Investigation into the circumstances surrounding the death of a woman in June 2007 whilst a prisoner at HMP Holloway

Report by the Prisons and Probation Ombudsman for England and Wales

November 2010

This is the report of an investigation into the death of a woman who was found hanging in her cell at HMP Holloway in June 2007. She was aged 34.

I wish to offer my sincere sympathy and condolences to the woman's family for their loss. I would also like to apologise for the delay in issuing this report.

This investigation was conducted by one of my senior Investigators.

I would like to extend my thanks to the Governor and her staff at Holloway for their help and co-operation during this investigation. I also thank the prisoner who agreed to take part in the investigation process.

A clinical review of the care and treatment received by the woman whilst at Holloway was conducted by a panel convened by the local Primary Care Trust. I am grateful to the clinical reviewers for their report.

The woman had been involved with the criminal justice system since 1985 and had a total of 45 convictions, the majority for offences of theft. She had been in prison on numerous occasions.

She had a long history of mental illness and had been diagnosed with schizophrenia in 1999. There had been no recent concerns about her self-harming although concerns rose occasionally, dating back to 1994. This is a sad case in which neither the prison staff nor the prisoners at Holloway had any thoughts that she was contemplating ending her life.

I have made one recommendation in line with that in the clinical review.

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

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

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SUMMARY

The woman arrived at HMP Holloway on remand from Magistrates Court on 26 May 2007. She was well known at the prison, having been released only the previous week. Staff knew that the main issue for her was her constant need for tobacco and cigarettes. She was given three written and several verbal warnings during the following few weeks for approaching other prisoners' cell hatches to ask for cigarettes.

The woman was liked by the other prisoners, some of whom felt sorry for her as she rarely had money to buy tobacco. The staff allowed her some leeway as well and several tried to get her extra cigarettes when they could.

She was receiving medication for schizophrenia diagnosed in 1999. She was not known as a self-harmer, although concerns rose occasionally, the last being in March 2006, when she banged her forehead out of frustration at court. She admitted to using cocaine and cannabis on a regular basis.

Staff and prisoners were aware that the woman had a boyfriend who was unwell and in hospital, but as was usual she did not talk very much about her private life.

On 26 June, she tried to find out the telephone number for her boyfriend's hospital. A member of the resettlement staff was able to find it for her. It is now known that she attempted to contact her boyfriend during the afternoon and evening of 29 June.

During the night, the woman was seen apparently asleep in her bed at least up until 6.00am. At 7.32am, the night duty member of staff, an Operational Support Grade (OSG), looked into her cell and saw her hanging from the end of her upturned bed.

The alarm was raised and staff entered the cell and cut her down. Officers and healthcare staff attempted resuscitation until they were relieved by paramedics. At 8.00am, the Helicopter Emergency Medical Services (HEMS) doctor declared that she had died.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Holloway on 2 July 2007 by my investigator. The Governor and her staff produced the woman's core record and a large number of other documents for examination. Notices were displayed around the prison to inform both staff and prisoners of the investigation.

2. A number of members of staff and a prisoner were formally interviewed regarding the woman's death.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the woman's death.

4. One of my Family Liaison Officers contacted the woman's family and offered the opportunity to meet her and my investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. They met with the woman's parents on 1 August 2007. Her parents raised the following concerns:

   - Why was the bed in her cell not bolted down?
   - Was she on any kind of self-harm watch?
   - Why was she located in prison healthcare?
   - Would she have taken her life had she been in a shared cell where she would have had support from other prisoners?

5. I have done my best to address the concerns of the woman's family's within the report. I hope it helps them better understand what happened in the time leading up to their daughter's death.

HMP HOLLOWAY

6. Holloway is a women's local prison located in north London that serves courts throughout the South-East of England. It holds just under 480 women and is a prison with many diverse functions. Its main role is to hold women on remand or waiting sentence. It also has a Mother and Baby unit, a Young Offender unit that holds girls and young women between 15 and 21 years old and a unit for life sentence prisoners.

7. On 1 April 2004, the local Primary Care Trust took on responsibility for commissioning healthcare at Holloway. It was one of the first trusts to have healthcare commissioning responsibilities in prisons in England.

8. The woman's death was the fourth apparently self-inflicted death at Holloway since April 2004 when the Ombudsman took over responsibility for the investigation of all deaths in prison custody. The issues in those deaths were not similar to that of the woman who is the subject of this report. There has unfortunately been a further death since that of the woman.

9. The most recent report by Her Majesty's Chief Inspector of Prisons was published in January 2005 and was based on an inspection during October 2004. The report showed an improving prison.

10. The Independent Monitoring Board published their annual report at the end of 2007. In the Executive Summary they wrote:

> "2007 was a year of consolidation under the leadership of the new Governor. Considerable work has been done on embedding a performance culture at all levels and this has clearly paid dividends as in December the prison gained Investors in People accreditation, the only London prison to achieve this award."
>
> "Although the absolute recorded number of incidents of self-harm was reduced from 2006 there were nevertheless 1,023 during the year. Rarely a day went by without two or three incidences of women tying ligatures. Only by virtue of the vigilance and dedication of the nursing and discipline staff, did many of these not result in very serious consequences or at worst deaths in custody. The Board continues to ask why these women are in prison and not being cared for in a more appropriate place."

KEY FINDINGS

11. The woman arrived at Holloway from the Magistrates Court on 26 May 2007. She had been charged with an offence of dishonesty. She was well known at Holloway and had been released only the week before.

12. As part of the routine reception process the woman was seen by a prison doctor. He noted that she had no thoughts of self-harm, did not drink alcohol, and was positive and stable in mood. The woman was dependent on crack cocaine, although she told the doctor that she had been crack free for the last month. She was referred to the prison drug service and the mental health team.

13. A new patient screen was completed by a reception nurse. She recorded that the woman had been released from Holloway on 20 May, and that she had not had her zuclopenthixol injection whilst she was out of prison. (The woman was prescribed zuclopenthixol by injection for schizophrenia, a condition she had been diagnosed with in 1999.) She told the nurse that she smoked 20 - 39 cigarettes a day and that she had started her menstrual period that day. A routine pregnancy test was negative.

14. Although the woman was assessed as low risk of harm to others, she was allocated a single cell. The explanation was that, due to her previous behaviour at Holloway, she normally had a cell to herself. The staff knew that generally she did not associate well with other prisoners and they in turn found that she constantly asked for cigarettes.

15. On 27 May, a resettlement form was completed by an officer. The woman gave her address as a hostel in Lewisham where she had lived for the previous six months. She told the officer that she did not use drugs. That is in direct contrast with the resettlement form completed a month earlier during her previous sentence when she claimed to have a daily crack and heroin habit. The explanation for this discrepancy may be found at the back of the most recent form where it is noted that, “only left custody a week ago and does not want to complete this paperwork”.

16. The following day the woman was located in room (cell) 21 on unit A4. This room is located on a residential wing, not within the healthcare unit as her parents believed. I can confirm that she was not located in healthcare during this period in custody.

17. The woman received her zuclopenthixol injection on 30 May, which was then about a week overdue. My investigator was told that a delay of that level would have little or no effect.

18. At 12.45 am on 31 May, the woman was given a written IEP warning for being rude, misusing the cell bell and demanding a light for a cigarette. (IEP stands for Incentives and Earned Privileges Scheme. If prisoners at Holloway receive three such written warnings they revert to the basic regime which, amongst other things, means that the in-cell television is removed.)

19. The woman returned to the magistrates court on 1 June, and was convicted. She was sent back to Holloway to await sentence at Crown Court.

20. Unsentenced prisoners are encouraged, but not compelled, to attend activities and work. The staff told my investigator that the woman would be very slow in the mornings as she tended to be awake a lot during the night. She was generally short of money and did not earn any, which was why she constantly tried to get tobacco or cigarettes from staff and other prisoners. It was only that behaviour that brought her to the attention of staff and the majority of the staff interviewed did not view her as a difficult prisoner. My investigator considered that staff spoke positively about her and were very tolerant of her needs.

21. On 3 June at 12.00 pm, an officer gave the woman her second IEP warning. On that occasion it was because she constantly approached the door hatches of other prisoners' cells. The officer explained her reason during her interview with my investigator:

> "I think on that day she was quite desperate for tobacco so she continuously kept going to them and asking them for tobacco, continuously went to the hatches and I gave her I think it was two verbal warnings beforehand and because she continued to do it I had to give her an IEP. But she was, she knew it was coming, she didn't argue back, so that's why she was issued an IEP."

22. Five days later on 8 June, the woman complained of toothache and was given pain relieving medication.

23. An officer made an entry in the woman's history sheet on 9 June, regarding her not conforming to the prison regime. Her reasons for not taking matters further are again explained during her interview. The officer explained that the woman's habits were tolerated unless they became disruptive, in which case a warning would be issued.

24. A mental health social worker saw the woman on 12 June. She had known the woman for just over a year during her previous periods in custody. She noted in her medical record that the woman was feeling and looking well, with no symptoms of mental illness. The woman was unsure whether the hostel accommodation would still be available to her after her court date in July. The social worker promised to contact her care co-ordinator to find out.

25. My investigator asked the social worker for a verbal picture of the woman:

> "She was a young woman who had a pattern of repeat offending. She was in and out of prison quite frequently. She had a diagnosis of schizophrenia and personality disorder, borderline personality disorder. She was a loner, she liked to be alone, she didn't get on too well with other people, she didn't mix very much with other people. And her mood fluctuated over the time I worked with her, sometimes she'd be

down, other times she would be happier. But she was never acutely unwell as long as I worked with her... The times when she was particularly low in mood was times when she was sharing dorms with other women and felt the pressure of other women sort of telling her what to do to, kind of be more hygienic, sort of really conform maybe to the dorm standards. And she found that quite stressful actually and she liked to be alone in her own room. Generally if she was going to education, getting off the landing, she was more upbeat, her mood was pretty good actually. With fluctuations when she felt a bit low but nothing serious that I thought she would ever harm herself in any way."

26. On 13 June, the woman was given her third IEP warning, this time for misusing her cell bell. The warning was written up on a new form and it was therefore not identified that it was her third and final one.

27. A wing officer wrote in the woman's history booklet on 16 June, "The woman doesn't conform to the regime, she always goes to the hatch asking for cigarettes and pressing cell bell unnecessarily." In her interview the officer said that the woman was always at the hatches asking for cigarettes. Some of the other prisoners asked for their doors to be locked so that no one could enter their cell and take their cigarettes. She added that everyone liked the woman and as far as she knew there were never any problems between her and the other women.

28. The mental health social worker saw the woman again on 20 June. She had spoken with a care co-ordinator with the Community Mental Health Team, who told her that the woman's accommodation had been cancelled as they were expecting her to receive a custodial sentence. He said that the team was considering other placements but there were few that suited the woman's needs. The social worker recorded in the woman's medical record that when she told her about the accommodation she found the news difficult to take and did not want to continue the meeting.

29. On 24 June, the wing officer wrote an entry similar to her previous one, "The woman is very demanding. She's constantly pressing her cell bell when locked in for various things, such as lighters, or wants to come out. She is slow to conform to regime." Like the other officers interviewed, this officer did not view her as a problem prisoner.

30. On 26 June, the prison's Resettlement Project Manager was in his office on the fours landing when the woman came in. He described the meeting in his interview:

> "On the 26th she actually approached me in my office and asked if she could make a phone call. I enquired who she needed to contact. I spoke with the officers, found out if there were any ACCTs against her and if this was OK and they said fine. [ACCT stands for Assessment, Care in Custody and Teamwork. It is a document used to monitor and assist those prisoners considered to be at risk of suicide or self harm.] And she, I believe, contacted her probation officer because she needed

to get hold of her boyfriend. Her boyfriend is, or was, at the time at hospital. She'd tried several times to try and get through to him but she was unsuccessful that day. But she was happy enough, she went away and she wasn't sort of distressed about anything. I suppose on the day what I had noticed, she had a, I can't remember what the card said on it, but it was either a Christmas card or a birthday card that she had clenched in her hand and I think the words stated 'To The One I Love' or something, but I'm not sure what it actually said. But it was just odd and she said she'd just received it from her boyfriend and she was really happy about it and she just wanted to contact him. And as I said she tried several times to get through but she was unsuccessful. The next day that I saw her was on the Thursday when I came back to work and she was full of smiles. And all I said to her was 'did you actually get through in the end' and she said yes and she's really happy about it and that was it."

31. One officer said in her police statement that at about 6.30pm on 29 June, the woman came into the wing office and said that she had been trying to call her boyfriend at hospital but could not get an answer. The officer tried to check the telephone number on the internet but could not find it. The woman said that she thought it was a payphone number at the hospital. She left the office, saying that she would speak to the care co-ordinator in Resettlement on Monday.

32. A prisoner told the police investigating the woman's death that she saw her crying at the nurse's hatch on the wing at about 7.00pm that day. She complained of stomach pain. My investigator interviewed the nurse who was on duty. He said that he knew the woman but he had no recollection of the incident.

33. From 3.30 pm on 29 June, the woman tried to call the hospital payphone numerous times, the last at 7.48pm. On all but two of the occasions the call was terminated at the hospital end and on the other two occasions she ended the call.

34. The Operational Support Grade (OSG) was the officer on duty during the night of 29 June. She was responsible for 31 women on A4 landing and 16 on B4. She started her patrol at 9.00pm, checking every prisoner in every cell. When she arrived at the woman's cell she looked through the door hatch. She saw her dressed in her nightdress lying on her bed. The officer said, "Goodnight", and she replied in kind.

35. The OSG patrolled the landings every half an hour throughout the night, later recalling that the woman was in her bed and the cell light was off. The OSG did her final official count at 6.00am. On that occasion, the woman was still in her bed.

36. At about 7.32am the OSG looked into the woman's cell for her final check before handing over to the day shift officers. She could not see the bed. Looking closer, she saw the bed stood on end to the left of the door. The

woman was hanging from the topmost part of the bed frame with a ligature made from bed sheeting around her neck. The OSG immediately pressed the fire alarm bell which was next to the cell several times. In an interview for this investigation she said that she could not recall whether she was carrying a radio.

37. I note that in her police statement the OSG states that the time of her discovery was 7.20am. The official log kept by the control room staff has the time as 7.32am and the other officers who responded to the alarm put the time at about 7.30am. As the OSG was very distressed I am content to accept the official timing.

38. Officer A had recently started her duty on A3 unit. She heard the alarm signal over her personal radio and made her way to A4 to assist. She arrived on the landing and saw the OSG in a very distressed state. The OSG pointed along the landing and said, "Cell 21, cell 21". The officer went to the cell but could not see the woman inside. In her police statement Officer A said that the part of the toilet area where the sink is located is a blind spot for staff looking into the cell. Officer B arrived seconds later and used his key to open the cell door. There was resistance at first and initially he thought that the woman was behind the door. In fact it was obstructed by the mattress and bedding from the bed. Upon entering the cell the officer saw that she was hanging from the upturned bed as previously described.

39. Officer B immediately supported the woman's body to relieve the pressure from around her neck. Officer C, who had arrived at the cell, used an issued safety knife, known as a 'fish knife' due to its shape, to cut the ligature. The woman was then lowered onto the floor of the cell. Officer D arrived and used her radio to call for a nurse with oxygen to respond. The message was relayed as a 'code blue' by the control room at 7.34am, ('code blue' means a life threatening situation usually involving breathing difficulties). Other officers arrived and Officer E and Officer C commenced cardio pulmonary resuscitation (CPR). Officer C reported in his police statement that the woman's jaw hardly moved when he tried to open her mouth.

40. A Nursing Sister, who had been making her way to the cell as a result of the alarm calls, arrived and immediately asked for an ambulance to be called. She took over the breathing part of the CPR. She too noted the stiffness of the woman's jaw and neck. Other nursing staff arrived and a defibrillator was attached to the woman's chest. The machine advised that no shock should be given to the patient but the staff should continue CPR. The machine was checked four times over the next few minutes with the same result.

41. The ambulance arrived at the prison gates at 7.44am and the crew were directed to the cell, arriving at about 7.50am. They took over CPR and were joined about five minutes later by the Helicopter Emergency Medical Services (HEMS) doctor. The woman was pronounced dead at 8.00am.

42. A hand written note was found in the woman's cell after her death. In the note, she wrote to her boyfriend at the hospital and appears to be intimating that she wanted more than friendship from the relationship.

43. The staff who found the woman and those who had been involved in the attempts to resuscitate her went to the prison boardroom for a 'hot' debrief. The purpose of this debrief is to offer support and reassurance to staff, to give them a chance to share information and to calm their emotions.

44. The family said that the woman's mother was told of her death by local police when she returned home at 4.30pm. She telephoned the Governor on the number she had been given at 6.00pm. During the conversation the Governor invited them to come to the prison if they wished and also offered to pay for a simple funeral. At that time the woman's mother declined the offer of a visit, but she accepted the following day when she spoke with a duty governor. The duty governor arranged a taxi to collect the woman's mother and father for them to visit the prison on 2 July.

45. Late in the evening after the woman's death an officer was told by a prisoner that she believed the woman had been pregnant and had miscarried the previous weekend. There is no evidence to support that story. In fact, as previously mentioned, the woman gave a negative pregnancy test when she arrived at the prison and also said that it was the first day of her menstrual period.

46. The woman's parents told my investigator and family liaison officer (FLO) that they felt positive about the help and support they had received from the prison's FLO. They did raise a concern about the cost of the funeral. They had understood that the prison would pay for the funeral "whatever the cost" and were therefore very distressed when they were told after the event that the prison would only pay what amounted to two thirds of the cost. The woman's parents said that the prison's FLO managed to arrange to meet the cost to prevent the family incurring a debt, for which they were very grateful. However, it is a useful reminder for those staff who are in liaison with the family to be as clear and realistic as possible about what support, whether financial or otherwise, the prison is able to provide.

47. Replying to the draft report, the Governor has set out her understanding of what happened regarding the funeral costs as follows:

> *"As, you have noted, the woman's mother and next of kin was advised very soon after her death that the prison would be pleased to pay for a simple funeral. I understand that some time after the funeral, the woman's mother visited the Funeral Directors to check that the account had been settled, whereupon she discovered that it had not. She then contacted our Family Liaison Officer to express her concern about this. In response, our Family Liaison Officer contacted the Funeral Directors to establish why the invoice had not yet been sent to the prison and to clarify details of the account. It was explained to him that the invoice was in two parts, one being the funeral costs, the other being for a*

memorial plaque which the woman's father, who was separated from her mother, had ordered. The Family Liaison Officer tried unsuccessfully to contact the woman's father to clarify the matter with him. Assuming that an error had been made in merging the two costs onto one invoice, the Family Liaison Officer requested that the invoice for the funeral be sent direct to the prison, for his personal attention, and that any additional expenses that the woman's father had authorised be sent to him. Presumably unaware that her parents were no longer living together; the Funeral Directors forwarded the invoice for the additional costs to the woman's mother. Upon receipt, she rang the Family Liaison Officer in an anxious state explaining that she was not able to pay for the memorial plaque. At this point, it was agreed that the prison would settle both parts of the invoice."

ISSUES

48. In the executive summary of her 2007 report, "A Review of Women with Particular Vulnerabilities in the Criminal Justice System", Baroness Jean Corston wrote:

> "I do not believe, like some campaigners, that no women should be held in custody. There are some crimes for which custody is the only resort in the interests of justice and public protection, but I was dismayed to see so many women frequently sentenced for short periods of time for very minor offences, causing chaos and disruption to their lives and families, without any realistic chance of addressing the causes of their criminality. I acknowledge that some low-level offending women are persistent offenders who breach their bail conditions and this cannot be ignored. But breach is ratcheting up the use of custody to little avail and there are alternative community solutions which I explore in my report… There are many women in prison, either on remand or serving sentences for minor, non-violent offences, for whom prison is both disproportionate and inappropriate. Many of them suffer poor physical and mental health or substance abuse, or both. Large numbers have endured violent or sexual abuse or had chaotic childhoods. Many have been in care."

49. The woman had been involved with the criminal justice system since she was 12 years old. Much of the above applied to her. She was a persistent offender and several non-custodial disposals had been tried without success.

50. When the woman arrived at Holloway on 26 May, a cell sharing risk assessment was completed. It was decided that she was a low risk which would normally mean that she was suitable for sharing a cell or dormitory accommodation. However, the reception staff had the advantage of knowing her. They were aware that she preferred a single cell and that her habit of continuously asking for tobacco or cigarettes could be a source of friction with other prisoners. That decision is backed up by the mental health social worker who said that she found sharing quite stressful and preferred to be in her own room.

51. The clinical review panel examined the prison records, including the woman's healthcare records and staff statements made to the police. I have reproduced their conclusions below:

> "The panel noted that the woman had been upset at being informed of the loss of her planned accommodation and that this would have been distressing to her. However, there is no clear evidence that this would have precipitated an act of self harm on her part or merited her being placed on enhanced observations."
>
> "The panel's view is that both the physical and mental health care of the woman whilst she was in custody was of an equitable quality to what she would have received had she been treated in an NHS facility,

so the panel conclude that the incident was not linked to the standard and quality of care received in custody."

"The one area of concern that was noted was the blind spot that was reported in the woman's cell and the ability to move the bed into this blind spot. The panel feel that this should be looked at in the context of reviewing contributing factors."

"The panel would like to commend the detailed notes and statements that were available for scrutiny in this investigation."

52. Whilst I note the description of a "blind spot" reported by Officer A, the OSG was able to see the upturned bed and the woman when she looked closely into the cell. There is a tension between concerns for the safety of the prisoners and the prisoners' entitlement to a certain level of privacy for reasons of decency. Nevertheless, I feel it is worth recommending that staff be encouraged to bring any concerns about cell safety to the attention of the prison's safer custody coordinator to be actioned as appropriate.

The Governor should remind staff of the importance of their role in the safe custody of prisoners in their care. They should report any concerns about cell safety to the Safer Custody Co-ordinator to be actioned as appropriate.

53. The OSG who found the woman hanging in her cell was very distressed by the discovery. When my investigator spoke with her she could not recall if she had been carrying a radio that night. In any case she immediately raised the alarm which brought other officers to the cell within two minutes. Whilst it is true that those staff did not realise that they were responding to a medical emergency until the 'code blue' was transmitted over the radio two minutes after the first alarm, I do not believe that it had any detrimental effect in this instance. Staff reported that the woman's jaw and neck were stiff when they attempted CPR. It is possible that the stiffness was due to the early onset of rigor mortis (a stiffening of the muscles after death) which generally begins with the small muscles of the face and neck.

54. The prison records indicate that the woman had trouble sleeping at night. It is therefore likely that she was aware of the night officer's routine. She was in her bed at the 6.00am check. After that time she was able to lift her metal bed into an upright position to act as an effective ligature point. My investigator shares the concerns of her parents about the ease with which she was able to use the bed, although I realise that there may have been other parts of the cell that could have been utilised.

55. I reproduce a memo from the suicide prevention co-ordinator issued as the result of questions raised by my investigator during this investigation:

"I have spoken to the previous Suicide Prevention Co-Ordinator and a Works Manager in preparing this response. The key points are:

- Dormitory beds have historically been bolted down to reduce the risk of substantial barricades being constructed.
- Beds have not been bolted down as a suicide prevention measure. This decision was based on a considered judgement that the additional risk posed by being able to upend a bed was not on balance significantly more than that posed by a bolted down one. The crucial aspect of lethality being that of the ligature rather than whether it was used in suspension or not.
- In recent times beds have been bolted down on an ad-hoc basis as and when individuals of known raised risk have been residing in a single room.
- This ad-hoc practice has led to a review of the earlier decision not to bolt all beds down for suicide prevention purposes. Currently it has been decided that all beds should be bolted down. It is difficult to evaluate if this has a definitive risk reduction outcome. However, on balance it was felt that it was preferable as the removal of even one strong suspension point may be positive and has no detrimental effects that have been identified."

63. I am pleased to be able to report that the Governor and her staff have reacted promptly to this particular issue and they have now bolted all the beds in place.

64. I was disappointed to learn that the woman's mother had been told of her daughter's death by a police officer and not personally by a member of the prison staff. Prison Service Order 2710, "Follow up to deaths in custody", sets out the rules and guidelines that should be used. As can be seen from the extract below, whilst not mandatory, best practice is that the sad news of a person's death should be given face to face by prison staff:

> "4.7 Telling a family that a relative has died in prison is probably the hardest task any member of staff is likely to have to do. There is no easy or right way to do this. The only mandatory requirement, which appears in PSO 2710 "Follow up to deaths in custody", is: *"Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened".* The following paragraphs set out some alternative methods available to Governors and provide some guidance on good practice and the pitfalls of making a poor choice. There are opposing views across the Prison Service and outside consultees but the vast majority believe that the first contact must be made directly by the establishment so that the family recognise that the death is a matter of great concern to the establishment. Families bereaved by a death in custody and groups representing them unanimously support this view and evidence from longstanding litigious cases indicates that the first approach to the family can colour the entire relationship. Remember that "you do not get a second chance to make a first impression"."

65. I wholeheartedly support the view expressed in the PSO. The prison FLO told my investigator that he believed the decision to use the police was taken by the Governor. My investigator spoke with her regarding this matter. She understood at the time that as the prison Governor she was required to go and break the news personally to a bereaved family. She is now aware that she could have delegated that responsibility and will do so in the future if she is unavailable. She told me she has had positive relations with the woman's family and that she, the prison FLO and two other members of staff accepted the kind invitation to attend the woman's funeral. I accept that the PSO only provides guidance on who should notify the family, and so make no recommendation on this occasion.

66. Although after the woman's death some prisoners said that she was frustrated because she could not speak to her boyfriend, no one thought that she had any thoughts of self-harm and no concerns were raised either by prisoners or staff. My investigator found that the staff involved in the discovery and attempted resuscitation of the woman reacted swiftly and professionally to a very distressing situation.

Developments at the inquest into the woman's death

67. Following the inquest into the woman's death, the Coroner for the City of London wrote to the Secretary of State for Health on 24 September 2009 expressing concerns. During the inquest, it became clear that a member of nursing staff had made an unauthorised retrospective entry in the woman's computerised clinical record. The entry, made a few hours after the woman died, indicated that the nurse had given the woman an injection of an anti-psychotic drug on 21 June. Subsequent enquiries revealed that the entry was made after the woman died. (Although the medication chart was signed to show that the drug was given.)

68. The disciplinary investigation which followed, conducted by the nurse's employers, was unable to establish whether or not the nurse actually gave the woman the anti-psychotic drug on 21 June. Although the nurse made the entry retrospectively and did not make it clear that she had done so, she may have given the drug at the time and forgotten to record it on the computer. Unfortunately, she refused to attend the disciplinary hearing. The nurse retired from working at Holloway. The findings of the completed disciplinary investigation were submitted to the Nursing and Midwifery Council (NMC). At the time of writing (November 2010) the NMC are still investigating the nurse's conduct and she is currently still registered to practice.

69. The retrospective entry did not appear in the copy of the clinical record provided to the Ombudsman's office after the woman died. The copy given to the Ombudsman was printed out at about 9.00am on the morning the woman died. The nurse made her new entry on the computer at about 11.00am the same morning. The discrepancy between the two versions of the clinical record was only noticed at the inquest.

70. The Coroner expressed concern in his letter to the Secretary of State for Health that the computerised clinical record could be tampered with and that entries could give the impression that they were made on a particular date, when in fact they were not. The Head of Healthcare at Holloway has confirmed to my investigator that the way in which the nurse was able to make her entry was addressed and resolved as soon as the issue arose at the inquest. I gather that the computerised clinical record system at Holloway was amended whilst the inquest was still ongoing, in order to prevent a similar incident happening in future.

RECOMMENDATIONS

The Governor should remind staff of the importance of their role in the safe custody of prisoners in their care. They should report any concerns about cell safety to the Safer Custody Co-ordinator to be actioned as appropriate.