Investigation into the circumstances surrounding the death of a woman at HMP Styal in June 2007

Report by the Prisons and Probation Ombudsman for England and Wales

May 2009

This is the report of an investigation into the circumstances of the death of a woman, who died in June 2007 whilst in the custody of HMP Styal. She had been found hanging in her cell less than two days after her arrival.

I would like to offer my sincere condolences to the woman's family and all those touched by her death.

Immediately after the woman's death, the police investigated the care she received whilst she was in prison custody. The police commissioned a former prison service governor to assist them. A number of issues were raised, but the Crown Prosecution Service (CPS) decided that criminal charges would not be brought.

My investigation was delayed by over 14 months and only began after the police and CPS completed their work. I apologise for any additional distress the delay may have caused to the woman's family.

The investigation was conducted by two of my colleagues. Both they and I would like to thank the Governor of Styal and the Liaison Officer, for their co-operation during the course of our inquiries. Undoubtedly, it was difficult for staff to be investigated by my office so soon after being investigated by the police, and I appreciate their helpfulness.

The woman had arrived at Styal on 1 June 2007, charged with the murder of her 19 year old son. She had been prescribed medication by her local doctor for anxiety following his death. After her arrest and whilst in police custody, she admitted to harming herself and was placed on suicide watch. This was the first time she had come into prison.

During the woman's brief time in prison (approximately 41 hours), staff did not identify any specific concerns in respect of suicide or self harm tendencies. She was a high profile prisoner and her case had featured in the local media. Staff were aware that she had been charged with the murder of her own son, was in custody for the first time and could be vulnerable. She herself appeared adamant that she did not have any suicidal or intention of harming herself. As a result the prison's suicide and self harm monitoring was not put into place. Due to the seriousness of the charge she faced, the woman was referred to the Mental Health In-Reach Team and was waiting for a mental health assessment when she died.

Having played some part in assisting Baroness Corston during her year-long review of women with particular vulnerabilities in the criminal justice system, I am all to well aware of the damaged and vulnerable women who arrive in prison. The woman, unfortunately, was all too representative of them.

I also acknowledge the population pressures faced at Styal. The Prison Service has to remember that prisoners are at their most vulnerable in the days that immediately follow their arrival at a prison. It is vital that any risk of self-harm or suicide is identified at an early stage, and appropriate care and support plans are drawn up, implemented and monitored. This is of even greater importance given that the incidence of self-injury among women is much higher proportionately than for the rest of the prison population.

I make eight recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **May 2009**

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SUMMARY

The woman was arrested by the police on Wednesday 30 May 2007, on suspicion of murdering her 19 year old son, who had been found dead two days earlier in the family home. Whilst in police custody, she told staff that she had been prescribed diazepam (commonly used to treat anxiety and agitation) by her doctor for her nerves following the death of her son. Due to the nature of the alleged offence, the police decided to conduct 30 minute observation reviews of her.

The woman was examined by a police doctor who authorised the continued use of her medication. Later that evening, she told staff that she was depressed. When asked if she had ever harmed herself, she responded by nodding her head. As a result of her demeanor and response, the police increased the level of supervision to constant.

The following day (Thursday), the woman was escorted to court, charged with the murder of her son and informed that she would have to return to the court the next day. She returned to police custody and the constant supervision resumed until the following morning.

On Friday morning, the woman was prescribed diazepam by the police doctor at her request. Shortly afterwards, she was transferred into the custody of Global Solutions Limited (GSL) escorting staff and taken to court. GSL were informed of her potential suicide risk and details of her medication were listed in the documents handed over to them.

GSL staff arrived at the Magistrates' Court at 8.45am. After reviewing the information about the woman's state of mind, staff opened a prison document called a Suicide and Self Harm Warning Form. The form was opened around 9.00am and staff made observations and comments about her until 2.25pm while she waited to appear before the magistrates.

The form highlighted that the woman had a history of harming herself by cutting and described her as being a vulnerable prisoner. She was checked approximately every ten minutes whilst in the court holding cells. She appeared before the magistrates and was charged with murder. Bail was refused and told that she would be remanded into prison custody.

GSL subsequently transferred the woman to HMP Styal, arriving at the prison reception area at 5.48pm. They informed prison staff of all the concerns and passed the documentation to the reception staff.

There had been significant media interest in the woman because of her alleged offence and some staff were aware of her imminent arrival at the prison. After she was booked in at reception, she was immediately spoken to in private by two senior prison officers. During their lengthy meeting, neither officer referred to the police or court documentation, and no record was made of the conversation. In spite of the Suicide and Self Warning Form included in her paperwork, she was not considered by the reception staff to be at risk of harming herself. The prison's suicide and self harm monitoring procedures were not opened.

After the routine reception screening was completed, the woman was escorted to the First Night Centre (FNC) and handed over to the staff on duty. She arrived at the FNC at around 8.30pm where she was interviewed by an FNC officer and a Healthcare Assistant (HCA). Afterwards, she was allocated to a single room on the first floor. No immediate concerns were noted in respect of her mental or physical health.

The following day (Saturday), the woman received a routine second health screening around 12.30pm. She was assessed by a Registered General Nurse (RGN) and the prison doctor. It was recorded in the notes that she was tearful, but had no thoughts of harming herself. Aware that she had been prescribed diazepam for her anxiety by her own doctor, the prison doctor authorised its continued use.

At 7.00pm that evening, the woman made a telephone call to her daughter using the prison PIN phone. The conversation related to her son's death and both she and her daughter became distressed. When checked by staff later that evening, she said she was fine.

The following morning (Sunday 3 June) the woman was unlocked at 8.00am and proceeded to collect and eat her breakfast. An officer on duty spoke with her briefly and her demeanor caused him no concern.

At 11.20am, the prison lifer officer arrived at the FNC to interview the woman and was directed by FNC staff to her room. The room appeared to be empty and the door was locked. When the officer looked through the observation panel, he could see her sitting behind the privacy screen which had a ligature tied to it. He immediately unlocked the door and tried to go inside but found it barricaded by furniture. The officer shouted for assistance and used his radio to announce an emergency call. He then began kicking and pushing the cell door until he was able to enter the room. He received assistance from other staff very quickly.

The woman was suspended by a ligature (made from a pillow case) from the privacy screen. Staff cut the ligature and requested an ambulance. Healthcare staff and two prison doctors went to her room and began cardio pulmonary resuscitation (CPR) to try to revive her. Unfortunately, she was pronounced dead at 11.54am.

This woman's was the second death in custody at Styal since April 2004 when my office became responsible for investigating deaths in prison custody. Since her death, a further four women have died. Of these, two were apparently self inflicted with the cause of death being hanging.

THE INVESTIGATION PROCESS

1. The investigation into the woman's death was opened by one of my investigators, on 6 June 2007 when he visited HMP Styal. He met the Governor and some of his staff. Notices of the investigation and terms of reference had already been sent to the prison to invite anyone with any information to contact my investigators. No prisoners came forward to be interviewed.

2. My investigator also met representatives of the Prison Officers' Association and the Head of Healthcare. He visited the reception and first night centre (FNC), where the woman lived during her short time in custody.

3. My investigator was due to return at a later date to conduct interviews accompanied by his colleague. However my investigation was suspended as a result of the police enquiries. The police were concerned about the level of care given to the woman throughout her time in prison. They believed that prison staff had not acted upon the suicide warning information provided to them on her arrival at prison. As a result, the police seized all prison documentation and interviewed a number of staff under caution. Their investigation included commissioning a former prison governor to assist them and assess their findings. The police willingly shared key documentation including staff witness interview statements, with my investigators.

4. Following submission of the police report to the Crown Prosecution Service, it was decided that criminal charges would not be brought against any individual within the prison. This process took approximately 14 months. The Governor of Styal was informed of the findings of the police investigation. Once my office was informed of the CPS decision, my investigators were able to resume their investigation.

5. My investigator informed the prison once again of the Ombudsman's investigation. Staff and prisoners were informed to contact him with any information they felt might be relevant to the investigation. There was no prisoner response to this. My investigator however conducted several interviews with staff accompanied by his colleague and fellow investigator.

6. My investigator fed back the findings of this report to the Governor following the interviewing of staff. A number of these findings had already been documented by the police investigation.

7. I also commissioned a clinical review from the local Primary Care Trust (PCT) to assess the woman's medical care. I am grateful to the clinical reviewer for his report.

8. One of my family liaison officers (FLOs) contacted the woman's daughter and informed her of my investigation. Her concerns about her mother's death are listed below. I hope that my report goes some way to addressing them.

- The woman's daughter believed her mother was clearly disturbed and mentally unstable – she had killed her own son and as the Prison Service knew the information, it is hard to understand why she was not on a suicide watch.

- A year after the woman's death, her personal belongings had yet to be returned to her family and this had caused them some concern. (The matter was followed up by my investigators and the belongings were subsequently returned to her family in December 2008.)

- Following receipt of my report, the woman's daughter told my FLO that her Aunt and Uncle said they had telephoned the police and the prison (although it was not known who they spoke to) before her mother died, to warn them that she had tried to commit suicide in the past and was at risk of doing so again. My FLO informed the woman's daughter that no evidence of this had come to light from the police or my investigation.

- The woman's daughter also said she was pleased to see that Styal had made a number of changes to improve procedures since her mother's death, although she was disappointed these changes had not been in place earlier and it took such a tragedy for such improvements to be made.

9. The woman's daughter told my FLO that she believed that her mother was depressed and had been for some time. However, instead of seeking help, she had used alcohol as a way of self-medicating to cope with her depression.

HMP STYAL

10. HMP Styal began life as a children's home in 1898. It was then used to house refugees, before finally opening as a women's prison in 1962. In April 1999, Styal's population increased in size by 60 per cent following the change of role from a training prison to a local prison, and the closure of the women's wing at HMP Risley. Today, Styal has an operational capacity of 460 prisoners.

11. Styal is the only local prison for women from the North West and North Wales. It holds mainly short term sentenced prisoners and those on remand awaiting trial. The prison also has a small number of women serving indeterminate sentences. Approximately 3,000 women are received through its gates every year.

12. Styal is essentially two prisons within one perimeter. The accommodation is divided into 16 Victorian houses or villas on one side, and the conventional prison block (Waite wing) on the other. The houses provide shared accommodation for sentenced prisoners and are self contained. Waite wing takes prisoners on remand. The Keller unit is for women who are prolific self-harmers or have serious mental illness. The prison has a separate Care Support and Reintegration Unit (CSRU), which provides temporary accommodation for prisoners who need to be segregated or are considered too vulnerable to remain in the main prison. There is also a mother and baby unit and Willow unit which houses young women from 17 to around 25. The woman was located in the First Night Centre (FNC), Oak House, which accommodates 25 prisoners. Styal does not have any safer cells in the establishment.

13. Between August 2002 - 03, there were six self inflicted deaths at Styal. All six women had histories of drug misuse. Five of the women were located on Waite wing, and one woman was in the CSRU. All died within one month of arriving at Styal.

14. Since those events, Styal has made considerable investment in reception, first night in custody and induction procedures. There is no longer an inpatient facility in healthcare and the original mental health facility, the Reeman Unit, has closed. A new mental health strategy has been put in place.

15. According to the prison service, women in prison tend to commit less crime and their offences are generally less serious. In 2006, 33% of sentenced women had committed drugs offences; 19% were convicted of violence against the person; 12% for theft & handling and 9% for robbery. Women tend to have a different type of drug use from men with higher levels of hard drug use. They are also normally the primary carers for elderly relatives and children. Up to 80% of women in prison have diagnosable mental health problems, with 66% having symptoms of neurotic disorders (anxiety, poor sleeping). The comparable figure in the community is less than 20%. Up to 50% of women in prison report having experienced physical, emotional or sexual abuse.

16. After a full announced inspection of the prison in September 2008, HM Chief Inspector of Prisons published a report which contained the following observations amongst her findings:

> "Styal is one of the largest women's prisons. All women's prisons hold a disturbed and challenging population, but at Styal the needs of a heavily substance-dependent population were extreme, complex and growing. On arrival at Styal, over a third of women said they had felt depressed or suicidal, over 40% said they had health problems, over half drug problems, and nearly 40% alcohol problems. The last was significantly higher than the 9% at comparator prisons, or the 10% on our last inspection three years ago.
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> "Reception and first night arrangements were mostly good, but induction needed improvement. Anti-bullying procedures were not robust. The level of self-harm was very high and procedures to support women at risk were inadequate."
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> "A number of interventions were delivered through the resource centre staffed by healthcare that aimed to support women who had been abused, raped or experienced domestic violence."
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> "The level of need and vulnerability of the women at Styal, even by the standards of women's prisons, was extremely high. Incidents of self harm occur on a daily basis. Between January and July 2008, there were 1,335 recorded incidents of self-harm with on average 190 incidents each month."

Recommendations made in the inspection report included:

- "Prisoners should wait in reception for as short a time as possible.
- The first night centre should be staff by dedicated and experienced officers who interact with and support new arrivals.
- New arrivals should receive essential fist night procedures irrespective of their time of arrival."

Assessment, Care in Custody and Teamwork (ACCT)

17. As at all prisons, ACCT has been introduced at Styal to monitor and support prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk. At ACCT plan review meetings, a prisoner's level of risk can be reviewed and noted as either 'Low, Raised or High' depending on the level of concern staff have about an individual.

18. Each prisoner is assessed within 24 hours (ACCT assessment) and then reviewed further at intervals decided on an individual basis. The ACCT

guidance says that, to be effective, the review should involve the people who know the person at risk or are involved in their care.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

19. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes, offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary, by application of the prisoner.

Cell Sharing Risk Assessment (CSRA)

20. In order to make sure that unsuitable prisoners do not share cells (for example to prevent the location of a known racist prisoner with someone of the targeted group or a prisoner with disturbed behaviour or mental illness from cell sharing inappropriately), a cell sharing risk assessment form is completed by reception when a prisoner is first admitted and is a live document which can be reviewed at any point and follows the prisoner on transfer to another establishment.

First Night Centre (FNC)

21. All prisoners who come into custody at Styal are initially located in the First Night Centre (FNC). On arrival from reception, the prisoner is interviewed by a FNC officer, a doctor and a nurse. After an induction period, usually of two to three days, women are allocated to the normal prison wings (known as houses) according to their needs. The FNC holds around 25 women consisting of a mixture of single and double rooms and a four bed dormitory room. All rooms have a safe for the storing of valuables. There are no designated “safer” cells in the FNC. Whilst on the FNC prisoners do not work or attend any education classes, but are allowed periods of association (time out of their rooms).

Induction

22. Induction is the process of introducing new prisoners or newly sentenced prisoners into custody. It is designed to explain the immediate consequences of being in custody, to explain the routines of the prison, rules and regulations they must observe, the procedures governing certain processes such as obtaining visits and to offer practical advice on obtaining goods and services as well as helping them to understand how to navigate their way around issues of imprisonment. The induction period includes sessions with various agencies such as Mental Health In-Reach Team, the chaplain, probation and CARATS. Staff check that prisoners understand what is going to happen to them and attempt to deal with any immediate problems.

Listeners

23. Listeners are selected prisoners trained by the Samaritans to provide a listening ear by a peer. Like Samaritans, they do not offer counselling but are there to offer support particularly for prisoners at risk of self harm. The support which they provide is confidential.

Mental Health In-Reach Team

24. Community Psychiatric Nurses (CPN) within the In-Reach team assess prisoners following concerns about their mental health being identified.

Prisoner Escort Record (PER)

25. The PER form accompanies each prisoner on all journeys between police, courts and prison, as well as any other journeys. It is compiled by the escort staff and gives a chronological record of the journey, for example that meals were served or the time that a journey started. It includes a section which records whether a prisoner poses any risks to themselves or others.

Prison Service Order 2700

26. The Prison Service has a duty of care for all prisoners and staff. This Prison Service Order (PSO) provides the Service with instructions on identifying prisoners at risk of suicide and self-harm, and on providing the subsequent care and support for such prisoners and support for the staff who care for them.

Reception

27. Prisoners are handed over to the prison reception staff and their paperwork is handed over by the escorting contractor. The prisoner is then booked in by prison staff at the front desk. Prisoner details are checked against the documentation received and relevant files are opened. Prisoners wait in a waiting room and are processed individually by staff. This includes being searched, providing information about prison, providing prison clothes, checking their property and answering any initial questions. After this process, prisoners are escorted to the First Night Centre. Dependant on a prisoners time of arrival, they are also allowed to make a telephone call on their day of arrival.

Women in custody

28. The number of women in prison custody in January 2008 was approximately 4,189. Prison Service states that women tend to commit less crime and their offences are generally less serious. In 2006, 33 per cent of sentenced women had committed drugs offences, 19 per cent were convicted of violence against the person, 12 per cent for theft and handling and 9 per cent for robbery. However this should not be overshadowed by the fact that the level of need and vulnerability of the women at Styal, even by the standards of women's prisons, is extremely high.

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KEY FINDINGS

Prior to the woman arriving at HMP Styal

29. The woman was arrested by the police at 8.15am on Wednesday 30 May 2007, on suspicion of murdering her 19 year old son. He had lived with his mother and had been discovered dead at their home the previous day.

30. Whilst in police custody, the woman told staff that she had been prescribed diazepam by her doctor for her nerves following her son's death. Due to the nature of her alleged offence, the police decided to conduct 30 minute observation reviews. She was examined by a police doctor who identified a scratch with bruising on her left wrist as well as bruises to the back of her legs and both arms. The doctor authorised the continued use of diazepam, describing her as being well in herself and not suffering from any current mental illness.

31. At around 9.00pm later that evening, whilst a review of the woman's detention was taking place, she informed the police officer that she was depressed. The officer asked her if she had ever harmed herself to which she responded by nodding her head, although she gave no further details. Her risk of self harm was raised and she was placed under constant supervision. This meant her cell door remained open and a member of the police custody staff remained outside the cell monitoring her.

32. The following day, Thursday 31 May at 5.05pm, the woman was escorted to court and charged with murder. The court took the decision that she should be remanded into police custody in order to appear before the Magistrates' Court the following morning, Friday 1 June. She was therefore returned to the police custody where she remained under constant supervision.

33. On 1 June, at around 8.40am, the police medical doctor authorised that the woman could be given three diazepam a day, at her request. She was then transferred to the custody of GSL escorting staff who were made aware of her potential suicide risk and details of her medication. Both were listed in the PER Part A and B escort documents and handed over to staff with other documents. In respect of the risk she was thought to pose to herself, the following information was recorded on the PER Part A document:

> "Charged with murder of her son. Intelligence has been received that the DP [detained prisoner] may self harm. She has a small cut to her wrist and has been kept on const s/v [constant supervision] whilst in police custody."

34. The escorting GSL staff arrived with the woman at the Magistrates' Court around 8.45am. The information they were given about her state of mind caused them to open a document called the Suicide and Self Harm Warning Form. She told the GSL escorting officer that she had other family to care for and would not do anything "silly". Nevertheless the form was opened shortly before 9.00am and staff made observations and comments about her until

around 2.25pm, whilst she waited to appear before the magistrates. The following was written about the woman:

> "DP [detained prisoner] states she does not self harm at this time she has not come to terms with the offence of which she has been charged [murder of her son]. DP has had lunch and seems to have come to terms with being remanded she is chirpy and enquiring about facilities at HMP Styal."

35. The form also highlighted that the woman had history of harming herself by cutting, and she was described as a vulnerable prisoner. She was checked approximately every ten minutes whilst in the court holding cells. During this time, it was recorded that she was given two of the three recommended doses of diazepam. The first was issued to her by GSL staff at 9.45am and the second at 12.35pm.

36. The woman appeared before the magistrates and was charged with murder. Bail was refused and she was remanded into prison custody. She was to return to Preston Crown Court for a hearing on 14 June.

The woman's arrival at Styal

37. The woman was subsequently transferred to HMP Styal by GSL, arriving at the prison reception area at 5.48pm. All the documents mentioned were transferred with her and presented by the GSL staff to the prison reception staff.

38. From her police statement, the GSL escort officer said that they arrived at Styal at 5.35pm and she asked to speak with the prison senior officer (SO) in charge of reception. All the prisoners at this point remained on the van. Although the GSL escort officer could not recall the SO's name (she did recall that it was a female member of staff), she said that she had informed her that the woman had been the subject of suicide watch whist in police custody. She told the SO that, as a result, GSL had also placed her on four irregular checks each hour. The GSL escort officer said that the SO's response was that the woman should be removed from the escorting vehicle first and be risk assessed.

39. One of the concerns raised by the GSL escort officer with the SO, was that the woman had not come to terms with the offence she had been charged with. She also passed over the police PER Part A and B document which had been updated to show all the checks completed whilst she was in transit. The last entry on the GSL log sheet was shown as made at 5.48pm, when a member of the Styal reception staff received her into custody. The PER Part B form and the Suicide and Self Harm Warning Form were handed over to prison staff, together with her belongings.

40. The GSL escort officer's statement to the police concludes by saying that the woman was escorted from the GSL vehicle into the reception area and introduced to the officer who was on the reception front desk. The GSL escort officer said she handed over all the paperwork relating to the woman. The GSL

staff then took the remaining three prisoners off the vehicle one by one and booked them into the prison reception.

41. At interview with my investigators, the reception officer said that she could not recall any details about the woman's arrival. She confirmed that GSL would normally give the PER forms containing the warrant, property and other documents to the prison reception booking-in officer to check. She could not remember whether she was taken off the GSL van first, but said that generally prisoners would be escorted into the reception area one at a time. The reception officer said she would then ask standard questions to confirm the prisoner's identity, address and religion, check their property and details of their offence and then provide information about the reception process.

42. The reception officer confirmed that she received the woman's PER Part A and B documents from GSL. Contained within them were other documents and information about her. Although the GSL escort officer said she handed over the Suicide Self Harm Warning Form to prison reception staff, the reception officer said she did not receive such a document for the woman. The reception officer said that she would only check the warrant documentation, which she did whilst going through the standard questions with the woman. The other documents contained in the PER forms would be read by the officers who would interview her afterwards. The reception officer said that the woman expressed no concerns whilst she was being questioned by her. She was not aware of any medication that she was currently taking and she did not bring it to her attention.

43. At interview with my investigators, an SO said that she was in charge of the reception area on the day the man arrived, which was the first time she had carried out this duty. The SO said that when she arrived for duty on Friday morning, she checked the staff and the First Night Centre (FNC) and there were no concerns.

44. The SO said that she learnt of the woman's case from the Principal Officer (PO). That morning, the PO had seen the high level of interest the woman's case had generated in the local news and was aware that she had been remanded into prison custody. As Styal was the only women's prison in the North West, she knew that she would be located there. The PO, who was the Oscar 1 (duty officer in charge of the prison), also confirmed this at interview with my investigators. The PO told staff to inform the SO as soon as the woman arrived at Styal, as she wanted to speak with her to check on her well being. (It should be noted that an interview with senior staff is not part of the routine reception procedures.) The PO had seen the woman on the television news and believed that she was coming into prison under extremely stressful circumstances given the nature of the alleged offence.

45. When the woman arrived at Styal, neither the PO nor the SO were in reception. Staff contacted both officers who arrived in the reception area simultaneously. They said that the woman had not yet been processed by reception staff and was standing at the front desk with a member of staff from GSL. The PO told my investigators that she recognised her from the news and immediately

escorted her into a side interview room. Both officers confirmed that they did not speak to the GSL staff about her. None of her paperwork was shown to them, and neither asked the reception officer for the woman's documentation before speaking to her. My investigators confirmed that both senior officers were trained in the Prison Service's ACCT procedures for assisting prisoners at risk of suicide and self harm.

46. The PO introduced herself and the SO to the woman and offered her a drink. They then engaged in an informal conversation with her and talked about a number of issues including the events surrounding the death of her son. The PO said that the woman talked about her offence, saying that her family were all supportive and she had a good network around her. The PO asked her about self harm issues and whether she had "thought of harming herself" in any way. She gave no indication and did not speak of any concerns. The PO then left the room leaving the SO to continue her talk with her and to put her at ease. Not having any of the escort paperwork, both officers were unaware that the police and GSL had monitored her in accordance with their suicide and self harm monitoring procedures.

47. The SO said that the purpose of taking the woman into a private room was not to interview her but solely to have an informal chat with her and see if she was okay. This was something the SO said she would do for anyone who arrived at the prison with "any difficulties or any stresses", or if it was their "first time in custody and they needed that comforting time". The SO described the conversation as quite lengthy and relaxed, and included taking her outside to show her the prison courtyard. The SO said that the woman had been very convincing that she was coping with things. When she talked to the SO about her alleged offence, she said it was an act of self defence and that she was not the main aggressor in the incident that had occurred. The SO told my investigator that the nature of the woman's offence would not immediately raise her risk level and that she was "just another woman for a serious offence".

48. Neither the PO or the SO were aware that the woman had arrived with a Suicide and Self Harm Warning Form. The SO said that she had not seen any of the woman's documentation, nor did she ask to see any of it, during or following her lengthy chat with her. Neither was any record made on her prison file regarding the lengthy conversation with the two officers.

49. After their conversation ended, the SO returned her to the reception waiting area. She told my investigators that she had no concerns about her so was to be processed in the normal way. No formal handover was provided to the officer who was asked to interview the woman.

50. The woman was fully searched according to the normal procedure. This meant that she would have to remove all her clothing with prison staff conducting the search in two halves. She would remove clothing above the waist, then dresses again before removing clothing below the waist. Whether or not staff (only female staff search prisoners) noticed the marks on her wrist, arms and legs (which were identified whilst she was in police custody) is not known, as no record of them was made.

51. At interview with my investigators, the interviewing officer said that there are usually five members of staff in reception. The Operational Support Grade (OSG) stays behind the desk, the SO moves between the FNC and the reception, and three officers share the general work of interviewing and booking in prisoners.

52. When the woman arrived, the interviewing officer noticed that she was taken immediately to a holding room where she remained for a considerable amount of time in the company of the SO and PO. Following this conversation, she was searched in one of the interview rooms. The interviewing officer said that it was not unusual for senior staff to speak with a prisoner on arrival, if that prisoner was charged with a serious offence. She said that the reason was to identify any issues that the prisoner wished to bring to their attention. Although Styal had received individuals in the past who were charged with murder, the officer said that the arrival of a prisoner charged with the murder of their child was less common.

53. The interviewing officer said that she read the woman's paperwork, including the warrant and both parts of the PER form. My investigators found some confusion when they spoke to the interviewing officer as to whether she had read the Suicide and Self Harm Warning Form completed by the GSL staff. In her police statement, she said she did see it but in interview with my investigators she was unsure. The interviewing officer said that there was a general problem when receiving documents in reception. GSL handed over all paperwork stapled together and staff would have to unclip, separate and then sort them out. There was sometimes confusion with the large amounts of paperwork for each prisoner and it was possible that some pieces were filed incorrectly.

54. The interviewing officer proceeded to ask the woman questions whilst completing the cell sharing risk assessment (CSRA). She knew that it was her first time in prison. She told the interviewing officer that she had never abused drugs or alcohol. There is a section on the CSRA form which asks if there is any evidence of the prisoner being on a previous F2052SH (later replaced by ACCT document). As she had never been in prison before, the interviewing officer ticked the 'No' box, and made no reference to the Suicide and Self Harm Warning Form completed by GSL.

55. The PER Part A and B document stated that the woman had a medical condition and had received diazepam. The interviewing officer was not aware of, nor did she ask her about any medication she was currently receiving. She told my investigators that she was not medically trained and therefore this was an issue for the nursing staff.

56. The interviewing officer said that medication which arrived with a prisoner, which was handed over by GSL staff, would be stored behind the counter in reception. It would be taken over with the prisoner to the First Night Centre (FNC) and given to the nurse. Prior to this arrangement, problems had sometimes occurred as GSL often put all of a woman's property into one big

bag, including their medication, which was supposed to be kept in a separate bag. The interviewing officer checked the woman's property bags and signed for it. She told my investigators that she did not recall seeing any medication.

57. Due to the nature of the woman's offence, the publicity it had attracted and this being her first time in prison custody, the interviewing officer deemed her vulnerable but not at risk of harm to herself. The officer identified her as "High Risk" in respect of sharing a cell with another prisoner, which meant that she would have a single room in the FNC. The CSRA document was duly completed with this information.

58. The interviewing officer said that she asked the woman a number of times if she had any thoughts of harming herself. She repeatedly said that she did not and also did not declare a history of self harm. The interviewing officer had seen comments made on the PER Part A document about a small cut on the woman's wrist and asked her about them, to be told that they were not an attempt to harm herself.

59. A number of core prison records (an Offender Management record, CSRA and two wing files) were opened for the woman by the interviewing officer during their interview, which lasted around 35 minutes. She then escorted her to the FNC and said she handed these documents to the staff there.

The woman's arrival in the First Night Centre (FNC)

60. The woman was introduced to an officer in the FNC at around 8.30pm, about two and a half hours after arriving at Styal. The interviewing officer said that she gave the officer in the FNC a verbal handover and also brought to her attention the comments she had made about the woman in the wing file. They provided the information about her which had been collected from their interview.

61. At interview with my investigators, the officer in the FNC explained that prison staff had been talking about the woman before her arrival because of her alleged offence. The officer in the FNC was however unaware of any further information about her until she was brought over to the FNC. Neither the PER Part A and B or the Suicide and Self Harm Warning Form were included in the handover papers she received from the interviewing officer.

62. The officer in the FNC said that Fridays were generally quite busy in reception and it could sometimes take a couple of hours for a prisoner to arrive at the FNC. Although she was unable to say how many prisoners had come in that evening, they were still waiting for two or three more women to be brought across after the woman's arrival.

63. The officer in the FNC interviewed the woman for approximately 15 minutes. The conversation took place in the dining room because there was nowhere else available. The officer carried out an initial induction to the FNC and recorded details about her. She was offered a shower and an immediate needs assessment was conducted. The officer recorded that the woman was worried

about the security of her home and mortgage payments. She said she had no thoughts of harming herself or suicide at present. She was given something to eat whilst the officer in the FNC spoke with her, went through the Offender Management file and asked a number of questions. The woman told her that Styal seemed a nice place and everybody had so far treated her okay. The officer wondered if the woman could be in shock, but she denied it.

64. The officer in the FNC issued the woman with an Induction booklet. She also explained a number of prison practices and procedures which included the violence reduction policy, smoking policy, personal officer scheme, emergency cell bell procedure and the Listeners and Samaritans scheme.

65. The duty Governor that evening, having been informed by the PO that a woman charged with murder was in their custody, she made her way to the FNC to see her. The duty governor told my investigators that her purpose was to see if things were satisfactory with the prisoner. When she arrived, she was being interviewed by the officer in the FNC and the duty governor joined them. The duty governor spoke briefly to the woman to ensure that she was well and let her know that she should ask if she needed anything. She responded that she was fine. The duty governor then left the officer in the FNC to continue with the interview. After the officer had completed the interview, the woman was taken to be interviewed in the healthcare suite in the FNC by a member of the healthcare team.

The woman's contact with healthcare staff

66. The head of healthcare described their role as crucial and complex. At interview with my investigators, she explained that on arrival many women need observation and treatment for drug or alcohol withdrawal. Some women become depressed and exhibit signs of having mental health problems. Many also have physical problems and may not have engaged with clinical services outside of prison. The head of healthcare said that the key challenge for staff is to identify the problems, and put plans in place quickly, as the average stay for women at Styal is only about six weeks.

67. The healthcare assistant (HCA) told my investigators that she interviewed the woman after the officer in the FNC. The HCA had been at Styal for about 15 months and she was not a qualified nurse. Her training consisted of working alongside and assisting qualified nurses and undertaking first aid training. If she had particular concerns about a prisoner, she would speak to the qualified nurse on duty, who was located in the room next door with the prison doctor. At the time, the HCA was not ACCT trained. She said, however, that if she thought that an individual was at risk, she would be able to open one. In her police statement, she said that she had opened an ACCT document before for other prisoners, but had done so under the guidance of a qualified nurse.

68. The role of the HCA is to conduct an initial screening of the prisoner using a national healthcare screening document. The screening identifies a prisoner's immediate physical and mental health needs, drug addiction and suicide or self-harm issues. The screening is not an assessment but to collect information. It

is described as a quick screening process to immediately identify what issues a prisoner may have on that particular evening. If necessary the doctor would then prescribe the appropriate treatment. Women who do not see the nurse or doctor on their first evening will see them the following day, at the second health screening.

69. A verbal handover was not given by the officer in the FNC to the HCA, who collected the woman's paperwork from the desk in the FNC. The only document the HCA said she received for the woman was the CSRA, which did not contain any medical information. She was interviewed in a private room, next door to the nurse and doctor. The HCA said that she used the new electronic medical information system (EMIS) to record a prisoner's data, which had only recently come into operation within the prison.

70. The HCA did not consider that the woman appeared upset and her mood raised no concerns. From her responses, the HCA noted that she did not use drugs and was not alcohol dependent, although she had consumed 20 units of alcohol in the week preceding her custody. The HCA also noted that she had been charged with murder and was on remand.

71. My investigators found that no information was recorded by the HCA on EMIS referring to the woman being prescribed any medication. However reference to her medication was hand written in her medical record.

72. Section three of the CSRA form is completed by the Healthcare Team, and was signed by the HCA. She noted that the woman had "No current thoughts of self harm" and her risk of harm to others was reduced to "Medium Risk".

73. The HCA told my investigators that she was aware that there were some other prisoners who had been identified as being drug users who also arrived at the prison that evening. As is usual in the FNC, they have to prioritise anyone with a medical history of substance misuse issues. The doctor's shift was due to end very soon (9.30pm) and so the HCA asked the nurse on duty if she would want to see the woman, who appeared to be drug and alcohol dependent free that evening or the following morning. The nurse said that she would see her the following morning because she had to prioritise treatment for those women who needed alcohol and drugs detoxification.

74. The HCA subsequently made a referral for the woman to be seen by a member of the Mental Health In-Reach team on Monday. (The team did not work at weekends at the time of her arrival.) She made the referral because of the offence the woman had allegedly committed and the long length of sentence that she might receive.

75. The woman was then returned to the wing staff to be located in her room for the night. She was allocated room three, which is a single room on the first floor. The head of healthcare confirmed that if any concerns had been raised about her, or any other prisoner during the night, there was a qualified nurse on duty who could deal with them.

76. The officer in the FNC said that at around 9.15pm she was in the FNC checking and locking the women into their rooms, when she came across the woman waiting in the corridor. She said that she was waiting to see the doctor. The officer presumed that the woman had seen a nurse already. She was aware of an incident elsewhere in the prison which the nurses were called to attend, and informed her that it was unlikely that she would be seen by the doctor that evening. She was therefore escorted to her room.

77. The duty governor said it was normal procedure for her to review the CSRA form for prisoners who are assessed as "High" risk. Later that evening she reviewed the woman's CSRA paperwork and agreed that she was a "High Risk". This simply meant that she could be of risk to others if placed in a cell with another prisoner. The assessment would be reviewed after seven days. No concerns were relayed to the duty governor about the woman's well being. In interview the duty governor said that she was not told staff that there was any record from the police or GSL that she was at risk of harming herself. She would rely upon the judgement of staff as to whether the opening of an ACCT document was necessary. The duty governor said that staff described the woman as positive.

78. During the night period, no concerns were reported about the woman, who was checked every hour by the night duty officer. (This is standard practice for all new arrivals at Styal during their first night in custody.)

Saturday 2 June

79. The following morning, Saturday 2 June, the woman left her cell soon after 8.00am to collect her breakfast. The SO was in the FNC where she saw her briefly and asked her if she had been given a telephone call yet. She said she had not. The SO told her that she would sort this out and spoke to the officer in the FNC to arrange it.

80. From evidence gathered during the police investigation, another prisoner saw the woman in her room crying shortly after breakfast. The woman told the other prisoner that she was fed up with other prisoners "scrounging her sweets". Staff interviewed by my investigators were unaware of the incident.

81. Later that afternoon, the woman's induction routine continued. She was medically assessed by a registered general nurse (RGN) and her RGN colleague. (At the time of my investigation, the RGN was no longer employed at HMP Styal.) The HCA's notes from the previous evening were referred to. in the RGN's police statement, she said that having logged onto the EMIS system that afternoon, she had noticed that the woman had arrived the previous night and had not had a urine test or seen the doctor. During her assessment, the nurses took her blood pressure, weight and a urine sample which were recorded on EMIS.

82. The RGN noted that the woman said that she had no thoughts of deliberate self harm. She told the RGN that she had been taking the diazepam prescribed by her doctor. She subsequently tested positive for benzodiapines and was

referred to the prison doctor. The RGN further noted that the woman was to be referred to the Mental Health In-Reach Team and was fit for normal prison location and work. Again, there is no reference to the Suicide and Self Harm Warning Form that had been completed by GSL.

83. A GP worked at Styal two days a week (at the time of my investigation, he too no longer worked at Styal) and examined the woman soon after she had seen the nurse. His entry on the EMIS system for her was made in the RGN's name as he was unable to log on for himself.

84. The GP noted that the woman had "anxiety with depression". He recorded that the recent death of her son had been very traumatic for her. She had been prescribed diazepam (2mg) and some other medication (no information was recorded as to what this was) by her doctor to help her through this period. The GP prescribed the continued use of diazepam for her anxiety and ranitidine for gastro-oesophageal reflux (leakage of stomach acids), a problem which she had had for many years. The GP said that the woman was tearful, said she had no thoughts of self harm and was to be referred to the Mental Health In-reach Team. It was also noted that she drank excessively at times but not every day. In his interview with the police, the GP said that he was not aware of the PER documents or the Suicide and Self Harm Warning Forms for her, and neither was he ACCT trained.

85. When interviewed by my investigators, the RGN colleague's recollection of events relating to the woman was very vague. The nurse said that she had come for her second health screening and seemed fine when she arrived. No concerns were noted on her wing history after this.

86. Later that afternoon, the prison chaplain spoke with the woman. He told my investigators that it was part of his normal duties to see new prisoners who had never been in prison before. The chaplain said that he spoke with the woman in a room on the landing. He did not judge that she was at high risk and he did not notice anything worrying about her demeanour. She told him that she was anxious about her family but did not go into any detail. Their meeting ended with the chaplain reminding her that he was available should she ever need to talk to anyone.

87. According to the woman's medication prescription chart, she received her first dose of diazepam at 6.50pm. There is nothing noted on her medical file which highlighted any concerns about her when it was issued.

88. At 7.00pm on Saturday evening, the woman made a telephone call to her daughter using the prison PIN phone. The telephone was located on the ground floor. At interview with my investigators, a second SO explained that she had been asked earlier that day to facilitate a telephone call for the woman to her family as she had not made one since her arrival at the prison. As is normal procedure for a prisoner's first telephone call, the second SO entered a pin number and dialled the number she wished to ring. Once the telephone started to ring, she passed the telephone over to her and left her to talk in private to the recipient of the call.

89. The call was not monitored by prison staff. From prison records made available after the woman's death, my investigators found that her conversation was with her daughter and they talked about the death of her son. Both she and her daughter were distressed throughout the call. The call was terminated after three minutes in mid conversation because the maximum call time had been reached.

90. After making the telephone call the woman returned to her room. From the police investigation and from a statement given to my investigators from a fellow prisoner, it appears that she had confided in another woman that a pair of her earrings and some sweets had gone missing from her room. She also said that she had made a telephone call that had left her feeling down and upset. It appears that no staff were aware of the concerns she expressed to the other prisoner.

91. The second SO said she saw the woman soon after she had made her telephone call (between 7.15pm and 7.30pm), when she was locking prisoners into their rooms for the night. She had gone specifically to check her and ensure that she was okay and there were no concerns about her.

92. This was the woman's second night in custody. She was not subject to ACCT monitoring and night staff were not required to conduct hourly observations.

Sunday 3 June

93. An officer had worked the previous day, Saturday, when he met the woman. He had no concerns about her from their first meeting. On Sunday morning, the women's rooms were unlocked at 8.00am. The officer recalled seeing her in the queue waiting on the ground floor to collect her breakfast pack, eat it and wash her cutlery afterwards at around 10.00am. She was polite when he spoke to her and had said good morning to staff.

94. A short while afterwards, the officer had cause to visit the woman's room whilst carrying out the accommodation and fabric checks (AFC). (This is a daily check to ensure that the fabric of all the rooms is in good working order and that there is no damage.) When he arrived at her room, she was not there. The officer assumed that she was in the television room on the ground floor and so continued with his check of her room.

95. The lifer manager went to the FNC at around 11.20am to interview the woman. All prisoners who are serving a life (or potential life) sentence are assigned a lifer manager to assist them with concerns and administrative matters at all stages of their sentence.

96. The lifer manager told my investigators that the woman's case had a high profile in the media. He was directed to her room by two officers. Both officers told the lifer manager that the woman appeared to be okay, had not displayed any adverse behaviour, and, although she kept herself to herself, was polite to staff.

97. When the lifer manager arrived at the woman's room, the door was locked. He looked through the door observation panel and saw her sitting behind the cell privacy screen with a ligature tied to it. He unlocked the door but found that it was barricaded with room furniture. The lifer manager then quickly shouted for assistance and used his radio (recorded as occurring at 11.25am) to announce a Code Blue emergency over the net. (A Code Blue emergency call means that a prisoner is not breathing or is suspended.) He then began kicking and pushing the door until he was able to go inside.

98. Once inside, the lifer manager found the woman suspended by a ligature (made from a pillow case) from the privacy screen. The two officers who had previously directed him, responded to the shout for assistance along with the officer in the FNC. They arrived at her room just as the lifer manager had got inside. The lifer manager believed that from the woman's appearance she was dead, her face was cold and her eyes and lips were deep purple.

99. The lifer manager cut the ligature away from the woman's neck with his standard issue ligature knife, and requested an ambulance over his radio (recorded by Communications as being called at 11.32am). Along with one of the officer's, he placed her in the recovery position. Whilst the lifer managerl was clearing her airway, healthcare staff arrived and took over. The officers left the room.

100. The RGN colleague was carrying out the medication round on the FNC with the an officer, who was monitoring the prisoner medication queue. She was alerted by an officer at the medication hatch who said medical assistance was required immediately upstairs as someone was having a "fit". The HCA was also in the medication room and locked the medication cupboards whilst the RGN colleague grabbed the emergency bag which contained resuscitation equipment. She too made her way to the woman's room.

101. It took less than a minute for the RGN colleague to arrive at the woman's room. She saw her lying in the recovery position on her side. She told my investigators that she looked blue and was unresponsive. The nurse placed the oxygen mask on her and, whilst turning her onto her back, noticed a ligature mark on her neck. She could not find a pulse.

102. Another nurse also arrived at the woman's room within moments of the emergency call and together they commenced cardiopulmonary resuscitation (CPR). The RGN colleague administered cardiac compressions at the rate of 30 compressions to two breaths whilst the nurse controlled the ambu-bag (air compression bag). The HCA also arrived and was asked to collect the defibrillator from the wing and the prison doctors who were in the healthcare unit. During this time other staff attended to assist.

103. The HCA returned with the defibrillator (a machine which delivers a therapeutic dose of electrical energy to the affected heart), which was used by the nurses to assess the woman's heart activity. The defibrillator stated that there was no "shockable" rhythm and that CPR should continue. Two doctors arrived at her

room (recorded as 11.30am) and assisted with CPR. One of the doctors noted that there was no response from the woman and he believed that she had been dead for at least 30 minutes. He administered adrenalin into her arm but she still failed to respond to their resuscitation attempts.

104. The ambulance paramedics arrived at the woman's room at 11.47am. They carried out tests on her and, with the doctors, agreed that CPR should cease. She was pronounced dead at 11.54am.

Events following the woman's death

105. The prison's Death in Custody Contingency Plan was immediately activated by the Duty Governor. The Governing Governor and the necessary agencies were contacted, including the police. The police were at the prison for most of the afternoon. Notices regarding the woman's death were also displayed around the prison for staff and prisoners. All prisoners on the FNC were informed of the morning's events and offered support from Listeners and Samaritans. The prison care team were informed of the woman's death and attended to offer support to staff the on duty.

106. The Governor held a hot debrief meeting at 1.25pm. All staff who had had some involvement with the woman attended to explain their contact with her from the day of her arrival.

Contact with the woman's family

107. A governor was appointed as the prison family liaison officer and attended the hot debrief meeting. She left the prison with the Governing Governor after the meeting to inform the woman's family of her death. When they met with the family, they explained what had occurred and provided them with the contact numbers for the prison, undertakers and offered financial assistance with the funeral expenses.

108. Although arrangements were made for the return of the woman's personal belongings, they were not actually given back to her family. Her daughter raised the issue when she spoke to my family liaison officer in November 2008 and they have since been returned.

Post Mortem

109. A post mortem was conducted on 4 June 2007. The pathologist noted that over the front of the woman's left arm were a series of very shallow interrupted abrasions which were consistent with healing recent self inflicted injuries (probably several days old).

110. The woman's cause of death was compression of the neck, caused by hanging. The toxicology examination found that she had consumed diazepam a considerable time before her death. There were no traces of any alcohol, commonly encountered drugs of abuse (except diazepam) or prescription and non prescription medicines.

ISSUES RAISED IN THE INVESTIGATION

Information sharing in reception

111. The clinical reviewer makes a number of recommendations which will be shared with the Primary Care Trust. Of his recommendations, I concentrate on those which I believe are the most pertinent to the circumstances of the woman's death.

112. The first relates to the sharing and recording of information between the escorting contractor, GSL, and prison reception staff. What is clear from my investigation is the fact that all the staff in the reception area failed to recognise the importance of the documentation provided by GSL. The clinical reviewer recommends that the information flow into the prison from agencies such as police and GSL should be reviewed and improved and I endorse his recommendation. My investigator found no evidence in the woman's prison records that, when she arrived, reception staff questioned the escorting staff about their document or indeed her current risk of harming herself. It is therefore of concern to me that the Suicide and Self Harm Warning Form was not acted upon.

    The Governor should ensure that all staff in reception and the FNC are aware of their responsibility to read any significant information relating to risks to a prisoner.

113. The woman arrived at Styal accompanied by clear documentation which said that she had been on suicide watch for the previous two days and that she was receiving prescription medication for anxiety following her son's death. GSL staff maintain that the medication and the records were given to reception staff. However, staff in reception said they had no recollection of receiving the medication, and there is no record that any was received.

114. Either way, the medication was listed on the woman's documentation. I find it incomprehensible that staff did not question, note or check to confirm whether or not she was actually in possession of medication. There are both health and security implications with such an oversight. The Head of Healthcare told my investigator that although a procedure existed relating to the receipt, recording and transfer of medication to the FNC, the procedure was not written down.

    The Governor and Head of Healthcare should formalise a procedure for the receipt of medication when prisoners arrive in reception.

115. The woman spent around two hours and 40 minutes in the reception area before being escorted to the FNC. The officer who escorted her failed to ensure that the warning forms which related to her were taken to the FNC with her. The omission affected the ability of other prison and healthcare staff to assess her appropriately. The CSRA document was the only relevant document which contained any information about the woman's present level of risk. The risk that others, that is the police and GSL, believed she may have

posed to herself was therefore not known when she was seen by the healthcare assistant (HCA). That said, there is no guarantee that the presence of the other documents would have influenced the HCA's decision making.

116. Furthermore, the HCA is not a qualified nurse. In this instance, the HCA was also not ACCT trained despite having contact with prisoners on their first day in custody, when they are most vulnerable. ACCT is the fundamental tool used by the Prison Service to help identify and care for prisoners at risk of suicide or self-harm. It is imperative that all staff conducting health screenings are appropriately trained, and most notably are aware of, and alert to, a prisoner's vulnerability.

    The Governor and Head of Healthcare should ensure that all staff in regular contact with prisoners are trained in the ACCT procedures.

117. It was noted that the woman had no immediate health needs, and she was referred to see a qualified nurse and doctor the next day. Her second health screen was postponed so that other new prisoners deemed to have more immediate needs, such as detoxification, could be seen first. The HCA said that she confirmed the arrangement with the nurse on duty but it is not recorded in any of the woman's medical records.

118. My investigators found interpreting the chronological order of the entries made in the woman's medical records very difficult and worrying. Most notably, the HCA had made entries and comments for actions that she did not carry out herself and it could not be identified who had done so. The records also caused the RGN colleague some confusion during her interview. The EMIS printout provided to my investigators appeared to show more logical entries made by the HCA and the RGN. Asked about the discrepancies, the HCA told my investigators that at around this time, the EMIS computer system had suffered from a lot of teething problems. My investigators were informed during the investigation that all healthcare staff are now fully trained to use EMIS.

    All clinical staff should be reminded of their obligations in record keeping as set out in the relevant Nursing and Midwifery Council Guidelines.

Time spent in reception

119. The late arrival of prisoners into reception is a known problem across the prison service. Styal is no different, with late arrivals with self harm and drug or alcohol problems being assessed in reception during the evening.

120. Nonetheless, I believe that the time the woman spent in reception was unduly delayed by senior staff who spoke to her for over an hour. They did not have the benefit of studying the records transferred from the police and escort company. From their conversation, they concluded that she was of no cause for concern. Unfortunately, no details of their conversation were recorded anywhere. I do not doubt their good intentions of offering support to her, but I do wonder if their curiosity got the better of them given the media attention she

had attracted. I fail to understand why a significant contact with a prisoner was not recorded, especially one who was vulnerable by her alleged offence.

121. It is imperative that all staff record significant contact and any concerns about an individual, especially when they arrive late from court. This will assist FNC and healthcare staff if a quick assessment has to be carried out on a prisoner due to time constraints. I have mentioned many times in previous reports the importance of good and clear record keeping, and how invaluable it can be. Staff should be reminded of this.

The Governor should remind staff of the importance of record keeping.

122. Senior staff should also have been aware of the time pressures faced by reception and FNC staff when they are processing prisoners who arrive in the evening. That the woman spent this amount of time in reception reduced the opportunity for her to be assessed by a qualified nurse and doctor. However I am pleased to report that since this death, the doctor's hours have been extended until 10.00pm.

The Governor should review the reception procedures and ensure that prisoners' waiting time in reception is as short as possible.

Opening an ACCT document

123. The woman was seen by various members of staff, and had the opportunity to express any concerns about her wellbeing. She did not do so and the staff judged that opening an ACCT was unnecessary. However their judgements were reached without any knowledge of her history of harming herself. Whether their opinions would have been different had they had access to the information is unclear. Their decisions were also made without noticing that she had recently harmed herself as the records had not been read and the search had not identified her injuries.

124. The lifer officer told my investigators that he was surprised that the woman had not been on an ACCT document when she arrived at Styal because of the alleged offence she had committed. He believed that this must have been a traumatic experience for her and thus would have made her a vulnerable prisoner. My interviews with other staff do not suggest that the charges faced by the woman formed part of their judgements. I am aware that prisoners charged with offences of violence are at greater risk of harming themselves and I believe that the staff at Styal should be aware too.

125. I understand why staff, who only considered the way in which the woman spoke and presented herself, failed to identify that she would attempt to take her own life. When they asked her, she gave no suggestion that she intended to harm herself. However, if only from the nature of her offence, and that it was her first time in custody, I believe that opening an ACCT was justified.

126. PSO 2700 (issued in 2003 and in force when the woman arrived at Styal) states that reception and first night staff should, when receiving prisoners with

F2052SHs (the document used prior to the ACCT document), talk to the prisoner and to the escort staff, to check whether their risk is current or historical. It is obvious that the woman would not have had a previous F2052SH because she had never been in prison before. However this document, like the ACCT document, fundamentally relates to the well being and concerns about risk of self harm. This was exactly the type of information which was detailed in the Suicide and Self Harm Warning Form handed to the prison staff by GSL.

127. I have already mentioned the need to improve the information flow from agencies such as police and GSL into the prison. My investigators also found discrepancies with documentation handling in the prison reception area, meaning that useful information was not necessarily being passed on to those individuals who were assessing prisoners' risks.

128. In his response to the police investigation, the Governor acknowledged that, given the way the reception process was working at the time, relevant and important information was not always being passed onto staff whose role it was to assess prisoners on arrival. Since the woman's death, a new procedure has been implemented within the reception area. Primarily, documents are no longer separated or detached from each other whilst a prisoner is going through the reception and FNC process. This should ensure that necessary information is passed on quickly to staff making assessments.

129. The introduction of the new procedures is of course welcome, but it does not detract from the issue, that staff still need to read and acknowledge information on warning forms received and to clearly document such information.

130. In conclusion on this matter, since the woman's death, a new safer custody Prison Service Order (PSO 2700 October 2007) was issued which provided guidelines for prisoners charged with homicide against a partner or family member and which describes them as an exceptionally high risk of suicide. The PSO states:

> "Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder/murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken."

I am pleased to learn that the duty governor has confirmed that all staff are aware of the PSO and so make no recommendation here.

Availability of Mental Health In-Reach over the weekend period

131. At the time of the woman's death, the In-Reach team did not work over the weekend, so, despite a referral being made, she would not have had an appointment until at least Monday. Had she been seen by In-Reach, they might have provided vital intervention with regards to her mental health. I am

pleased to note that since her death, members of the In-Reach team are now available over the weekend.

Staff response to the emergency

132. Staff responded quickly to the emergency call in the woman's room. The nurse on duty however said that she was informed that emergency was an individual having a "fit". Although this in no way affected the nurse's promptness to deal with the situation when she arrived at the woman's room, it is imperative that clear and accurate information is relayed to healthcare staff about what kind of incident they are attending.

The Governor should remind staff to use the correct terminology and emergency code calls when requesting emergency assistance.

Return of the woman's personal belongings

133. I am greatly concerned that it took approximately 18 months for the prison to return the woman's personal belongings to her family and that the matter was only resolved at the instigation of my office. I cannot underestimate the impact this could have had. It is of paramount importance that, following a death in custody, a prisoner's personal belongings are returned to the next of kin as soon as possible.

The Governor should ensure that, following a death in custody, the family liaison officer immediately arranges for the return of prisoner's personal belongings to their next of kin.

CONCLUSION

134. I have no doubt that the incident which caused the woman's imprisonment was very traumatic for her. To face the charge of killing one's child must be amongst the most extreme. She had been prescribed medication for anxiety as a result and was already deemed to be at risk of harming herself before she arrived at Styal. She had marks on her left forearm which were caused by harming herself. This information was all documented whilst she was in the custody of the police and the escorting contractor.

135. Tragically when the woman arrived at Styal, the concerns about her well being were overlooked by the staff who assessed her in reception. Unusually two senior staff came to speak to her to supplement the routine procedures. They too failed to read about her history, failed to recognise the additional risk from the charges she faced and failed to notice anything untoward.

136. Much of the information gathered at reception was not recorded or passed onto those who subsequently assessed the woman in the First Night Centre. I think that staff in both reception and the FNC focused on what she told them herself about her risk rather than considering those identified by other agencies with the most recent and accurate knowledge. Ignoring this information is even more pertinent than ignoring the significance of her alleged offence.

137. Time and time again I report that a prisoner does not declare that they intend to harm themselves. In some investigations, it appears that the thought of taking their life is an act which has come about instantaneously. It is impossible to judge for the woman. By virtue of her alleged offence, she was a vulnerable woman. I have no doubt that the level of support she may or may not have expected from her family would have added to her anxiety.

138. Although in my view these circumstances should have triggered the immediate opening of the ACCT procedures, I am not convinced that it would have diminished the woman's thoughts of taking her life. There is no doubt that she had a lot of contact with staff at the prison, but an open ACCT would have provided additional support. Increased monitoring and observations might have helped to keep her safe from harm.

RECOMMENDATIONS

1. The Governor should ensure that all staff in reception and the FNC are aware of their responsibility to read any significant information relating to risks to a prisoner.

   The Prison Service have accepted this recommendation.

2. The Governor and Head of Healthcare should formalise a procedure for the receipt of medication
3. n when prisoners arrive in reception.

   The Prison Service have accepted this recommendation.

4. The Governor and Head of Healthcare to ensure that all staff in regular contact with prisoners are trained in ACCT procedures.

   The Prison Service have accepted this recommendation.

5. All clinical staff should be reminded of their obligations in record keeping as set out in the relevant Nursing and Midwifery Council Guidelines.

   The Prison Service have accepted this recommendation.

6. The Governor should remind staff of the importance of record keeping.

   The Prison Service have accepted this recommendation.

7. The Governor should review the reception procedures and to ensure that prisoners' waiting time in reception is as short as possible.

   The Prison Service have accepted this recommendation.

8. The Governor should remind staff to use the correct terminology and emergency code calls when requesting emergency assistance.

   The Prison Service have accepted this recommendation.

9. The Governor should ensure that following a death in custody, the family liaison officer immediately arranges for the return of prisoner's personal belongings to their next of kin.

   The Prison Service have accepted this recommendation.