Investigation into the circumstances surrounding the death of a woman at Royal Surrey County Hospital, Guildford, while a prisoner at HMP Send, in July 2009

Report by the Prisons and Probation Ombudsman for England and Wales

August 2010

This is the report of an investigation into the death of a 45 year old woman at HMP Send who died in July 2009.

I would like to add my personal condolences to those already expressed to the woman's family on behalf of this office by one of the Ombudsman's Family Liaison Officers. I apologise for the delay in issuing my report and any additional distress this may have caused.

The investigation was conducted by two of my colleagues. In addition Surrey Primary Care Trust appointed a clinical reviewer who undertook a review of the woman's clinical care. I am grateful for the assistance they all received from staff at HMP Send and would like to thank the Head of Send and his staff for their co-operation.

Only six per cent of prisoners are women, but they account for over 50 per cent of all incidents of self-harm in prison. The woman harmed herself throughout her imprisonment, sometimes tying ligatures, latterly by cutting herself. Her self-harm was so frequent and severe that she was one of the most challenging women that the National Offender Management Service had to care for.

Two facts stand out in this report – how severely the woman harmed herself and how well staff cared for and supported her. I am impressed by the care and treatment that the woman received from staff across all departments in the prison. For the majority of the two years she spent at HMP Send, she was supported formally by well managed self-harm monitoring procedures. Perhaps even more impressive are the many ways staff supported her on a day-to-day basis. Prison staff have a duty of care to all those in their custody. In the highly individualised care they provided the woman, this duty was discharged to the highest standard. My report contains many examples of good practice.

Sadly, in spite of staff efforts, in the early hours of 4 July 2009, the woman inflicted such serious injuries on herself that they led to her death.

I make six recommendations. These centre on access and sharing of information, the purchase of suitable equipment to assist ambulance staff taking injured prisoners from cells, support for staff and commending the woman's friend for the considerable care and support she provided. I also commend staff for their application of the self-harm and suicide prevention monitoring procedures, including allowing the friend to attend review meetings.

Jane Webb
Deputy Prisons and Probation Ombudsman **August 2010**

CONTENTS

Summary	4
The investigation process	5
HMP Send	8
Key events	11
Issues considered	22
Conclusion	31
Recommendations and commendations	32

SUMMARY

The woman was born in August 1963. She was 45 years old when she died in the Royal Surrey County Hospital on 4 July 2009.

The woman went into custody (on remand) at HMP Holloway on 2 October 2001. She was sentenced at Lewes Crown Court to life imprisonment (for causing grievous bodily harm with intent) on 24 January 2003. The woman was later held at HMP Bullwood Hall and HMP Cookham Wood. She transferred to HMP Send on 18 July 2007 when Cookham Wood was re-roled from a female to a male prison.

During the woman's trial, a consultant forensic psychiatrist diagnosed her as having an abnormal personality and a psychopathic disorder. Throughout her imprisonment, she frequently harmed herself, often so severely that she required hospital treatment. She was taken to hospital 22 times in the two years she spent at Send and was subject to self-harm monitoring for most of the period. This monitoring was sometimes raised to an enhanced level.

Prison discipline and healthcare staff put in place a number of strategies to monitor the woman's mood. They included a numbering and traffic light system and sharing information among staff regarding potential trigger dates. They also implemented the prison regime and policies flexibly, to permit the woman to be supported by a friend when prisoners were locked in their cells, as well as allowing her to undertake employment conducive to her wellbeing. In addition, she was seen regularly by the community psychiatric nurse and had weekly psychotherapy sessions. The friend who supported her also had a formal role as a support time recovery (STR) worker, described later in this report.

During the early hours of 4 July 2009, the woman was discovered in her cell bleeding severely from self-inflicted wounds. She was taken by ambulance to the Accident and Emergency Department at the Royal Surrey County Hospital. Unfortunately the woman's heart stopped during the journey to the hospital and resuscitation attempts by both paramedics and hospital were unsuccessful. Death was pronounced at 5.55am by a hospital doctor.

After it was confirmed that the woman had died, HMP Send activated its death in custody contingency plan. The police were informed and visited the prison. They found no suspicious circumstances.

I am impressed with the attention, level and flexibility of care given to the woman by staff at Send and I have drawn attention to a number of areas of good practice. I make six recommendations on a range of matters and also two commendations relating to the application of the suicide and self-harm monitoring procedures.

THE INVESTIGATION PROCESS

1. The investigation was opened on 6 July 2009 by one of the Ombudsman's investigators. She issued notices announcing the investigation to staff and prisoners. The notices included an invitation to anyone who wished to submit information relating to the woman's death to make themself known. No one came forward. The investigator also studied all relevant prison records, which included the woman's main prison record and her medical records.

2. The Surrey Primary Care Trust (PCT) commissioned a consultant forensic psychiatrist to carry out a review carry of the woman's clinical care. I am grateful to her for undertaking such a thorough review.

3. The investigators visited HMP Send on 10 July, 8 to 9 September and 12 October and discussed aspects of the woman's treatment with staff and a prisoner. They interviewed a number of discipline staff, as well as one of the chaplains. An additional interview with one of the Operational Support Grade staff was held in the Ombudsman's office on 5 November. The lead investigator also carried out joint interviews of some staff with a manager from Surrey PCT.

4. During one of their visits to Send, the investigators interviewed a prisoner who was the woman's friend and also worked with her in her role as "support time recovery" (STR) worker. The NHS defines an STR worker as:

   > "someone who works as part of a team, which provides mental health services and focuses directly on the needs of service users, working across boundaries of care, organisation and role. They will provide *support*, give *time* to the service user, and thus promote their *recovery*. STR workers play a key part in the co-ordination of care. They undertake a range of tasks to:
   >
   > - promote independent living
   > - provide companionship and friendship
   > - provide regular and practical support
   > - provide support with daily living
   > - facilitate people living "ordinary lives"
   > - help the service user to gain access to resources
   > - provide information on health promotion
   > - help to identify early signs of relapse
   > - support service users with involvement/participation with their treatment."

5. The lead investigator contacted HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, the report was sent to the Coroner to assist his enquiries into he woman's death.

6. One of the Ombudsman's Family Liaison Officers (FLOs) contacted the woman's family. This gave them the opportunity to discuss the purpose of the

investigation and to raise any concerns or questions that they wanted to be addressed. The woman's mother spoke very positively about the care her daughter received from the staff at Send. She said that the prison FLO had been very supportive and had already answered many of her questions and so she had no issues that she wanted to raise with this office.

7. The lead investigator and the FLO met the woman's father and his sister and brothers and explained the scope of the investigation. The woman's father said that they all felt that Julie should have been in hospital rather than prison and that he was unhappy about how he had learned of his daughter's death. I hope that this report provides the woman's family with a better understanding of the events leading up to her death.

8. The FLO contacted the woman's family after they had read the draft report. They spoke movingly of how well the staff had cared for the woman and how pleased they were to know that she had such a good friend.

HMP SEND

9. HMP Send first became a Prison in 1962 when it opened as a Junior Detention Centre. It remained as such until 1987 when it was re-classified as a category C Adult Male Training Prison. Its role changed again to a female prison in 1998. It was completely rebuilt by 1999 and currently operates as a closed Female Training Prison. Send has six wings. A,B,C,E,F and J Wings have single cellular accommodation, all with integral sanitation and individual showers. A Wing houses the Therapeutic Community. The Resettlement Unit is located on E and F wings. D Wing, the Addictive Treatment Unit, provides accommodation for 20 women with double rooms and communal showers.

10. Health services at Send are commissioned by the Surrey Primary Care Trust. There are no in-patient services. When medical emergencies take place in the evening or at night, staff call for an ambulance.

Performance rating

11. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four (one being “serious concerns” and four “exceptional performance”). For the last three quarters, HMP Send has been given a rating of four (or “exceptional performance”).

HM Chief Inspector of Prisons’ report

12. The most recent report by HM Chief Inspector of Prisons, Dame Anne Owers, followed an unannounced short inspection carried out in August 2008. Dame Anne wrote:

> “When we last inspected in early 2006, we assessed the prison as being very safe and respectful, with reasonable purposeful activity and resettlement provision. On our return, for this unannounced short follow up inspection, we were concerned to find the prison struggling with the impact of a less settled prisoner population and serious difficulties recruiting and retaining staff. As a result, there had been a significant deterioration in key areas, including safety, and a weakening of some other areas of previous strength.”

Dame Anne concluded:

> “Send has gone through a very unsettled period, with an expansion of its population and an increase in short-term prisoners, but without sufficient investment in the regime. The pervasive impact of the inability to recruit and retain staff had resulted in shortages, an influx of inexperienced staff and difficulty in maintaining an appropriate gender balance. On top of this, there had been an excessive turnover of

> governors – three in less than two years – and further uncertainty created by a new clustering arrangement with a women's prison in Sutton. The outcome had been slippage in some important areas since our previous inspection, including a worrying deterioration in aspects of safety. Send requires regional and national support to achieve a period of badly needed stability, so that it can focus on addressing the increased challenges that it faces."

Independent Monitoring Board Report

13. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The report for Send for the year 2008/09 drew attention to the concerns raised by HM Chief Inspector of Prisons including the following comments:

> "The Board's assessment of the prison during the first half of the year was supported by the findings of the HMCIP inspection in August 2008 when a marked deterioration in standards in several keys areas of the prison was identified since the last HMCIP visit in 2006. Like us, HMCIP were particularly concerned about staff shortages (especially in Healthcare and TC), the use of large numbers of detached duty staff, the under capacity of the Therapeutic Community, an increase in self-harm and attempted suicide attempts, and inadequate investigation/documentation of reported bullying incidents. "

The report also included the following comments:

> "The Board's view is that, despite the concerns detailed above, conditions for the prisoners had improved considerably by the end of the reporting period. The Board would particularly like to commend the new and committed senior management team who are addressing the issues raised and who have implemented a number of initiatives, which have resulted in considerable improvements in many areas of concern to us. By the end of the reporting year, the building work was completed, the prison was fully staffed without the need for detached staff, the management team appeared far more effective, and morale was higher than it had been for some time."

Assessment, Care in Custody and Teamwork (ACCT)

14. ACCT has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is subject to regular case reviews that will decide the level of observations/conversations, which are carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the multi-disciplinary case review team to decide the most appropriate place to locate an individual

prisoner within a prison.

15. Prisoners should be fully involved in the ACCT process. They first have an interview with a trained assessor, from which an individual care plan is drawn up. They then attend regular case reviews, where a case manager reviews the care and support they receive. After the ACCT plan is closed, the case manager has at least one post-closure meeting with the prisoner to discuss how they are coping.

16. On several occasions, the woman was on an enhanced ACCT plan. Prison Service Order (PSO) 2700 "Suicide Prevention and Self-harm Management sets out the instructions for staff about ACCT procedures. It states that enhanced ACCTs are used when a prisoner carries out "Prolific, sustained and/or extreme incidents of self-harming behaviour (usually requiring medical intervention)". The case manager's role is passed to a governor-grade member of staff and a wider range of people are invited to case reviews.

Incentives and Earned Privileges (IEP) scheme

17. The Incentives and Earned Privileges scheme was introduced to encourage and reward good behaviour in prisons. It has three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour and performance. The key earnable privileges/incentives are: extra and improved visits, eligibility to earn higher rates of pay, access to in-cell television, opportunity to wear own clothes, more private cash to spend and time out of cell for association. In addition to the key earnable privileges, establishments may make other privileges and incentives available to suitable prisoners according to local circumstances.

Previous deaths at Send

18. There were two self-inflicted deaths at Send in 2007 and two deaths from natural causes in the first half of 2009. The women who died in 2007 shared several of the issues that the woman had. In the Ombudsman's reports into their deaths, he made a number of recommendations, including improvements to mental health services and ACCT procedures. The recommendations were accepted and changes implemented, which had a positive effect on the care and treatment that the woman received.

KEY EVENTS

2001 - 2007

19. The woman was remanded into custody and taken to HMP Holloway on 2 October 2001. In January 2003, she was sentenced to life imprisonment (for causing grievous bodily harm with intent) at Lewes Crown Court.

20. In his report, dated 23 July 2002 (which was referred to during the woman's trial at Lewes Crown Court) a consultant forensic psychiatrist wrote:

> "In my opinion does not suffer from Munchausen's by Proxy. … The woman does suffer from an abnormal personality, characterised by her impulsivity self-harm behaviour … and poor relationships. Because of the woman's abnormal personality, she could be classed as suffering from a psychopathic disorder associated with abnormally aggressive and seriously irresponsible behaviour within the meaning of the Mental Health Act 1983. However, it is unclear whether hospital treatment would alleviate her condition or prevent deterioration."

21. In 2003, the woman's appeal against her sentence was dismissed by the Court of Appeal Criminal Division. She transferred to HMP Bullwood Hall on 26 September, where she remained until moving to HMP Cookham Wood on 2 June 2006.

22. Throughout the woman's imprisonment, she often harmed herself and was regularly on open Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support monitoring.

Transfer to HMP Send

23. In July 2007, Cookham Wood's role was changed from a female prison to an establishment for young male offenders. The prisoners were given a list of other female prisons and asked to say which they would prefer to move to. Managers at Cookham Wood recognised that the resulting uncertainty and disruption during the moves could have a negative impact on the woman, especially as she was on an open ACCT plan. She was therefore in one of the first groups to move.

24. A member of the Mental Health In-reach Team (MHIT) at Cookham Wood contacted a community psychiatric nurse in the MHIT at Send. They discussed the care and treatment the woman needed. Managers at both prisons also liaised in preparation for her arrival.

25. On 18 July, the woman transferred to Send, along with several other women from Cookham Wood. The mental health nurse introduced herself to the woman the day she arrived at Send. She said that she would assess her the next time she was on duty, which would be the following Monday. On 20 July, staff referred the woman to the Mental Health In-reach Team. On the same

day, the woman completed the induction process and moved to C wing. She was assigned to work in the prison laundry.

26. When interviewed as part of this investigation, a fellow prisoner and the woman's friend said:

> "When the woman first arrived here from Cookham, I was actually a laundry orderly. The woman was allocated working the laundry. Obviously the prison had recognised her as somebody vulnerable. Quite a lot of vulnerable people do get placed in the laundry because sometimes it's difficult for them to integrate. It can be difficult for them to be around other people – when somebody moves prison, it's always an unsettling time … She came, she struck me as somebody very, very vulnerable who was quite introverted, I won't say shy but she kept herself very much to herself and because she wasn't the most forthcoming of people conversationally. Quite a lot of effort was required but I saw something in the woman that was really worthwhile making that effort, there was a great deal of depth and caring and intelligence there, she just wasn't very forthcoming …"

27. On Sunday 22 July, staff found the woman with a ligature tied tightly round her neck in her cell. She was unconscious but still breathing. Staff cut the ligature off and a nurse administered first aid. The woman was escorted to hospital in an ambulance. She returned to Send three hours later and was put into the observation cell where she was monitored continuously by staff, known in prisons as "on constant supervision".

28. The following day, the mental health nurse assessed the woman who told her that two months earlier she had recovered memories of traumatic events from her childhood and that she sometimes had nightmares. The nurse recorded "care plan needed" and noted that it would be completed at the next meeting. She assessed the woman as being at "high" risk of serious self-harm and concluded that the risk was immediate. She decided that the woman needed to be cared for under an "Enhanced Care Programme Approach". Her successor told the investigator that this means that the patient has a care co-ordinator who is responsible for drawing up and monitoring a care plan. The care plan assesses and sets out how the patient's physical, psychological and social needs are met.

29. The mental health nurse attended the ACCT case review that evening. The level of observations was reduced to four per hour but the nurse remained close to the observation cell as the woman slept that night. Another review was held the following day and she told staff she was feeling better. She returned to the wing but remained on the same level of observations. Over the next week, the woman's mood improved and the level of observations gradually reduced.

30. However, at lunchtime on 4 August, staff found the woman bleeding from an old wound that she had re-opened. Staff in the healthcare centre treated her and she returned to the wing. The following day, again at lunchtime, the

woman rang her cell bell (used by prisoners to summon help from staff). When staff went to her cell, they found the woman with a cleaning cloth tied very tightly round her neck. She was not breathing. They cut her down and took her by ambulance to hospital for treatment. She returned to Send at 5.43pm the same day and was again constantly monitored.

31. At the ACCT case review the following day, the woman appeared very withdrawn. The mental health nurse wrote in The woman's mental health records that she: "Appeared quite flat throughout ACCT review, poor eye contact and picking at fingers. Difficulty expressing feelings/emotions."

32. The nurse suggested that the woman could use a "traffic light" system to tell staff how she was feeling. The cards would indicate how she felt, "Green - safe, amber - not sure, red - unsafe". The woman agreed and wing staff made the cards which she then used. Later on, the cards were replaced by a scale (from 1 to 10) which provided a wider range of options for the woman to describe how she felt. One was when she felt happy and at no risk of self-harm through to 10, which indicated that she was almost certain to harm herself. From then on, when staff asked how she felt, she would give a number in reply. Staff told the investigators that the woman's usual response was five or six but she did use other numbers when necessary.

33. On 18 August, the woman indicated to an officer that she felt very low by showing her a red card. The safer custody senior officer (SO) then spoke to the woman and wrote a note in her wing history sheet to alert other staff that she needed additional support. He wrote that the woman was pleased that she was on "constant supervision" as she felt that she might harm herself. She also told him that the following two weeks were going to be difficult for her.

34. At a meeting with one of her personal officers, in early September, the woman listed the dates that were significant for her and which might cause her to harm herself. (As part of the personal officer scheme, prisoners are given a named officer that they can approach for advice or to resolve complaints.) There were so many dates that staff realised that she needed constant high-level support rather than just occasionally. The then acting Governor issued a notice to staff about the woman on 7 September. It gave a brief summary of the woman's self-harm and listed triggers and 11 anniversary dates, adding that they were not exhaustive lists. The Governor also reminded staff that support was available from the care team and the staff welfare service.

35. At ACCT case reviews the staff encouraged the woman to assess for herself what level of observations she needed. They also asked her to keep staff informed of any changes in the level of risk of self-harm.

36. Over the next three weeks, the woman harmed herself four times, using a ligature three times and cutting herself once. On the first two occasions, she appeared to have stopped breathing and staff had to resuscitate her. Then, whilst on constant observation, she tied a sock round her neck. Each incident

was so severe that she needed hospital treatment. On the other occasion, staff in the healthcare centre tended her wounds.

37. The woman had an appointment with a psychiatrist on 4 September and he noted, “Still feeling down – nothing makes it better.” He adjusted her medication and arranged the next appointment for three or four months ahead. (During her imprisonment, the woman was prescribed a number of medications, including antipsychotic and antidepressant drugs, tranquilisers and sleeping tablets.)

38. From the middle of September, the woman’s mood gradually improved. By 20 October, at the weekly ACCT review meeting, staff noted that she had improved greatly. A note in the wing history sheet said, “The woman states at no.3 – one of the best levels since she’s been in prison.” The observation level was reduced to minimum checks. On 14 November, after ten weeks with no self-harm, the woman and the staff decided to close the ACCT plan. The first post-closure review took place a fortnight later.

39. A week before Christmas, the woman used a towel as a ligature and was treated in hospital before returning to prison five hours later. Staff opened a new ACCT plan to give the woman additional support.

2008

40. On 1 January 2008, the woman put a plastic bag over her head. She told the officers who found her that she had also swallowed a razor blade. She went to hospital but no blade was found. Two weeks later, the woman used a J cloth as a ligature. Staff called an ambulance but no hospital treatment was necessary.

41. The following month, the woman moved to Juniper (J) Wing. The unit accommodates prisoners on the enhanced level of the Incentives and Earned privileges (IEP) scheme and has a high proportion of life sentenced prisoners and women serving long sentences. It has a calm atmosphere and is quieter than the noisy and busy wings in the main prison. The woman settled in well, although she continued to be reluctant to mix with others. However, the woman’s friend was also on J Wing and they spent a lot of their free time together.

42. At the end of March, the woman and her personal officer had a meeting. The discussion included her offences and the offending behaviour work she had done. The officer noted, “Very remorseful. Done ETS, domestic violence, self-assertion. Starts Sycamore next week.” (Enhanced Thinking Skills (ETS) is a course on how to deal with problems. The Sycamore course is focussed on the impact a crime has on the victim.)

43. The woman harmed herself once in April by cutting her arms and in May by taking an overdose. On both occasions she went to hospital by ambulance for treatment. On 17 June, the mental health nurse wrote a note to all staff who were monitoring the woman on a constant supervision. She asked them

to record “any periods of wakefulness and/or distress during the night” as well as her behaviour and mental state. The information was important in assessing the woman’s risk to herself. The nurse wrote, “The woman has a long history of night terrors that precipitate the incidence of suicide attempts”.

44. Throughout June, July and August, the woman harmed herself frequently and severely, most often by cutting herself. She cut her shins and arms several times, on one occasion needing 26 stitches in each leg. During this time, she had several periods on constant observation when a nurse sat with her 24 hours a day. When this happened, the woman moved to a cell in a quiet corridor of the main wing. The cell was unfurnished, the bed a concrete platform on which a mattress and bedding rested. There were very few ligature points in the cell. It had a metal gate in place of a door. Staff told the investigators that the woman understood she was there for her own safety but she hated being in the cell.

45. Around this time, the preliminary arrangements were made for the woman’s next parole hearing, which was scheduled for summer 2009. The staff in the Offender Management Unit (OMU) began to prepare the parole dossier by asking many of the staff who had contact with the woman to prepare reports on her work, behaviour and progress. Each member of staff interviewed the woman before writing their report.

46. The prison’s seconded probation officer interviewed the woman in depth about her offence, the offending behaviour work she had completed and what work needed to be done in the future. The probation officer then had to assess the risk the woman presented to others and recommend whether she was ready to move to an open prison. She concluded that her risk had not reduced sufficiently for her to go forward.

47. In October, an SO became the prison’s lifer manager and, as such, she attended the woman’s Care Programme Approach (CPA) meeting on 6 October. CPA is the framework for the delivery of mental health services. She told the investigators that the discussion included three issues which she acted on afterwards. She helped the woman obtain a regular time at the gym, although she only went a few times. Secondly, as a supervisor in the industries department, the woman should have changed jobs after six months, in line with the policy to rotate the posts. The lifer manager’s opinion was that this would be too disruptive for her. She therefore liaised with the staff in industries and persuaded the manager to allow the woman to continue as a supervisor.

48. The third issue was the woman’s outstanding application for a community visit. (This is when a prisoner is allowed out of prison on a temporary basis. It only applies to prisoners in open prisons, some young offenders and female prisoners. A risk assessment will be carried out to ensure the prisoner is suitable for release.) The lifer manager arranged for the visit to take place four days later. She said at interview that the woman had really enjoyed the day. When the woman returned, the lifer manager asked how the visit had gone, she “… beamed this day and said to me, ‘Wonderful!’. She bought

herself a watch and she was dressed in different clothes … in her own clothes." Having successfully completed a town visit, the woman was entitled to apply for another one, which she quickly did.

49. During October, The woman had three appointments with a psychotherapist to assess whether regular individual psychotherapy sessions would be beneficial. The psychotherapist accepted the woman as a patient and, from then on, they met every Friday for 50 minutes. He told the investigator that each session was an opportunity of, "sitting down in a room with a psychotherapist who gives them time and space to allow thoughts to emerge from … the recesses of their unconscious". He and the MHIT expected that the psychotherapy would allow the woman to begin to understand her issues and offending behaviour and would continue for at least 18 months. The woman was very committed to the sessions and missed only two over the seven months until her death.

2009

50. After nearly four months without harming herself, the woman cut her arms and legs in the early hours of 17 January 2009. Staff found her trying to stem the bleeding when they responded to her cell bell. An ambulance was called and the paramedics dressed her wounds before taking her to a local hospital. She returned to Send later that morning. Staff opened an ACCT plan which was closed three days later.

51. As part of the woman's sentence planning and review process, the prison psychiatrist, prepared a psychiatric report. The psychiatrist had reviewed her in her clinic five times in the previous six months. Her diagnosis was:

> "… emotionally unstable personality disorder, borderline type, characterised by prolific self-harm, affective instability (repeated, rapid and abrupt shifts in mood) and poor self-image. In addition, she exhibits post-traumatic symptoms relating to abuse she suffered in childhood … These symptoms take the form of vivid nightmares and hypnopompic hallucinations (a vivid dreamlike hallucination that occurs as one is waking up), followed by self-harm in the form of cutting."

52. The psychiatrist assessed the woman's risk to herself as being through her self-harm, "which could potentially be fatal". She concluded, "The woman self-harms in an attempt to release distressing feelings, and the majority of the time her intent is not to die. However, she tends to cut very deeply, so there is a risk of accidental death." She also noted that the woman was waiting for an assessment to see whether she was suitable for transfer to an outside (non-prison) medium secure psychiatric unit.

53. The woman harmed herself four times during February, on three occasions needing hospital treatment. The following month, she self-harmed twice. On 6 March, whilst cutting herself, she nicked an artery and lost a lot of blood. She went to hospital where she received four pints of blood in a transfusion. On the last day of the month, the woman woke from a nightmare and cut her

forearms and shins. She went to the local hospital where her wounds were treated. On returning to prison, staff moved her to C wing which is closer to the main gate and therefore easier and quicker for ambulance access. On 8 April, the woman cut her limbs again and was treated in hospital.

54. Although the weekly psychotherapy sessions were working well, the timing caused problems for the woman. All prisons run a reduced programme on Fridays and prisoners are locked in their cells from early evening until the Saturday morning. This meant that any issues raised in psychotherapy remained with the woman when she was alone for a significant period of time. This was compounded by the fact that the woman found the weekends difficult as she had too much time on her hands. A lot of her self-harm happened at the weekend.

55. Wing staff tried to mitigate the effects in a number of ways. The most important strategy was to allow her friend to sit with the woman after prisoners were locked up and together they did relaxation exercises. The friend would remain with the woman until she fell asleep and then return to her own room. However, after the woman discussed the issue with the psychotherapist, the change of day was arranged from Friday afternoon to Wednesday mornings.

56. At the beginning of May, the manager of the Industries unit died unexpectedly. The workshops had to close and the women who worked there had to move to other jobs. Staff, particularly the lifer manager and probation officer, arranged for the woman to become the orderly in their office suite – the Offender Management Unit (OMU). One of the reasons they gave the job to her was that they would be readily available to support her when she read her parole dossier.

57. On 15 May, the woman went on her second town visit. The investigators interviewed one of the officers who escorted her to the local town where she shopped and had lunch. When the officer met the woman in reception, he was struck by how different her behaviour was. He told the investigators:

> " …it was quite a revelation really … she was smiling, the eyes, she made eye contact, she was clearly excited, very pleased to be going out. She was communicative, she spoke not in, as a direct response to a question, she would volunteer … information…She was very at home in the van, she asked if she could sit in the front …"

58. The woman shopped, had lunch in a fast food restaurant and sat in a seating area of the shopping centre. The officer said that, in his opinion, she "functioned exceptionally well" in the way she interacted with everyone. On her return to Send, staff in reception immediately recorded her new purchases in her property records. This enabled the woman to return to J wing with her purchases to show her friend, the way someone out of prison would take their shopping home to show to others. The friend told the investigators that the woman had bought everything on her list, including bedding and an alarm clock. She said that the woman assessed her mood as a "one" and this lasted for about a week. After that, she was at a "three" for some time.

59. However, on 26 May, the woman asked the nurse who had given her the morning medication to dress wounds to her shins. She said that she had cut her legs a few days earlier but had not told staff as she did not want to go to the constant-watch cell in the main block. The nurse cleaned and dressed the long cuts to each shin.

60. June was a very difficult time for the woman for a number of reasons. She had a very significant date early in the month, which appeared to pass without incident. However, three days later, she told her friend that she had taken an overdose of paracetamol to help her sleep. She said that she had saved up the pills as the date approached because she knew she would find it difficult to sleep. The friend spoke to staff, who then sent the woman to hospital. Tests revealed that she had not taken an overdose. However, when staff discussed the issue with her afterwards, she continued to insist that she had. The medication that the woman had been allowed to keep in her cell was removed and the head of healthcare arranged a review of how she received her medication.

61. Several times during the month, night duty staff who checked the woman as part of the ACCT procedures found her awake late at night. They opened her cell door and sat with her while she had a cup of tea. They only left once she was settled and ready to sleep. Another strategy was for the woman and her friend to search her cell each evening before being locked up. They put everything that the woman could use to self-harm in a box and gave it to the staff. Staff kept the box in the office overnight and returned it to the woman in the morning.

62. On Monday 22 June, the woman began reading her parole dossier, which contained about 200 pages. Staff updated the ACCT care map to increase the support for her. She had previously discussed how to manage this with OMU staff and her friend. The plan was to read a certain number of pages each day in OMU during an hour in the morning and another in the afternoon. The staff in OMU could then answer any questions she had. The friend would then meet her and they would discuss what the woman had been reading. The friend told the investigators, "The whole time was very, very stressful because it was constantly on her mind. She was getting through it…but it was very stressful…filled her mind." The friend had weekly one to one supervision, with the mental health nurse, as well as other team support in in-reach meetings.

63. Wednesday was a very bad day for the woman. She read the dossier in the morning and then attended her psychotherapy appointment. At lunchtime, she told the wing manager that she was "on a seven" and an emergency ACCT review was held. The people at the meeting decided that the woman should not read the dossier that afternoon but spend the rest of the day with her friend. The following day, at her regular appointment with the mental health nurse, the woman's eyes were red and she found it difficult to make eye contact. She told the nurse that reading the dossier made her feel that she was not improving. However, she had compared how she was coping

and her work with the psychotherapist with 12 months earlier when she was on constant supervision.

64. The woman finished reading the dossier on Friday. The friend told the investigators that the woman was happy because none of the reports recommended that she stay in a closed prison, either because of her self-harm or to complete the psychotherapy sessions. However, the probation officer said in her interview that she had been, "... really clear at the outset it would be very difficult to recommend open at this stage". As early as November 2008, she had discussed with the woman her opinion that she should remain at Send until the psychotherapy ended. Then she would try to arrange a place for the woman on the Primrose Project at HMP Low Newton. (This is a small unit for women who are classed as dangerous and having a severe personality disorder. The programme is designed to deliver more effective healthcare interventions for the women, to reduce the risk of harm to self and others.)

65. According to her friend, the woman spent the weekend relaxing. The following Saturday, 4 July, was another highly significant date for her and she and her friend decided to plan out the whole day well in advance. They drew up a timetable, choosing activities they could do together so that the woman would not be alone at any point.

66. Staff too were aware of the significance of the Saturday and held an ACCT review on Thursday 2 July. The woman asked for the level of observations to remain the same. She then described the plans that she and her friend had for the weekend. Staff agreed that the friend could stay with her in the evening, doing relaxation exercises until the woman was ready to sleep. The people at the review described it as positive and they planned additional support to help her through what would be a difficult day.

4 July

67. At 8.30pm on Friday 3 July, the staff on night shift came on duty and the prison went into night patrol state. Send, like other prisons operates at night with a reduced staff, known as patrol state. AN SO was the night orderly officer, the most senior officer on duty in the prison. She had an assistant night orderly officer. The wings were patrolled by officers and Officer Support Grade (OSG) staff, as usual. (An OSG is a member of prison staff at a grade below prison officer who work in many areas of the prison.) During night patrol state, only the night orderly officer carries a full set of keys which unlocks all the gates and cells. The assistant night orderly officer has keys that allow movement through the prison. The officers and OSGs are each issued with a cell key in a sealed pouch for use in emergencies. The staff instructions are that during the night, a cell may only be unlocked by a single member of staff when there is, or appears to be, immediate danger to life.

68. On 4 July, an OSG and officer were on night duty on J wing. The OSG arrived on the wing and checked which prisoners were on ACCT observations and how often. He checked and counted each prisoner and noted that the woman

was already asleep. He told the investigators that she often snored and was doing so that evening. He carried out the ACCT checks and other routines and said that it was a quiet night. Each time he and the officer checked the woman, she was asleep.

69. At 2.50am, the OSG looked through the observation panel in the woman's cell (J1-31) door and saw that she had cut herself very badly. He told the investigators that she was covered in blood, as was the bed, the wall next to the bed and the floor. She had turned in bed so that her head was at the foot of the bed and her feet on the pillow.

70. The OSG returned to the office, which is only a few metres away, to get assistance from the SO Green and officer. The officer took the emergency supply box and the three staff went to the cell. After the SO observed the woman through the observation panel she opened the cell door and they went in.

71. The SO saw that the woman had deep wounds in the crooks of both elbows. At interview, both she and the OSG described the wounds as "holes" rather than cuts. The emergency box did not contain any dressings so the OSG left the cell briefly and returned with sanitary towels for use as dressings. One wound had stopped bleeding but staff dressed both the woman's arms. The OSG described the woman as being "… still in a dream" but as staff spoke to her she "came round". She then began to struggle, trying to throw the staff off and made a low, keening sound. Both The OSG and SO checked the woman's legs to see if she had cut them too. She had cut her shins in the past but not this time. The SO found a razor blade and moved it out of the way.

72. The OSG used his radio to ask the assistant night orderly officer to come to the cell. The officer held a pad to the woman's left arm and raised it, to try to stop the bleeding. The SO went to the office to arrange for an ambulance to take The woman to hospital. When she returned, she supported the woman's other arm. The OSG took the SO's keys and ran from J wing, at the bottom of the prison to reception at the top end. There are six gates between the two buildings. As he reached each gate, he unlocked it and opened it wide, ready for the ambulance to pass through. At reception, he collected a hospital escort bag (this contains two sets of handcuffs, a mobile telephone and a pager). He was then told by another OSG that an ambulance was on route so he waited at the Gate Lodge and escorted it to J wing.

73. The assistant night orderly officer held one of the woman's arms whilst the officer applied bandages. The woman was still trying to push the staff away and saying that she was feeling hot. The assistant night orderly officer spoke to her and then got her to count out loud with her. As the woman counted, her breathing became less panicky and more regular. Staff soaked sanitary towels in cold water and put them on her forehead, which she said helped. The assistant night orderly officer continued to talk to the woman, asking her about her work and other topics. She answered the questions and, when The assistant night orderly officer made a joke, she laughed.

74. The two paramedics arrived at the woman's cell at 3.04am, each carrying a bag of equipment. They examined her and one paramedic then returned to the ambulance to fetch the stretcher. He unfolded it in the corridor outside the cell and put a canvas cover on it. However, because of the layout, the stretcher would not fit into the cell. The paramedic therefore left it outside.

75. The paramedics asked the prison staff to help the woman walk to the door of the cell. The SO and The assistant night orderly officer helped her to sit up slowly. The SO told the investigators that, as she did so, she noticed that the woman's eyes appeared glassy. As the officers helped her to stand, she lost consciousness, her legs buckled and she began to fall. The officers took her weight and lowered her to the floor. The SO later learned that she had torn the ligaments in her back whilst doing this.

76. The ambulance staff asked the officers to lift the woman onto the stretcher. They were unable to do so because she was too heavy for them to lift, especially with the SO's injured back. The paramedics could not find the woman's pulse, so one left the cell to call for another ambulance to attend. Meanwhile, his colleague administered oxygen to the woman through a facemask.

77. The OSG escorted the second ambulance to J wing, arriving at 3.31am. The crew took a spinal board stretcher to the cell but left it outside. Two minutes later, a paramedic took the cover from the stretcher into the cell and the paramedics and the OSG lifted the woman on to it. They then used the cloth handles on the edge of the cover to pull her into the corridor and lift her onto the stretcher. They wheeled her into the ambulance.

78. Two officers escorted the woman in the ambulance to the Royal Surrey County Hospital. At around 4.12am, they arrived at the hospital. As the ambulance drew up at the entrance to the Accident and Emergency (A&E) Department, the woman's heart stopped and the paramedics began cardio-pulmonary resuscitation (CPR). Hospital staff moved her into the resuscitation room and continued CPR for almost an hour. Sadly, their efforts were unsuccessful and a hospital doctor pronounced her death at 5.55am.

79. The duty governor arrived at the hospital whilst attempts were being made to resuscitate The woman. After her death, he returned to Send and a de-briefing meeting was undertaken with all of the night staff. Staff who were involved in the morning's events were offered support from the prison's care team. The police also asked to see all of the night staff before they went off duty. The Head of Send, was informed about the death at 6.25am. (The Governor was on leave so he was not contacted.)

80. After it was confirmed that the woman had died, Send activated its death in custody contingency plan. The police were informed and visited the hospital and prison. They found no suspicious circumstances. The Head of Send chaired a hot debrief and a fortnight later, staff had an opportunity to attend a critical incident debrief. (A hot debrief is a meeting of all the staff who were

involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other.)

81. The duty governor and a senior officer went into the friends's cell and told her privately that the woman had died. Staff made sure that she was supported throughout the day and for a considerable time afterwards. Around 8.30am, the duty governor started to attend each wing to break the news of the woman's death to the prisoners. He was accompanied by a member of the Independent Monitoring Board and an SO. They asked prisoners whether they required anything or wanted to speak to a Listener. (Listeners are trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress.)

82. The hospital staff had contacted the woman's next of kin whilst they were attempting to resuscitate her. The Head of Safer Custody was appointed as the prison Family Liaison Officer (FLO) and she visited the woman's mother to offer support and assistance. The woman's mother told my staff that the prison FLO was very supportive and answered all the questions she had.

83. The prison staff had no contact details for the woman's father, so they were unable to contact him directly. They asked the local police force to trace him and then notify him of the woman's death. However, the police did not contact him. Unfortunately, the woman's father learned of her death when an acquaintance expressed his condolences. The prison FLO later contacted the woman's father through his solicitors. I recommend that if the police are used in this way again that a manager from Send confirms that the police have contacted the family member.

84. The prisoners held a collection and raised over £100 which they used to send a wreath to the funeral and flowers to the memorial service. The funeral took place on 20 July and the prison FLO attended. A memorial service was later held at the prison, which staff and prisoners attended.

ISSUES CONSIDERED

Health

85. The clinical reviewer reviewed the clinical care that the woman received in prison. Her very detailed report is at Annex 1. She concluded that, "… those who sought to support the woman made well-co-ordinated and thought through plans to manage her behaviour."

Record keeping

86. The reviewer considered that the woman's medical notes were extensive and covered a significant length of time. However, the records of the Mental Health In-reach Team were held separately to the main healthcare records. She noted that it would be beneficial if there was one computerised record that all staff could use. In addition, for patients with complex needs like the woman, a case summary would be helpful as it could set out "the historical details" of treatment.

    The PCT should consider having one computerised records system, covering both general and mental health teams.

    The PCT should consider requiring staff to compile and update a summary of needs and treatment of patients with complex issues.

Mental health

87. The reviewer summarised the woman's mental health care as being:

    > "… managed under an Enhanced Care Plan by the Mental Health Inreach Team within the prison and was receiving regular Psychotherapy input, as well as seeing a Community Nurse on a weekly basis. In addition she was supported by an STR worker, who was another offender within the prison and was well known to the woman. She was receiving regular antidepressant and antipsychotic medication and in October 2008 a referral had been once again made to a secure psychiatric hospital by her CPN, to request a further review regarding the possibility of treatment in a hospital setting."

88. The reviewer notes that the care plan was available to MHIT staff but recommends that it should have been in the main healthcare files as well, to allow all healthcare staff to access it. This is covered by the first recommendation above. However, she goes on to recommend that where a prisoner has complex needs, the plan should be available for Prison Service staff to read, if the prisoner agrees.

    The PCT should consider, where a prisoner has complex needs, sharing the mental health services care plan with Prison Service staff, subject to the prisoner's agreement.

89. In October 2008, the community psychiatric nurse wrote a letter of referral to an NHS medium secure psychiatric unit. She asked the unit to assess the woman's mental health needs to see if they could offer her a place in the unit. She wrote again when she received no reply to her first letter but nine months later when the woman died, she was still awaiting a reply. The reviewer says in the clinical review, "I believe that a referral to a Medium Secure Psychiatric Service would have been better made by the Mental Health Inreach Team Psychiatrist, directly to the Psychiatrist involved".

90. The reviewer notes that the woman's psychotherapy was one of the very few treatment options available whilst she was in prison rather than hospital. She discusses whether it would have been preferable for the woman to have psychotherapy in a prison with a 24-hour healthcare centre. This would have enabled clinical staff in the prison to provide emergency treatment whenever she self-harmed. However, she concludes, "I do not however, believe that a 24 hour healthcare setting would have guaranteed the woman's safety".

91. In considering whether a transfer to another prison would have been preferable, there is also the issue of the effect a move would have had on the woman. After her arrival at Send, she had a period of frequent and severe self-harm. She then went for four months without harming herself. Also, it would have taken her many months to build up trust in staff at the new prison. Finally, her friendship with another prison was a major positive factor in the woman's life in prison. For these reasons, I am content that she remained at Send.

92. The woman's location within Send was also an issue that staff regularly assessed. She did not like C wing in the main prison and strongly disliked being in the constant supervision cell. She was well settled in J wing and had her friend as a neighbour across the corridor. However, the wing is at the other end of the prison from the main gate and there are six internal gates in between. So, it took a minute or two longer for an ambulance to reach J wing than to arrive at C wing. The woman's records show that staff regularly considered the best location for her.

93. The design of the cells on J wing has led to a problem when paramedics attend and need to move a woman on to a stretcher for transfer to the ambulance. There is not enough room between the bed (which is bolted to the floor) and the wall of the shower room for the trolley. It therefore cannot be placed alongside the bed. Staff and paramedics struggled to get the woman out of her cell and onto the trolley. They eventually succeeded by using the canvas stretcher cover to pull the woman into the corridor and lift her on to the trolley.

The Governor, in consultation with the Ambulance Service, should examine the best way for prisoners on J wing to be transferred from the cell onto a trolley and purchase suitable equipment to achieve this.

94. When the reviewer assessed whether the treatment the woman received in prison was the same as she would have had in the community, she concluded:

> "Had the woman been an individual living in the community presenting with such severe levels of self harm, it is likely that she would have been subject to periods of inpatient psychiatric hospital treatment. Some individuals who present with this level of self harm may well have received a specialist referral to services for those with deliberate self harm, either as an inpatient or an outpatient, this does not appear to have been available to the woman within her current setting, but clearly those who sought to support her made well co-ordinated and thought through plans to manage her behaviour."

95. The reiviewer discusses how best to support clinical staff in prisons who care for the small number of prisoners whose self-harm is as severe as the woman's. She suggests:

> "The development of a reference panel of those with expertise in this field, to whom referrals could be made, such referrals would include a full history detailing self harm and risk management strategies used, both past and present, and indeed the preparation of such a referral alone may well aid the development of a comprehensive understanding of the history and risk that will inform immediate manage. The reference panel would be able to offer expert advice on management and support those working directly with the prisoner. They may also be able to offer support for any referral to 24hr healthcare facilities outside of the prison establishment."

96. Such a proposal would have significant national and resource implications for both the National Offender Management Service and Department of Health. I acknowledge the benefits this might have on the small number of prisoners who are prolific self-harmers. However, I make no formal recommendation and leave it to the respective departments to consider how feasible it would be to implement this proposal. In the meantime, the local PCT may wish to consider how best to support clinical staff in prisons who treat patients such as the woman.

Staff management of the woman's self-harm

97. Throughout her time in prison, the woman frequently harmed herself, sometimes very badly. The frequency and severity of her injuries often meant that she needed hospital treatment. On several occasions, staff carrying out ACCT checks found her with a ligature round her neck and not breathing. Fortunately, each time, she was resuscitated after receiving CPR from staff and paramedics. Her records show that she went to hospital 22 times in her two years at Send. Many staff told my investigators how upset the woman was afterwards and how hard she tried to stop harming herself. The strain on her and staff was very great.

98. Staff worked with the woman to put strategies in place to reduce the level and seriousness of her self-harm. Clinical staff, prison managers and wing staff co-operated closely to care for the woman. The level of support they provided was commendable. In particular, I draw attention to the way staff treated the woman as an individual, tailoring not just strategies but also the prison regime to meet her needs. I commend the Governor and his staff for their most impressive care of the woman and highlight the actions below as examples of good practice.

ACCT plans

99. ACCT procedures are set out in Prison Service Order (PSO) 2700 "Suicide Prevention and Self-harm Management". The PSO contains a considerable number of requirements about actions, timescales and people to be involved in the plan. Staff at Send fully met all the requirements. At times when the woman's self-harm was intense, the ACCT was upgraded to an enhanced ACCT. This again required staff to take certain actions and again they did so. The Care Map was updated when necessary.

100. The woman was on an open ACCT plan from February 2009 until her death six months later. An SO, one of J wing's managers, was the case manager, apart from when it became an enhanced ACCT. On those occasions the Head of Safer Custody, managed it, as required by the PSO. At each case review, staff who knew the woman attended from many departments, including workshops, probation and the chaplaincy. Members of the Mental Health In-reach Team were always present. Enhanced ACCT reviews should be attended by a wider range of staff than usual. However, the woman's standard reviews were already fully multi-disciplinary and up to enhanced review requirements. The case reviews were never rushed, taking from 30 minutes to an hour or longer.

101. The most striking aspect of the ACCT case reviews was the way staff encouraged the woman's participation. Various members of staff told the investigators that she was a very private person, slow to trust others and not comfortable in groups. In spite of this, not only did she attend each case review, she took part in the discussions. The case manager organised each review in the same way, providing her with a stable structure for the meetings.

102. However, two other factors contributed greatly to the woman's relative ease in what, at times, could be a large group of people. The regular attendees were people that the woman knew well and with whom she had developed working relationships over weeks and months. The core of people at the reviews were staff with whom the woman had developed trust. The case manager told the investigators that he always asked her to suggest people who she would want at the next review.

103. Secondly, the woman's friend also attended the meetings to provide support and encouragement. The woman asked the staff if her friend could attend and they were happy to agree. The OSG told the investigators that she also asked for the friend to be present at the ACCT assessments. He said that the

friend would, "… ease it (information) out of her", which meant that he could build up a fuller picture of her issues and needs. The friend told the investigators that she sometimes prompted the woman to pass on information to the people at the meetings.

I commend the thoroughness with which staff managed the woman's ACCT plan.

I commend as good practice the inclusion of a close friend in ACCT meetings to offer support and encouragement.

104. When a person is on an ACCT plan for a long time, there may be a danger of the processes and checks becoming routine. Staff, particularly the safer custody team and the case manager, worked hard to keep the woman's support plan fresh and ensure that officers and OSGs carried out their checks diligently. The incident report forms completed by staff each time the woman harmed herself record four occasions when staff and/or paramedics had to resuscitate her. Many of the reports begin by saying that the officer was carrying out an ACCT check at night when he or she found that the woman had self-harmed. Her life was saved more than once by staff doing ACCT checks and summoning help immediately. I commend staff for these very successful interventions which helped to sustain the woman's life over an extended period.

Other strategies

105. Each ACCT review began by the case manager asking the woman how she felt. She replied by giving a number from one to ten to describe her feelings and mood. For most of the time her reply was four or five. Staff originally used a red/amber/green scale but changed it to the numerical one as it provided greater sensitivity in replies. The woman used it constantly, not just in ACCT meetings, and it helped a very private woman tell staff how she felt.

106. The case manager, kept staff informed of how she was. He very often used the internal email system to alert staff across the prison of when a known anniversary or trigger was approaching. This meant that they could further increase what was already a high level of support.

107. The woman's self-harm was mainly in the few seconds between having a nightmare and becoming fully awake, usually early in the morning. Staff encouraged her to ring her cell bell if she awoke from a bad dream. The case manager designed A4-sized posters to put on her wall next to the bed, encouraging her to call for staff after a nightmare. He regularly replaced them, varying the colour of the paper to try to keep them fresh in her mind. There were occasions when the woman did ring her bell after waking from a bad dream.

108. When the woman's mood was low, she found weekends very long without enough activity to keep her mind occupied. Staff occasionally arranged for her to work at the weekend, to keep her busy. One of the prison chaplains,

developed a good relationship with her. The woman would fairly regularly call at the chaplaincy and spend time with the chaplain. The chaplain told the investigators that sometimes they sat in silence but other times the woman would discuss her problems. She also spoke about her plans for her release. The chaplain said that the woman had a good sense of humour and she would sometimes joke about things she had seen or heard. These conversations gave her space and time apart where she could set the agenda.

Access to sharp objects

109. The woman self-harmed in a number of ways but the two main methods were by ligatures and cutting. She used whatever was to hand, including cleaning cloths, razor blades and a broken CD. Once, whilst at Cookham Wood, she tried to choke herself with the escort chain whilst out at hospital. (An escort chain is a length of chain between the handcuffs worn by a prisoner and an officer. It allows a little more privacy, for example during toilet trips.)

110. At times when the woman's mood was particularly low, she would empty her cell each evening of anything she could use to harm herself. Staff kept the items in the office and returned them in the morning. However, they never forced her to give up any of her possessions. When deciding how to manage a prisoner who is at risk of harming herself, a balance has to be drawn between preventing self-harm and enabling her to live in conditions of decency. I have no criticism of the prison for not removing such items as this is in line with national policy.

Summary of the woman's care

111. There are occasions when the Ombudsman's reports recommend that the Governor formally commends a member of staff for his or her actions. I have considered whether to do so in this report but, on reflection, I have not done so. Many staff are named in the report and their good work is highlighted here. The investigators are aware of others who are not named, who also did what they could to support the woman. As I said in the preface, I believe that the staff discharged their duty of care to the highest standard. It would, therefore, be divisive to single out individuals for commendation. However, I would appreciate it if the Governor would share my remarks with everyone who works at Send.

The woman's friend

Friendship

112. The woman met the friend when they both worked in the laundry. Over time, she began to open up to the friend and they became friends. When interviewed as part of this investigation, the friend described the woman as finding it difficult to trust people as she had been let down in the past. She said that their friendship developed slowly over quite a considerable length of time at a pace that suited the woman. The friend said that, although staff

supported the woman with the issues relating to her self harm, they were not always able to spot when her mood was low. This was because she could be quite uncommunicative.

113. The friend described The woman as a “planner” in relation to her daily life and a very organised person. She thought that even some of the woman’s self-harm was planned, although not when she awoke from a nightmare. The friend said that the woman:

> “… used to have these fugue stages (an altered state of consciousness in which a person may move about purposely and even speak but is not fully aware) where there was one, there was once instance that particularly comes to mind … She’d had the nightmare, she’d self harmed and it was at the end of the self harm that she actually realised that she’d self harmed and she said that she’d actually got sanitary towels to put on her arm because she didn’t realise how deep it was. It was only when she went to get up that she nearly passed out and she just about made it to the buzzer. And if she hadn’t made it when the paramedics arrived, they’d said that if she hadn’t made it to the buzzer in the next few minutes, it would have been too late because she’d lost so much blood.”

114. The friend said that the woman’s life was very structured. She would get up in the morning and collect her medication and then go to work. If she had an appointment, she would always leave in time for the appointment. She would collect her medication again around noon and then have lunch. After watching the news and the first part of ‘Neighbours’ she would then return to work. After she finished working, the woman would again collect her medication and then settle down to watch television for the evening. The woman liked watching the soaps and nature documentaries. They would also on occasion watch DVDs of Disney films. The friend described how they would spend time outside during the summer. She said:

> “And then the weekends as well, we’d always try and go out for a bit of time, just lie in the sun. We had a little area where there was a little nest of – I always used to say they were red ants but she insisted they were red spiders and we could spend ages, just like, just sitting there watching the activity of them scurrying around.”

Support Time Recovery work

115. The friend also worked as part of the Mental Health In-reach Team supporting vulnerable prisoners. As part of this role she offered support to the woman. In one to one sessions they worked on techniques to help her to cope with her low moods. The friend said that the psychotherapy sessions could be very difficult for the woman. The initial timing of the appointment, on a Friday afternoon, meant that shortly after the session she could be locked up until the following morning. The friend would ask staff for permission to be locked in with the woman to support her after her session:

> "So they used to let me go in on Friday evenings and often Saturday evenings as well. Often between seven and eight in the evening, before but around the time we knew her medication would kick in after eight o'clock and so it was to release and talk through anything she needed to in the hope that once she'd done that, she'd fall asleep relaxed and that might prevent a nightmare."

116. This is not routine procedure in prisons but was an example of how Send and the friend tried to support the woman thorough these difficult episodes. It was later decided to change the day of the woman's appointment with the psychotherapist to a Wednesday.

117. The friend said that the alternative of seeing a Listener was not an option that the woman wanted to pursue. Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress. She said:

> "The issues that she discussed with me, I can't see her ever talking to a Listener, it was after knowing me so well and trusting me so much that she actually and it took so long for her to get to the stage where she talked about those issues with me. It's not something she'd casually talk about. Or even in moments of distress, it's not something she'd talk about. She'd spent her entire life oppressing her emotions, so it's almost something that she was used to doing."

118. The friend also produced a tape to help the woman to relax. She said:

> "The tape was simply a relaxation technique, we'd identified that the woman's safe place and the place she enjoyed going to the most was the beach. So she'd simply lie on the bed, close her eyes, we'd focus on her breathing and I'd talk her through the beach where she had her own beach hut. It was somewhere when she was very stressed she could escape to relax, her safe space in her head. And sometimes when she was very stressed, simply having me talk her through that helped and I taped the session so that when I wasn't there and she was stressed, perhaps after a nightmare, she could simply put the tape on and it would help."

The Governor should formally commend the friend for the care and support she gave the woman.

119. The clinical reviewer expresses concern about using the friend as an STR worker. She notes that because she was a prisoner she had no opportunity to have "down time away from the job". She gives the following advice:

> "Great care needs to be exercised when engaging another prisoner as an STR worker and the boundaries of support must be clearly agreed by all parties, including prison staff, inmate patient and Inreach Team. There also needs to be regular supervision and review of the post to prevent the intensity escalating."

The friend was given support during weekly one to one supervision sessions and case discussions during in-reach team meetings.

Support for staff after the woman's death

120. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. When interviewed as part of this investigation, the assistant night orderly officer spoke about the support offered to staff after the woman died on 4 July. She said:

> "So we had the debrief, … no one had asked us how we were or whether we would be in to work that night or whether we were supposed to go in to work, "We don't want you in tonight," there was none of that, so we just spoke about it amongst ourselves …….., I said "Well as far as I know I will be in tonight" but I'm not sure how I'm feeling at the moment, but we all turned up that night.."

121. Other staff confirmed that they turned up for work the following night as they had not been told of other arrangements. It would appear that it was not made clear to staff what support was available and the measures that were going to be implemented to deal with their next duty at Send. The assistant night orderly officer confirmed that support was later offered by the care team at Send.

122. I was surprised that support was not immediately offered to staff. This was unfortunate and meant that staff who had dealt with a very difficult situation were left feeling dissatisfied. I recommend that Send reviews its support and care team policy, in case this situation arises in the future, so that whenever a death (natural or self-inflicted) occurs, staff are offered support at the earliest juncture.

The Governor should review the support mechanisms for staff after a death in custody.

CONCLUSION

123. The woman was serving a long term of imprisonment and Send was her fourth prison. Throughout her time in prison she harmed herself in a variety of ways, sometimes inflicting serious injuries. However, most of these took place after nightmares and all those who knew the woman were of the opinion that her self-harm was not a wish to die.

124. In the two years the woman spent at Send, she made progress, which she acknowledged in what was to be her final meeting with the community psychiatric nurse. She had two periods of around three months when she had not self-harmed and made two successful town visits. She had begun examining her problems in psychotherapy and had read her parole dossier. Her friendship with another prisoner was supportive and helped her relax.

125. I judge that staff made great efforts to contain the level and severity of the woman's self-harm during her time at Send. My investigation has found an exceptionally high standard of care and support from her support time recovery worker and from prison staff. Sadly, in spite of all the positive factors and all the support and care she had from staff, the woman inflicted fatal injuries on herself and died on 4 July 2009.

RECOMMENDATIONS AND COMMENDATIONS

1. The PCT should consider having one computerised records system, covering both general and mental health teams.

   Accepted by the PCT.

   "The PCT and Surrey and Borders Partnership Foundation NHS Trust are now using a single records system - System 1."

2. The PCT should consider requiring staff to compile and update a summary of needs and treatment of patients with complex issues.

   Accepted by the PCT.

   "System 1 will record all events, and allow reporting all high risk interventions for audit and clinical review. We are currently working through our Governance structures on agreement for the classification of incidents to allow reporting and gathering summaries."

3. The PCT should consider, where a prisoner has complex needs, sharing the mental health services care plan with Prison Service staff, subject to the prisoner's agreement.

   Partially accepted by the PCT.

   "When appropriate and when the client agrees. However, this is not always appropriate. Even if the client agrees there are no protocols in the prison about how information is stored. We are not clear why the plan would need to be shared given that our staff should be working (and were in this case) on formulating a care map with safer custody. The care map and the relevant elements from the care plan should therefore be the same."

4. The Governor, in consultation with the Ambulance Service should examine the best way for prisoners on J wing to be transferred from the cell onto a trolley and purchase suitable equipment to achieve this.

   Partially accepted by the prison.

   "Send recognises that there are inherent difficulties with the use of standard ambulance trolleys on landings throughout the establishment. However all ambulances should be equipped with suitable apparatus which facilitates transfer of patients from difficult to access areas as standard. The establishment will liaise with the relevant PCT and Ambulance service to examine this issue and identify what alternative equipment already in use on ambulances can be best utilised in the prison environment."

5. The Governor should formally commend the friend for the care and support she gave the woman.

Accepted by the prison.

“A formal letter of thanks has been sent to the friend.”

6. The Governor should review the support mechanisms for staff after a death in custody.

   Accepted by the prison.

   “The governor will review the death in custody contingency plan to ensure that it fully reflects the need for supporting staff following such incidents is dealt with as matter of highest priority. In the immediate aftermath of the incident all staff involved were debriefed by the Governor and formally offered all means of available support. In the days following the incident, all staff involved were written to by both the governor and the orderly officer to recognise their involvement and to further offer support. Additional night staff were called in to support the existing night staff complement for the nights following the incident.”

Commendations

1. I commend the thoroughness with which staff managed the woman’s ACCT plan.

2. I commend as good practice the inclusion of a close friend in ACCT meetings to offer support and encouragement.