The death of a prisoner at HMP Buckley Hall on 1 June 2004

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

April 2005

This is the report of an investigation into the death of a woman who died on Tuesday 1 June 2004, at 5.07 pm in the local infirmary. The woman had been a prisoner at Buckley Hall prison and that day, at 4.00 pm, had been found in her single cell with a plastic bag over her head, which was secured by shoelaces around her neck. This report sets out my findings.

I offer my sincere condolences to her family. Despite coping with her mental health problems, they remained loyal, loving and supportive. I have great respect for the dignity they have shown.

I also offer my sympathies to the management and staff at Buckley Hall. They work under difficult circumstances with large numbers of vulnerable women. The number of deaths that have been prevented thanks to the care and diligence of prison staff can never be truly quantified. When a death occurs, it has a profound effect on staff and they often feel personally responsible.

I am grateful to the Governor of Buckley Hall, for the help and hospitality received during the investigation. Every assistance was been made available to my investigators and all staff co-operated fully and readily with the enquiry.

An investigator from my office led the investigation and was ably assisted by two Prison Service Governors. I would also like to thank the Prison Service, for seconding to me two Governors to assist with the enquiry. Their knowledge, commitment and hard work have been of immense value in the investigation.

I am also grateful to Rochdale PCT for their help in conducting a comprehensive clinical review.

The woman had long-term mental health problems, exacerbated while in prison by her non-compliance with medication. This investigation has also revealed that the medication she did take was not always supplied at the correct time.

What part this played in her death can only be speculated upon. Likewise her transfer from Eastwood Park to Buckley Hall, a transfer that took the woman far from home and from local support networks.

The woman had been the subject of F2052SH procedures on four occasions. A decision to close the form is criticised in this report, although probably made little difference in practice.

I have also noted that the woman had attempted to harm herself using a plastic bag on two previous occasions (25 September 2003) and (9 March 2004), and spoken about this method of self-harm in a mental health interview on 12 May 2004.

This is a relatively unusual method of taking one's own life, although I understand it is more common amongst older prisoners and amongst women. I do not believe that a ban on plastic bags is feasible or would achieve anything in terms of the overall rate of self-inflicted death in prisons. However, any pattern involving an individual prisoner should obviously be taken into account in devising a care plan relevant to their specific needs.

This report has been anonymised for publication on the website of the Prisons and Probation Ombudsman.

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

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Summary

The woman was 40 years of age at the time of her death on 1 June 2004. She had a troubled life, which in her adult years included recurrent episodes of mental ill health and deliberate self-harm. Despite good support from both her family and community psychiatric services, she had difficulties in managing emotional and social stress, and over time she was involved in a number of impulsive incidents that caused risk to herself and others. On 18 September 2003, she set fire to the sofa in her flat. The woman was remanded into custody at HMP Eastwood Park and subsequently sentenced to 3½ years imprisonment at Crown Court on 26 March 2004. This was despite the recommendations from a consultant psychiatrist and the local probation service that she should be assessed as an in-patient in an RSH.

Whilst at HMP Eastwood Park her mental state fluctuated, and she was involved in at least four episodes that included threats of, or acts of, self-harm. This resulted in three periods when she was the subject of F2052SH supervision (suicide prevention procedures). The last of these concluded on 15 April 2004. Throughout this time, her mental health was not considered to be such as to require any transfer into the NHS. I consider Eastwood Park provided an appropriate and effective level of general support and care, including specific F2052SH supervision, throughout her stay at that establishment.

The woman was transferred to HMP Buckley Hall on 11 May 2004. The woman herself seems likely to have seen this move in a negative light, as it took her even further away from her family and other potential local support arrangements.

On 12 May at Buckley Hall, the woman was again monitored through the F2052SH procedures after she had indicated that she would harm herself at some stage using a plastic bag. Over the course of the next fortnight or so her mood remained variable, although there was no further indication of any act of or intention to self-harm.

On 27 May, a case review concluded that the F2052SH was no longer required. The view was taken that her circumstances appeared to be stabilising. This review did not take into account her decision to stop taking her medication. This points more generally to systemic deficiencies in the way in which Healthcare and uniformed staff at Buckley Hall share, document, and take account of all available information relating to individual prisoners at case reviews and during the associated care planning stage of the F2052SH process.

I consider that her F2052SH form should have remained open. However, it is unlikely that this would have resulted in any different practical supervision arrangements over the course of the next days through to her death. Her mood over the Bank Holiday weekend of 29-31 May appears to have been generally positive. The woman reported physical complaints, but no other apparent problems, when she spoke to a variety of staff over the course of 1 June. She received appropriate support and management.

The woman appears to have last been seen alive at 2.30 pm on 1 June, when she spoke with another prisoner and indicated she had no problems. She was discovered at 4.00 pm in her cell with a plastic bag over her head. The bag was secured by shoelaces tied around her neck. All appropriate attempts were made to save and resuscitate her. Sadly, she was pronounced dead at 5.07 pm.

Contingency plans were activated appropriately, with support being offered to both staff and prisoners immediately after the incident and in the longer term.

Communication with her family following her death was not well managed. They were told of the death by the local police on the evening of 1 June, but were unable to contact the prison that night to gain further information. A misunderstanding with the prison the next morning meant that the family discovered further details of her death from a newspaper report. This caused them great distress.

There are deficiencies in the prison's notification arrangements with bereaved families, and with telephone access. This should be remedied as a matter of urgency.

The investigation identified more sensible arrangements for the location of emergency response equipment. Changes have since been made to bring these into effect. However, I do not consider that the arrangements that were in place at the time in any way contributed to her death.

The report includes nine recommendations and identifies four areas of good practice. Additionally those made by the clinical review are endorsed.

Glossary Of Terms

Term used	Explanation/Definition
Adjudication	Prison disciplinary hearing
Basic regime	Restricted privileges such as association, visits and pay. Applied to prisoners who consistently fail to follow prison rules
CPR	Resuscitation, usually kiss of life and chest compression
Comms	Communications (as in Communications room)
Duty Governor	The Governor grade who for a fixed period, usually 24 hours, is "in charge" of operations whether physically in the prison or not
Escort	The staff responsible for moving prisoners from one place to another
Enhanced regime	Prisoners who conform to regulations and who receive additional privileges, e.g., additional visits
F200IMR	A prisoner's medical record
F2050	A prisoner's main core record
F2052A	History sheet for general observations
F2052SH	Documentation for recording the monitoring, care and support of prisoners identified as being at increased risk of suicide/self-injury
F2052SH Open	Prisoner is actively monitored under F2052SH procedures
F2052SH Closed	Prisoner was being monitored under F2052SH procedures but, following a case conference, not now considered to be at heightened risk
F2169	Medical reception assessment
Gov	Governor grade
HCO	Healthcare officer
HCSO	Healthcare Senior Officer
Healthcare centre	The prison's hospital wing and treatment centre
HMP	Her Majesty's Prison
Hot Debrief	A debriefing of staff as soon as possible after an incident
Hourly watch	Prisoner identified at risk of suicide/self-injury is observed at hourly intervals
NOO	Night Orderly Officer - the member of staff "in-charge" of prison at night
Observation book/log	General compilation of staff observations of prisoners
Officer	Prison Officer
Operational Manager	A Senior Prison Service Manager with responsibility for the operation of the Women's Prison Estate
Orderly Officer/Oscar 1	The uniformed Prison Officer (usually a PO or SO), initially managing incidents within the prison
Oscar 2	Orderly Officer's Assistant
Ordinary Location	The main prison wings

OSG	Operational Support Grade
Personal Officer	An Officer assigned to take close interest in a group of prisoners
PO	Principal Prison Officer
SO	Senior Prison Officer
Safe cell	A cell designed to make the act of suicide/self-harm as difficult as possible by, for example, minimising the number of ligature points
Self-harm/injury	Self inflicted harm or injury
Standard regime	Relates to the Incentives and Earned Privileges Process. A prisoner on a 'standard regime' is receiving the standard level of privileges
Unfurnished cell	A cell devoid of loose furniture
YOI	Young Offenders' Institution

Background

Establishment and Female Estate Background

In March 2002, Buckley Hall was re-rolled from an adult male to a closed female training prison, in response to wider national population pressures affecting the overall female prison estate.

Buckley Hall's Certified Normal Accommodation and Operational Capacity figures are ordinarily 350 and 385 respectively, although recently its capacity has been some 60 or so places below these levels, as a result of refurbishment work on one of its six residential units. Since the re-role the establishment's prisoner population has been drawn widely from across the country, and has also included significant numbers of foreign national prisoners.

The establishment has had a good history in the support and management of prisoners who have been vulnerable to self-harm and suicidal behaviour. Only one death by suicide has been recorded, and this was of a male prisoner in 1997. The woman's death was therefore a special shock to both staff and prisoners at Buckley Hall, as the establishment had taken pride in its efforts in this area. Most of the prisoners who were interviewed in relation to the woman spoke well of the care and support which staff are ready to offer women with regard to individual problems.

The establishment maintains an open and active regime, and, whilst some reference was made to occasional relationship problems in some areas amongst individual prisoner groups, the majority of prisoners who were interviewed compared their experiences at Buckley Hall favourably with those at other locations. The establishment was often characterised as being 'stricter' than other settings, although this was seen as a positive feature, and relations and interactions between staff and prisoners were also for the most part commented upon favourably.

In common with many other female and male training prisons, Buckley Hall has no in-patient Healthcare accommodation. A full and wide range of primary care clinics and services are available to prisoners through dedicated National Health Service general nursing and mental health teams, who provide 24 hour primary care cover with the support of sessional GP cover and other on call GP provision.

The wider female prison estate currently comprises 18 establishments. Seven of these establishments perform a local prison role, including HMP Eastwood Park, whose primary function is to hold women whilst on remand or until proceedings in court have been completed. The other 11 establishments are training prisons, three of which are open establishments, with Buckley Hall and seven other establishments together comprising the remaining closed female training prison estate.

The geographical spread of these establishments provides a poor match in certain areas of the country to facilitate individual prisoners' closeness to home. This is particularly true with regard to the West of England and Wales, and, as a local prison, HMP Eastwood Park draws the greater number of its prisoners from South Wales, Pembrokeshire, Cornwall, North Devon, Dorset, Wiltshire and Avon. There is also no

female training prison of any kind in the West of England. Eastwood Park attempts to fulfil such a Resettlement function for women from these areas, who are serving short sentences and who are assessed as needing to remain in closed conditions. When possible, it will accommodate women in similar circumstances for the final three months of longer sentences, after the bulk of their sentence has been served elsewhere in the female training estate. If wider population pressures dictate, it is not unusual for Eastwood Park to temporarily accommodate out-of-area remand and trial prisoners, should other female local prisons not have the immediate capacity to do so in their own right.

In the face of this overall picture, Eastwood Park is considered to fulfil its varying roles to best effect. It was the woman's misfortune that, once sentenced, she would have been assessed as being unable to remain in this establishment, despite its relative proximity to her home and family. HMP Buckley Hall in Greater Manchester and HMP Foston Hall in Derbyshire were then the primary closed female training prison allocation routes for prisoners in her circumstances, destinations which would equally apply to women whose homes might be as far away as Pembrokeshire or Penzance.

Investigation Process

The investigation team made an initial visit to the prison. This initial visit was very much for familiarisation with the establishment and for immediate fact-finding. Notices to Staff and Prisoners providing outline details of the Investigation were also drafted and issued, and informal meetings took place with the establishment's Governor and Deputy Governor.

On 14 June, the investigator visited the woman's family at their home, when he met with her mother, stepfather, two sons, brother and one of her two sisters. This visit gave an opportunity to explain how the investigation might proceed and to establish liaison arrangements with her family. They were able to raise a range of concerns and issues, at the same time as they provided a useful and significant amount of background information about the woman both prior to and after her reception into custody.

Another member of the investigation team subsequently visited the woman's mother and step-father, with her elder son also in attendance on 5 July. An update was then given of the progress of the investigation, with the family again providing further helpful details to clarify a number of issues and to improve the general understanding of her history. Further telephone contact with her family was also maintained both prior to and after this visit.

The investigation team met collectively for the first time at HMP Buckley Hall on 17 June. The team then took possession of the wide range of available documentation relating to the woman, and also took steps to commission other information that was not at that point to hand. Agreement was also reached as to the identities of those staff, prisoners and others whom the team might wish to formally interview as part of their inquiries, and related arrangements were made to give appropriate notifications to the various parties concerned.

The Senior Investigating Officer also met formally and individually with the establishment's Governor; the Chair of its Independent Monitoring Board, its Acting Compliance Monitor and two members of its local Prison Officers' Association Committee, to explain how it was expected that the investigation might proceed. All concerned were co-operative and helpful in their responses, something which characterised all of the exchanges in which the investigation team were involved both within and beyond the establishment, as their inquiries and full range of interviews took place across the remainder of June and the first half of July.

The Prisons and Probation Ombudsman asked the Rochdale Primary Care Trust to conduct a Clinical Review of the woman's medical care throughout her time in custody. Liaison was maintained with representatives of the Trust. Information and provisional thinking was freely exchanged between these two groupings, with this resulting, in some instances, in shared interviews with individual members of the establishment's Healthcare staff. Similar liaison was maintained once each side's respective inquiries and interviews had been

completed, in order to develop a common perspective on shared issues and documentation.

In addition to their inquiries at HMP Buckley Hall, the Prison Service Investigation Team also visited the woman's previous establishment, HMP Eastwood Park, to interview its Deputy Governor and its Safer Prisons Co-ordinator, in order to gain a better understanding of her time at that establishment and the circumstances surrounding her transfer to Buckley Hall.

An interview was undertaken with the woman's Community Psychiatric Nurse (CPN), whose contact with the woman dated back to the early 1990s. The National Probation Service were helpful in providing documents relating to her appearance for sentencing at Crown Court, several of which were of particular use with regard to her general background and her overall circumstances during the early part of 2004.

The Incident And Events Leading Up To The Death

The woman was first remanded into custody at HMP Eastwood Park on 19 September 2003, after she had appeared before the Magistrates Court on a charge of arson with intent to endanger life. Earlier that day, she had been assessed by a doctor in the local Accident and Emergency Ward. She displayed no psychotic symptoms or any other sign of active mental illness, appeared alert and well-orientated and, whilst describing previous suicidal thoughts, also indicated no current active intention to self-harm.

On reception at HMP Eastwood Park, the woman's mental health history and current medication arrangements were appropriately noted. She was then assessed using the Prison Service Cell Sharing Risk Assessment Tool (CSRA). This is a mandatory procedure designed to assess an individual's risk to others and is used as the basis for allocating a prisoner to either single cell or other shared accommodation. She appears to have been correctly assessed as high risk for any form of cell sharing, given her earlier history of violence towards other patients in psychiatric institutions.

On 25 September 2003, after the woman had previously been assessed as fit to attend the next day's remand court appearance, she rang her cell bell and was found by staff with a cellophane bag over her head which was tied with a very loose ligature. The woman then remained in her existing location and became the subject of F2052SH procedures, the Prison Service's supervision, support and management arrangements for prisoners who are considered to be at risk of suicidal or self-harm behaviour.

The woman remained the subject of continuing F2052SH supervision, with reports being received on 10 October that she had been asking other prisoners to help her to kill herself. On 5 November, the woman made superficial cuts to her wrist, and following a subsequent fuller assessment on 7 November, when she was found to be very confused, verbally aggressive and agitated, she was located in the Healthcare Centre. It was also noted that she had previously failed to have her depot injection on 26 October. This was then administered and her subsequent mood monitored. the woman then appears to have stabilised, and on 18 November her F2052SH form was closed, although she continued to be held in the Healthcare Centre as this was considered the most appropriate current location for her supervision and support.

On 1 January 2004, deterioration was noted in her mental health over the course of the previous 24 hours, as she appeared unsettled and agitated and was expressing some bizarre statements and paranoid ideas. The view was then taken that her existing medication should be maintained, with continued monitoring of her associated mood. On 8 January, the doctor again saw her for assessment relating to his psychiatric report for the court. It was his view that her mental health did not warrant any transfer to hospital at that time, and that continued liaison should instead be maintained with her care staff at HMP Eastwood Park.

On 17 January, the woman was again made the subject of F2052SH procedures after she had been found having tied a ligature to a table leg, and was constantly tearful and generally low in mood. the woman once more appears to have stabilised after this episode, and her F2052SH form was closed on 3 February. She continued to be located in the Healthcare Centre.

On 9 March the woman was once more made the subject of F2052SH procedures after night staff during their routine rounds discovered her with a plastic bag over her head with an accompanying ligature. She then indicated concerns about her forthcoming Crown Court appearance for sentencing and about the welfare of her sons.

The woman was sentenced to 3½ years imprisonment at Crown Court on 26 March. Both the doctor's report and her Probation Service Pre-Sentence Report had recommended that a further adjournment be made to allow a fuller psychiatric assessment in a regional secure unit, and both the woman and her family appear to have been surprised and disappointed that this option was not adopted.

The sentencing Judge indicated that, given the circumstances of the offence, his main concern had to be the safety of others and that it was clear to him that at that time he could not take the risk of her release. He added that, for the same reason, he did not feel able to consider the suspended sentence option, which her legal representatives appear to have instead canvassed at the hearing, also stating that he did not consider that such an option could be justified under the relevant accompanying legislation.

On her return to Eastwood Park, the woman was again initially located in the Healthcare Centre and continued to be the subject of F2052SH supervision, but she then moved to A Wing cell 1-18 on 30 March for standard sentenced prisoner induction arrangements. She was further relocated to E Wing cell 1-04 on 2 April. At the time of her move to A Wing, the woman threatened that she would involve herself in a joint suicide pact with a fellow prisoner, although this was interpreted as an attempt by both parties to manipulate their location in the Healthcare Centre. The woman otherwise appeared to be generally stable at this time, and indicated that her current medication regime appeared to be effective. Her F2052SH form was accordingly closed on 15 April.

On 10 May, the woman was given notification that, together with five other similarly sentenced prisoners, she would be transferred to Buckley Hall on the following day. These arrangements had been directed by the Prison Service's Population Management Unit as part of a wider co-ordinated set of moves to best utilise prisoner accommodation at both Eastwood Park and other establishments in the female estate. The woman was disappointed at this news, and she indicated to staff that she was expecting a visit from her mother and her sons, in the company of her CPN, later in the week, together with a subsequent psychiatric review. She asked if her move might be delayed in these circumstances, but no alternative arrangements were then made. The woman advised her mother of this development in a telephone call later in the day,

when, whilst still indicating her disappointment, she concluded on a more positive note that this move might give her the opportunity for a new start and better prison employment.

The woman was then received at Buckley Hall on the afternoon of 11 May, together with the five other prisoners from Eastwood Park. As sentenced prisoners, all were familiar with prison reception procedures and were taken through the processes relating to prisoners who have been transferred from other establishments. Her identity and property were checked and she would have been given some immediate information about her new establishment. The reception building at Buckley Hall is purpose built, well lit and decorated. Information about the support available for prisoners and the Prison Listeners Scheme is displayed on notice boards in the Reception area.

A reception officer then also identified the woman as a high risk on the cell sharing risk assessment, whilst the CPN identified her as a medium risk. A manager's assessment is required to confirm the CSRA and, in her case, Acting Manager F, reviewed the recommendations and concluded that the woman should be located in single cell accommodation.

As part of Buckley Hall's Reception process, a member of the Mental Health Team interviews all newly received prisoners. This practice is not a mandatory requirement of the Prison Service, but is regarded as good practice in assessing the vulnerability of prisoners who have been newly received into prison custody. A CPN saw the woman on the following day, 12 May. During this interview the woman stated that she would harm herself at some stage and that she would use a plastic bag. She also stated to the CPN that she would 'not be coming back from this'. On hearing this statement, the CPN made the decision to open an F2052SH at risk form and to initiate associated monitoring procedures from 12:45 that same day. At this stage the woman did not offer any more detailed account of her vulnerability, and no subsequent statement was made to staff.

Following completion of the reception process, the woman was located on the D Wing Induction Unit in cell 1-17. This unit provides newly received prisoners with accommodation during a structured induction programme, which is delivered over a two-week period and includes educational assessments, allocation of work placements and opportunity for familiarisation with establishment rules and procedures.

Whilst on the Induction Unit the woman was allocated a Personal Officer, a standard procedure for all prisoners. The primary purpose of the Personal Officer Scheme is to provide prisoners with a named contact in order to discuss issues and assist prisoners in adapting to life in prison. The woman did not express any specific concerns to her Personal Officer. She did not disclose an increased vulnerability. It would appear that, during her stay on D Wing, the woman seemed to give the general impression to staff and prisoners that she was settling into life at her new establishment. The woman also specifically told her Personal Officer that she was happy at Buckley Hall.

The woman was described by her Personal Officer as a very pleasant and polite individual. She complied fully with the Induction programme but did not seek out the company of others. Her presentation to staff was described as reasonably consistent, and her demeanour during this period did not cause staff a heightening level of concern. However, her Personal Officer also stated during interview that she was aware that the woman was a rather fragile person and that she spent a lot of time on her own. Her fellow prisoners described her variously as a loner, a quiet individual, and someone who chose to spend a lot of time alone.

The woman remained on an open F2052SH throughout her period on D Wing. Her Personal Officer stated that she did receive additional support during this period although the woman appeared to be preoccupied with concerns about her physical health. On a number of occasions, the woman stated to staff and other prisoners that she experienced difficulty in relation to physical pain as a result of multiple injuries which she had sustained in 1993. Some of her concerns focussed on her ability to undertake the work to which she had been allocated. She stated that she wished to speak to Healthcare staff in order to gain a doctor's exemption from work. Her Personal Officer also stated during interview that the woman sometimes had difficulty using a knife and fork.

On 14 May, her medical records also note that she was referred for consultation with a Consultant Forensic Psychiatrist. On 17 May, the woman stated to Healthcare staff that she was stressed and not sleeping. On 19 May, she attended Healthcare to report that she was sick and to complain of back, leg and arm pain. She stated that she had arthritis and was given a sick note, exempting her from the requirement to participate in regime activities for the rest of that day.

The woman refused food on six separate occasions, 12 May, 21 May (twice), 22 May, 24 May and on 25 May, the day on which she was moved to E Wing. There is no documentary evidence that this information was used as part of the F2052SH review or that the woman was spoken to about the reasons why she was not eating all her meals. However, it appears from her medical records that she felt her medication caused her to put on weight and that she sometimes limited herself to one meal a day. At other times, the woman was observed by fellow prisoners as having a good appetite and eating well.

On 17 May, the woman was seen by the wing SO and a CPN for the 72hr Review of her F2052SH at Care Plan. She stated that she continued to have thoughts of self-injury but that she was attempting to think positively and attempting not to act out those thoughts. The outcome of the review was to maintain the F2052SH monitoring procedures.

The woman complied fully with the D Wing Induction programme, and she was allocated to work in Workshop 3 on 24 May. Workshop 3 is a packing workshop where prisoners are involved in a range of activities related to re-packaging curtains and other smaller items. She was also allocated accommodation on E wing, and moved there from D Wing on 25 May at 10.30 am to cell 1-09 where

she remained until her death on 1 June. The woman remained on her F2052SH at risk form.

During this period, a number of entries were made in her medical records which suggest that she was struggling with the range of duties in Workshop 3, and that she stated that she was experiencing pain as a result of her previously sustained injuries. It should be noted, however, that her initial task in Workshop 3, the folding of curtains, was changed to work involving cotton wool balls. This was because she had found the initial work too complicated, rather than too physically onerous. With hindsight, her complaints relating to her physical health were probably not particularly the product of the demands of this work, but rather more indicative of her overall response to her immediate circumstances and her feelings about her situation in general.

On 27 May, the woman was seen by another wing SO and a CPN to review her F2052SH arrangements. The woman stated during this review that she was not taking the medication prescribed to her for her mental health conditions, although this was not recorded in the F2052SH. She stated that the medication had many side effects and that she needed time without the medication. the woman was asked if she had any thought of self-injury or any hallucinations, and she stated that she did not. It appears that the woman presented throughout feeling better and that her mood was apparently stabilising.

The outcome of the review was to close the F2052SH at risk form and to place the woman on an extra support card. The use of extra support cards is not a mandatory requirement of the Prison Service F2052SH at risk procedures. The cards are used as part of Buckley Hall's additional support to those who may no longer require monitoring as part of the F2052SH procedures but who may continue to need informal staff support in relation to specific issues. It is not clear that her medical records were accessed as part of this review, or that her refusal to take prescribed medication was explored in depth during this assessment, which is therefore now considered to have been at least partially deficient. Given the fact that the woman remained the subject of extra support card arrangements, her level of supervision would not have differed greatly than if her F2052SH had remained open, although it is still considered that this decision to close the F2052SH at that time was not soundly based. This appears to highlight a potentially systemic weakness in the way that Healthcare and Residential staff shared, or documented, information relating to her.

Over the course of the Bank Holiday weekend of 29-31 May, the woman appears to have interacted quite naturally with other prisoners and staff on E Wing. With the help of another prisoner her hair was braided, and her overall mood is reported to have been generally positive. Although a series of letters to her parents reflecting this apparent upswing are undated, these would also appear to have been written during this period.

On the morning of 1 June, it appears that the woman was unlocked at 7:30 as part of the normal E Wing routine. During this period prisoners eat breakfast

and have an opportunity to take exercise in the open air. Those attending work then leave the unit to attend workshops at approximately 8:30.

The woman was seen at approximately 8:45 by a landing officer, when she asked if she could remain in her room that morning. She stated that she did not feel well and that she wished to make contact with Healthcare in order to resolve her concerns about attending work in Workshop 3. The woman stated that she was registered disabled and that it was her understanding that disabled people are excused from the requirement to attend for work. She also restated her concerns about her physical health in relation to pain management, but gave no further indication of any other problems.

The officer responded to her concerns by allowing her to rest in her room that morning and stated that she would contact Healthcare and make enquiries in an attempt to clarify the position on prisoners' exemption from work. the woman then remained in her room all morning. We have no report as to whether or not the woman ate her lunchtime meal. However, no records of any refusal to take a meal were made in the appropriate wing register. Given its postmark and receipt later in the week, it seems possible that during this morning period the woman may have written an undated letter and posted this to her CPN in the community, in which she indicated the intention to take her life. None of this was reflected in her exchanges with the staff or other prisoners who came into contact with her during the course of that day.

Shortly after 13:00 and the lunchtime roll check, the woman appears to have had separate conversations with officers, during which she restated her request to remain in her room that afternoon, and to not attend activity in Workshop 3. The woman repeated that she was registered as a disabled person and she wished to be excused work as she experienced difficulty as a result of her physical infirmity. At no time during these conversations did the woman state that she was feeling low in mood or that she had any suicidal intentions. the woman was allowed to rest in her room, and assured that enquiries would again be made with Healthcare about her possible exemption from the requirement to attend work.

At approximately 13:15, the woman was called to attend the wing interview office for an interview with the CPN. This interview formed part of the ongoing support for prisoners with mental health problems and was not a response to heightened concerns about her medical condition. The interview was not connected to any formal follow-up procedures for those recently removed from the F2052SH monitoring arrangements. The woman had not herself requested to see the Community Psychiatric Team.

The woman was not accompanied by any wing staff during this appointment. During the 30-minute interview, the woman presented a positive outlook and did not state at any time that she had suicidal intentions. No specific concerns were raised with the CPN.

At the conclusion of the appointment, it appears that the woman made her way back to her cell. There are no reported sightings of the woman during this period. However, it is common practice for those attending such interviews to make their way back to their accommodation using their personal issue courtesy key. The wing cleaner and fellow prisoner stated during interview that she subsequently observed the woman standing at her cell door and that the door was unlocked at about 14:30.

After this last exchange there were no further reported sightings of the woman and there were no recorded call bells from cell E1-09.

Post Incident Response

At approximately 15:55, two of the landing officers became aware that an iron, available for prisoners to use on E wing, was missing, and they began searching for this item moving from cell to cell in turn.

Approximately five minutes later, one of them unlocked cell 1-09. During interview, he stated that he entered the room and observed the woman lying on the bed, facing the wall. He began a visual search of the room. He stated that he was not aware of anything immediately unusual and thought that the woman was asleep on her side. He expected that the noise he created in the room would awaken her. When this was not the case, he spoke out loud to explain his presence. It was at this stage that he became concerned about the lack of response from her. He then went across to the bed, standing directly over her.

The officer then became aware that the woman was not asleep and was lying on her side with a plastic bag over her head. The bag was secured by shoelaces tied around her neck. He immediately called for assistance from the other landing officer, who was next door at this point searching for the iron, turned the woman onto her back and removed the plastic bag and shoelaces, which were securing the bag around her head.

The officer finding her raised the alarm using the radio urgent message procedure. The message was called over the radio net as a Code Blue. This Code is used to identify that there is a medical emergency requiring resuscitation or that a prisoner is experiencing breathing difficulty. The officers were not clear that the urgent message procedure had been received by the Radio Control Room, as a number of difficulties had been previously experienced by staff using the radio net that day. Without clear acknowledgement that the urgent message had been received, the officer that responded therefore left the cell to phone in the message at 16:06, using the telephone in the E wing office.

At this point two other officers were despatched to ensure that all other prisoners on E Wing were locked into their rooms. The wing SO attended the cell and ensured that the Radio Control Room was informed that paramedical assistance and an ambulance should be called to the prison to attend to her. At the same time, Healthcare staff had been informed of the Code Blue medical emergency on E Wing and two nurses made their way from the Healthcare Building, taking with them oxygen and emergency equipment.

On arrival, the nurses took over care of the woman and continued resuscitation. An initial assessment of her medical conditioned confirms that the situation was very serious and that her condition appeared to be life threatening. One of the nurses's stated during interview that the woman did not appear to be breathing and that they could not find a pulse. The other nurse requested the defibrillator be brought from Healthcare and the officer finding her was despatched to collect it. The Healthcare Manager and a third nurse also attended the scene and took

part in operating the defibrillator and monitoring the woman for any indication of breathing.

Paramedics and an ambulance attended the prison at 16:20. Both were given access to the prison without delay. On their arrival at E Wing, staff ensured that access to her cell was unimpeded. Healthcare staff handed over her care to the emergency paramedics, who then determined that the woman should be transferred to the Infirmary as her condition appeared to be critical. The ambulance departed the prison without delay at 16:40.

At 17:07, prison staff were informed that the woman had unfortunately been pronounced dead at the Infirmary.

At approximately 17:15, the Police, Duty Independent Monitoring Board member, and the Chaplain, were also informed of this outcome. The Deputy Governor then conducted an immediate post incident debrief and ensured that the Care Team were informed and available to provide support and guidance to staff and prisoners. Prisoners were informed of her death in small groups and permission for a longer period of association was granted in order to provide the opportunity for peer support.

The police local to her family informed them of her death later that evening. The establishment telephone numbers were given to her family by the police together with limited information. Despite her family's continuing efforts to get through to the establishment by telephone, it was not until the morning of 2 June, that they were finally able to speak to Deputy Governor.

The telephone conversation appears to have taken place on the basis of a misapprehension on Deputy Governor's part. She believed that the family was already fully aware of the circumstances of her death, and, on that basis, such details were not provided. In fact, the family only knew that the woman had died, by apparently taking her own life, but not how this happened. This was regrettable, with matters then being further compounded by the family only discovering this information when reading a report in a national newspaper, whose source would appear to have been a Headquarters press briefing. This aspect of the whole affair can only have added to the general distress experienced by her family.

Further communication with the family was well handled.

Level Of Compliance With Authorised Procedures

The applicable areas where compliance has been assessed are:

- Management of prisoners at risk of self-injury or suicide
- Compliance with contingency plans

Management of Prisoners at Risk of Self-Injury or Suicide

The Investigation team recognised a significant establishment commitment to Safer Custody and support for prisoners in particular. Staff at Buckley Hall appear to be conscientious in their approach to the care of prisoners at risk and compassionate in their response when concerns are raised about individual wellbeing.

The establishment has a Suicide Prevention Co-ordinator (SPC). The SPC also has responsibility for a residential Unit at Buckley Hall. However, it was clear to the Investigation Team that the SPC exhibits high levels of personal commitment to Suicide Prevention and to compliance with Prison Service Procedures and Standards of care for those at risk.

The quality of entries made in the woman's F2052SH documentation was variable and lacking detail outlining meaningful interactions. It would have been particularly beneficial had her F2052SH accompanied her to her place of work and entries made to provide residential staff with more information about her demeanour and attitude in the Workshop.

Her F2052SH was due for a mandatory 72hr review on 15 May. This did not take place until 17 May, at this point the 72hr review was some 40 hours overdue. It is mandatory for all 72hr reviews to take place within the specified timescale.

Compliance with Contingency Plans

Compliance with the establishment's Death In Custody Contingency Plan was good on the whole. It would appear that staff were clear about their responsibilities and fulfilled tasks with diligence and sensitivity.

Incident Management at the Scene was good and appeared to be well led by those managers involved. A log of events was taken at the Scene and care was taken to ensure that the impact on the regime was limited to provide an appropriate level of care for all other prisoners.

It seemed to the Investigation Team that Section 4.7 of the establishment's Death In Custody Contingency Plan was not completed. This Section provides a comprehensive log of information related to the death of a prisoner at Buckley Hall.

Whilst the Investigation Team did not conclude that the issues relating to the radio net significantly affected the establishment's response, it is clear that a fully functioning communications system is vital to the implementation of any Contingency Plan Response.

Findings

The woman had a troubled history, childhood and from her early adult years she had repeated episodes of mental ill health. Despite the support of her family and community psychiatric services, she had periods of difficulty in coping, and was sometimes a risk to herself and others.

Whilst at Eastwood Park, her mental health was at times variable. She was involved in at least four episodes which included threats of, or acts of, self-harm, which resulted in three periods when she was the subject of F2052SH supervision, the last of these concluding on 15 April 2004. Throughout this time, however, her mental health was at no time considered to be such as to require any transfer into the psychiatric system. Against this background, Eastwood Park is seen as having provided an appropriate and effective level of support and care for the woman over the course of her time there.

In particular, Eastwood Park is considered to have made a correct Cell Sharing Risk Assessment with regard to her, given her earlier history of violence towards other patients in psychiatric institutions and the nature of her immediate offence. Her location in normal residential prisoner accommodation during the final weeks of her stay at Eastwood Park is also regarded as having been appropriate, given the apparent relative stability of her circumstances once she had been sentenced.

The overall current configuration of the female prison estate, and the related absence of any female training prison of any kind for the West of England, then resulted in the woman being allocated and transferred to Buckley Hall, an establishment a considerable distance from her family and other local support networks.

Buckley Hall currently draws its prisoner population across the country, including women prisoners with such a sentence length as her from the West of England. It has a regime that offers prisoners opportunities to gain educational and employment skills in order to better equip themselves for their return to the community. The establishment also appears to be well-regarded by the greater part of its prisoner population, with more or less all of the women interviewed in the present inquiries commenting favourably about the care and support which staff were ready to offer women with regard to any individual problems. Her own move there would seem likely to have prompted significant anxieties for herself, however, given its unfamiliarity and distance from her family.

The arrangements relating to her reception and induction at Buckley Hall look to have been managed correctly and with sensitivity. She was sensibly made the subject of F2052SH procedures, whilst appropriate community psychiatric nurse support was deployed which was then maintained on an ongoing basis. This included exchanges with psychiatric services in the community to better inform their future local engagement with her. The confirmation of the previous Cell Sharing Risk Assessment relating to the woman also appears to have been soundly based. At the end of her fortnight's induction period on D Wing, the

woman remained the subject of F2052SH arrangements. Her exchanges with both staff and prisoners at this point suggest that she was gradually adapting to her new environment. Her transfer to E Wing and her allocation to activity in Workshop 3 appear to have been appropriate in these circumstances. Whilst the woman may still have had issues relating to pain management, the particular work in which she was engaged was in no respect physically demanding.

On 27 May, a formal review was undertaken, with the woman in attendance, of her F2052SH arrangements. She appeared to those present to have successfully managed both her immediate move to E Wing and her introduction to Workshop 3, and no additional reports had been received from either the woman herself or any other party of any further intention to, or act of, self-harm. With this information, it was concluded that she might be more appropriately managed by the closure of her F2052SH, but still being the subject of the establishment's local extra support card arrangements. It was at the same time also noted that the woman was not currently taking her prescribed medication.

This refusal of medication is not considered to have been given proper weight in the wider assessment of her overall situation. Whilst there was no means of compelling the woman to take her medication, she had a previous history of a reduced tolerance to stress when not complying with her medication regime. Despite her own presentation, and the other ostensibly more positive aspects of her immediate situation, it would therefore seem preferable to have maintained F2052SH supervision until any issues relating to her medication had been fully resolved, and for her to have returned to full compliance with such arrangements. Whilst subsequent developments suggest that the continuation of existing F2052SH arrangements may ultimately not have had an impact on the outcome of events, this decision to end such supervision is still considered to have been ill-founded, and not to have paid sufficient heed to her previous medical history.

Her mood throughout her time at Buckley Hall would look to have swung up and down, although this would seem to have been more apparent privately and in her own communications with her family. Her characteristic presentation to staff was generally more positive than this, with issues relating to physical pain being the only specifically reported problems after her statement on 12 May to the CPN that she would harm herself at some stage. On the Bank Holiday weekend of 29-31 May, the woman had various exchanges with other prisoners, staff and her family, which each indicated that she was rather more settled than she had been at that earlier point.

Against this background, there was nothing in her exchanges with both staff and prisoners on 1 June to suggest any basic change in her apparent outlook, other than her report of physical pain that prevented her from attending work. It is possible that during the course of the morning the woman wrote to CPN in the community to indicate that she intended to take her life. However, the woman shared none of this with the staff and prisoners with whom she spoke over the course of the lunchtime and early afternoon period.

After her last reported interaction with a fellow prisoner at 14:30, there looks to have been no further contact with her until the landing officer entered her cell at roughly 16:00, as part of the search for the missing iron.

The establishment then activated its internal Contingency Plans appropriately, and offered good support to both staff and prisoners immediately after the incident.

Communication with her family was initially not managed well. Incorrect assumptions were made about the information that had been passed on by the police. Her parents were unable to make telephone contact with the establishment for a period of almost 12 hours following the first notification of her death. Contact finally took place and full details of what had happened were, inadvertently, not provided. The family's distress was then further compounded after they learned of the fuller picture from a report in a national newspaper. Later exchanges between the establishment and her family were managed well, but this earlier and important phase was, regrettably, clearly mishandled.

An inquest was held into the woman's death in December 2009 at Heywood, Lancashire. The jury unanimously returned a verdict that "[the woman] took her own life whilst she was suffering from an enduring mental health condition".

Conclusions

There was an awareness of the woman's vulnerability at both establishments, even if the woman may not have enjoyed in either setting the closer and longer established relationships that were associated with her life in the community. This lack of familiarity, and her failure to sometimes present herself and her concerns directly or accurately to those involved with her care, would look to have made it difficult to assess her true mood on a day-to-day basis. On the Bank Holiday weekend which immediately preceded the day of her death, there would seem to have been reasonably consistent indications in her exchanges with other prisoners and staff at Buckley Hall, and with her own family, of at least an apparent stability.

The only factor which in any way stands against this judgement would look to be an underestimation, or lack of effective awareness, of her decision to at least temporarily stop taking her medication, something which, on other occasions in her past, had often been a precursor to problems. The decision to close her previous F2052SH form on 27 May is seen as being ill founded in this light.

Had greater weight been given to this medication issue, it seems unlikely that any significant change would have been made to her immediate supervision. The options for her care in any prison setting might at any time cover a spectrum from constant observation, in a highly controlled environment, through to the general support arrangements for somebody who was known to have some vulnerability that were in place at the time of her death. But it seems reasonable to suggest that it would have only been the former option that might have led to any different outcome in her case. The extended use of such arrangements for any prisoner effectively removes from the individual concerned any sense of control or normality, and then excludes them from any of the wider opportunities of a prison's regime. Taking every factor into account, it is hard to see that this would have really been an appropriate or the preferable option under which the woman might have served her sentence.

From this perspective the efforts of both Eastwood Park and Buckley Hall to manage her care are seen as having been appropriate.

The current overall population management arrangements and limited allocation options that apply in the female prison estate, and which resulted in her allocation and transfer to Buckley Hall (and some considerable distance from her family and other local support systems) are at the same time seen as an aggravating factor in her underlying circumstances and prospects. From her point of view, it seems likely that she will have seen her move to Buckley Hall in a negative light, as it took her even further away from her family and other local support arrangements.

With the exception of the decision to close her F2052SH form on 27 May, both Eastwood Park and Buckley Hall are considered to have otherwise managed her appropriately under the general provisions relating to F2052SH arrangements. On the basis of this last specific instance, however, consideration needs to be

given to the extent that Healthcare and uniformed staff at Buckley Hall are fully and effectively sharing, documenting and taking account of all available information relating to individual prisoners at each review and associated decision-making stage of the F2052SH process.

Although her F2052SH form may have been wrongly closed on this last occasion, E Wing staff at Buckley Hall still offered the woman appropriate contact and support, and in response to any specific issues which she raised, over the course of both the Bank Holiday weekend and on the day of her death.

Following the discovery of the woman in her cell on 1 June, proper and concerted attempts were made to resuscitate her.

Contingency plans were appropriately activated, and good support was provided locally to both staff and prisoners in both the immediate and longer-term aftermath of the tragedy.

Communication with her family following her death was regrettably not well managed. Mistaken assumptions were made about what information had been made known to them, and this would point to deficiencies in procedures for notification arrangement with bereaved families. Over the course of the night following her death, her family – despite consistent efforts – were also unable to get through to the establishment by telephone, and improved procedures are clearly required in this area.

Recommendations

1. The practice of holding F2052SH reviews without prior access to all relevant prisoner information should be discontinued.

2. Case reviews should be multi-disciplinary with the attendance of health care professionals with appropriate knowledge of the prisoner.

3. The establishment Suicide Prevention Leader should ensure attendance of multi-disciplinary staff at F2052SH reviews, and that a greater emphasis be placed on all appropriate departments contributing to the Suicide Prevention procedures.

4. Buckley Hall's radio communication system should be audited and a full maintenance check should be completed in order to satisfy the establishment requirement in providing an effective incident response.

5. The Investigation Team found that there was a lack of clarity about the medical emergency response codes and this placed additional stress upon those providing the response and in dealing with the situation. Clear written guidance should be issued to all members of staff and necessary training be initiated for all staff at Buckley Hall.

6. The Healthcare Manager should prepare recommendations on the appropriate location of emergency response equipment at Buckley Hall.

7. Post death in custody protocols should be reviewed to incorporate a clearer emphasis on the provision of information and support for bereaved families, including an identified point of contact.

8. Arrangements for communication after such tragedies should be immediately reviewed and a dedicated phone line and number be enabled. These arrangements should be made known to bereaved families when first contact is made.

9. Buckley Hall should investigate the possibility of utilising training to enhance their support for bereaved families, through attendance on the Family Liaison Course.

Good Practice

1. The Buckley Hall Care Team appear to have acted in an exemplary manner throughout the post-incident period following her death. Their actions would look to have made a significant contribution towards reducing the stress and anxiety amongst those staff and prisoners who were most affected by these sad events. Support was offered to those concerned with sensitivity and compassion, together with a great deal of practical guidance and information. This particular area of activity impressed the Investigation Team as a clear area of excellent practice.

2. The establishment's general response to its prisoner population following the death of the woman is also considered to be worthy of commendation. The arrangements for a local memorial service - which was attended by some 250 members of the Buckley Hall prisoner and staff community - seems to have been universally well-received by those prisoners with whom we spoke. This collective opportunity to remember the woman would also look to have been accompanied by other individual examples of support and opportunities for personal grieving.

Recommendations Re: Staff Performance

1. The efforts of the officers and their interactions with the woman on the day of her death should be recognised as having been appropriate, in the light of the information that was available to them about her immediate circumstances. All three of these Officers responded to the woman with diligence and support to her presenting needs, and made what seemed at the time to be the right arrangements for the woman to stay off work, and for her to be referred to Healthcare for further assessment of her reported physical problems.

2. The emergency response of nurses should also be commended. Both acted in a thoroughly professional and appropriate manner throughout the incident, with both themselves and all other Healthcare staff who attended also trying to serve her interests with care and compassion.