and began to harm herself because she said the relationship had got into difficulties. Three ACCT documents were opened and closed in a short period of time. She was refused HDC and, owing to her behaviour, placed on disciplinary charges and the anti-bullying procedure. The woman was reduced to basic regime.

174. The woman and her partner argued again, and this led to the woman fighting with another prisoner and being removed to the segregation unit. She was subsequently made subject of an open ACCT with two observations an hour. She hanged herself shortly after the adjudication, between observations and less than 20 minutes from when she was last seen. Her death came within 18 hours of being located in the segregation unit.

RECOMMENDATIONS

The Governor should:

1. Remind reception staff to make sure that they refer to all available information and not just to the prisoner's own report.

   Foston Hall has accepted this recommendation (annex 8)

2. Remind staff that, where a decision has been made to open an ACCT, consideration is given to recording the rationale for removing or not removing property from the person or cell that can be used to self harm.

   Foston Hall has accepted this recommendation (annex 8)

3. Ensure that, when a prisoner on an ACCT has a change of circumstances such as an adjudication, consideration should be given to conducting a review as soon as practicable.

   Foston Hall has accepted this recommendation (annex 8)

4. Ensure that he has properly trained staff to carry out the role of Family Liaison Officer

   Foston Hall has accepted this recommendation (annex 8)

The Governor and Primary Care Trust should:

5. Review communication between healthcare and prison staff.

   Foston Hall and the PCT have accepted this recommendation (annex 8)

The Primary Care Trust should:

6. Review communication between healthcare staff when prisoners express suicidal thoughts.

   The PCT has accepted this recommendation (annex 8)

7. Ensure that referrals to healthcare take place as requested.

   The PCT has accepted this recommendation (annex 8)

Good Practice

I have been most impressed by the prison's response to finding the woman hanging and then to her death. The staff who first found her responded quickly and efficiently to the emergency. The family liaison was sensitively handled. The woman's mother was told promptly and the Governor spoke to her when she rang the prison at 7.30pm. The way in which small groups of

prisoners were told the news was also most impressive, as was the professional support for them and for staff.