Investigation into the circumstances surrounding the death of a woman at HMP Send in August 2010

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

This is the report of an investigation into the circumstances surrounding the death of a woman at HMP Send in August 2010. She was 34 years old when she died.

The woman had no previous convictions when she was sentenced to nine months in prison for offences of fraud in 2009. After her release she was made the subject of a confiscation order, the terms of which she agreed, requiring her to pay £20,000 to the court. She failed to do so and magistrates committed her to prison for non-payment of the order for the default term of 12 months imprisonment on 14 May 2010. She was taken to HMP Eastwood Park before transferring to Send on 4 June.

Over the next couple of months, the woman's behaviour changed. She would hide in her cell, curl up in a ball and become completely unresponsive. She was subject to periods of self-harm monitoring twice in June and July and taken to hospital once after apparently harming herself. She repeatedly expressed anxiety about being bullied and about her obligation to repay the confiscation order. An anti-bullying investigation was completed but no formal steps were taken to monitor any bullying.

After the woman was found motionless in her cell on 21 August, she was taken to hospital. She became aggressive and repeatedly tried to strangle herself. The doctor advised escort staff to keep her under observation when she returned to Send. Staff at Send discussed whether to supervise her constantly. After meeting her, the duty governor thought that self harm monitoring was unnecessary. Nevertheless a senior officer insisted that she should be checked at least once an hour. She was found hanging in her cell less than three hours later.

I would like to extend my sincere condolences to the woman's friends and family.

The investigation was completed by two of my investigators. They visited Send to interview discipline and healthcare staff and prisoners. One of my Family Liaison Officers contacted the woman's family in order to explain my investigation and discuss their concerns.

A clinical review of the treatment that the woman received in custody was undertaken by a clinical reviewer, appointed on an independent basis by the local Primary Care Trust. She assessed whether the care that the woman received in custody was comparable to that she would have been offered in the community. I am grateful for her assistance.

I would like to thank the staff and prisoners at Send for their cooperation whilst the investigation was completed. I am particularly grateful to the Deputy Governor for arranging the interviews.

The woman was a mother of two with no history of offending behaviour prior to 2009. She struggled to cope with prison life. Significantly, she was the only woman prisoner to take her own life in England and Wales in 2010. Her

death raises a number of questions about how staff can best help vulnerable women whose mental health problems are not easily resolvable. I make extensive reference to the work of an author who reviewed the way that vulnerable women are treated by the criminal justice system.

The report explores breakdowns in communication, not just amongst prison staff but also between the prison and the local hospital. I believe that the failure to take account of all the available evidence culminated in the duty governor's opinion that self harm monitoring was unnecessary (although I recognise that ACCT monitoring was implemented and ongoing when the woman died). My investigation examines the measures taken to address bullying, as well as the mental health treatment which she was offered.

The woman expressed anxiety about her sentence and her ability to repay her confiscation order. I explore the precise nature and implications of this type of order in the report.

This is a distressing report which makes harrowing reading. Although the events of 21 August 2010 primarily affected the woman's family, they also had a profound impact on staff who responded to the emergency. The statement made by one senior officer in particular is one of the most vivid accounts I have read of efforts by staff to save a prisoner's life. Although unsuccessful, in my view the Governor should commend the SO for her efforts.

I make 16 recommendations and endorse three recommendations made by the clinical reviewer.

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.

Thea Walton
Acting Deputy Ombudsman
December 2011

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SUMMARY

1. The woman received a nine month custodial sentence at Crown Court for offences of fraud in March 2009. She was released under the home detention curfew (HDC) electronic tagging scheme two months later. In September of that year, a judge at Crown Court made a confiscation order to recover approximately £20,000 (that being the amount which she had obtained through her offences). She was allowed six months to pay the money (the maximum time period then available). She agreed the terms of the order and did not apply for it to be varied or for further time to pay it.

2. Because the woman failed to pay the money she owed the court, the magistrates committed her to prison for the 12 month default term on 14 May 2010. She was taken to HMP Eastwood Park. She was prescribed the same antidepressants that she took in the community. A week after she arrived, she was found lying on the floor of her cell. She was physically well but initially completely unresponsive.

3. On 4 June, the woman transferred to HMP Send. She had asked to move to be nearer her family. About a week later, she told an officer that she was surprised to be allowed to keep her shoelaces. Her laces were removed and kept in her wing file for her own safety.

4. Staff became more concerned about the woman on 17 June after they found her hiding under her bed. They began the Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring that evening. She told staff that she was worried about repaying her confiscation order (something she was still required to do upon her release) and her relationship with her family. She talked about taking a knife from the kitchen and was subsequently reallocated to work in the gardens.

5. The woman was assessed by a mental health nurse on 23 June. He referred her to a doctor for a review of her antidepressant medication. Staff became concerned about her again in the early hours of 25 June. They had found her curled up in a ball in her cell and she talked about being bullied. The night orderly officer decided to increase the frequency of checks on her overnight.

6. Staff again became worried about the woman on the evening of 27 June. They went into her cell and found her hiding in the shelving unit. She was holding a dressing gown cord, which staff confiscated. She again mentioned her anxiety about the confiscation order and staff increased the frequency of ACCT checks.

7. In total, the woman's ACCT monitoring was reviewed five times before eventually being closed with her consent on 2 July. A doctor reviewed her medication on 5 July and prescribed a decreasing dose of her current antidepressant before introducing a different antidepressant.

Although the doctor planned to review the impact of the new drug, this did not take happen.

8. On the evening of 12 July, the woman was found lying on the ground outside the gym. She claimed to have repeatedly banged her head and was taken to hospital for a check up, but no evidence of serious injury was found. She returned to Send that night and staff put the ACCT monitoring in place again. She said that she was still worried about the confiscation order.

9. The woman became particularly tearful at an ACCT review meeting on 18 July. Later that day, the senior officer responsible for dealing with bullying issues held a mediation meeting between her and another woman who she alleged was bullying her. During the meeting, the two women appeared to be reconciled.

10. The woman attended five review meetings during the second period of ACCT monitoring. Although she complained about her new antidepressant medication, discipline staff did not refer her to the doctor. The ACCT document was closed with her agreement on 22 July.

11. On the evening of 29 July, the woman was verbally threatened whilst using the gym. The matter was referred to the violence reduction team. Over the following weekend, she would not come out of her cell and did not collect her antidepressant medication. On 2 August, staff went to her cell and again found her hiding motionless in the shelving unit. A mental health nurse and chaplain came to talk to her.

12. The next day, a senior officer with temporary responsibility for violence reduction carried out an anti-bullying investigation. He interviewed the woman and the two alleged bullies. The other women were warned about their behaviour but no further formal action was taken. She had moved to another wing away from the other two women. The same day, she had a panic attack and the mental health nurse came to check her. She made no further complaints about bullying and did not attract the concern of wing staff in the fortnight that followed.

13. On the morning of Saturday 21 August, staff found the woman hiding in her cell. She was curled up into a ball and could hardly be seen. The officers managed to move her bed and cover her in a blanket. She continued to lie on the floor and remained unresponsive. She was taken to hospital on the advice of a nurse later in the morning because staff could not persuade her to move or talk.

14. Two officers escorted the woman to the hospital. She remained still and silent for another couple of hours, but began to become agitated after 1.00pm. She tried to harm herself by pulling a canula (a tube delivering fluid) out of her arm. Staff had to repeatedly restrain her as

she attempted to get up and leave the room. She became more aggressive and the doctor gave her a sedative.

15. Because of the woman's agitated behaviour, a senior officer arrived at the hospital to help his colleagues. As well as her, another woman was out at hospital, meaning that five staff were away from the prison. The duty governor struggled to keep the regime running and the other prisoners were not allowed their usual activities in the afternoon. He considered releasing her on temporary licence whilst she remained at hospital. He also thought about moving her to another prison, HMP Bronzefield, if she needed continuing medical observation. An additional officer was recruited to work that evening in case she stayed in hospital.

16. The woman remained in an agitated state at the hospital. She was handcuffed to an officer using an escort chain (a length of chain with a handcuff at either end). She repeatedly dragged the chain around her neck to try to strangle herself, but in each instance was restrained from doing so by the escorting officers. She was taken for a scan which confirmed that she did not have a head injury which was causing her behaviour.

17. After the scan, the doctor in the accident and emergency department discharged the woman. The doctor had already spoken to the senior officer to advise him that she presented a risk of harm to herself. They agreed that she would need to be monitored constantly when she returned to Send. The senior officer telephoned the orderly officer at the prison and advised that they should consider placing her in a safer cell with constant supervision by staff.

18. The doctor expected the woman to undergo a mental health assessment when she returned to the prison. She did not realise that mental health staff do not work in Send over the weekend. She recorded her assessment and plan of action in her clinical notes, but the officers were not given a copy of the notes to take back to the prison.

19. The officers escorted the woman back to Send. She went into a meeting with the duty governor, the senior officer who had been with her at hospital and the orderly officer at about 5.10pm. None of the other escorting officers were asked for their account of what had happened. The duty governor left the meeting believing that self harm monitoring of any kind was unnecessary. However, another senior officer had already formally begun this process. When the orderly officer advised her of the duty governor's decision, she refused to end self harm monitoring. They agreed that she would be checked at least once an hour.

20. The woman was escorted back to her cell where she was given a meal. The nurse at the medication hatch refused to issue her antidepressant

medication because she could not be sure what drugs she had been given at the hospital. She was locked in her cell alone and was checked three times by an officer at 6.00pm, 7.00pm and 7.45pm. On the last occasion, she asked to speak to a Listener (other prisoners trained by the Samaritans to support distressed women). However, the Listeners' suite was occupied and the officer confirmed with his managers that she should wait until the room was free. She agreed to wait.

21. The woman was found hanging in her cell 50 minutes later at 8.35pm. She had used shoelaces to form a ligature. Staff cut her down and raised the alarm. The night orderly officer (the only member of staff with up to date first aid training) gave cardio pulmonary resuscitation. Paramedics arrived and she was taken to hospital. However, she did not recover and was declared dead shortly after 10.00pm. The duty governor notified her family of her death by telephone 20 minutes later.

22. This was the only instance of a woman taking her own life in a prison in England and Wales in 2010. The investigation has identified good practice during the first two periods of ACCT monitoring. However, I am critical of decisions made on the day she died. In particular, I have found that communication broke down amongst staff and between the prison and the hospital.

THE INVESTIGATION PROCESS

23. The investigators were notified of the woman's death on 23 August 2010. Notices were issued to staff and prisoners telling them about the investigation process and inviting them to contact my investigators.

24. The investigator liaised with the Deputy Governor during the investigation. He visited HMP Send on 26 August to speak to staff and collect paperwork relating to the woman's time in custody.

25. The investigator contacted the local Primary Care Trust (PCT) to ask for a clinical review of the medical treatment which the woman received in custody. The purpose of this review is to establish whether the care which she was offered in prison was comparable with that she would have received in the community. A consultant forensic psychiatrist was appointed to complete the review.

26. Both investigators visited Send on 4, 5 and 7 October to interview discipline and healthcare staff. They were joined by an assistant clinical reviewer from the PCT (acting on the clinical reviewer's behalf). An investigator and the assistant clinical reviewer returned for further interviews on 20 October. The investigator and a colleague visited Send to conduct interviews on 19 November. The investigator carried out more interviews with staff and a prisoner on 28 January 2011. The investigator and assistant clinical reviewer visited the hospital on 4 February to speak to the doctors who treated the woman. The investigator conducted second interviews with some staff at Send on 4 March.

27. The investigator wrote to the local Coroner's office at the start of my investigation to inform them of its nature and scope. HM Coroner will be provided with a copy of my report.

28. One of my Family Liaison Officers contacted the woman's family in mid-September. She explained the purpose of my investigation and arranged to visit them.

29. The investigator and the Family Liaison Officer visited the woman's mother, step-father, husband and sister on 23 September. The family asked how she was able to take her own life whilst being subject to self-harm monitoring. In particular, they thought that prison staff should have been keeping her under close observation because of the events that had taken place earlier in the day on 21 August.

30. The family also asked why she was allowed to keep her shoelaces (which she used to form a ligature) and why she was allowed to remain in her own cell, rather than a gated safer cell. They expressed their confusion about the fact that she was only checked once an hour after she came back from hospital. They thought that she should have been searched when she returned to Send and that her cell should also

have been checked. They also believed that her mood might have been affected by the fact that she was not given her antidepressant medication when she returned to Send.

31. The family expressed their dissatisfaction with the manner in which they were told of her death and subsequent communication from senior staff at the prison. They did not feel that the staff volunteered information readily. The woman's husband said that he telephoned the prison every hour throughout the night of 21 August to find out more about her death, but the telephone was not answered.

32. The woman's mother expressed her unhappiness about going to the prison on 22 August and seeing a notice about her daughter's death at the entrance. She accepted that such notices allow staff to help prisoners deal with upsetting events, but she thought that the notice could have been placed in an area away from public view.

HMP SEND

33. Send holds a maximum of 282 women. The woman was located on A-wing when she died. The wing holds 40 women who live in single cells with their own toilets and showers.

34. A special gated 'safer' cell is located near the reception area. Any woman judged to require constant supervision (because staff think there is an imminent likelihood she might take her own life) can be moved from her own cell to the 'safer' cell. Once there, they are observed at all times by a dedicated member of staff. This is measure of last resort that has to be agreed by both discipline and healthcare staff.

Healthcare

35. Primary healthcare services at Send are commissioned by the local Primary Care Trust. There are no in-patient beds. Primary care nursing staff work in the prison from 7.30am until about 6.30pm on weekdays and from 8.00am until about 5.30pm on weekends. There are no mental health nursing staff on duty in the prison on weekends.

36. Specialist mental health services in Send are delivered by Surrey and Borders Partnership NHS Foundation Trust. Their focus is on women with serious, enduring or complex mental health problems. Just after the woman arrived at Send, the only full-time registered mental health nurse left their employment, leaving a part-time mental health social worker, a part-time registered mental health nurse, a sessional counsellor and a sessional psychotherapist. The full-time nurse was not replaced before the woman died. A Support, Time and Recovery (STR) worker was recruited but had not yet started working at Send. A mental health nurse from a nearby women's prison was working extra shifts at Send to provide additional support.

37. Once a month the manager of the mental health in-reach team offers a consultation session to discipline staff carrying out ACCT assessment interviews. Staff can ask him about particular prisoners who are thought to be at risk of harming themselves and seek advice about their behaviour.

38. There are no nursing staff on the premises overnight. When prisoners have medical problems after the day staff go home, the night staff have to either call the out of hours telephone service for advice or call an ambulance in an emergency. At the time the woman died, there was one trained first aider on the premises overnight who could perform cardio pulmonary resuscitation. This is the night orderly officer who is responsible for running the prison. The prison's defibrillators are held in the healthcare centre (which is locked overnight) rather than on the wings.

Discipline staffing

39. The woman moved from C wing to B wing and eventually to A wing between 4 June and 21 August. Each of these wings is typically staffed by one officer between 7.30am and 9.00pm. An operational support grade (OSG) member of staff will join each officer to assist during busy periods. She was hoping to move to J wing, which is staffed by two officers during the day shift.

40. Overnight, ten staff work in Send. The staff on duty comprise five officers, one senior officer and four OSGs. One officer and one OSG work on J wing, another pair work on E and F wings and a final pair cover A, B and C wings. Another officer works alone on D wing and an OSG operates the communications room. The final officer works as the assist night orderly officer, alongside the senior officer who is the night orderly officer (in charge of running the prison overnight). If a prisoner is subject to constant supervision in the gated safer cell, then an additional member of staff is paid to work overtime to sit with the woman.

Her Majesty's Inspectorate of Prisons

41. HM Chief Inspector of Prisons completed an announced inspection of Send in December 2010. He wrote :

> 'When we last visited, we were concerned that staffing problems, management change and an unsettled population had led to a serious deterioration in performance. On our return for this announced full inspection, we found a more settled and stable establishment, with some impressive aspects to the regime. However, there was scope for further improvement …
>
> 'Most women reported feeling safe but, while there was little overt bullying or violence, many women reported insidious low level intimidation by other prisoners and this had not been adequately addressed. Those at risk of suicide were well supported, but rates of self-harm remained high …'

42. I refer to several of the Inspectorate's specific findings within the 'Issues' section of my report.

Independent Monitoring Board

43. The most recent annual report published by the Independent Monitoring Board (IMB) at Send covers the year from April 2009 to March 2010. (The IMB at each prison is made up of members of the

public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The Board commented:

> 'During the reporting period there has been significant improvement in many aspects of prison delivery …
>
> 'The prison has benefited greatly from a professional and committed senior management team, and improved staff continuity …
>
> 'It is with regret that in the period 1 April – 30 June 2010, a number of serious difficulties with the provision of healthcare by the PCT have been noted by the Board. Members are concerned that these may negate some of the improvements of the last year.
>
> 'The chaplaincy staff are also very supportive to the women at vulnerable times.'

Previous deaths at Send

44. The deaths of two women in 2007 raised concerns that I return to again in this report. Amongst a number of recommendations that I made at the time, I highlighted issues surrounding in-possession medication, self harm monitoring and the way in which bullying is tackled. I return to these issues in this report. I refer to my previous investigations and recommendations in the relevant parts of the 'Issues' section.

45. The clinical reviewer is critical of the prison's failure to fully implement and maintain some of the recommendations made in the report of an investigation in 2007 to which she contributed the clinical review.

Assessment, Care in Custody and Teamwork (ACCT)

46. Assessment, Care in Custody and Teamwork (ACCT) monitoring is started if a prisoner is thought to be at risk of harming herself. The prisoner is interviewed and a plan for her care is drawn up in response to her needs and concerns. The process is ongoing and the document remains open whilst the risk remains. The ACCT process should be reviewed at intervals determined by the level of risk the woman is judged to present to herself. Any staff who have contact with a prisoner should make entries in the document. The frequency of observations by staff is set out on the front cover, for example, 'hourly'. Staff must check the prisoner at least this often, they should conduct their observations at random intervals and write down all the checks in the ongoing record. Some of the scheduled checks must be 'quality observations', meaning that the member of staff speaks to the prisoner at some length and has meaningful interaction with her in order to gauge her mood and the risk she may present to himself.

Bullying

47. Many minor disputes between the women at Send are addressed in the first instance by wing staff, who are responsible for keeping order and monitoring daily interaction between the prisoners. If the situation continues to escalate, then staff can make a referral to the violence reduction coordinator (VRC) responsible for leading the prison's anti-bullying strategy. They can try to deal with the bullying by inviting the women involved to a mediation session. If this does not resolve the problem, then a three stage Safer Community Process can be initiated. The Senior Officer (SO), who was the VRC at the time, explained the process to my investigator.

48. At stage one the alleged perpetrators are monitored for two weeks. Their behaviour and any incidents are recorded in a yellow anti-bullying book. If three pieces of evidence indicating separate incidents of bullying are recorded, then stage two is implemented.

49. At this point the perpetrators are subjected to a number of restrictions. Their privileges are taken away, they cannot go to the dining hall to mix with other women and their televisions might be removed. They have to stay on their own landing, nobody else can go into their cells and they cannot go into other women's cells. They cannot mix with the other women during the association period.

50. If these restrictions do not prove effective and the bullying continues, then stage three of the process can mean that the perpetrator is transferred to another prison. In the woman's case, the Safer Community Process was not started because it was thought that a mediation meeting and then an anti-bullying investigation had resolved the problem.

Listeners

51. Listeners are prisoners who have been specially trained by the Samaritans to sit with and listen to other prisoners who are in distress. Their support is confidential and is not disclosed to staff or others.

KEY EVENTS

52. The woman was originally released from custody on 14 May 2009 after serving just over two months of a nine month sentence for offences of fraud. On 4 September, she was ordered to pay a confiscation amount of nearly £20,000 at the request of the prosecutor. She agreed to the terms of the confiscation order and was told that she had six months to pay it. She failed to pay any of the order by 4 March 2010 and did not ask the courts for more time to pay (as she was entitled to do). She did not apply for a variation of the order.

53. On 14 May, the woman appeared at Magistrates' Court. (Magistrates' courts oversee the administration of confiscation orders.) She was unaccompanied and declined the offer of an adjournment to seek legal advice. She told the court that she did not have a viable proposal as to how she might pay the order. She was told that she would be sent to prison that day, would serve one half of the default prison sentence and would still be expected to eventually pay the order as well as accumulated interest. The magistrates found her guilty of culpable neglect in not paying any of the order. They committed her to prison for 12 months and she was taken directly from court to HMP Eastwood Park. Her release date was set at 12 November 2010, halfway through the 365 day sentence.

54. When she arrived at Eastwood Park, the woman was assessed by a nurse, who completed a first night health screening as part of the reception process. She tested positive for benzodiazepines (medication often used to treat anxiety, the most common being Valium). She confirmed that she had not taken any unprescribed or illegal medication. She was allowed to keep a quantity of her medication 'in possession' in her cell, rather than collecting it each day from the nurses' station.

55. In response to standard questions, the woman said that she was not considering harming herself. The nurse recorded that she had tried to take her own life using a ligature whilst in Bronzefield during her original sentence. She said that she was normally prescribed 60mg of fluoxetine (an anti-depressant) each day. The nurse confirmed her prescription with her surgery in the community and arranged a mental health assessment. She said that she was more mentally prepared for prison on this occasion and the nurse thought that she seemed calm.

56. Later that day, a prison doctor assessed the woman. He recorded that she had been assessed by a psychiatrist in September 2009 and her anti-depressant medication had been regularly reviewed by her community doctor. (She had been to her local surgery the week before, because she anticipated a custodial sentence. The community doctor had maintained her fluoxetine prescription at this appointment.)

57. The doctor continued the prescription for 60mg of fluoxetine and a 28 day supply of medication was dispensed on the woman's first night for her to keep in her cell. She told the doctor that she was not thinking about harming herself and that she wanted to move to HMP Send to be nearer her family. She underwent a secondary health screening on 19 May.

58. On 21 May, discipline staff called a nurse to the woman's cell at about 8.30pm. She was lying on the floor and was not responding to staff. However, she was otherwise physically well and was breathing normally. Staff tried to make sure that she was comfortable.

59. Three days later, on 24 May, the woman went to a mental health assessment with a nurse. The nurse noted that her community doctor had diagnosed her with clinical depression, and that she had been referred to her local community mental health team (CMHT). However, she failed to engage with the CMHT and had not been offered further appointments. She said that her church had paid for her to go to some treatment sessions and she had undergone mental health assessments at Bronzefield the previous year.

60. The woman reported a history of self harm, including cutting her feet and twice using a ligature at Bronzefield. She also said that she would bang her head against a hard surface until she blacked out. The nurse recorded that the most recent incident of this nature had taken place a week earlier. (It is unclear from the records whether this was before or after she came back into custody. The only recorded incident that might suggest this behaviour took place on 21 May.)

61. During the assessment, the woman told the nurse that she did not think her prescription of fluoxetine was helping. She reported feelings of 'uselessness and helplessness'. She told the nurse that she was having 'strong' thoughts of self harm, but was managing to control them. She indicated that sharing a cell was helping her in this regard although she reported trouble sleeping. She expressed concern for her children and commented that they were better off with their father because she was 'not much of a mother'.

62. The nurse found no evidence of clinical depression and thought that the woman's problems were 'likely to be personality related'. She arranged for her to be given a 'distraction pack' (reading material and puzzles to keep her occupied). She did not allocate her as a patient to the mental health team. (My investigator has also confirmed with the Safer Custody Manager at Eastwood Park that she was not subject to self-harm monitoring whilst she was held there. Their Safer Custody department have no record of any incident of self harm involving her. Nonetheless, she subsequently told staff at Send that she had tried to harm herself at Eastwood Park.)

63. On 25 May, the woman attended an induction appointment with a member of the prison's probation department. She asked for a transfer to either Bronzefield or Send where she would be nearer to her family. Her request was passed to the Observation, Classification and Allocation (OCA) Department (responsible for organising prisoner transfers). She asked about the possibility of release under the HDC scheme, but the member of the probation department was unsure whether this was permitted, given that she had been sentenced for non-payment of a confiscation order.

64. The member of the probation department recorded that the woman had tried to harm herself in the past. She explained that she could not remember committing the original offence of fraud because she had experienced 'a nervous breakdown' at the time. She said that she had considered selling the family home to pay the confiscation order, but thought that her family would be deemed voluntarily homeless and might not be re-housed by the council.

65. The woman met her personal officer on 28 May. (Each prisoner is allocated a personal officer to whom they should report any problems or address any questions in the first instance.) The officer noted that she tended to stay in her cell most of the time, and he asked her if anything was wrong but she denied that there was.

66. On 4 June, the woman left Eastwood Park and transferred to Send. Upon arrival, she was assessed by a nurse as part of the routine reception process. The nurse recorded a history of deliberate self harm for the last eight years (although she wrote that there were no current concerns in this regard). She referred her to the mental health in-reach team. The nurse wrote in the clinical record that she had been deliberately harming herself 'nearly every day' at Eastwood Park by banging her head. She also reported that she had cut her legs whilst in the community. The nurse added the following comment:

> '[The woman] appeared settled and stable in mood said she was happy being closer to family so she now can see her children.'

67. The nurse administered her three 20mg capsules of fluoxetine which she was allowed to keep 'in-possession' in her cell. She moved into a single cell on C wing (the induction unit) to begin with.

68. The woman's personal officer met her on 9 June. The woman said how pleased she was to have transferred to Send, where she could be closer to her family and receive more visits. She explained that she valued the opportunity to be alone with her thoughts at times, and her single cell allowed her to do this. She said that Send was much quieter and cleaner than Eastwood Park.

69. Because the woman had not yet been given permission to use the wing telephone, she had not been able to contact her family to arrange a

visit. The officer resolved the issue for her immediately. She mentioned that she was looking forward to getting a job and staying busy.

70. The woman told the officer that she had last harmed herself two weeks earlier. She said that she did not want to harm herself at Send. The officer asked her if she had started to harm herself because she was in prison. She indicated that she had initially harmed herself in the community when she experienced post-natal depression. She said that she had subsequently had a 'nervous breakdown' and it was during this period that she committed her offences. She said that nothing was presently worrying her apart from wanting to get some new books to read from the library and wanting to telephone her family.

71. On 12 June, the woman expressed surprise to an officer that she had been allowed to keep her shoelaces. The officer made entries on the P-NOMIS system and in the wing observation book noting her concern about the remark. (P-NOMIS is the electronic record system where officers record relevant information about prisoners.)

72. The officer understood that the woman had previously been subject to self harm monitoring. She wrote that staff should 'be aware' of her remark. The officer arranged for her shoelaces to be kept in her wing file. She wore plimsolls and was only to be given her shoelaces when she needed to wear her boots for certain activities away from the wing, such as going to the gym.

73. On 14 June, a pharmacist issued the woman with a new 28 day supply of fluoxetine (60mg to be taken each day). Two days later, a prison doctor prescribed her 30 capsules of fluoxetine, again at a strength of 60mg. She was instructed to take one daily.

74. Three days later, on the evening of 17 June, an officer became concerned about the woman because she was hiding under her bed. After she was persuaded to come out, she explained that she had been banging her head whilst she was under the bed. She told staff that she wished she was dead and was thinking about suicide. She said that she had not been eating and talked about taking knives from the kitchen.

75. Staff began the Assessment, Care in Custody and Teamwork, or ACCT, self harm monitoring at 8.00pm. The woman's depression was recorded as a potential trigger for self harm. She remained in her single cell and officers were told to check her twice an hour and have two conversations with her each day of sufficient length to be able to judge her mood.

76. Staff explained to the woman that she could speak to the Samaritans on the telephone. She was no longer allowed to keep any medication or razors in her cell. At about 8.45pm, she went to speak to a Listener.

77. The woman attended an ACCT assessment interview at about 8.30am the next morning, 18 June. She spoke to the assessor, Officer A, about her long term depression. She said that she had been under the care of the local CMHT since the birth of her first child eight years earlier. Before then, she said that she had not discussed her feelings of depression with anyone.

78. During the interview, the woman said that she was worried about being unable to repay the confiscation order imposed by the court. She said that she tended to harm herself by cutting her feet and banging her head against a surface (she mentioned that she would do this above her hairline to conceal it). She explained that she had previously tried to take her own life at Bronzefield using a ligature. She told the officer that she was feeling 'dead in respect of [her] emotions' and was 'at a very low point'.

79. The woman told the officer that she wanted to take her own life and planned to do this by using her shoelaces as a ligature. (He removed her shoelaces from her after she offered them to him. It is not clear from the records what had happened to the arrangement made on 12 June to keep her laces in her wing file.) She confirmed that she had been thinking about using the sharp instruments in the kitchen area to take her own life. (A record made in a second ACCT document at midday on 14 July subsequently indicated that she had actually managed to obtain a knife from the kitchen during this period.)

80. During the meeting, the woman said that she visited the chapel as a source of support. She told the officer that her main worries were the outstanding confiscation order, the potential loss of her home and the breakdown in the relationship with her family. He suggested that she make an application to speak to Senior Officer (SO) A (who helps prisoners access advice about debt).

81. After the assessment interview, the woman then met Senior Officer B and Officer A at about 9.00am to complete the 'Action following assessment' section of the ACCT document. (The SO works in the safer custody department as the violence reduction coordinator which means that he addresses problems with bullying. He was also assigned as her ACCT case manager.) The meeting provided a chance to talk about how she would be monitored and think about what steps could be taken to address her anxieties.

82. The SO noted that the woman had been prescribed antidepressants and referred to the mental health in-reach team when she arrived at Send. (Because she had not yet been assessed and was now subject to ACCT monitoring, the officer made a fresh mental health referral on

18 June to make sure that she was examined.) The SO recorded that she had tried to take her own life more than once during her original custodial sentence. She confirmed that she did not want to work in the kitchen anymore because of the knives which were available to her there.

83. The woman said that she thought that her marriage might be ending because of the stress caused by her sentence and the confiscation order. She was looking forward to a visit from her family but was also apprehensive because of her husband's scepticism regarding her depression.

84. From 9.30am on 18 June, the ACCT monitoring required staff to have one meaningful conversation with the woman in the morning and afternoon. After she was locked in her cell for the night, staff had to check her every hour until she fell asleep and then make one random observation overnight. (This frequency of observations was agreed with her, who confirmed that the period just after prisoners were locked up for the night was the time when she felt most vulnerable.) Staff also had to check her when they completed their roll check in the morning. The SO agreed to meet her again to review her ACCT monitoring on 21 June.

85. Although the woman said that she was not eating, on 18 June her personal officer recorded that she had seen empty wrappers in her cell which seemed to indicate that she had eaten her weekend canteen pack. She told an officer later the same morning that she would start using the dining hall again and try to eat a proper meal. Later that day, another officer noted that she was sitting in one of the cells on C wing talking to another prisoner.

86. The next day, 19 June, staff recorded that the woman seemed to be getting on well with the prisoner and were pleased to see her 'coming out of her shell and having a laugh with friends'. She received a visit from her mother, husband and two daughters at 4.00pm. She had looked forward to the visit and the prisoner helped her to put her make up on.

87. After the visit, the woman's personal officer recorded that it seemed to go well and she enjoyed seeing her children. She said that she now thought her husband had a greater understanding of what she was going through. Although the visit 'ended tearfully', the officer thought that she seemed 'much happier afterwards'. The officer recorded information provided by Senior Officer B after the ACCT review meeting the day before:

> '… [the woman] has issues regarding her self esteem and worthlessness, she is married but her husband does not believe in depression and this is causing problems in her marriage that she feels is on the brink of ending …'

88. On 21 June, the woman started working in the gardens. She was allowed to keep her shoelaces while she was working but had to hand them in at other times. She was given a pair of plimsolls and a cardigan that her family had brought in and was said to be 'over the moon' to have her belongings. (Her plimsoll laces were taken off her and kept separately by staff ready for when she wanted to use the gym.) The personal officer wrote that she 'is in much better spirits and her mood has lifted'.

89. Later, at midday on 21 June, the woman attended a second review of her ACCT monitoring with Senior Officer B and a nurse from the mental health in-reach team. The SO recorded that she seemed 'much more positive'. Her family visit had gone well and her husband was more understanding of her situation. She mentioned that some of the other prisoners were resentful of her because staff were spending time talking to her when she could not sleep. She was enjoying working in the gardens. The frequency of ACCT observations remained the same. In accordance with the ACCT care map, she was referred to the mental health in-reach team in order to "address her feelings of isolation and worthlessness". The nurse could not locate the original referral and so she completed a new one.

90. The woman went to a meeting about the 'Toe By Toe' reading scheme in the chapel on 22 June. (The scheme allows literate prisoners like her to help other women to learn to read.) A record of the meeting shows that she was 'totally absorbed' throughout. Her personal officer noted in the ACCT document that her mood had continued to improve since her family visit.

91. At midday on 23 June, the woman went to an appointment with Nurse A (a mental health practitioner) at the in-reach psychiatric monitoring drop-in clinic. Her ACCT document was supposed to accompany her but it remained on the wing. She became anxious in the waiting area as she felt intimidated by other prisoners. Nobody actually said anything to her, but she became stressed by the number of people present because the situation reminded her of a previous bad experience at Eastwood Park.

92. The nurse told the investigator that he conducted a 30 minute 'mini mental health assessment' with the woman. He noted her history of post-natal depression as well as recording that she had been prescribed antidepressants for several months and diagnosed with depression prior to her recent court appearance. She said that she felt 'helpless and hopeless' and that her current medication was not helping her.

93. The woman mentioned that she did not feel that she was getting support from her family, because neither her husband nor her mother believed that she had a depressive illness. She told the nurse that she

initially felt relieved when she spoke openly to her family about her problems but would then feel guilty for having done so.

94. The nurse recorded that the woman was still unclear about the details of her sentence and release date. She mentioned that she planned to appeal against her sentence. She also described periods of forgetfulness and blackouts, saying that she had experienced visual hallucinations for about three years whenever she was in a low mood. She would see shadows and become so scared of them that she would hide under her bed.

95. The woman described a long history of self-harm by cutting and said that she had tried to take her own life recently at Eastwood Park using a ligature. (My investigator has found no evidence of this incident.) She said that she tended to plan her acts of deliberate self harm, but told the nurse that she was not currently having suicidal thoughts. Nonetheless, she commented that her current low mood had been going on for some time, despite taking the maximum dose of anti-depressant available to her. She talked about coping strategies, such as using the gym and going to art class, saying that she wanted to work as a teaching assistant after she was released.

96. The nurse gave the woman advice about coping with her distress. He arranged for a doctor to review her antidepressant medication. He also thought she should get involved in more activities in order to stay busy.

97. At interview, the nurse explained his intended course of action to the investigator. He thought that, were the woman to require further help, a full referral for a psychiatric assessment could take place after her medication was reviewed by the doctor. (A psychiatrist visits Send once a week.) In the meantime, he recommended that she continued to receive support from the in-reach team by attending their drop-in clinics. She returned to the wing and told an officer that she was pleased that she was going to be referred for further treatment and that her medication would be reviewed.

98. The woman's family visited her on 24 June. Afterwards, she spoke to her personal officer at length about her family and said that she felt better for having told her family how she felt. She was looking forward to becoming a 'Toe By Toe' mentor and talked about how this might assist her plan to work as a teaching assistant after her release.

99. At 7.45pm on 24 June, the woman told an officer that she felt low after her difficult experience in the healthcare waiting room the previous day. The officer offered to provide a Listener or telephone call to the Samaritans, but she declined both. The officer encouraged her to press the cell bell if she felt anxious and she replied that she was not thinking about harming herself. She still presented as feeling low when staff checked her at 8.55pm. At 9.10pm, Officer B checked her

and noticed that she was sitting on her bed clutching a pillow. She said that she was 'very depressed'.

100. The woman's mood declined and she continued to sit silently on the bed clutching her pillow. Just after midnight on 25 June, the officer called out and knocked on her door but did not obtain a response. She became concerned that she could not see her and so she broke open her sealed key pouch, unlocked the cell and called for assistance on her radio. (At night, officers carry a cell key in a sealed pouch that they are only supposed to open in an emergency. This measure prevents officers from entering prisoners' cells without good reason during the night.) She went into the cell and found her curled up in a ball, wrapped in a sheet, hiding under the table. She was completely still.

101. The officer roused the woman, calmed her down and helped her out from under the table. She had no injuries. She later told the officer, Senior Officer C (the night orderly officer in charge of the prison) and Officer C (the assist orderly officer) that she felt scared. Officer C remembered during interview that she held her dressing gown cord up to her face and smelt it. She said that the smell reminded her of home and her children. He told the investigator that staff did not confiscate the cord on this occasion because they thought it was comforting for her to hold it and there did not seem to be an undue level of risk associated with it at the time.

102. During interview, Officer C recalled that the staff managed to persuade the woman to sit up on the bed. She said that she was worried about being bullied whilst working in the gardens. She told the officer that she enjoyed the work but was anxious that officers could not always keep an eye on her in the gardens. She was worried that some of the women who had transferred from Eastwood Park at the same time as herself were also working in the gardens and might be planning to bully her again.

103. The officer asked the woman to name the alleged bullies but she refused. The officer did not make an anti-bullying referral to Senior Officer C because, although she was anxious, she said that no actual bullying had yet been perpetrated at Send. She was very tearful and said that she was frightened to come out of her cell. The officer tried to calm her down and eventually she settled.

104. Senior Officer C asked staff to make half-hourly checks on the woman (doubling the frequency of observations) until she fell asleep. Officer B recorded that she had not harmed herself and the situation was now 'under control'. Staff checked her throughout the rest of the night.

105. When he was interviewed, Officer C told the investigator that, following this incident, he took a number of steps to help the woman. He contacted the Head of Healthcare to ask about her medication. He

also emailed the gardens department about the possibility of moving her away from the gardens to education classes (in order to reduce her vulnerability to bullying). He also asked another SO to explain her sentence to her (because this was her area of expertise). She had repeated that she was anxious about the confiscation order and worried that her family would be made homeless because of the money which she owed the court. The officer told the investigator that she was 'really worried' about her sentence.

106. The woman met Senior Officer B and another SO to review her ACCT monitoring for a third time at 8.30am on 25 June. She was worried that she had kept the other prisoners awake all night. She could not recollect the events of the previous night but mentioned that she had experienced blackouts before. She felt isolated and thought that she was a burden to staff.

107. Senior Officer B reassured the woman that she should speak to staff whenever she felt the need. They discussed the forthcoming review of her medication, and she said that she expected to experience a low mood if one antidepressant was reduced and another introduced. The SOs promised to monitor her during this period. Senior Officer B encouraged her to apply for the Enhanced Thinking Skills (ETS) course. (This is a cognitive behavioural programme run by the Prison Service to encourage prisoners to examine and change the way in which they make decisions to avoid further offending.) She remained uncertain about the earliest possible date for her release. Following the ACCT review, the frequency of observations did not change.

108. Later that day, the woman asked to move to a different cell on C wing and this happened over lunchtime. She also applied to attend the ETS programme. The next morning, she attended another 'Toe By Toe' meeting in the chapel. Her mood seemed to improve and she appeared to be pleased with the way the meeting went.

109. Just after midnight on 27 June, staff saw the woman clutching a pillow. She did not reply when they spoke to her and just shrugged her shoulders. The officers took no further action.

110. In the morning, the woman did not collect her fluoxetine when the nurses dispensed the daily medication. She approached a nurse at lunchtime, who explained that medication was supposed to be handed out at a certain time. She became angry and left without collecting her medication. The nurse recorded that she refused her medication. She told an officer that staff would 'have to deal with the consequences of her missing her meds [medication]'. In the early evening, she became withdrawn and unresponsive.

111. At 9.30pm on 27 June, the frequency of the woman's ACCT observations was increased after an officer checked her. He could neither see her in the cell nor obtain a verbal response when he

knocked on the door. He and Officer C (again the assist night orderly officer) went into the cell and found her curled in a ball at the end of her bed inside the shelving unit with her duvet wrapped around her. She remained unresponsive and held her dressing gown cord near her neck.

112. Officer C persuaded the woman to move so that she could be examined. Senior Officer C (the night orderly officer) came to the cell and she explained again that she had been holding the cord close to her for comfort because its smell reminded her of home. Although she did not refer to being bullied, the officer remembered in interview that she was preoccupied with the confiscation order and 'deeply concerned' about the possibility of her family being made homeless if they had to sell their home.

113. As a precaution, the SO increased the frequency of checks so that the woman was monitored every half hour until she fell asleep, and then checked every hour overnight. When the staff eventually left her in her cell, Officer C recalled that she was 'laughing and joking' and showed him photos of her children.

114. Although it was not recorded in the ACCT document, both officers both told my investigator that the dressing gown cord was taken away from the woman for her own safety on this occasion. Officer C thought that the level of potential risk that she presented to herself had increased because this was the second time in a few days that staff had found her clutching the cord and his concern was raised.

115. At 8.30am on 28 June, the woman's ACCT monitoring was reviewed for a fourth time by Senior Officer B and another SO. She was quite withdrawn to start with but began to open up as the meeting progressed. She referred to the incident overnight and explained that she had forgotten to take her medication the previous day.

116. Both SOs tried to help the woman to think of ways to remember to collect her medication. They also discussed a possible move to J wing. (J wing is a quieter residential unit in another part of the prison. I discuss the proposed move to J wing in the 'Issues' section of the report.) Senior Officer B told her that she would be an ideal candidate for a move to J wing but that a move could only be considered if and when her ACCT monitoring ended.

117. After the meeting, the frequency of ACCT observations reverted to their original level prior to the incident overnight. Staff were to have one meaningful conversation with the woman in the morning and the afternoon, then she was to be observed every hour from the time when prisoners were locked in their cells until the time when she fell asleep. Staff were then instructed to perform one random check overnight.

118. At about midday on 28 June, the woman still seemed withdrawn. During the afternoon she felt unwell and vomited and a nurse was called to see her. She complained of feeling sick and having a headache. She attributed her ill health to being out in the sun whilst gardening. The nurse took her blood pressure, pulse rate and temperature and advised her to drink lots of fluids and rest.

119. On the same day, programme delivery staff noted that an OASys assessment of the woman had not yet been completed. (OASys is an electronic risk assessment tool used by prison and probation staff to determine an offender's likelihood of reoffending and the risk of harm they present. The results are used to categorise offenders and decide whether they are suitable for programmes such as ETS.) She could not be given a place on the ETS programme without the assessment. Programmes staff asked her offender supervisor to complete an OASys assessment and also wrote to her to explain the situation.

120. The woman spoke to a member of the chaplaincy on 29 June about the possibility of moving to J wing. The next day, Senior Officer B instructed wing staff that she could have her shoelaces to go to the gym as long as she returned them afterwards. an officer wrote in the ACCT document later that day:

> '[The woman] said she wanted to get off the wing for a bit as said some of the girls had been making remarks about her… We agreed she was doing the best thing by taking herself out of the situation. Said I would see her later on.'

121. On 1 July, the woman told her personal officer that she was keen to move to J wing. By this stage, she was using the gym, visiting the chapel and working in the garden, and seemed to be engaging with daily prison life in order to keep herself occupied. At 9.00am on 2 July, she met Senior Officer B and another SO. A fifth and final ACCT review took place and all present agreed to end the period of ACCT monitoring. Senior Officer B wrote that she:

> '… was in the best frame of mind that I had seen and was very positive in her behaviour and demeanour.'

122. The woman said that she had decided to be more positive and had told herself that she could cope at Send. She mentioned that a couple of prisoners had 'been saying things', but she had chosen to ignore them. She was looking forward to moving to J wing and Senior Officer B promised to check the waiting list and let her know when this would happen. The SO noted that she was due to attend a further appointment with the mental health team, which a nurse would arrange. (However, the nurse left her job at Send around this time and did not meet her again.)

123. On 4 July, the woman spoke to her new personal officer, after her recent cell move. She said that, so far, she was coping well following the end of ACCT monitoring. The officer recorded that she continued to receive visits from her family.

124. A prison doctor reviewed the woman's antidepressant medication on 5 July. She said that she had been taking the maximum 60mg daily dose of fluoxetine for several years (although she had switched to citalopram for a short while and had noticed some improvement). She asked if she could try a different antidepressant because her mood remained low although she told the doctor that she was not currently thinking about suicide. The doctor told the investigator that, when she assessed her, she did not think it likely that she would try to take her own life. The doctor agreed to change her prescription to escitalopram (a different antidepressant) and then review her progress.

125. The doctor prescribed the woman 11 capsules of fluoxetine at a dose of 20mg. She was instructed to take two capsules together for the next four days, then take one each day for another three days, and then stop taking this drug and switch to escitalopram. The doctor prescribed a 28 day course of escitalopram at a dose of 10mg and told her to take one a day from 13 July, once she had stopped taking fluoxetine.

126. The clinical record also shows that the woman was prescribed 30 capsules of fluoxetine at a strength of 60mg on 5 July and instructed to take one capsule each day. As I discuss in the 'Issues' section of the report, this would seem to have been an administrative error and my investigator was assured that the additional antidepressant medication was not dispensed.

127. On 8 July, Senior Officer B carried out an ACCT post closure interview with the woman. (The interview takes place a week after ACCT monitoring ends.) She told the SO that she felt 'very well' and he thought that she seemed more confident. She said that she was sleeping better, had contact with her family and was talking to staff and friends she had made. She was working full time and going to education and cookery classes. The SO wrote that she spoke to the Listeners when she needed to and had settled on C wing, where she had made a few friends. On the same day, a nurse assessed that she could keep her medication in possession in her cell.

128. At about 7.30pm on 12 July, the woman was found to be missing at the evening roll check. The prison grounds were searched and staff found her lying on the ground outside the gym at about 7.50pm. Officer D told the investigator that her pulse was strong and fast. She said that she had been banging her head against the wall since 7.00pm until she passed out.

129. The officer remembered during interview that the woman was in a very negative frame of mind. She was very worried about the confiscation order imposed by the court. She thought that she was going to keep returning to prison if she could not repay the debt. She told the officer that she had banged her head 47 times against a brick wall. However, she maintained a coherent conversation. Although she claimed to have been unconscious and said that her vision was blurred, this seemed unlikely to the staff.

130. Officers made the woman comfortable and gave her a blanket. Staff called a 'code red' emergency over the radio and an ambulance was called. When the paramedics arrived, they could find no obvious swelling or bruising to the back of her head. Officer D recalled that a paramedic took her aside and said that they would take her to hospital as a precautionary measure, but they thought it likely that she had deliberately engineered a situation to get out of the prison for a few hours.

131. Nevertheless, the woman was taken to hospital at about 9.00pm, returning about two hours later. She explained to staff that she had been in a low mood because she had argued with her husband and was worried about her sentence. She repeated that she had hit her head 47 times, and that it normally took her 46 times to render herself unconscious. She mentioned that she had last cut herself eight weeks previously. She explained that, had certain officers been on duty, she would have spoken to them about her problems. However, she said that she did not know the officer on duty at the time well enough.

132. Hospital staff prescribed the woman paracetamol for pain relief. Whilst she was at the hospital, she told the escorting officer about alleged drug misuse by three prisoners. The officer submitted a Security Information Report (SIR) about her allegations. As a result of the SIR, staff decided to search the other women's cells and conduct mandatory drug tests. When she came back from hospital, the only physical symptom she complained of was a headache.

133. Staff began ACCT monitoring for a second time whilst the woman was out at hospital. Initially, staff were required to check her at least once an hour after she returned, until her assessment interview and first case review could take place the following morning. Upon her return from the hospital at 11.10pm, the night orderly officer marked on the ACCT 'Immediate Action Plan' that she would remain in her own single cell and be checked every half hour until she fell asleep and then at least once an hour. As before, she was reminded about the presence of Listeners and access to the Samaritans by telephone. She agreed to press her cell bell if she needed the staff or was thinking about harming herself.

134. At about 2.30pm on 13 July, Officer E sat down with the woman and completed the ACCT assessment interview. The officer noted that she

was not happy that her antidepressant medication was being reduced. Her mood seemed to be low and she said that she had fallen out with her husband on the telephone before harming herself the previous evening. The officer recorded that she had also previously harmed herself when she had fallen out with her husband. She told the officer that she did not plan to harm herself again. They agreed that her friends on the wing, the chaplaincy staff and her work in the gardens were sources of support.

135. Officer E and Senior Officer B (the case manager) met the woman at 3.00pm to carry out the first review of her ACCT monitoring. She expressed continuing anxiety that she would still have to repay the confiscation order when she was released and that, if she did not, she might have to return to prison. The SO promised to clarify the situation but told her that he did not think that this was the case.

136. On the ACCT care map, staff wrote that the woman needed to work with the healthcare team whilst her medication was changed. (There is however no evidence in the clinical record of any communication between the discipline staff and the prison doctor or any further reviews of the antidepressant medication by the doctor.) She would telephone home regularly to try and resolve any problems with her husband and prison staff would try to give her peace of mind regarding her sentence by clarifying the way in which a confiscation order worked.

137. Following the ACCT review, the frequency of observations was changed. The woman and the officers agreed that her main period of vulnerability was after the cells were locked in the evening. Staff were asked to check her every two hours between 7.30am and when she fell asleep at night, and then twice overnight. They were also supposed to record one meaningful conversation with her during the course of the day.

138. As a result of the ACCT monitoring being put in place again, healthcare staff took the woman's in-possession medication away from her. She had to collect her antidepressant tablet from the medical hatch every day and take it in front of the nurse. She went to Catholic mass in the chapel in the early evening.

139. On 14 July, an officer noted that the woman tended to become quiet and withdrawn and only represented a risk of harm to herself. She was in good spirits and had been joking with another officer. She had now made friends with another prisoner. At midday, she went to a mental health group meeting. (The entry in the ACCT document does not make clear the purpose of this session but she seemed to participate and engage well with the group.) She went to the chapel and the gym later that day.

140. In the early evening on 15 July, Senior Officer B and another SO met the woman to review her ACCT monitoring again. She seemed in a better mood and said that her new medication was starting to take effect. Senior Officer B confirmed to her that she would only have to serve half of her sentence. The frequency of ACCT monitoring was reduced with her agreement. Staff were required to obtain a response from her during roll checks. They were also supposed to carry out two random checks overnight and have one meaningful conversation with her during the day.

141. Later that day, Senior Officer B checked with the discipline department who told him that the woman would be released at the half-way stage in her sentence and given time to pay back the money which she owed. They said that as long as she was trying to pay back a small amount of the confiscation order, a further prison sentence was unlikely. (This information is contained in a Prison Service Order.) The SO wrote in the ACCT document that he would pass this information on to her.

142. At 9.30am on 16 July, the woman moved into a cell on B wing. She spent the afternoon in the chapel. On 17 July, she was subject to a mandatory drug test (MDT) and afterwards was visited by her husband.

143. Just after midnight on 18 July, an officer noticed during an ACCT check that the woman seemed to be packing her property in her cell. Bags containing her belongings were laid out on the floor. She asked her what she was doing and got a 'sharp and stroppy response', stating that she had recently moved on to B wing but had not yet had a chance to unpack.

144. At 1.55pm on 18 July, the woman met two SOs to review her ACCT monitoring. Senior Officer B anticipated that the meeting would be short and they were likely to close the ACCT document. However, she was tearful throughout and disclosed a 'mountain of problems'. She was unhappy to have been the subject of an MDT and thought that some of the other prisoners present blamed her for prompting their own tests.

145. The woman also said that she had heard 'bad things' about an officer and as a result was withdrawing her application to move to J wing. She was upset and felt very low. Senior Officer B felt that she was looking to blame others and trying to imply that staff treated prisoners in different ways. He tried to reassure her that they did not. At the end of the meeting, she said that:

> '… she was feeling so bad that she was probably going to end it all as she had nothing left to live for'.

146. During the review meeting, the woman told the officers that she would use a ligature to take her own life. They tried to remind her of her family as a reason for staying alive. Senior Officer B also said that unsuccessful ligaturing might mean that she sustained brain damage and spent her 'life in a wheelchair'. He thought that this remark had an impact on her.

147. Because the woman was 'ranting' and tearful and was stating her intention to use a ligature, the SOs increased the level of observations to at least once an hour for the next 24 hours. She was disappointed with this, as she had hoped that ACCT monitoring might end altogether. Senior Officer B planned to check her the next day to assess if her mood had improved.

148. At 2.45pm, Senior Officer B held a mediation meeting to resolve the differences between the woman and another prisoner. (She had gone to the SO in tears complaining that the prisoner was bullying her.) The SO noted that they had all had a 'good chat' and that 'everything seemed to be resolved'. He told the investigator that the prisoner apologised and the two women hugged and kissed at the end of the meeting. During the afternoon, she moved to a different cell on B wing.

149. The Safer Prisons Coordinator responsible for overseeing the ACCT process met the woman on 19 July at Senior Officer B's request to review her ACCT monitoring. She wanted her ACCT document to be closed, but the SO was only inclined to reduce the level of observations slightly until the next review. The Coordinator told the investigator that he would be reluctant to close an ACCT document unless he had been fully briefed about the relevant issues. Staff were asked to check her every two hours and have a conversation with her during the morning, afternoon and evening. She mentioned to staff the 'weird dreams' that she had been having since she changed her medication.

150. The woman met her new personal officer on 19 July. She said that she preferred her second cell on B wing because the toilet and television had not worked properly in the first one. She told the officer that she now felt 'a lot happier'. She said that she had felt 'very stressed' over the weekend because of the conditions in her first cell and because she was made the subject of an MDT without knowing why. The officer explained that even staff were not told the reasons for MDTs.

151. At 4.45pm, the woman handed in her shoelaces to an officer . This was a daily procedure to allow her to wear her boots to work, but prevent her from accessing the laces at other times.

152. On 21 July, staff noted that the woman was talking to another prisoner and seemed to be in good spirits. An officer completed a P-NOMIS entry about her on 22 July. She wrote that she was unhappy with

ACCT monitoring but accepted that the checks had to continue. She was having nightmares and trouble sleeping. The officer noted that she was a quiet person who did not mix with the other prisoners. However, she had been seen talking to the prisoner. She was attending an information technology course and seemed to enjoy both this and her work in the gardens. The officer noted that she had 'no problems at present' and seemed a lot happier since moving cells.

153. The same day, Senior Officer B and an officer reviewed the woman's second ACCT document with her and decided to end self harm monitoring. (The review was delayed from the previous day.) They noted an improvement not only in her mood but also in the entries in her ongoing record.

154. The woman thought that her recent agitated behaviour at a review meeting was the result of the change in her medication. (Again, there is no evidence of discipline staff referring her to the doctor to review her antidepressants.) However, she did comment that she was now feeling the benefit of the new medication, having taken it for over a week. She wanted the ACCT monitoring to end and said that she was no longer thinking about harming herself or taking her own life. Staff agreed to close the ACCT document, advising her how to cope better with other prisoners. The SO encouraged her to keep talking to staff and recorded that the mental health team were due to assess her. (There is no evidence of a further mental health assessment taking place until her behaviour deteriorated again in early August.)

155. On 26 July, the woman cut her finger whilst working in the garden and healthcare staff dressed the wound. She asked for a tetanus injection, but it is not clear from her clinical record if this subsequently took place. On the same day, she was prescribed 28 tablets of escitalopram at a strength of 10mg daily.

156. Two days later, a SO carried out an ACCT post closure interview with the woman. She said that she had coped well since the ACCT monitoring ended, and did not currently require any extra support. She felt settled on B wing but was looking forward to moving to J wing during the final part of her sentence. She seemed calm and said that she was no longer thinking about harming herself. She agreed to tell staff if she felt low again.

157. On 29 July, the woman's latest personal officer made an entry about her. The officer wrote that she seemed happier on B wing, was getting on well with other prisoners and was pleased to no longer be subject to ACCT monitoring. The officer wrote that she was 'polite to staff and raises no cause for concern'.

158. However, at about 7.20pm that evening, the woman was in the gym when two prisoners apparently came to the window and verbally threatened her. (Another prisoner was also present but was not

involved.) She told a SO (who was running the gym) about the incident. She did not name the prisoners but said that some women seated outside the gym had witnessed the threats. The SO spoke to the witnesses, who provided the names of the three prisoners who might be involved. The SO escorted her back to her wing at 7.30pm because she was worried about further bullying.

159. The following day, 30 July, the SO submitted all of this information on an anti-bullying referral form. (The information in the referral form led to the completion of a security incident report.) She wrote:

> '[The woman] stated on previous Wednesday that a prisoner had alleged that she had been subjected to a target search because of her. Two alleged perpetrators have since made verbal threats accusing her of 'squealing'.'

160. The woman told staff that she was being bullied by two prisoners. (The third prisoner's name was also mentioned at this stage.) The two women apparently believed that she had provided staff with information which had led to them undergoing MDTs.

161. A different SO initially investigated the allegation of bullying in the absence of Senior Officer B. He asked the woman how she wanted to proceed and she indicated that she did not want staff to approach the two women yet. The SO used the wing observation book to ask staff to monitor any interaction between her and the two prisoners. He wanted to gather evidence before beginning the Safer Community Process (a formalised way of dealing with bullying). He also planned to refer the issue to Senior Officer B when he returned to work on 2 August.

162. The woman received a visit from her family on 31 July. However, on 2 August, an officer noted that she was having a 'tough week'. Following the alleged threats from other prisoners, she had locked herself in her cell all weekend. The officer wrote that she was 'scared of everyone'. She had not collected or taken her antidepressant medication for three or four days. The clinical record does not indicate that staff took the medication to her cell instead.

163. Later that day, the officer found the woman hiding in her cell and summoned the healthcare team. A nurse came to B wing to check her in her cell. She did not respond to either voices or physical stimuli. The nurse spoke to her whilst she remained curled up under the bed. Initially, she did not respond to the nurse, but she began to engage after a few minutes. She was scared 'that people were after her'. She did not feel safe on the wing, telling the nurse that she 'could not trust anyone'. She said that she was not eating and the nurse noted that her mood appeared low. She explained that she was not collecting (and therefore had not been taking) her medication because she did not want to mix with the other prisoners and was worried that

somebody would harm her. However, she denied having any suicidal thoughts.

164. The woman said that she had been sleeping under her bed because she suffered from panic attacks and felt safer there. The nurse organised for her to be assessed by a member of the mental health in-reach team at 2.00pm and to be escorted to the appointment. At 11.00am, the officer made the following entry in the wing observation book:

> 'The woman has been given a mental health in-reach appointment this afternoon at 14:00hrs. She is to be escorted there as she is scared of people and trusts no one not even staff. Over the past couple of days, she has been sleeping under her bed as she said that she feels safer there. Can staff please talk to her when unlocking her door as she has been requesting to stay locked in.'

165. In the margin, the officer wrote, 'ACCT not wanted by the woman'. The officer told the investigator that she spoke to her, who reassured her that she preferred to remain hidden away under her bed because she felt more secure there. The officer told the investigator that she did not think that ACCT monitoring was necessarily warranted, but she thought that she should check whether she herself felt that she needed it. Below the officer's comment, the SO wrote the following on 3 August:

> 'Please remember staff decide if ACCT is required not the offender. Open ACCT if concerns prisoner is at risk!'

166. When they came to collect the woman to escort her to her mental health appointment at about 2.25pm, two officers found her lying motionless and wrapped in a blanket under the shelves in her cell. They pulled her bed out to get nearer to her and confirmed that she was completely unresponsive but had a pulse. Staff called a 'code amber' emergency over the radio and healthcare staff came to the cell.

167. Two nurses went to the cell and found the woman still lying on the floor under her bed, completely unresponsive. She then roused, panicked and curled herself up in a ball underneath her shelves without engaging with anybody. The nurses asked a member of the mental health in-reach team to come to the cell and another nurse attended.

168. The nurses also asked an Anglican chaplain to come and speak to the woman, as they knew she had a good relationship with her. Eventually, the chaplain persuaded her to come out from hiding under the bed. She said that she was afraid that she would be harmed and that she was being accused of being a 'grass'. She agreed to go to the chapel to speak with the chaplain. She explained to the nurses

that she had taken her antidepressant tablet that morning and did not want any other medication.

169. An officer spoke to her managers and arranged for the woman to move to a new cell on A wing because of her anxieties and the possibility that she was being bullied on B wing. (The officer told the investigator that the two women alleged to be bullying her lived on B and C wings and therefore A wing seemed to be a good alternative.) Staff planned to monitor her interaction with other prisoners.

170. The mental health nurse told the investigator that he discussed referring the woman to a psychiatrist, but wanted to wait for the prison to investigate the bullying which she had reported. Essentially, he wanted to know if the bullying was real and ongoing. If there was no evidence, and it seemed that the problem was imagined by her or exaggerated by a mental health issue, then he thought that a psychiatric referral would be the right way forward. (There is no indication in the clinical record of the results of the anti-bullying investigation being communicated to a member of the in-reach team or of a subsequent psychiatric referral.)

171. Senior Officer D reassured the woman that the staff were keen to deal with any bullying which she was experiencing. She said that she was 'much happier' on A wing. The SO wrote in the wing observation book:

> '[The woman] has just moved from B wing – she suffers from mental health issues and is subject to an anti-bullying investigation in which she is the victim – please monitor her – she sometimes sleeps under her bed etc – any behaviour like this must be reported to Res[idential] SOs + safer custody + mental health team.'

172. The SO told the investigator that he wrote this comment because he was unsure how worried staff needed to be about the woman's behaviour. He wanted them to keep an eye on her. He was worried that they might too readily dismiss her behaviour as unremarkable in the context of life in a women's prison.

173. Senior Officer E returned from sick leave on 2 August. He was asked to stand in for Senior Officer B as the violence reduction coordinator because the latter was now on sick leave for several weeks after being involved in a road traffic accident. The SO told the investigator that he had no previous experience of overseeing the prison's anti-bullying investigations. His first task was to investigate the woman's allegations.

174. On 3 August, Senior Officer E wrote to the woman. He acknowledged receipt of her complaint about bullying and said that he would be in touch following completion of his investigation into the allegations. He reminded her that support networks such as the Samaritans and the

Listeners were available and advised her that she might want to dispose of his letter to avoid other prisoners finding it.

175. The SO opened an anti-bullying investigation the same day. He interviewed the woman discreetly in the safer custody office away from her wing. He established that the third prisoner had nothing to do with the alleged bullying. He did not talk to the wing staff about how she was coping. He was unaware of her recent concerning behaviour such as hiding under her bed. She told the SO that she had been threatened with violence and had given the other two prisoners items from her canteen. The bullying was alleged to have begun after she apparently gave prison staff information which led to one prisoner's cell being searched.

176. With the woman's consent, the SO also separately interviewed the two women who she claimed were bullying her. He completed these interviews on the same day in the safer custody office. The first prisoner denied all knowledge of the issue and the second said that she would not bully anybody. She confirmed that she and the other prisoner had been to the gym recently (something the woman denied). She also agreed that she and the woman had disagreed following a cell search. The prisoner said that the woman had given information about her to staff and later admitted this to her.

177. Officer F spoke to the woman on the same day, 3 August. She had been sent back from her education class after having a panic attack. She said that she had become anxious because of the number of people present. The officer told the investigator that the woman had not been off the wing very much. She reassured the officer that she had had similar panic attacks in the community and was not thinking of harming herself. She said that she wanted to be alone for a while and the officer made it clear that staff were available to support her if she needed it.

178. The officer contacted the healthcare team. She initially wrote in her entry in the wing observation book that healthcare staff 'did not feel the need for [the woman] to be seen'. However, the mental health nurse did check her at 11.15am. He told my investigator that he found her to be lucid and no longer suffering the effects of a panic attack. She was calm and lying on her bed. He tried to advise her on how best to manage panic attacks. He told her to get in touch with the mental health in-reach team if her situation got worse and said that she could go to the drop-in clinic if she needed to. Following the nurse's assessment, she told the officer that 'she was OK'. The chaplain also came to speak to her and arranged to check her the following week.

179. Senior Officer E told the investigator that he ascertained that the woman and the other prisoners alleged to be bullying her were located on different wings. He concluded the anti bullying investigation on 4 August with the following remarks:

> ‘Both prisoners were warned of consequences should any further evidence come to light. The woman stated she was happy with outcome and understands she can approach any member of staff with concerns. During interview, she stated that the third prisoner is not alleged perp[etrator].’

180. The same day, the SO wrote to the woman:

> ‘Following the recent bullying referral I received and our recent chat, I can now confirm that I have fully investigated the matter.
>
> ‘Both prisoners have been spoken to and warned about their future behaviour and the consequences of any further incidents.
>
> ‘I know this has been a difficult time for you and I hope you can now put this behind you and be positive about the rest of your sentence. If you need any further help or advice you know how to get hold of me …’

181. The SO did not speak to wing staff about the outcome of the investigation. No further monitoring of the interaction between the woman and the other prisoners was planned.

182. On 4 August, the woman failed to go to a doctor’s appointment. She had a visit from her family on 12 August. Officer G spoke to her on 15 August. Another officer had been allocated as her new personal officer but, because she was working nights at the time, Officer G was covering her duties. (The personal officer did not return to day shifts until 30 August.) She told Officer G that she had settled in well on A wing and was ‘doing much better’. She felt able to move around the prison and had been able to eat in the dining hall without feeling threatened.

183. The woman told Officer G that she had not experienced any further difficulties with other prisoners and her recent family visit had gone well. The officer tried to reassure her that her family would offer her support. She told her that she had not felt the need to hide under her bed for two weeks, which she was pleased about.

184. On Tuesday 17 August, the woman attended Catholic mass in the chaplaincy as usual. The Roman Catholic chaplain spoke to her about the possibility of her local parish priest visiting her, which she welcomed. The chaplain made a telephone call and discovered that her priest was on holiday, and promised to arrange the visit when he returned from leave. She telephoned her husband on 20 August.

21 August

185. During the morning roll check, at about 7.30am on Saturday 21 August, An officer found the woman hiding at the end of her bed in the bottom of the shelving unit. She had curled up into a ball and had managed to climb into a position where she could hardly be seen. She did not respond when the officer spoke to her. Four officers helped the SO to move the bed and they managed to guide her out and remove her duvet in order to check her.

186. The orderly officer that day arrived in the cell. The SO checked the woman's pulse and breathing, both of which were normal. He also checked for any ligatures. She remained completely unresponsive to staff and lay still. The officers placed her in the recovery position and covered her with a blanket, because she was only dressed in her underwear.

187. The woman was lying on the floor, so staff placed a pillow under her head to make her more comfortable. The orderly officer asked for a member of the healthcare team to come to the cell as soon as they arrived at work. In the meantime, he told two officers to stay with her. One officer told my investigator that she sat with her and talked to her, but she did not respond. The other officer told my investigator that she would occasionally move her fingers slightly.

188. The orderly officer told staff to keep checking the woman and to try to engage with her. A nurse had arrived a little early for her 8.00am shift. She went directly to the cell at 7.45am and checked her, but could find nothing physically wrong with her. She checked her pulse and blood pressure. She remained unresponsive to verbal and physical stimuli, although she was breathing normally.

189. When the nurse lifted the woman's eyelids, only the whites of her eyes were visible. There was a fresh bruise on her upper left arm and some smaller, older bruises on her legs. (The nurse confirmed during interview that she did not consider the bruises to have been caused by an assault.) The orderly officer and nurse agreed that a member of staff should remain with her to monitor her. They decided that the nurse should complete the delivery of medication to other prisoners and then return to check her.

190. After the nurse completed her assessment and confirmed that there did not seem to be anything physically wrong, the SO told my investigator that the woman was locked in her cell. Staff checked her every five to ten minutes by looking through the observation flap in the door.

191. The nurse suggested that staff should ask the Anglican chaplain to come and speak to her as she had been able to engage her when a similar situation occurred at the start of the month. However, the chaplain does not work on Saturdays. The Roman Catholic chaplain was working in Downview (the nearby women's prison that shares staff with Send) that morning but was not contacted by staff at Send. She

told my investigator that she would have been willing to make the half hour car journey to Send. This meant that no one from the chaplaincy team went to speak to her.

192. At 8.30am, the orderly officer told the duty governor that the woman was lying on her cell floor and, although conscious, was entirely unresponsive and might well need to be taken to hospital. The duty governor went to the cell and spoke to her with an officer, but neither of them managed to persuade her to speak or engage with them. The officer told the duty governor that she had behaved similarly in the past. Healthcare staff visited twice more to keep checking her.

193. The woman remained completely unresponsive. The nurse requested an ambulance at about 10.00am. She was unwilling to let her remain on the floor of the cell indefinitely. The chaplain was not on duty and she knew that there were not enough nurses on duty to care for her properly in her present condition.

194. A single paramedic arrived at Send at about 10.06am and an ambulance followed at about 10.17am. The paramedics, the duty governor and the nurse agreed that the woman should be taken to the accident and emergency department at the hospital. An escort chain (a length of chain with two handcuffs at either end) was attached to both an officer and the woman at 10.45am.

195. The ambulance left Send at 10.50am and arrived at the hospital at about 11.05am. The woman was escorted by two officers. The nurse provided the paramedics with a copy of her clinical record (including the entries from that morning), on which she handwrote that she normally received a 10mg daily dose of escitalopram, but had not yet been given that day's dose.

196. Two members of staff were already escorting another prisoner who was out at hospital. Once two more officers were dispatched to accompany the woman (later to be joined by a third), the prison regime was left significantly depleted and normal activities had to be suspended for the rest of the day. During the afternoon, the member of staff running the control room was redeployed and the radio network was opened up. The afternoon association period for the prisoners was cancelled.

197. The duty governor remained in touch with staff at the hospital via the orderly officer because it was proving difficult to gather enough officers to volunteer to escort the woman if she stayed in overnight. During the morning, he considered releasing her on temporary licence (ROTL), which would have allowed one officer to return to work at Send. The other officer would have remained with her. He asked staff to consider her eligibility for ROTL.

198. For the first couple of hours at hospital, the woman remained completely unresponsive and did not speak or engage with staff. She did not respond to any of the pain stimuli attempted by hospital staff either. She was initially treated by a doctor, who subsequently called her senior colleague in for further advice about how to proceed.

199. The woman stayed handcuffed to Officer H by the escort chain. At 12.50pm, she was given intravenous fluids by the nurses and started to rouse about 15 minutes later. She opened her eyes and turned her head, but still did not speak.

200. At about 1.15pm, the woman became distressed and pulled a canula out of the front of her hand, causing a considerable amount of blood to spill. The officers tried to prevent her from doing this by taking hold of her hands, but it proved difficult to stop her from pulling at the canula. Officer H applied some cotton wool to the wound. Officer I fetched a nurse to dress the wound.

201. About ten minutes later, after the nurse had left, the woman removed the dressing and tried to take the other canula out of her arm (it was on the inside of her elbow). The officer continued to try to prevent her from hurting herself. However, she managed to remove the cap from the canula, causing it to bleed continuously. At Officer I's request, a doctor came into the room to replace the canula.

202. Once again, the woman pulled at her canula. She used her other hand to press at the wound to encourage it to bleed. She managed to remove the cap from the canula but Officer I replaced it. She then tried to remove the drip from her arm that was delivering intravenous fluids. When the officers tried to prevent her from doing this, she pinched the tube to stop the fluids getting into her body. Officer H told her that the fluids were for her own good, but she pulled the tube out completely and then tried to push it back into her arm.

203. The woman refused to undergo a scan and became aggressive, but still did not communicate verbally. Officer H told the investigator that she made angry noises instead. Officer I asked her if she wanted to clean herself because she had blood on her hands after pulling out her canula. She nodded but did not speak. She washed her hands and then used tissues to clean up the blood on the bed. At about 1.40pm, Officer I telephoned the orderly officer to tell him about her behaviour.

204. Two other officers were escorting the other prisoner at the hospital (who had been admitted with stomach pains). Officer I visited the two officers to tell them that he and the other officer would take over the woman's escort because they were working a later shift. The officer then returned to his escort.

205. At 2.00pm, the woman climbed over the raised bars on the side of the bed and tried to make her way out of the door. The two officers had to

use control and restraint techniques to stop her leaving. Once she sat down, they removed their hold on her arms. Officer I tried to ask her what was wrong, but she would not speak. She eventually said that she wanted to clean her bed, which was stained with blood. She got up to try and do so.

206. The woman again had to be restrained by both officers (who each took one of her arms) at 2.20pm when she tried to force her way out of the room. Staff attempted to calm her down and she sat on the bed. The officers removed the arm locks, but about a minute later she again tried to force her way towards the door. She used enough force to push both officers against the wall and furniture. The officers restrained her again and sat her back on the bed. They kept the arm locks in place for about three minutes, until she calmed down. Officer H told the investigator that she grunted but did not speak coherently.

207. Officer I left the room to ask a nurse if the woman could be discharged and taken back to the prison. Officer H tried to engage her in conversation, but she still did not speak and tried to force her way out of the room again. Officer I saw through the door that her colleague was having to restrain her and re-entered the room. Both officers restrained her.

208. The woman stood on the escort chain to pull it tight, causing Officer H pain and bruising her wrist. She stamped on Officer I's foot. Hospital staff came to assist and the officers asked them to call the other officer, who joined his colleagues. Whilst the two officers continued to restrain her, Officer J telephoned the duty governor to tell him what was happening. The duty governor told the officer to call the police if 'the situation got out of control'.

209. The officer returned to the room at 2.25pm, and found his colleagues holding the woman by her arms down on the bed. They were assisted by a member of hospital security staff. Officer H ensured that she was facing sideways so that she could breathe. Officer I asked her how she was but she did not reply.

210. A doctor gave the woman an 1mg injection of lorazepam to sedate her. (Lorazepam is used to calm agitated patients.) Officer H told the investigator that the sedative had an immediate and dramatic effect on her behaviour. The doctor said that she would need to undergo a scan to make sure that she did not have a head injury.

211. Officer J telephoned Send again and asked the orderly officer if the SO, who was coming to the hospital to oversee the swapping of the two escorts, could remain to help supervise the woman. Both officers released the restraint they had been applying to her. She knelt down and curled up on the floor. The bed was removed from the room and a mattress was brought in for her to lie on as staff thought that she would be safer lying on the floor.

212. Officer H left to escort the other prisoner and Officer J attached himself to the woman using the escort chain (he was handcuffed with his left hand, she with her right hand). He replaced Officer H partly because, as a control and restraint instructor, he was thought to be better placed to deal with her aggressive behaviour.

213. At 2.45pm, the woman moved across the mattress, tried to crawl under a cabinet and managed to get halfway underneath. She banged her head for a couple of seconds against the underside of the cabinet. Officer I told her to stop and she did. The doctor told the third officer that the injection she had been given would start to take effect. She then moved onto the mattress, lay face down and seemed to fall asleep.

214. As a result of the concerns about the woman's violent behaviour, the orderly officer and duty governor agreed at 3.00pm that the SO should go to the hospital and remain there to help supervise her. If staff were required to use further control and restraint procedures, three officers needed be present.

215. The duty governor asked Nurse B to check if a prison with 24 hour healthcare would accept the woman if she was discharged from the hospital and still required medical treatment and medical observation. Nurse B asked another nurse to make arrangements with Bronzefield (a women's prison with 24 hour nursing cover) to accept her if necessary. Nurse C spoke to a senior member of healthcare staff at Bronzefield and obtained their provisional agreement to a transfer. The nurse told the duty governor and Nurse B that the arrangements had been made. The duty governor also spoke to the duty governor at Bronzefield to confirm the arrangement.

216. Senior Officer F arrived at the hospital at 3.30pm. When he arrived, the woman was lying on the mattress and completely unresponsive. He managed to engage her, who spoke coherently for the first time that day. He quickly persuaded her to get on the trolley so that she could be taken for her scan. She was moved to a different room to wait approximately 30 minutes for the scan (to rule out a potential brain injury as an explanation for her behaviour).

217. Officer J sat on a chair next to the trolley with the escort chain still attached to himself and the woman. The officers covered her with a blanket to preserve her dignity as she was only wearing a hospital robe. She tried repeatedly to get off the trolley and was restrained by the SO and the third officer. She also tried repeatedly to wrap the escort chain around her neck in an attempt to strangle herself. The SO told the investigator that she gathered the slack of the escort chain on to the trolley beside her, and would suddenly grab it and wrap it around her neck. He described her behaviour as 'erratic and difficult'.

He confirmed that she took the chain up and over her head before trying to wrap it around her neck.

218. During interview, Officer J told the investigator that the woman managed to wrap the escort chain around her neck. He confirmed that she was in danger of strangling herself had staff not intervened. He said that she would calm down and then try again suddenly to wrap the chain around her neck. He estimated that she tried to do this between five and seven times during the time they were at hospital.

219. Officer I described to the investigator how the woman deliberately took the chain above and behind her head, trying to move it around the back of her neck and then pull the two lengths in her hands tightly in an 'x' shape in front of her chest. Both officers and the SO prevented her from doing this each time and restrained her for her own safety.

220. Although the woman's previous behaviour at the prison had been unusual and concerned the staff, prompting the two earlier periods of ACCT monitoring, this was the first confirmed incident of attempted self-strangulation using a form of ligature. Officer J remembered her saying a number of times that she wanted to die and felt worthless.

221. Senior Officer F continued to talk to the woman. Officer J remembered that the SO was able to build a rapport with her and calm her down (but that she unexpectedly became agitated again). She talked about the bullying she was experiencing, saying that, although she had reported it, nothing had changed and the prisoners were still 'getting away with it'.

222. The SO told the woman that he would address the bullying problem when they returned to Send and involve the violence reduction coordinator. The SO told the investigator that her behaviour became more compliant and, although still very upset, her mood changed a little. She remained quiet and he was not so concerned by her behaviour at this point.

223. A doctor made an entry in the hospital record at 4.00pm that the woman was now talking coherently. She also made the following entry:

> 'IMP [Important]: Functional behaviour. At high risk of self harm and needs mental health input.
>
> 'Prison staff aware of this and will put in place monitoring / MH [mental health] referral.
>
> 'D/C [discharge] to prison.'

224. When she was interviewed by my investigator, the doctor remembered speaking to a male member of staff (whose name she did not know)

shortly before the woman was taken for her scan. My investigator has established that this was Senior Officer F rather than Officer J. The officer was handcuffed to her using the escort chain inside the room. He remembered the doctor speaking to the SO several times outside the room.

225. The doctor remembered that she spoke to the SO for several minutes and advised him that she would be discharging the woman if her scan did not show any abnormalities. She was satisfied that she conveyed to the SO that the woman needed ongoing mental health treatment and that there was a risk that she would harm herself.

226. The doctor recalled during interview that she clarified with the SO that she was discharging the woman because she did not require 24 hour healthcare for a specific medical problem. Nonetheless, she said that she made it clear to the SO that she expected the woman to be kept under constant supervision at the prison because of the risk she presented to herself. She said that she was reassured that measures to keep her safe would be put in place and that she would be supervised constantly by staff. (The SO remembered agreeing to ACCT monitoring but not to a specific frequency of observations.)

227. The woman was taken for her scan. She complied with the instructions given to her by hospital staff and lay still whilst the procedure was completed. However, at 4.20pm, whilst in a corridor returning to the accident and emergency department, she tried to get off the trolley. In the presence of prison and hospital staff, she again attempted to form a ligature around her neck using the escort chain. The three prison officers managed to prevent her from doing this. The SO described her as ‘difficult and unpredictable’. Another officer then took over from Officer I, whose shift had ended.

228. The SO telephoned the orderly officer at about 4.35pm, telling him that the woman was being discharged and expressing concern about her. During the telephone call, he said that he explained her behaviour at the hospital and her use of the escort chain to try to strangle herself. He mentioned that she said that she had nothing to live for and that staff would need to consider placing her under constant supervision.

229. The orderly officer then told the duty governor what the SO had said to him on the telephone. He also separately relayed the SO’s words to Senior Officer G. She recalled during interview that the orderly officer told her that the woman had used the escort chain to try to strangle herself on ‘half a dozen occasions’. She remembered him telling her that the SO had suggested the need for constant supervision. She told the orderly officer that she would prepare for ACCT monitoring in anticipation of the woman’s return.

230. Nurse B wrote in the clinical record that, were the woman to be discharged from hospital without requiring healthcare intervention, the

orderly officer had told her that she would be 'put on constant watch' because she had tried to strangle herself using the escort chain at the hospital. (The orderly officer recalls telling the nurse that 'they would be considering constant supervision'.) The nurse told my investigator that the plan to transfer her to Bronzefield's 24 hour healthcare centre was abandoned because staff believed that she had been discharged without needing further medical observation.

231. The nurse asked the orderly officer if he wanted a mental health nurse to work an extra shift overnight to monitor the woman whilst she was subject to the proposed constant supervision. He said that this was not necessary because he had already booked an extra officer in case she stayed in hospital, so the same officer could be used to oversee constant supervision instead, if required. The nurse wrote in the clinical record that she suggested contacting the manager of the mental health in-reach team for advice and was told that 'the officers' would do this. However, nobody contacted him on 21 August.

232. At the hospital, Senior Officer F continued to try to engage the woman in conversation. Every so often, she got off the bed and tried to leave the room. She spoke to staff to say that she wanted to leave. The senior officer explained that they needed to wait for the doctor to discharge her. She tried a couple more times to form a ligature by using the escort chain and she attempted forcibly to escape from the room, banging into the SO.

233. The SO and Officer J restrained the woman, supported her under her arms and tried to move her back towards the bed. The other officer stood by the door to prevent her from leaving. Whilst Officer J had hold of her right arm, she hit him in the groin. The escort chain was attached to this arm. The SO took hold of her left arm but she continued to struggle and lash out.

234. Officer J managed to bring the woman's right arm up behind her back and the SO did the same with her left arm. The officers decided to remove the escort chain and handcuff her hands together behind her back to control her. The officer and the SO stood on each side of her to support her and stop her from falling off the bed. She then sat down and sobbed.

235. The SO sat down on a chair in front of the woman and tried to encourage her to talk about what was wrong. He told the investigator that, having burst into tears, this was the moment when she finally expressed herself and opened up to him. She calmed down and spoke about being bullied (although without giving any details), which was proving too much for her. She said that she wanted to move to a different wing. She was upset as she thought that a member of the chaplaincy had broken her confidence. He tried to explain that this would only have been done for her own protection.

236. The officers felt that the woman no longer needed to have both her arms restrained by handcuffs behind her back and instead she was handcuffed by one arm to Officer J. Because the scan had not shown any physical abnormalities or brain injury, five minutes later the doctor told the officers that they could leave. She discharged the woman from hospital. The doctor prepared a form titled 'GP letter and summary' which was to be sent in the post to the healthcare team at Send in accordance with hospital policy. A copy was not provided for the escorting staff to take back to the prison. The doctor wrote the following comments:

> 'Functional behaviour.
>
> 'Ongoing high risk of self harm.
>
> 'C.T. [computerised tomography scan of her] head – N.A.D. [nothing abnormal detected].
>
> 'Needs full mental health assessment & constant supervision… relayed to prison staff.'

237. During interview, Officer J recalled the doctor telling them that the scan had shown no abnormalities. He remembered the doctor agreeing to discharge the woman but checking with the SO that the prison had measures in place to keep her safe whilst she was so distressed. The officer remembered the SO assuring the doctor that this would happen. The SO told the investigator that he agreed with the doctor that the woman would be subject to self harm monitoring when they returned to the prison.

238. The officers gave the woman some fresh clothes. She washed her face and tidied her hair. Officer J was handcuffed to her as they left the hospital with one cuff on her wrist and the other on his. She remained quiet and cooperative in the escort vehicle during the journey back to the prison shortly before 5.00pm.

239. Meanwhile, back at the prison as a direct result of the information from the orderly officer, Senior Officer G had taken a duvet and pillow from the woman's cell and placed them in the 'safer cell' next to the reception area to prepare for a smooth transition to the anticipated period of constant supervision. (A 'safer cell' has a gate allowing staff to see the prisoner at all times.) The SO opened an ACCT document (based on reports from staff at the hospital) at 5.00pm, in preparation for her return from hospital. When she opened the document, Senior Officer G was under the impression that ACCT monitoring would begin with constant supervision in the safer cell.

240. The SO made an immediate P-NOMIS entry, stating:

> ‘The woman has been placed on constant supervision as she has stated she is being bullied and would rather be dead, she has been at hospital most of today and had to be restrained by staff as she was trying to use the closet chain to self-strangulate. She was not at hospital due to an act of self harm. Once she returned to the establishment, she was placed on constant supervision and an ACCT opened.’

241. Senior Officer G said during interview that she was told by the orderly officer (who had spoken to Senior Officer F) that the woman had wrapped the chain around her neck half a dozen times. She wrote in the ACCT document that self harm monitoring was starting because she had stated that ‘she wants to be dead’. On the ACCT ‘Concern and Keep Safe Form’, Senior Officer G ticked the boxes to indicate that she had either made a suicide attempt or a statement of intent to kill herself, that she had exhibited unusual behaviour and that her mood was very low. The SO wrote:

> ‘The woman has stated she is being bullied and wants to be dead. She has been on escort at hospital and has attempted to use the closet chain to self strangulate.’

242. Neither a formal ACCT assessment interview nor the first case review were carried out that evening because staff have up to 24 hours to complete these procedures once the document is opened. The ‘Care map’ was not completed because this would normally follow the assessment interview and first review meeting. Ongoing entries were made in the ACCT record over the next few hours. At 5.00pm, Senior Officer G made an entry stating that the woman had been out at hospital and had tried to strangle herself using the escort chain. She also noted that she was being placed under constant supervision when she returned to Send.

243. During the journey from the hospital, Officer J remembered that the woman apologised to him for her aggressive behaviour and they shared a joke about this. Senior Officer F also recalled she seeming brighter and chatting to the staff. They arrived back at the prison at about 5.10pm. (The other prisoner who had been receiving treatment at hospital returned at about the same time with the other escort officers in a taxi.)

244. After they returned to Send, the officers who had restrained the woman at the hospital completed ‘Use of force’ forms. Officers J and I also completed a ‘Self harm / attempted suicide’ form which detailed her attempts to use the escort chain to harm herself.

245. The woman was uncuffed from Officer J in the reception area and went into the reception waiting room. Neither of the two healthcare staff in the prison at the time were asked to assess her. She initially sat down

on the floor next to a sofa until Senior Officer F asked her to sit up on the furniture.

246. The duty governor then chaired a meeting in the holding room to discuss the woman's welfare. The woman and the orderly officer both joined him. Senior Officer F was not specifically asked to stay but he decided to do so because he had been at the hospital with her and thought it sensible to provide information. Halfway through the meeting, Senior Officer G passed the ACCT document that she had just opened to the orderly officer and then left.

247. Senior Officer F briefly explained events at the hospital and said that the woman had tried to wrap the escort chain around her neck. The orderly officer remembered that in the meeting she 'engaged with [staff] positively'. He told the investigator that her mood during the meeting was completely different from first thing that morning in her cell. Apart from the SO, none of the other officers who had spent the day at hospital with her were asked to contribute to the meeting which lasted about 25 minutes.

248. The woman said that she wanted to be left alone to lie on the floor in her cell. She explained that she found this comforting and she could not be bullied if she stayed in her room. The orderly officer said that, were this to happen, she would have to respond verbally when staff checked her (because otherwise they became worried about her), which she agreed to do.

249. During the meeting, the woman talked about the bullying she said that she had been experiencing on the wing. She was angry that, in her opinion, this had not yet been dealt with effectively. She said that the prisoner and her friends were intimidating her. She mentioned that she had given this information to the chaplain. She was upset that the chaplain had (in her opinion) betrayed her confidence by reporting the problem to the prison. She had thought that her disclosure was a private matter. She said that she could no longer trust the chaplains and would only deal with a visiting priest from her own church from now on. The duty governor reassured her that he would personally make sure that her allegations of bullying were re-examined.

250. The three members of staff discussed with the woman how to keep her safe until the violence reduction coordinator had had the opportunity to carry out a full investigation. The duty governor offered to move her to J wing on Monday 23 August once the scheduled release of other prisoners created vacancies. (I discuss the prospect of a move to J wing in the issues section of the report. The wing is set away from the main block at Send and prisoners can apply to move there.)

251. The woman thought that Senior Officers B and F had told her that prisoners subject to ACCT monitoring could not progress to J wing, but Senior Officer F did not recall this conversation and explained that she

was mistaken. The orderly officer and duty governor reassured her that moving to J wing was possible and seven women there were subject to ACCT monitoring at the time.

252. The duty governor suggested that the woman should aim to progress on to one of the resettlement wings with a view to applying for release on temporary licence (ROTL). He stressed that she was only months from release. She said that her solicitor had advised her that, because she was serving a sentence for the non-payment of a confiscation order, she did not qualify for ROTL. He said that he thought she was eligible and that, as Head of Resettlement, he would look into the matter.

253. The woman and the three members of staff also discussed transferring to HMP Downview (a nearby women's prison) in order to keep her safe. However, Senior Officer F remembered that she 'adamantly' refused to consider this because she had a family visit scheduled later in the week which she was looking forward to. Staff thought it best to allow her to remain at Send and have the visit.

254. The duty governor later recalled that the woman was 'engaging really well' with the staff. Senior Officer F remembered that 'there was a marked improvement in her mood and demeanour'. She said that she could cope on A wing until Monday (when she could be moved) and they agreed that she would stay in her room for the rest of the weekend (with the door locked because she did not feel safe) and have her meals brought to her.

255. The woman agreed that the staff would check on her and she would lie on top of her bed and respond when they looked in. She expressed concern that staff might leave the cell door open when they came to check, but accepted that she would need to cooperate with the officers (by giving a clear response) if she did not want them to come inside.

256. During the meeting, the woman discussed her offence of fraud and the confiscation order. The duty governor reassured her that she met the criteria for release at the halfway point in her sentence, promising to confirm the details for her. She was worried that she could not repay the money she owed to the court. She was anxious that she was being charged interest on the debt and might have to return to prison again if she did not pay it. Were she to sell her house to pay the order, she still thought that she would render herself and her family intentionally homeless and she did not think that they would be rehoused by the council. He said that he would refer her to the housing and debt advisory services. He also promised to find out more about the confiscation order for her.

257. Because she had not eaten at the hospital, the duty governor arranged for the woman to have a meal. He thought that she primarily needed to have some sleep after a long day. The orderly officer and the duty

governor left Senior Officer F and the woman in the reception waiting room. When he left the meeting, the duty governor did not consider that she was likely to harm herself.

258. When my investigator interviewed the duty governor, it became clear that he did not look inside the ACCT document during the meeting and was unaware that Senior Officer G had written in it and therefore begun monitoring. He presumed that it was a blank document that the SO had passed into the room in case he decided to begin the ACCT process. He left the meeting thinking that ACCT monitoring was not necessary and had not been initiated. Because the doctor's discharge notes did not return to Send with the escort officers, neither he nor his two colleagues had the chance to read her comments. He expressed his opinion to the orderly officer that he did not think she required ACCT monitoring.

259. Senior Officer F stayed with the woman in the holding room. As the meeting concluded, he was under the impression that ACCT monitoring was underway because he had seen the orange ACCT folder that Senior Officer G had passed into the room. He thought that ACCT monitoring had begun before they convened and would continue.

260. When he spoke to my investigator, Senior Officer F said that he did not repeat his exchange with the doctor (about the need to monitor the woman) during the meeting because he presumed that the ACCT monitoring was already underway. He thought that he mentioned her placing the escort chain around her neck, but was uncertain whether he reiterated that she had said that she wanted to die. (He had said this to the orderly officer on the telephone earlier on.)

261. The meeting ended at about 5.45pm and shortly afterwards Senior Officer F escorted the woman back to her cell on A wing. (None of the three members of staff present in the meeting wrote in the ACCT document or on P-NOMIS about their discussion with her.) The SO briefed A wing staff and arranged for her to be given a baguette as well as his bacon sandwich, because she was very hungry after a long day. He remembered that her face lit up when she ate them. An officer also saw her eat her meal.

262. The officer remembered the SO saying that the woman had become agitated at hospital and her behaviour had been erratic. He recalled the SO telling him that she had been rolling around on the bed at hospital and the escort chain had ended up around her neck. The officer gained the impression that the SO was unsure whether she had deliberately tried to place the chain around her neck to strangle herself or if it had just got wrapped around her neck as a result of her agitated behaviour. The officer did not remember the SO telling him that she had said that she wanted to die.

263. The SO recalled that the woman was now ‘in much better spirits and was smiling’. She said to him before he left A wing, ‘I’ll be fine now, I’m just hungry and tired’. She assured him that she would feel safe until Monday once she was locked up alone in her cell, as long as the staff brought her meals to her.

264. Meanwhile, the orderly officer went to speak to Senior Officer G, taking the ACCT document with him. He told the SO that the woman seemed much better during the review meeting, that a move to J wing was planned and the duty governor did not think that ACCT monitoring was needed. The SO remembered during interview that the orderly officer asked her to close the ACCT document on the duty governor’s instructions. She recalled that she was surprised by the request. She pointed out to him that she had only just opened the ACCT document and she refused to close it.

265. The SO told the investigator that she was reluctant to take responsibility for the duty governor’s decision, based on what she had heard about the woman’s disturbed presentation at the hospital. She was equally reluctant to take responsibility for a decision made at a meeting which she had not been involved in. She also knew that, once opened, an ACCT document cannot be closed for the first 24 hours whilst at the very least an assessment interview and review are carried out.

266. Having refused to close the ACCT document, the SO suggested that the woman should be checked once an hour to monitor her progress and engagement with staff until an assessment interview and initial case review could take place the following morning. The orderly officer agreed that ACCT monitoring should continue at hourly intervals. She made another entry in the ACCT document recording the decision. She told my investigator that she then walked across to A wing with the ACCT document and gave it to an officer.

267. The orderly officer went to speak to the woman in her cell and told her that she would be checked at least once an hour and would need to engage with staff. She told him that she would have something to eat and drink and then settle down for the night. He advised her that the Listeners were available and she could telephone the Samaritans. She thanked him but said that they would not be necessary.

268. Before he left the prison to go off duty, the orderly officer spoke to Senior Officer G again. He also telephoned the gate to advise the duty governor (who was about to leave for the night) that ACCT monitoring had actually been started and would continue on her advice because of the threats of self harm the woman had made at the hospital. The duty governor supported the decision. He told the investigator that he then finished for the day and went home satisfied that she would be safe.

269. Officer K was responsible for checking on the woman in her cell at least once an hour. He was not asked by his managers to remove any potential ligatures (such as her shoelaces) from her cell or to search it. The women on the wing had already been locked up for the night (this happens at about 5.00pm on Fridays, Saturdays and Sundays) but some were still collecting their medication from the hatch (because this process had been delayed by the events of the day).

270. Once the last of the other prisoners had collected their medication and were locked up, the officer unlocked the woman. A senior officer waited for her at the healthcare hatch. Senior Officer G told the investigator that she seemed 'pleasant and normal' when she went to the hatch and did not seem agitated.

271. This was the first time that Nurse B realised that the woman had returned to Send and was not going to be placed under constant supervision. She would not dispense the woman's normal daily dose of escitalopram (that she had not collected earlier that morning) because she was unsure whether the hospital staff had given her any extra medication. She was concerned about any potential adverse interaction between drugs. She explained her reasons to the woman, who agreed to wait for her next scheduled dose the following morning.

272. Towards the end of her shift, the nurse told my investigator that she and another nurse had to spend some time treating the other woman who had been discharged from the hospital that afternoon. The woman was requesting pain relief, but the nurses had not been provided with a discharge letter from the hospital detailing the drugs she had already been given. The nurse said during interview that she had telephoned the hospital to obtain confirmation before providing the woman with appropriate pain relief. She remembered that the early evening had been 'quite hectic'.

273. After she was locked up again, Officer K made entries in the woman's ACCT document at 6.00pm, 7.00pm and 7.45pm. At 6.00pm, he helped her tidy her cell (the bed had been moved around that morning). At 7.00pm, he saw her lying on her bed facing the door and checked for movement.

274. When the officer returned during the roll check at 7.45pm, the woman had slipped a card under her door indicating that she wanted to speak to the Listeners. He spoke to her, and recalled during interview that she told him calmly that she wanted to speak to a Listener. However, both available Listeners allocated on the rota were sitting with another woman in the Listeners' suite at the time. (Only one woman at a time can be placed with the two designated Listeners overnight for safety reasons.) The officer told the investigator that she agreed to wait for the Listeners when the suite became free. He also remembered that he asked her if she wanted to speak to the Samaritans, but she declined.

275. The officer then sought Senior Officer G and K's advice. He told them that the woman had agreed to wait for the Listeners and did not want to speak to the Samaritans. The SOs told him that another prisoner presently sitting with the Listeners had been in the suite for a while and would probably be finishing soon. They agreed that the woman could wait until the Listeners were available and the suite was free.

276. The officer went back to the cell and told the woman that he would move her to the suite to speak to the two Listeners when it was available. He did not check the suite again in the next 50 minutes. He thought that the other woman had remained in the suite with the Listeners throughout this period.

277. A prisoner in cell A1-4 next to the woman's cell was also subject to ACCT monitoring and the officer made entries in her document after checking her at 5.10pm, 6.00pm and 7.45pm. She was not supposed to be checked as frequently as the woman.

278. At 8.35pm, the woman's personal officer (accompanied by Officer K) was carrying out the night roll check on A wing. (This is the time when the day shift hands the prison over to the night staff. The personal officer was beginning her night shift. The officer and the rest of the day staff were about to go off duty.) She knocked on the door of the woman's cell (A1-05) and looked through the observation flap. She sought a verbal response because she was subject to ACCT monitoring and because of the need to complete the roll check.

279. She saw the woman slumped on her bed. She could not see a ligature at this point. She called the officer over. He realised that she had used a ligature to hang herself and immediately unlocked the door. (The personal officer was on night duty and only carried an emergency cell key in a sealed pouch. The officer had keys because he was on the day shift.) The officer shouted for his colleagues and then went into the cell. As he walked in at 8.36pm, the personal officer used her radio to request assistance on A wing.

280. The officer approached the woman and found that she had used her shoelaces to tie a ligature around her neck and was suspended from the bars on the window. The officer used his anti-ligature knife to cut through the ligature where it was attached to the window frame and the personal officer cut the part of the ligature around her neck. A large amount of vomit came from her mouth as she was released.

281. Because the officer could not find a pulse and the woman was not breathing, she made a second call on the radio telling her colleagues in the control room that the emergency was a 'code red' (a critical incident requiring an ambulance).

282. Both SOs attended the cell, having heard the officer shout and heard the personal officer over the radio. Senior Officer K stayed in the cell. Senior Officer G met Officer L in the corridor and told him to ask the gate staff to call an ambulance immediately. The officer used his radio to relay this information and the ambulance service received a call from the gate staff at 8.37pm. Senior Officer K, Officer K and the personal officer placed the woman in the recovery position on the bed and continued to check her vital signs. The SO was concerned that her airway could be obstructed by vomit.

283. Officer L went into the cell and he initially thought that the woman was not responding in a similar way to her presentation earlier that morning. However, when he tried to talk to her, he moved her, saw the vomit and then realised what had happened. He could not find a pulse and recognised that they would need to start cardio pulmonary resuscitation (CPR).

284. Senior Officer I (the night orderly officer shortly due to take charge of the prison) had arrived for her shift a couple of minutes earlier. She was still in the gate lodge, heard the emergency call on the radio and responded immediately. (She was the only member of staff required to be fully first aid trained as the SO on duty overnight.)

285. Senior Officer I came into the cell and decided that the woman should be placed on the floor for CPR to be given. The officers and the SO moved her to the floor and the SO began to administer CPR. She turned her on her back. Because she had vomited, the SO turned her head to one side to allow the vomit to drain away. The personal officer provided the SO with a disposable CPR mask which she had been given by one of the nurses to carry on her person. The SO used her fingers to remove some of the vomit from the woman's mouth, and then placed the mask on her mouth. Unfortunately, it was the wrong way up and, when the senior officer corrected the mistake, she realised that the mask had become soiled with vomit and could not be used.

286. Whilst she performed CPR, the SO used a towel to clean the woman's mouth and nose. She began chest compressions and rescue breaths and realised that air was getting to the lungs because vomit was being expelled whenever she exhaled. The senior officer asked Officer L to wipe the woman's face with the towel between rescue breaths.

287. The SO called out the woman's name but got no response. She asked her colleagues if she had been given any in-possession medication that she could have taken and was told that she had not. The senior officer also asked if she had a condition such as epilepsy, but staff did not think so. Although the SO believed that she had probably died, she and Officer L agreed that she should continue CPR until the paramedics arrived.

288. Whilst the SO continued to give CPR, Senior Officer G telephoned the duty governor who prepared to return to the prison straight away. The assisting night orderly officer covered the window of the cell so that the women on B wing (which directly overlooks the cells on A1 landing) could not see the emergency in progress. Staff were worried about the other women becoming upset by what they saw and also the possibility of another prisoner trying to copy her.

289. Senior Officer K ran over to the gate lodge to provide more information about the woman's actions. (This was requested over the radio but the SO thought it more appropriate to give this information in person.) The SO confirmed with the gate staff that the ambulance was on its way. She gave permission to open both main gates simultaneously when the ambulance arrived to allow immediate access to the prison.

290. In the cell, Senior Officer I became very uncomfortable kneeling on the floor and a colleague provided a pillow for her to kneel on. She was becoming exhausted and asked if any of her colleagues were first aid trained. She did not get a response but continued to give chest compressions and breaths. Officer L started giving rescue breaths after a fresh CPR mask was brought to the cell.

291. The SO continued to give chest compressions whilst her colleagues wiped the woman's face. She asked for a defibrillator but there was not one available on the wing. (A defibrillator is a small portable machine that searches for an irregular heart rhythm. If one is found, the defibrillator can deliver an electric shock to reset the rhythm.) There is a defibrillator in the healthcare centre but this was locked. Only healthcare staff can access the centre and they had left for the night.

292. The personal officer initially kept a log of events at Senior Officer I's request. Two officers later took over the task. The first ambulance arrived at 8.49pm. Senior Officer K waited for the vehicle at the end of A wing and escorted both paramedics to the cell at about 8.50pm. The paramedics asked Senior Officer I to continue giving chest compressions whilst they attached a defibrillator to the woman. The SO told the investigator that the defibrillator was used several times, but that each time the machine advised that the woman should not be given an electric shock to stimulate her heart because no rhythm could be found.

293. The paramedics also attached an oxygen mask and pump to the woman's mouth to assist breathing. After a while, the SO moved to operate the pump whilst a paramedic gave the chest compressions. A second ambulance arrived at 8.56pm and two more paramedics joined their colleagues.

294. A third ambulance was requested at 9.15pm after another prisoner on J wing started having chest pains. The duty governor arrived back at Send at about 9.26pm.

295. At precisely the same time, the hospital doctor's discharge notes were faxed by staff at the hospital to the prison healthcare centre (which was locked because all healthcare staff had left for the night). It is unclear why the notes were sent to the prison by fax at this stage. Nurse B was fairly certain during interview that she had requested the notes for the woman and another prisoner by telephone earlier that day before she went off duty, but she could not be certain.

296. At 9.30pm, all of the prisoners on A wing were offered access to either a Listener or a telephone call to the Samaritans. At the same time, the paramedics moved the woman to the ambulance in order to escort her to the hospital. She remained unresponsive and was not breathing. Senior Officer K and Officer L travelled in the ambulance, which left Send at about 9.36pm. The paramedics continued to give CPR during the journey. Upon arrival at hospital at 9.46pm, she was taken directly to the resuscitation room.

297. Staff received a telephone call from the hospital asking for the duty governor to attend. The duty governor travelled to the hospital at about 10.00pm.

298. The woman did not recover and her death was pronounced at the hospital at 10.02pm.

299. Senior Officer G arranged for staff at Send to check other prisoners who were subject to ACCT monitoring. When the staff reviewed the ACCT documents, the senior officer increased the frequency of observations of one prisoner who was especially upset by the news about the woman's death. The SO arranged for a member of Send's care team to attend the prison to check how staff were coping after the emergency. Throughout the night, staff arranged for Listeners to sit with numbers of prisoners to help them to deal with what had happened.

300. After the duty governor arrived at the hospital, police officers asked him about the woman's next of kin. They offered to send a car to their home address. However, he decided to tell her family about her death as soon as possible by telephone at about 10.25pm. Contrary to Prison Service policy, he did not arrange for a designated family liaison officer or a member of the chaplaincy team to go to the family home in person to break the news. I address the way in which the family were told about her death in more detail in the 'Issues' section of the report.

301. At 7.45am the next morning, 22 August, the Governor held a briefing about the woman's death for 15 members of night staff who were

going off duty. Fifteen minutes later, he similarly briefed 11 members of staff who were beginning the day shift.

302. The Catholic chaplain was told by the Anglican chaplain about the woman's death at 10.00am that morning. Shortly afterwards, the woman's husband, mother and step-father visited Send. The Catholic chaplain travelled to the prison where she met the family. Over the next few days, the deputy governor and designated family liaison officer maintained regular contact with the family.

303. All of the women subject to ACCT monitoring were formally reviewed on 22 August. Senior Officer D spoke to the prisoner who had been particularly affected by the woman's death because she was subject to self harm monitoring and was in the neighbouring cell. As a precaution, the SO increased the frequency of checks on the prisoner following her ACCT review.

304. The woman's funeral was held on 2 September. A chaplain conducted a service of thanksgiving in the prison chapel on the same day. I gather that the prisoners prepared a book of condolence to give to the family.

305. A critical incident debrief was held on 10 September. This meeting allowed staff to discuss the woman's death and consider any lessons that could be learned.

306. The post mortem report indicated that the woman died as a result of hanging. A toxicology report showed traces of fluoxetine and escitalopram in her body.

ISSUES

307. In considering the issues raised by the woman's care in prison and the circumstances of her death, I have drawn on a review which was published in 2007. The author reviewed the way in which vulnerable women are treated in the criminal justice system. She wrote about some of the shared experiences of women who took their own lives:

> 'Many of these women had multiple anxieties in the days prior to their deaths, including … missing their families… being bullied and worrying about losing their accommodation … Most of them had recently been relocated, either within a prison or between prisons.'

308. Sadly, I believe that much of what the author wrote holds true for the woman who died at Send. She was a mother of two who experienced difficulties in her relationships with family members. She had neither offended nor been in custody before she committed her offences of fraud. She made several reports of being bullied. She often talked about the anxiety that the confiscation order caused her, thinking that she might have to sell the family home. She also moved cells several times in two and a half months (although I appreciate that this was sometimes at her own request).

309. Whilst the experiences of the woman who died at Send have a lot in common with those of other women, my investigation also highlights the particular ways in which her care may have been compromised. In this section of my report, I address each of the issues in a roughly chronological order.

Imposition of the confiscation order

310. When the woman was originally sentenced in 2009, the pre-sentence report prepared by the probation officer recommended the imposition of a suspended sentence. Although her offence of fraud was serious, she had no previous convictions, had young children and was not considered to present a risk of harm to the public. However, the judge imposed a nine month custodial sentence. He described her actions as a systematic and persistent fraud committed from a position with a high degree of trust, and stated that there was no alternative to sending her to prison immediately.

311. The prosecution also applied for a confiscation order. A confiscation order requires a person to pay back an amount up to the value of the proceeds of their criminal conduct. However, this amount cannot exceed the assets that the person has available.

312. The making of the order at the Crown Court meant that, if the woman did not pay £19,250 (the amount of money she had defrauded from her employer) within six months, she would default on the order and face the possibility of a further period of imprisonment. She did not subsequently ask for further time to pay the order (as she was entitled to) and she failed to pay any of the amount to the court.

313. It was in these circumstances that the magistrates committed the woman to prison for 12 months in May 2010. The magistrates had no power to reduce the length of the sentence or extend the payment period but they could have explored other methods of enforcement, including the appointment of a receiver. They could have adjourned the proceedings for that purpose but did not.

314. Prison Service Order (PSO) 4620 states:

> ‘A prisoner serving a term in default of a confiscation order is a criminal prisoner.’

315. Therefore the woman was due to be released halfway through her sentence in November 2010, like any other prisoner serving a 12 month term. PSO 4620 further states:

> ‘Interest starts to accrue from the date at which the time to pay expires …’

316. The woman repeatedly expressed her worries about repaying the order and the interest which was building up. PSO 4620 offers the following advice to officers working with prisoners in her situation:

> ‘Serving the default term does not expunge the confiscation order, but the defendant cannot serve another term in respect of the same sum. However, he/she should be made aware that

they can be given a further term in default by the court in respect of significant accrued interest.'

317. Unlike a fine, the confiscation order was not wiped out by serving an additional prison sentence. Upon her release from Send, the woman would still have been obliged to repay the court.

318. The woman repeatedly expressed her confusion to staff about the precise nature of the confiscation order and often discussed her anxieties during ACCT reviews. She was worried whether she might have to return to prison again if she still did not repay the order upon her release. Senior Officer D and Officer D both remembered her anxiety that she might have to return to custody again and again if she could not find the money. Staff tried to explain the order and put her mind at rest, but the debt and the interest continued to trouble her.

319. It was acknowledged that the most likely way for the woman to pay the confiscation order was to sell the family home. However, she was reluctant to do this because she believed that she would then have made her family intentionally homeless and they risked not being rehoused by the local authority. An officer recalled her worry about the possibility of her children being made homeless. He remembered that he struggled to explain the complicated nature of the confiscation order to her.

320. Senior Officer B spoke to the woman many times during ACCT reviews in June and July. He too remembered that the confiscation order preyed on her mind. At first, she was worried that she would have to serve the full 12 month sentence in Send. The SO managed to relieve her anxiety and told her that she would only serve the usual first half of her sentence in prison. However, he recalled that she was preoccupied by the debt she still had to repay and repeatedly questioned him about it.

321. Perhaps most notably, the duty governor told the investigator that the woman was still fixated on the interest accruing as a result of the confiscation order when he spoke to her on the evening of 21 August, a few hours before she died.

322. It seems that the implications of the confiscation order caused the woman anxiety. I hope that the account provided in this report has helped her relatives and friends to better understand the reasons why the order was made and the legal framework which led to its imposition.

Clinical care

A possible diagnosis for the woman's behaviour

1. In her clinical review of the care the woman received, the clinical reviewer comments on her behaviour and mood on 21 August:

> 'The woman was clearly presenting with severe mental disturbance, for which there was no physical explanation and the likely diagnosis was a mental health one with a diagnosis of depression already made in her case. She also presented in episodes that are best understood as dissociative stupor. It is also likely that she may have had abnormal personality traits given her difficulty in relationships and the resistant nature of her depression and also the dissociation that was occurring is more common in individuals with some emotional instability within their personality structure.'

2. The clinical reviewer thinks that the woman may have suffered from a condition called dissociative stupor. This disorder can be identified in patients who are experiencing 'intolerable or insoluble problems, disturbed relationships or traumatic events'. The clinical reviewer describes the beginning and end of the episodes that patients experience as 'often sudden'. Patients with dissociative stupor will have no evidence of anything physically wrong with them. They are likely to be going through a stressful time and will face difficulties with their relationships and circumstances that they may not feel able to overcome.

3. In my view and with the benefit of hindsight, the clinical reviewer's explanation seems to be applicable to the woman. There was never a diagnosis of any physical health problem that could explain her changes in mood. In July, she claimed to have repeatedly banged her head against a wall, but there was no evidence of physical injury. On 21 August, a scan ruled out the possibility of a head injury as a reason for her unresponsive behaviour.

4. The woman faced a number of problems and told staff that she could not foresee any easy resolutions. She was worried about bullying, the confiscation order, the prospect of financial ruin and a further return to prison if she did not pay the interest on her debt. She repeatedly expressed anxiety about her family and her relationship with her husband. She also lacked experience of the prison environment. The clinical reviewer thinks that there is clear evidence of the types of 'insoluble problems' associated with dissociative stupor.

5. In her clinical review, she adds:

> 'Dissociative stupor is diagnosed on the basis of a profound diminution or absence of voluntary movement and normal

responsiveness to external stimuli such as light, noise and touch.'

6. As the clinical reviewer comments, this is precisely the sort of behaviour that staff observed in the woman on several occasions, most notably on 21 August. She would not speak, would not move, did not respond to verbal encouragement or gentle pinching and was usually found curled up or cocooned in the furthest reaches of her cell.

7. The clinical reviewer also thinks that dissociative stupor is a likely diagnosis because of the way in which episodes can come to an end 'suddenly without any seeming reason'. This distinguishes it from other forms of stupor, which tend to be 'unremitting'. The woman seemed to emerge from these episodes within a reasonably short space of time, such as when she was found outside the gym in July or when Senior Officer F managed to coax her into talking about her problems at the hospital on 21 August. However, it seems that she could just as easily return to this sort of unresponsive state.

8. In her review, the clinical reviewer does consider an alternative diagnosis of 'malingering' (fabricating or exaggerating the symptoms of a mental disorder). However, she rules this out because the episodes were clearly genuine to the woman who was often completely unresponsive despite being physically prodded. As the clinical reviewer points out, the staff at Send did not think that she was pretending and were genuinely baffled by her behaviour.

Mental health treatment

9. In her report about women in the criminal justice system, the author highlights the prevalence of mental health problems amongst female prisoners and the need to provide adequate resources to address their needs:

> 'Mental health problems are far more prevalent among women in prison than in the male prison population or in the general population. Up to 80% of women in prison have diagnosable mental health problems.'

10. The clinical reviewer comments on the treatment the woman received in her clinical review:

> '[The woman] would appear to have merited a psychiatric review by a medical doctor trained in psychiatry prior to the incident that led to her death on 21 August 2010. I am not sure then that her clinical care was equitable with the wider community.'

11. The woman was referred to the mental health in-reach team on the day she arrived at Send. However, when ACCT monitoring began about two weeks later, Officer A noticed that no progress had been made in

this regard and made another referral. A nurse also subsequently pursued the referral. HM Chief Inspector of Prisons explored this issue in his report about an inspection of Send in December 2010:

> 'Following a death in custody earlier in 2010, there was recognition [by staff] of the need to strengthen systems to ensure early referral from reception screenings to the mental health team.'

12. Nurse A subsequently assessed the woman in late June and referred her to the doctor for a review of her antidepressant medication. The nurse was working occasional shifts at Send to compensate for staff shortages in the mental health in-reach team (he normally works at the sister prison, Downview). The team was not fully staffed during the summer of 2010. The only full-time mental health nurse at Send left her job shortly after the woman arrived at Send and had not been replaced by the time that she died.

13. The prison doctor reviewed the woman's medication on 5 July. She decided to change her antidepressant from fluoxetine to escitalopram. She prescribed a decreasing dose of the former for a week before introducing her to the latter. However, she seems to have made an additional entry in the clinical record on 5 July indicating the prescription of another, simultaneous and seemingly contradictory supply of fluoxetine.

14. The investigator confirmed with the Head of Healthcare that this was an administrative error by the doctor. He stressed that the drug administration chart shows that the additional dose of fluoxetine was never actually dispensed. The doctor expressed her confidence that the nursing staff would have queried a simultaneous prescription of two antidepressants.

15. A doctor at the hospital told the investigator that she thought the woman might have indicated on 21 August that she was being prescribed fluoxetine and escitalopram. However, aside from the entry on the electronic clinical record, there is no evidence to suggest that the apparent simultaneous prescriptions made on 5 July continued for the next month and a half.

16. The clinical reviewer comments in her clinical review that the prison doctor did not need to wean the woman off fluoxetine before introducing escitalopram. She considers that a subsequent appointment to review the impact of the new antidepressant should have been scheduled on 5 July.

17. The investigator confirmed with the Head of Healthcare that there is nothing in the clinical record to indicate that a further review of the woman's new antidepressant medication was scheduled prior to 21 August. The doctor said that she did not personally book a review of

the switch to escitalopram after she had assessed her on 5 July. She told the investigator that she had intended to review the effect of the new antidepressant about six weeks later. She explained that a nurse was present during the assessment on 5 July and might have expected the nurse to schedule a review for her.

18. The doctor said that, if the change in antidepressant medication improved a patient's mood, then she would not expect a review to be necessary. She explained that she expected the prisoner herself to speak to the nurse dispensing the medication each day if she did not think that it was working. She said that the nurse would then refer the patient back to a doctor for their medication to be reviewed.

19. During interview, the doctor confirmed that none of the discipline staff asked her to review the effects of the new antidepressant when the woman was subject to ACCT monitoring later in July. The woman twice mentioned to officers during ACCT review meetings that she was unhappy with the reducing dose of one anti-depressant and the switch to an alternative and that this was affecting her mood. However, there is no evidence that the officers referred her back to the doctor. I make the following recommendation:

The Governor should remind ACCT case managers of the importance of referring prisoners to the mental health in-reach team when there are relevant concerns.

20. The clinical reviewer stresses the need for the doctor and her colleagues to have adequate time to review a prisoner's progress. She also highlights the importance of doctors having access to as much information as possible about the patient's behaviour. The clinical reviewer thinks that the doctor should have considered referring the woman to a psychiatrist because this 'would almost certainly have been beneficial'.

21. The doctor told the investigator that she treated the woman's depression just as her general practitioner colleagues in the community are expected to treat members of the public presenting with the same symptoms. However, when she assessed her on 5 July, she was unaware of her ongoing behaviour such as her tendency to hide under her bed. She told the investigator that, had she known about this type of 'highly unusual' behaviour, she would have made a psychiatric referral. In this instance, information known to the discipline staff and ACCT case managers was not communicated to the healthcare team trying to support her.

22. The clinical reviewer criticises the failure to use the woman's electronic clinical record to clearly document communication between healthcare and discipline staff. I endorse her recommendation:

The Governor and the Head of Healthcare should review the channels of communication between discipline and healthcare staff to ensure that valuable information about prisoners is made available to all relevant parties.

23. Nurse A assessed the woman when she started to hide under her bed again in early August. He discussed her behaviour with his manager and considered the possibility of a psychiatric referral. However, the nurse wanted to wait until he knew the results of the anti-bullying investigation, which was underway at the time. He wanted to know whether the woman was actually being bullied or might be exaggerating or imagining the incidents (which might indicate mental health problems).

24. There is no evidence of the mental health in-reach team being told the results of the anti-bullying investigation or of a subsequent psychiatric referral taking place. Because he normally worked at Downview, Nurse A did not work another shift in Send before 21 August when the woman died, which may explain why the matter was not pursued. The clinical reviewer concurs:

> 'It is not clear that the primary care mental health in-reach assessment that took place after the woman was found in her cell unresponsive was followed up in a pro-active way for a more detailed assessment to take place …'

25. To summarise, the woman was not placed under the ongoing care of a mental health in-reach worker and was not assessed by a psychiatrist whilst at Send. She was not considered to have a severe and enduring mental illness. She was given regular daily antidepressant medication. The nurse offered sessions with a newly appointed Support, Time and Recovery worker (who unfortunately did not start working at Send before she died) and reminded her to visit the mental health drop-in clinic if she felt low.

26. The manager of the mental health in-reach team has already acknowledged the problems with the woman's mental health treatment, including staff shortages at the time. He put together an action plan to address these problems in the weeks after she died. His determined and prompt analysis of the issues is encouraging.

Clinical records

27. The clinical reviewer is critical of the failure of healthcare staff at Send to obtain a copy of the woman's clinical record from her time at Eastwood Park. (During the advance disclosure process, staff at Send commented, 'Although an electronic copy was available which didn't highlight any significant concerns that were later found in paper records.) My investigator was subsequently provided with a copy in order to write this report. Additionally, healthcare staff did not request

copies of her records from her community doctor or local mental health team. I make the following recommendation:

The Head of Healthcare should ensure that staff obtain previous clinical records relating to newly arrived prisoners, whether these be from other prisons or community treatment providers.

28. In her review, the clinical reviewer also notes that the Anglican chaplain's attempts to talk to the woman in her cell in early August were not recorded in any detail. She comments:

> 'The sharing of information about [the woman] may have been critical to understanding her presentation and deciding on its appropriate care and management, given that different individuals seem to have different parts of her story …'

29. The manager of the mental health Inreach team and prison doctor both acknowledge that the electronic clinical record system (which had only recently been installed when the woman arrived at Send) experienced early difficulties. The system was in its infancy and staff were learning how best to use it. It was not fully operational and electronic referral forms were not initially available to staff.

<u>In-possession medication</u>

30. In her clinical review, the clinical reviewer questions the way in which prisoners at Send are assessed to allow them to keep their medication in their cell. Although the woman described a history of deliberate self harm when she arrived at Send on 4 June, a nurse initially allowed her to keep a quantity of her antidepressant medication with her in her cell and take her daily dose without supervision. (I note that nursing staff at Eastwood Park also allowed her to keep a supply of medication in her cell.)

31. In her clinical review, the clinical reviewer describes a nurse's decision to again grant the woman permission to keep her medication 'in-possession' on 8 July as 'questionable'. The alternative (which was reinstated when she was made the subject of ACCT monitoring for a second time a few days later) is for women to collect a daily dose of their medication at the dispensing hatch and take it in front of the nurse.

32. The clinical reviewer thinks that the risk assessment completed by the nurse on 8 July may have overlooked the woman's unusual behaviour which led to the first period of ACCT monitoring (which had only recently ended) and her history of depression. I find it worrying that a woman who was behaving strangely and who had recently had her shoelaces taken from her should be trusted with a significant quantity of antidepressant medication so soon afterwards.

33. I am concerned that I previously highlighted this issue when I investigated the death of another woman at Send in 2007. I recommended that the prison review the way in which medication was dispensed. The prison accepted the recommendation and replied at the time as follows:

> 'A thorough risk assessment is carried out on each of the female prisoners at Send before in-possession medication is given.'

34. The clinical reviewer's findings would seem to indicate that this issue has still not been adequately addressed. I endorse her recommendation:

The Head of Healthcare should review the use of 'In-possession medication risk assessments' to ensure that staff take full account of women's mental health histories and any periods of ACCT monitoring.

Tetanus injection

35. The woman's family have expressed concern that the cut to her finger which she sustained in the gardens did not seem to be healing up. The Roman Catholic chaplain also remembered that the wound had looked infected. An officer recalled speaking to her several times in late July and early August about the wound, which she thought looked 'very nasty'. The clinical record shows that healthcare staff planned to treat the cut by giving her a tetanus injection. However, it is unclear from the clinical record if she was ever given the jab. I draw the matter to the attention of the Head of Healthcare although I do not think that the omission was relevant to the circumstances of her death and make no recommendation.

Bullying

36. The woman repeatedly complained that she was being bullied whilst she was at Send. My investigator was told by several staff that she struggled to fit into the prison environment. She had never been to prison prior to her brief spell in Bronzefield in 2009 and staff agreed that she was not typical of the general prison population. Senior Officer B described her as rather naïve. Staff thought that she had not really developed a means of winning the friendship of the other prisoners. The clinical reviewer comments that she seemed to be very vulnerable to (and easily upset by) the views of others, whether they were her family or other prisoners.

37. The woman seems to me to have been susceptible to victimisation. Senior Officer B recalled that she struggled to mix with other prisoners when she worked in the gardens. She would not work in the sun because of her fair complexion. He told the investigator that she found the situation frustrating. Her skin burnt very easily, so she worked in isolation in the shade.

38. To some extent, the woman resembles another prisoner who died at Send in 2007. In the report of that investigation, I described that prisoner's appearance and behaviour:

> 'By remaining on the wing as much as possible, A wing staff felt that [the other prisoner who died] was in fact drawing attention to herself. The description of [the other prisoner who died] as looking like a timid, frightened rabbit caught in the headlights was one frequently repeated by prisoners. Combined with her slight physical frame, she enhanced her visibility to those wishing to target her.'

39. I believe that this description bears some comparison with the woman. Both women lived on A wing and both inadvertently seemed to encourage further bullying through their behaviour. As we know, she had a tendency to hide inside her cell. She would conceal herself under her bed or inside a large shelving unit. It was difficult for staff to persuade her to come out and talk. She would wrap her duvet around her or hold on tightly to a personal item such as her dressing gown cord. Her actions caused the staff to focus their attention on her, something the other prisoners may have resented.

40. My investigator discussed the woman's behaviour with a number of the staff. It was agreed that her actions seemed to have been a sort of coping mechanism that she employed in order to deal with prison life. Senior Officer B thought that it was similar to the nesting behaviour of animals, who burrow into tight spaces to feel safe. It meant that there was nothing behind her apart from the wall of the cell, and she was able to see anybody who might come into the room. Although he had

seen lots of unusual behaviour by the women at Send, the SO said that he had not seen anything quite like hers.

41. Senior Officer D recalled during interview that the woman could be very negative and demotivated and often felt that 'the world was against her'. The staff did not gain the impression that she was able to easily brush off any jibes from other prisoners.

How bullying is addressed

42. I have already described the prison's procedures for dealing with bullying in the section of this report entitled 'HMP Send'. Minor disputes should be addressed initially by wing staff and, if the situation continues to escalate, staff should make a referral to the violence reduction coordinator (VRC). The VRC is responsible for the anti-bullying strategy and can initially deal with bullying by inviting the perpetrator and the victim to a mediation session. If this does not resolve the problem, then a three stage Safer Community Process can be initiated. In the woman's case, the Safer Community Process was never started because it was thought that the mediation meeting and the anti-bullying investigation had resolved the problem.

Sequence of events

43. The woman first expressed concerns about the risk of bullying in late June whilst she was subject to a period of ACCT monitoring. She told Officer C that she thought some of the women in the gardens where she worked were likely to bully her. She said that these women had been at Eastwood Park and had bullied her there. The officer explained to the investigator that inevitably the few staff overseeing work in the gardens cannot observe all of the women at all times. There are numerous poly-tunnels and, unavoidably in this sort of environment, there is the opportunity and space for bullying to take place.

44. During July, the woman complained that she was being bullied by two prisoners. (She had previously seemed to be making friends with one of them.) It seems that the two women were unhappy that she might have spoken to staff about their drug misuse whilst she was out at hospital on 12 July.

45. Senior Officer B arranged a mediation meeting between the woman and one of the prisoners on 18 July, after which it was hoped that the problem had been resolved. One of the alleged bullies still lived on B wing, as did she. I consider that the SO took reasonable steps to address her concerns at this stage.

46. A further incident involving the two prisoners took place in the gym on 29 July, after which a referral was made to the VRC. From the end of July and throughout the first few days of August, the woman

experienced a period of significantly heightened anxiety. ACCT monitoring was not put in place, although she exhibited some concerning behaviour. She stayed in her cell and did not mix with the other prisoners. Nurse A and a chaplain were asked to speak to her more than once.

Anti-bullying investigation

47. Senior Officer E was asked to deputise for Senior Officer B as VRC when the latter unexpectedly went on sick leave after being involved in a road traffic accident. Senior Officer E told the investigator that he had no previous experience in the role and had not yet received any relevant training.

48. The Deputy Governor at Send has overall responsibility for safer custody and violence reduction. My investigator spoke to her about the role of the VRC and the difficulties the prison faced when Senior Officer B was unwell. She explained that the role had seemed suited to Senior Officer E, who himself was returning from sick leave and was not yet expected to return to work with prisoners on the wings on a full time basis.

49. The VRC role needed to be filled by a senior officer. She was under the impression that Senior Officer E had some prior experience in the role. She said that she would normally have asked Senior Officer D (Senior Officer B's colleague in the safer custody team) to take over his duties temporarily, but she felt that a more long term solution was needed because Senior Officer B was likely to be away from work for some weeks.

50. The National Offender Management Service (NOMS) does not provide any formal training for staff who take on the VRC role. They can consult a 'toolkit' which is accessed using the Prison Service information technology system, but no face to face training is delivered. The Deputy Governor commented that staff are expected to call upon their experience of prison life and ask for help if they need it. She did not remember Senior Officer E asking for assistance or complaining whilst the alleged bullying of the woman was being investigated. She said that she chose Senior Officer E for the role because it required some sensitivity in dealing with the women, and she knew that he had a reputation for working well with the prisoners.

51. Senior Officer E was appointed to the VRC role on 2 August, his first day back at work after returning from sick leave. He had not met the woman before. Hers was the first anti-bullying investigation which he had undertaken. He told the investigator that he relied on Senior Officer B's administrative assistant and Senior Officer D (the suicide

prevention coordinator) to help him locate the necessary paperwork and computer records. He opened an anti-bullying investigation on 3 August and closed it the next day.

52. During his investigation, the SO said that he spoke discreetly to the woman and the two alleged bullies in three separate interviews in the safer custody office which is away from their wings. He did not consult wing staff who might have known more about her behaviour and interaction with other prisoners. He told the investigator that he wanted to carry out the anti-bullying investigation as quickly as possible and felt under some pressure because he had unexpectedly stepped into the role. He said that he would have tried to find out more information 'in an ideal world'.

53. The SO told the investigator that he did not know anything about the woman before he met her, including her recent worrying behaviour such as hiding under her bed. However, having interviewed her, he did not notice anything that prompted him to be especially concerned about her.

54. In concluding his investigation, the SO reminded the two prisoners of the consequences of any further bullying behaviour. He ascertained that the women were now located on different wings. (The woman's personal officer had arranged for her to move to A wing, whilst the two alleged perpetrators remained on B and C wings.) The SO did not advise the wing staff supervising the different women of the action he had taken and did not ask them to monitor the situation. He told my investigator that he was not completely familiar with the processes of an anti-bullying investigation.

55. During interview, the SO told my investigator that he was confident that he had resolved the woman's complaint to her satisfaction. He said that she understood that the anti-bullying investigation would not be taken any further unless she made further allegations. He confirmed that the investigation was left on file. The SO told her how to get in touch with the anti-bullying team again if she had further worries. None of the three stages of the safer community process were implemented.

56. After the anti-bullying investigation was closed at the beginning of August, the woman did not have contact with the anti-bullying team or the in-reach team again before she died. There is no evidence of her raising the issue of bullying during the next couple of weeks. When she spoke to Officer G on 15 August, she said that she no longer felt threatened.

57. However, the woman's anxiety about bullying resurfaced on 21 August. She spoke about it to Senior Officer F at the hospital and to the duty governor when she returned to Send. She was angry that she did not think that the issue had been resolved. Staff tried to reassure her that

the matter would be dealt with. It would appear that Senior Officer E's investigation only temporarily resolved the issue, but that the bullying may have resumed later in the month.

58. Senior Officer E told my investigator that he became very worried about the position he had been placed in when he later found out that the woman had died. He was concerned that a woman who had reported bullying had taken her own life. He was particularly anxious because this had been his first ever anti-bullying investigation. He said that he had wanted to help the management team by taking over Senior Officer B's responsibilities but had not felt confident in the VRC role.

59. Senior Officer B did not return to work for some time and Senior Officer E continued in the post of VRC. On 24 August, he asked his managers how many hours per week he should be devoting to his temporary violence reduction responsibilities. In the light of the woman's very recent death and the bullying issues that had come to light, the Deputy Governor told him to model his working hours on Senior Officer B's agreed duties, meaning that violence reduction would be his 'primary role' and he was allocated 21 hours (about half of his working week) as the VRC. Senior Officer B said that the number of hours would vary depending on the number of bullying issues he had to address and whether his other duties allowed him more time to spend investigating allegations of bullying.

60. During interview, Senior Officer E told the investigator that, for the next couple of weeks, he did not feel that he was allocated the required amount of hours to complete the task. The Deputy Governor told the investigator that Senior Officer E did not express any concerns to her about his ability to manage his workload during this period.

61. Senior Officer E's comments echo my findings during an investigation of the death of a woman at Send in 2007:

> 'I am concerned, however, that staff tasked with operating the anti-bullying strategy were not … allocated {enough] time and that referrals could remain unread for over a week.'

62. I understand that the VRC role was to be filled by an officer rather than a senior officer from April 2011. The role will now be full time. HM Chief Inspector of Prisons completed an inspection of Send in December 2010. The report included the following comments about prisoners' experiences which strongly echo what happened to the woman:

> 'Most women reported feeling safe but, while there was little overt bullying or violence, many women reported insidious low level intimidation by other prisoners and this had not been adequately addressed …

> ‘In many of the cases we reviewed, the quality of the investigations was poor and not enough action had been taken to monitor and challenge the behaviour of the alleged perpetrators. Too often, it was assumed that the situation had been resolved because the alleged bully had been spoken to or the victim had said she did not wish to pursue the matter. The onus was on the victim to report to staff any further problems. Some women said they were reluctant to report incidents as they did not believe they would be taken seriously.’

63. The Deputy Governor told the investigator that copies of all anti-bullying investigations are now sent electronically to her and her colleague to ensure that they are satisfactory. I commend this proactive decision. The prison has also produced an action plan in response to the initial findings of the investigation. They provided the following response:

> ‘A multi-disciplinary approach to providing interventions for both victims and perpetrators [of bullying] will be developed whereby different departments (chaplaincy, education, gym, mental health) all contribute to providing bespoke interventions so that there is an individual response to victims and perpetrators.’

Staffing levels on the wings

64. The woman often felt vulnerable and chose to spend several days alone in her cell to avoid the attentions of other prisoners. She did not always feel safe and wanted to lock herself away. Given the staffing levels on A, B and C wings (typically one officer running a wing of about 40 women with assistance during busy periods from an OSG staff member), her concerns perhaps had some foundation. It is not difficult to imagine how she could have been verbally bullied by other prisoners during the association period whilst out of sight of an officer.

65. Officer L was critical of staffing levels in this regard during his interview. He commented that the wings run safely as long as there are no additional demands placed on staff. However, if one or more women are subject to ACCT monitoring, and the frequency of observations is, for instance, every 15 or 20 minutes, then a wing officer’s time is devoted to these tasks and the regime can inevitably suffer in other areas. I draw his comments to the Governor’s attention.

The impact of the woman’s behaviour on the regime

66. The impact of the woman’s admission to hospital on 21 August (along with another prisoner) was felt by the other women. The afternoon association period was cancelled. Her friend (another prisoner at Send) wrote a very detailed and thoughtful letter to the investigator.

She believes that the woman's behaviour prior to and on 21 August unwittingly made things more difficult for her. As we know, she would sometimes hide and become unresponsive, in part because she said that she was being victimised by other women. However, the prisoner explained that her behaviour only served to aggravate the other prisoners, who resented her even more when staff had to devote their attention to helping her.

67. On 21 August, the woman was keen to avoid queuing for medication at the hatch with the other women when she returned to Send. She wanted to remain alone in her cell for the rest of the weekend until she could be moved to J wing. Although it is impossible to know exactly what she was thinking, it may well be that she anticipated the impact that her hospital admission (amongst other factors) had had on the regime. She may have worried that she had further antagonised the other women.

Events on 21 August

Using the chaplaincy

68. Before the woman was taken to hospital on 21 August, staff tried to find the chaplain who had previously been able to persuade her to talk. However, she does not work on Saturdays. Although the chaplain had previously been very helpful, she is the Anglican chaplain and the woman was actually a Roman Catholic. The Roman Catholic chaplain was working at Downview (Send's sister prison) that morning. She explained to the investigator that she could have driven to Send to talk to her, but that nobody telephoned her to ask for her advice or assistance. She also suggested that the other chaplain would have been happy to be contacted at home.

69. Chaplains can be a great source of support to prisoners generally and to the women at Send. The woman regularly attended mass and involved herself in religious life at the prison. Whilst I gather that she was upset with the Anglican chaplain because of what she may have told staff about the bullying problem, prisoners such as her can benefit from talking to a chaplain in times of crisis. I therefore make the following recommendation:

The Governor should ensure that a rota detailing the availability of each chaplain and their whereabouts (whether at Send or Downview) is always available to the duty governor.

The use of control and restraint techniques

70. I have given careful thought to the events at the hospital and especially to the use of control and restraint techniques by staff. Prison staff have to be trained in approved techniques and must have regular refresher training before they are allowed to restrain prisoners. Careful planning is expected whenever practicable and the use of restraints should, wherever possible, be filmed. However, these requirements would typically apply in the prison environment when a prisoner has a history of uncooperative and violent behaviour.

71. From what I have learnt, I am satisfied that the staff escorting the woman at the hospital used appropriate and necessary restraint techniques to prevent her from harming herself and others. Her behaviour could not have been predicted because she had not previously behaved aggressively at Send and had been completely unresponsive throughout the morning. I am told that she quickly became extremely agitated and started to endanger herself and the prison officers. The staff were outside the safety of a prison environment and so the situation was both less predictable and harder to contain.

72. My investigator asked Officer I why she and her colleagues did not swap the escort chain for handcuffs when the woman started to wrap the chain around her neck in an attempt to strangle herself. The officer explained that she had been lying on a mattress on the floor, and that it would have been both impractical and potentially quite dangerous to switch to handcuffs at that stage. The officer in question would have had to sit on the floor with her.

73. Officer J also explained that it would have been impossible for hospital staff to perform the scan (to check for a head injury) if he had been handcuffed to the woman. The escort chain allowed him to have sufficient distance from the machine. After she started to wrap the chain around her neck, he said that he started to keep the slack part of the chain in his hands to try to stop her from using it to strangle herself.

74. Senior Officer F agreed that medical treatment would have been problematic if an officer had been handcuffed so closely to the woman. He confirmed that the three members of staff present successfully intervened each time she tried to use the escort chain to harm herself. I am satisfied that the escorting officers prevented her from strangling herself with the escort chain.

75. I commend the way in which Senior Officer F engaged the woman when he arrived at the hospital on 21 August. He managed to persuade her to speak for the first time that day and persuaded her to go for the scan. Of the staff present, he was the only one whom she had met before. Officer J remembered that the SO managed to build a rapport with her and calm her down. He thought that the SO 'did very well'. I also commend all three officers for keeping her safe when she became very distressed. They managed to control the situation and prevent her from harming herself. I consider that they showed compassion and resilience during a very testing few hours at the hospital.

<u>The absence of a psychiatric assessment</u>

76. The woman did not undergo a psychiatric assessment whilst she was at the hospital. The doctor who worked in the accident and emergency department on 21 August told the investigator that this was because she was a prisoner. She said that the Crisis mental health team only assess members of the public. (The Crisis team is based within the local region and can be called in to assess a patient if an accident and emergency doctor has concerns about their mental health.)

77. Because of the way that the funding is organised, the Crisis team are not responsible for assessing the mental health of prisoners who are brought to the hospital. Any assessment must be carried out by the mental healthcare provider in the prison. The doctor explained that visits by prisoners to hospital are usually only for immediate treatment for physical injuries and such like.

78. During interview, the doctor confirmed that, had the woman been a member of the public, she would have asked the Crisis team to assess her on 21 August because she was sufficiently worried about her mental health. The doctor considered that she needed a psychiatric assessment when she returned to Send because a scan had ruled out a physical explanation for her behaviour.

79. The doctor did not know that the mental health in-reach team do not work in Send at the weekend. The doctor discharged her on Saturday afternoon expecting her to receive a psychiatric assessment at the prison because the Crisis team would not offer one. The earliest that she would have been assessed would realistically have been Monday morning.

80. The absence of a psychiatric assessment on 21 August is especially regrettable because, albeit with the benefit of hindsight, the clinical reviewer has suggested a likely diagnosis of the woman's symptoms. I make the following recommendation:

Surrey PCT should ensure that accident and emergency staff understand the scope and availability of mental health in-reach provision in Send so that a prisoner's care can be managed accordingly. Accident and emergency staff should be able to offer a psychiatric assessment as necessary whenever mental health in-reach staff at Send are off-duty.

<u>The offer of mental health resources</u>

81. When she heard that the option of constant supervision was being considered, Nurse B offered to book a mental health nurse to sit with the woman. (None of the mental health in-reach team work at the weekend and the primary care nurses go off duty in the early evening.) She told the investigator that she thought that mental health nurses normally perform constant supervision because of its delicate nature.

82. However, the nurse said that the orderly officer told her that her offer was unnecessary because an extra discipline officer had been booked to either staff the hospital escort or carry out the proposed constant supervision. (The nurse recorded her discussion in the clinical record. During interview, the orderly officer did not recall the nurse making the offer.)

83. Nurse B also offered to contact the manager of the mental health in-reach team to seek his advice, but was told that the discipline staff would do this. The duty governor told the investigator that he was unaware of both the nurse's offer to secure the services of a mental health nurse and her offer to contact the manager. However, the orderly officer told the investigator that the nurse and duty governor

discussed the possibility of contacting the manager. Ultimately, nobody from the prison called him to seek his advice.

Options considered whilst the woman was being treated at hospital

84. On 21 August, 13 officers were on duty in the morning and 14 in the afternoon. Eight were required to staff the wings, four to manage social visits and one (depending on demand) may have been allocated to the reception area in the event of new arrivals. There is no provision for emergency escorts to hospital at weekends (whilst there are two officers allocated to escort duty during the week, this is for scheduled and routine appointments).

85. I am concerned about the level of staffing available to the duty governor on the day that the woman died. He told the investigator that the removal of just one member of staff at the weekend can 'cripple' the prison regime. He said that the loss of four officers to two simultaneous escorts at hospital on 21 August was 'staff-intensive' and that he had no option but to shut down the usual regime. Instead of having 13 or 14 officers available, the duty governor was left with nine or ten inside the prison. Senior Officer F (one of the two senior officers on duty) also went to the hospital.

86. The prisoners' regular association period in the afternoon was cancelled and the member of staff operating the radio network had to leave their post and work on the wings. The radio network was left open so that all communication could be heard by all the staff. (Normally, communication is relayed only to those members of staff who need to hear it.)

87. During interview, the duty governor described it as a 'difficult day' from the outset. He recalled that there were a high number of women subject to ACCT monitoring (12 in all). In order to care for the woman and keep the regime running, he considered several different options during the day to improve staffing levels.

i) Releasing the woman on temporary licence (ROTL)

88. The duty governor started making plans to release the woman on temporary licence (ROTL) in the morning. He was keen to improve staffing at the prison by releasing one of the two officers from her escort. The other officer would have stayed behind with her, although they would no longer have been handcuffed to her. Once the hospital had discharged her, she would have been expected to return immediately to Send with the remaining officer and her period on licence would have ended. She only had two or three more months to serve and she was assessed as presenting a low risk of harm to the public. Her risk of re-offending was also low. The duty governor thought that she was therefore a candidate for ROTL.

89. During interview, the duty governor told the investigator that he thought the period of ROTL might last overnight or for however long the hospital decided the woman needed to be treated. He told the investigator that he did not consider her to present a risk to herself whilst he was planning her ROTL on the Saturday morning. He abandoned the option when it became clear that her behaviour was deteriorating at the hospital and that she was becoming aggressive.

90. Although the plan was never taken forward, I consider it somewhat hasty and ill-advised. I am concerned that the decision to start planning the woman's ROTL was motivated by the need to release a member of staff from the hospital. The decision was not primarily based on her welfare. At the time, she was completely unresponsive. Her state of mind was unclear but similar previous behaviour had prompted ACCT monitoring. If she had been released on licence temporarily, the sole remaining officer may well have struggled to prevent her from harming herself. However, I emphasise that the duty governor went through the correct risk management procedures and ultimately correctly determined that she was not eligible for ROTL.

ii) Transferring the woman to HMP Bronzefield

91. Again with a view to improving the staffing levels, the duty governor provisionally arranged for the woman to transfer to Bronzefield. He reasoned that, were hospital staff to advise that she needed ongoing medical observation, she could receive this in a prison with a 24 hour healthcare facility rather than a hospital. (There is no healthcare provision in Send overnight.) Staffing levels at Send would increase as a result because two officers would no longer be required to escort her at hospital. (Although his staff found one extra officer to work overtime, the duty governor said that he was 'really struggling' to secure a second officer to stay with her at the hospital overnight.)

92. The duty governor told Nurse B to make provisional arrangements for the transfer. The nurse asked her colleague Nurse C to speak to healthcare staff at Bronzefield. The duty governor told my investigator that he also telephoned healthcare staff at Bronzefield to arrange the transfer. They agreed to accept the woman. At this stage, it was still not clear whether she would require ongoing medical supervision and hospital staff had not been consulted about a move to Bronzefield.

93. During interview, the duty governor told the investigator that he later abandoned this plan as well because he only intended to pursue it if told that the woman needed continuous medical observation and assessment. Because he did not see the doctor's discharge notes (a breakdown in communication which I go on to discuss), he did not believe this to be the case.

94. The clinical reviewer is critical of the decision not to use the place arranged for the woman at Bronzefield. She considers that 'a 24 hour

healthcare environment' would have been more suitable given her worrying behaviour and the doctor's intended plan of action. The duty governor said that he would have considered moving her to Bronzefield if he had been aware of the doctor's comments.

iii) Securing extra discipline staff

95. Senior Officer G told the investigator that she and her colleagues were ringing around 'everybody on rest days and weekend off' as well as other nearby prisons to secure an additional officer to work overtime. The duty governor confirmed during interview that another officer from a neighbouring prison was secured but never actually used.

96. The extra officer was initially supposed to escort the woman at the hospital if she was kept in overnight. However, when she was discharged, Nurse B and Senior Officer G then understood that the extra officer was going to sit with her and carry out constant supervision overnight back at Send.

97. The duty governor told the investigator that this had been the original intention, but that he no longer required the additional officer after he abandoned plans for constant supervision. (Again, this is a decision I go on to discuss.) He acknowledged that the hospital's decision to discharge the woman relieved the pressure at Send.

<u>Whether staffing and financial pressures determined decisions about the woman?</u>

98. When my investigator conducted interviews at Send, some staff expressed concerns about staffing levels and budgetary constraints. Senior Officer G expressed her opinion to the investigator. She claimed that low staffing levels and financial considerations affected the decisions that were made about the woman's care on 21 August. She thought that there was disagreement about whether payment for the staffing of the proposed constant supervision would come from the healthcare budget or the discipline budget. She felt that it was 'insinuated' by her managers during the day that certain options were not desirable for financial reasons.

99. During interview, the SO told the investigator that she perceived a reluctance to consider constant supervision whilst the woman was at hospital (even though this was being suggested by Senior Officer F on the telephone). She gained the impression that constant supervision was considered 'pointless' and a 'waste of money'. The SO expressed scepticism about the duty governor's plan to release the woman on temporary licence. She also commented on what she perceived as a reluctance to pursue a transfer to Bronzefield.

100. Officer L stressed to the investigator that discipline staffing levels are too low at Send, meaning that there is no 'slack' in the regime. He

pointed out that the prison can fall below the minimum level of acceptable staffing as soon as an emergency occurs and an escort is sent to hospital.

101. During interview, the officer also expressed the belief that Send should have 24 hour nursing cover. He agreed with Senior Officer G that there is a reluctance to use constant supervision at Send because of cost implications. The officer voiced the opinion that the prison keeps running largely due to the willingness of staff to work overtime.

102. I have considered these points of view. While I question the reasoning behind the duty governor's decision not to proceed with constant supervision later in the report, on balance it does not seem that the choice was made to save money. I am satisfied that plans were made to recruit an extra discipline officer who could have sat with the woman overnight. My investigator has learnt that the duty governor personally arranged for her to transfer to Bronzefield but chose not to pursue the option because he lacked crucial information from the hospital rather than for any other reason. I am not minded to ascribe the choices that were made about her care to budgetary considerations.

103. Nonetheless, I consider that the duty governor and his colleagues had to make decisions under some considerable pressure within a context of low staffing levels. The duty governor faced a particularly difficult set of circumstances, and some of his choices may have been ill-judged because he felt pressure to manage with limited resources.

104. The duty governor told the investigator that, regardless of cost, he would not have hesitated to implement constant supervision if he had thought it necessary. He said that financial considerations did not affect the provision of constant supervision at Send. However, he did accept that staffing proved to be a challenge on 21 August. The orderly officer also refuted any suggestion that budgetary constraints affected the care the woman was offered.

Assessment, Care in Custody and Teamwork (ACCT) monitoring

Prior to 21 August

105. Prior to the events of 21 August, the woman was subject to ACCT monitoring twice at Send (from 17 June until 2 July and from 12 until 22 July). I have found that the ACCT documents for both periods were regularly and thoughtfully reviewed. Senior Officer B carried out the majority of the reviews and the observation levels were increased or decreased in response to her mood and behaviour. Triggers for self harm were identified and observations were focussed on the times she said she felt vulnerable.

106. For a number of days at the end of July and the start of August, the woman would not leave her cell and she stopped taking her medication. She had reported a further incident of bullying and the VRC had yet to carry out his investigation. This crisis period culminated in the Anglican chaplain talking to her and the mental health in-reach team being called over to the wing. Although the crisis period seemed to pass and she did not harm herself, I am somewhat surprised that staff did not begin ACCT monitoring. They had twice previously begun ACCT monitoring on the basis of very similar incidents. Senior Officer D (the suicide prevention coordinator) actually made a comment in the margin of the wing observation book stressing that staff should not be reluctant to open an ACCT document just because the woman said it was not necessary.

107. However, when her behaviour became especially strange and concerning, I consider that prison staff acted appropriately and with laudable caution by escorting her to hospital on 12 July and again on the morning of 21 August.

ACCT procedures on 21 August

The meeting chaired by the duty governor

108. I have serious reservations about the meeting chaired by the duty governor when the woman returned to Send. The interviews my investigator carried out demonstrated that communication broke down not only between the prison staff, but also between the prison and the hospital. Senior Officer F and the orderly officer were also at the meeting.

109. I believe that critical decisions about the woman's care when she returned to Send were taken on the basis of very limited evidence. It became clear during the investigation that important pieces of information were either not available to the three members of staff who held the review meeting with her at 5.10pm (or were not properly communicated). To some extent this could not be helped, but the three members of staff also failed to consult colleagues and

documents which might have helped them to take a more appropriate course of action.

110. The duty governor and the orderly officer were not acquainted with the woman or any of her recent behaviour at Send. The duty governor did not know about her history of mental health problems. Senior Officer F was on duty in the reception area when she arrived on 4 June and attended two of her ACCT reviews, but did not really remember her. He told the investigator that he had no recollection of her previous unusual behaviour, such as hiding under the bed.

i) Reference to the woman's previous ACCT documents

111. Before they spoke to the woman, the duty governor and his colleagues did not consult the two recently closed ACCT documents. They were therefore unaware of relevant entries explaining that she felt especially vulnerable after she was locked up for the night and might use her shoelaces as a ligature. (For a while, her laces were taken from her on the wing and only given to her when she went to work or the gym.) I accept that time is not always available to read previous ACCT documents in detail. However, given that she died shortly after the wing was locked up having hanged herself using her shoelaces, it seems frustrating that her earlier warnings to staff were not easily accessible.

112. I am pleased that the prison produced an action plan in response to initial feedback from my investigator outlining the early findings of the investigation. They provided the following response:

> 'A notice to staff will be issued reminding them of the correct process when an ACCT is opened, with reference made to the importance of collating information from all available sources (including historical information) and involving all relevant available staff including healthcare staff if they are in the prison. Reference will also be made to the importance of information sharing.'

ii) Consulting the other escorting officers

113. The duty governor's understanding of the woman's attempts to use the escort chain as a ligature differed from that of the escort officers who spent the day with her at the hospital. Of these colleagues, only Senior Officer F went to the meeting back at Send. Throughout the day, information from the hospital was given by Officer J (and then Senior Officer F) to the orderly officer by telephone. The orderly officer then relayed this information verbally to the duty governor.

114. My investigator spoke to the three officers and SO, all of whom escorted the woman at hospital. He established that, until quite late in the afternoon, she remained unresponsive. She had not spoken since

staff found her in her cell at about 7.30am that morning. She became increasingly distressed and agitated whilst at the hospital.

115. Officer J was not asked to contribute to the meeting. The orderly officer said that this was because any information that the other officers could have provided had already been relayed to the duty governor via himself over the telephone. Officer J told the investigator that the woman tried to deliberately wrap the escort chain around her neck to form a ligature between five and seven times at hospital. He remembered that she expressed a wish to die several times.

116. Officer I expressed surprise during interview that she was not asked for her opinion about the woman's behaviour when the escorting officers returned to Send. She thought it might have been useful if she had described her behaviour at the meeting. She too recalled during interview how she had deliberately tried to wrap the escort chain around her neck.

117. Officer H told the investigator that the woman seemed angry at hospital. The officer recalled that her mood was very different from previous occasions. She said that she had never seen her act like this before. The officer recalled how she used violence against the staff and tried to strangle herself at the hospital, neither of which she had ever done before in Send.

iii) What Senior Officer F told the duty governor and orderly officer

118. The duty governor told the investigator that he was not sure how many times the woman had tried to wrap the escort chain around her neck at the hospital. He did not realise that she had made a number of repeated attempts throughout the afternoon. He could only recall being told once by telephone that she had tried to wrap the chain around her neck.

119. During interview, the duty governor said that he did not realise that the woman's latest attempt to strangle herself had taken place as recently as 4.20pm. He thought that Senior Officer F told him in the meeting that she tried to wrap the chain around her neck a couple of times. He remembered that the SO was uncertain whether she genuinely wanted to take her own life with the chain.

120. The orderly officer told the investigator that he also remembered being told that the woman had tried to wrap the escort chain around her neck a couple of times. He was similarly unaware that she had tried to do this as recently as 4.20pm. He gained the impression from the SO that she was trying to express her frustration rather than genuinely trying to take her own life.

121. The SO confirmed during interview that, when the woman wrapped the escort chain around her neck, it had been a deliberate gesture.

However, because she refused to speak for several hours, he thought that she was trying to express her feelings of anger by gesturing with the chain. He did not think that she was actually trying to take her own life because she would have realised that there were three staff present to prevent her. He said that she stopped making the gestures with the escort chain after she broke down in tears and spoke about her anxieties.

122. During his earlier telephone conversation with the orderly officer, the SO had relayed that the woman was saying that she wanted to die. (Senior Officer G subsequently wrote this comment in the ACCT document.) Although he suggested constant supervision during the call, he reminded the investigator that their conversation took place before she broke down and cried and told him her problems. He felt that this was a pivotal moment. He thought that he had made progress and that, having reached her lowest ebb, her mood was now gradually improving.

123. The SO only recalled two attempts by the woman to form a ligature. This was fewer than the other officers remembered, possibly because he only arrived later in the afternoon and did not witness all of her agitated behaviour. He did not witness the level of violence that she used against the escorting officers before she was given a sedative. The officers who did witness this level of distress and aggression were not asked to contribute to the meeting.

124. Because of her agitated and violent behaviour, the woman was given an injection of lorazepam at the hospital at about 2.30pm. The sedative altered her behaviour and calmed her down. It is unclear precisely when its effects wore off. The SO was aware that she had been given this medication. However, neither the duty governor nor the orderly officer remembered him telling them about the injection.

<u>Misunderstandings about the outcome of the meeting that took place when the woman returned to Send</u>

125. A critical breakdown in communication took place during the meeting with the woman. Each of the three staff who were there made different assumptions about the status of the ACCT document and had different perceptions of the outcome of the meeting.

126. To reiterate, Senior Officer G (a trained ACCT assessor and case manager) was on duty at the prison when she decided to begin ACCT monitoring just before the woman's return. Her decision was prompted by Senior Officer F's description of her behaviour at the hospital and his advice on the telephone that constant supervision might be required. All of this had been relayed to her by the orderly officer.

127. In the ACCT document, Senior Officer G recorded that the woman had used the escort chain to form a ligature at hospital and said that she

wanted to die. She passed the ACCT document into the meeting between the woman and the three members of staff after it had begun but did not stay for the discussion. Unlike Senior Officer G, none of the three men in the meeting with the woman were trained ACCT assessors. (Although there was no obligation to have a trained ACCT assessor present because the meeting was not being held as part of the ACCT process.)

128. The duty governor did not look inside the ACCT document. He held onto the document during the meeting and nobody else had the chance to read it. He thought that it was a blank template which Senior Officer G had provided in the event that he decided ACCT monitoring should begin. He was unaware that the SO had also prepared the safer cell. Because he did not read the ACCT document, he was also unaware that the woman had stated that she wanted to die whilst at hospital. When he left the meeting, he did not think it likely that she would try to harm herself. He did not realise that an ACCT document had already been opened and filled in and he did not consider that it was necessary to begin ACCT monitoring at all.

129. Senior Officer F thought correctly that the ACCT document which Senior Officer G passed into the meeting had been opened beforehand. He was left with the impression when the meeting ended that ACCT monitoring would continue because he was not privy to the final decision made by the duty governor with the orderly officer. He presumed that the meeting was a preamble to the ACCT process and fully expected the woman to be subject to self harm monitoring.

130. The orderly officer left the meeting under the impression that the duty governor did not think the woman required ACCT monitoring and wanted the document to be closed. He explained to the investigator that he got called out of the meeting to answer telephone calls. He said that he had no serious concerns that her mood might deteriorate after the meeting. He told the investigator that the duty governor asked him and Senior Officer F whether ACCT monitoring was necessary, but did not seem to direct the question at her herself.

Rejection of constant supervision

131. The hospital doctor is certain that she told Senior Officer F that the woman should remain under constant supervision until her mental health could be assessed. She made a written entry in her notes to this effect. The SO mentioned the need for constant supervision when he telephoned the prison. The safer cell was prepared by Senior Officer G in anticipation of her return. A member of staff was recruited to sit with her.

132. Senior Officer G told the investigator that constant supervision in a special ‘safer cell’ is reserved for those very few women who ‘really can’t see a future and a way forward and won’t listen to any sort of

discussion …' The SO did not think that the woman fitted this description by the time she returned to Send.

133. Annex 8Y of Prison Service Order (PSO) 2700 rightly acknowledges that constant supervision is a measure of last resort and that it can be counter-productive:

> 'Constant supervision is a temporary arrangement (see below - Reducing the level of observation and engagement).
>
> 'Constant supervision is where a prisoner is supervised by a designated member of staff on a one-to-one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly. It is required when it is believed that the prisoner could, at any time, make an attempt to kill themselves.'

134. The recollections of all the staff involved indicate that the woman's mood had improved by the time she returned to Send. The duty governor remembered her as 'astute, intelligent and articulate'. She did not actively voice any suicidal thoughts or behave in an overtly worrying manner during their meeting.

135. Nurse B told the investigator that, once she realised that the woman had returned to Send and would stay in her own cell rather than being placed under constant supervision in the safer cell, she did not have any reason to question the decision. She remembered how her mood had quickly improved during a previous episode in early August.

136. The duty governor told the investigator that he thought that the use of constant supervision would have been 'counterproductive' because the woman's mood had improved. Senior Officer F thought that constant supervision was no longer necessary despite her earlier attempts to use the escort chain to strangle herself.

137. HM Chief Inspector of Prisons' report about his inspection of Send in December 2010 comments on the safer cell, its suitability and its use for constant supervision:

> 'A gated cell used for women under constant supervision was situated on a corridor in the main block adjacent to reception, which was not ideal as the corridor was also used by staff and prisoners ...
>
> 'It had been used 15 times in the six months to October 2010.
>
> 'One woman said she had deliberately misled staff into believing her mood had improved so that she could get out of the constant observation cell, which she had found depressing and oppressive.'

138. The decision to pull back from constant supervision was based on the woman's improved mood and demeanour in the meeting. As we know, the hospital doctor's opinion that she should be subject to continuing observation was not communicated to the duty governor and hence not acted upon. I bear in mind that the doctor may not have really grasped exactly how much of a 'measure of last resort' constant supervision is in a prison, or indeed understood the regime which operates in Send over a weekend.

139. I consider that it would have been reasonable to abandon constant supervision if instead staff had monitored the woman very closely. However, as I will go on to discuss, I believe that hourly observations were simply too low.

<u>The duty governor's opinion that ACCT monitoring was not required</u>

140. After a woman died at Send in 2007, I made the following recommendation which the prison accepted:

> 'The Governor should ensure that ACCT documents remain open until all underlying issues have been identified and effectively managed.'

141. My investigator's interviews demonstrated that the principal factor influencing the duty governor's decision about how the woman would be monitored was her mood in the meeting. I am not wholly satisfied that sufficient caution was applied and weight given to her behaviour throughout the day. I think that staff seemed to accept at face value her more positive attitude at the meeting.

142. The duty governor thought that the woman 'opened up' to them during the meeting. However, little over an hour earlier, as late in the afternoon as 4.20pm, she was still making gestures as if to form a ligature at the hospital. The clinical reviewer stresses that:

> '… particularly in relation to psychiatric illness…feelings and actions can be unpredictable.'

143. She considers that:

> '[The woman's] behaviour at hospital and also her total history of psychiatric presentation … do not seem to have had sufficient influence on risk management planning. Rather it appears that the decision was made on the basis of how she presented during that single conversation.'

144. I endorse the clinical reviewer's recommendation:

The Governor should ensure that staff managing ACCT reviews take into account the prisoner's current mood but also balance this against any evidence of recent and long standing behaviour.

145. I consider that the duty governor's opinion that ACCT monitoring was unnecessary ignored the evidence which was available to him at the time. Even without the hospital's discharge notes (something I go on to discuss), many of his officers could have told him that the woman had been repeatedly and deliberately gesturing with the escort chain to strangle herself during the afternoon.

146. Officer J could also have emphasised how the woman's behaviour had gone from one extreme to the other. She would be calm for a while and then suddenly become agitated and distressed. This kind of insight might have assisted those present at the meeting in understanding that her mood did not necessarily reflect a permanent improvement.

147. The escorting officers could have described how the woman had initially seemed to be in a kind of trance, before becoming chaotic and violent, then trying to strangle herself and saying she wanted to be dead. These events were unprecedented.

148. The orderly officer was told at one stage that the hospital might be unwilling to discharge the woman until she had undergone a mental health assessment. Therefore he was aware that there were concerns about her state of mind. However, he told the investigator that he was reassured by her mood during the meeting.

149. During the two previous periods of ACCT monitoring, the clinical reviewer points out that the woman responded well to the extra support and her mental health seemed to improve. I consider that the duty governor's decision not to offer her this support on 21 August was wrong and he should have taken a more cautious approach.

Senior Officer G's refusal to end ACCT monitoring

150. The orderly officer went to speak to Senior Officer G to tell her the duty governor's decision and he asked her what she thought. She correctly informed him that an ACCT document had already been opened and therefore could not be closed until an assessment interview had been carried out with the woman during the first 24 hours. The SO was also reluctant to end ACCT monitoring because of what she had heard about her behaviour at the hospital and because she had not had the opportunity to assess her herself. She had not been invited to the meeting and did not want to take responsibility for a decision she had not been involved in.

151. The SO told my investigator that she thought the suggestion not to implement ACCT monitoring was 'unusual' and the 'wrong decision'.

She refused to close the ACCT document and instead suggested that the woman be subject to hourly observations, which the orderly officer and then duty governor agreed to.

152. I commend the SO's actions by first opening the ACCT document and preparing the safer cell. I also commend her for later insisting that ACCT support should remain open (effectively overruling her managers). I believe that it was the right decision to do both these things. She was the only member of staff to insist on any level of observation at all. Without her determination, my concerns about the woman's wellbeing and the way she was looked after would be even greater. However, as I have already indicated, I have serious concerns about the sudden reduction in staff contact with her.

The frequency of ACCT observations

153. Although technically the woman had not been under 'constant supervision' on 21 August, effectively she had been accompanied by a member of staff for most of the day. Senior Officer G accepted during interview that hourly observations were a marked decrease in the level of staff interaction with her. She had been checked at least every ten minutes between 7.30am and 10.00am and was then constantly accompanied by a prison officer at hospital. When she returned to Send, she went directly into the meeting with the duty governor and was then walked back to her cell by Senior Officer F. Then she was left in her cell on her own for up to an hour at a time.

154. This is something that the woman's family have asked about. The manager of the mental health in-reach team commented that the rapid switch to hourly checks was a 'brave' choice. (However, he also stressed that staff at Send are normally overly cautious with regard to the frequency of ACCT checks.) I am certainly minded to think that the decision was unwise, taken in the context of her worrying behaviour throughout the day.

155. At the time, the orderly officer agreed to Senior Officer G's suggestion to set observations at hourly intervals. However, he said during interview that more caution should have been applied by staff based on the evidence available to them on the day. He accepted that a more gradual reduction in checks would have been sensible. He conceded that the move to hourly observations had been 'drastic'. The clinical reviewer comments in her clinical review:

> 'The final ACCT plan does not appear to be adequate given the severity of [the woman's] disruptive behaviour whilst at hospital.'

156. The clinical reviewer thinks that hourly checks were 'quite a minimal plan' in comparison to the way the woman was monitored in the early evening during the two previous periods of ACCT monitoring. She

observes that her behaviour had never previously been as extreme. She comments:

> 'It appears that the decision to place her on hourly observations rather than continuous observations was the key decision that allowed her the opportunity to end her own life.'

157. Whilst a prisoner remains in her own cell at Send, staff can set the level of observations as they see fit. A prisoner can be checked at varying intervals such as every ten, 15 or 30 minutes. Unless she is placed under constant supervision (as we know, a measure of last resort), she will be kept in her own cell and will not be taken to the safer cell.

158. I consider that the move to hourly checks was abrupt. I think that it would have been sensible to implement gradually reducing levels of observation, perhaps checking the woman every ten minutes during the early evening, then every half hour until she fell asleep, before moving to hourly checks. Whilst such a move would not necessarily have prevented her death, this method had previously been used during ACCT monitoring to help her through the vulnerable period after the women are locked up for the night. Such a plan would have been a more prudent and defensible approach to her care. I make the following recommendation:

The Governor should remind staff of the need to gradually reduce interaction with suicidal prisoners who have been closely monitored and the impact that sudden withdrawal of supervision can potentially have.

159. Senior Officer G accepted during interview that she might then have raised the level of observations from hourly at 7.45pm, when Officer K came to her and Senior Officer H to say that the woman was asking to speak to the Listeners. She was frank in acknowledging that the request was a possible indication that she felt more anxious and this might have prompted staff to increase the frequency of monitoring.

<u>Recording the outcome of the meeting</u>

160. The orderly officer relied on Senior Officer G to make an entry about the meeting in the ACCT document based on what he told her, despite the fact that she was not present. None of the three members of staff at the meeting made an entry afterwards in either the ACCT document or on the P-NOMIS electronic records system, even though they had obtained a considerable amount of detail from the woman. The review meeting was not treated as a formal part of the ACCT process because the duty governor was unaware that ACCT monitoring had actually begun. This was also the reason that he did not make an entry in the ACCT document. As the clinical reviewer comments in her

clinical review, 'the significant event that led to the reduction of observations from constant to hourly should have been documented'.

The lack of a multi-disciplinary approach

161. As the clinical reviewer writes in her review, making use of healthcare and mental health in-reach staff during ACCT reviews is best practice. This approach was often absent during previous ACCT reviews in June and July, but was most notably omitted on 21 August.

162. Given that both Senior Officer G and Nurse B were in the prison at the time, it might have been constructive if one of the people attending the review meeting was either a female staff member, a trained ACCT assessor or somebody with medical training. The nurse offered to contact the manager of the mental health Inreach team, who provides out of hours mental health advice on an apparently informal basis over the weekends. Her offer was not taken up by the discipline staff.

163. The duty governor said that he did not consider inviting one of the nurses into the review meeting. He told the investigator that he would only have involved healthcare staff in the decision making process if he had pursued the option of constant supervision (since the Prison Service Order requires a duty governor and a clinical member of staff to agree to the implementation of such a measure).

164. I am concerned that this reasoning effectively excluded the opinion and advice of healthcare staff. In my view, the duty governor took an autonomous, pre-emptive decision not to implement constant supervision. The nurses may have had a different opinion about the woman, but were not given the chance to assess her or to comment on the plans for her care.

165. Senior Officer F suggested during interview that Nurse B had the chance to assess the woman when she went to the hatch to collect her medication. However, this encounter was not a formal assessment and took place apart from the decision making process.

166. The orderly officer accepted during interview that with hindsight he and his colleagues should have involved the healthcare staff in their decision about constant supervision. He said that it did not occur to him at the time to ask one of the nurses to attend. I make the following recommendation:

The Governor should remind all managers to involve healthcare staff in ACCT decisions especially when constant supervision is being considered.

167. I appreciate the difficulties that staff experience when assessing the risk a prisoner presents to herself and determining the ways in which she can be looked after. The three members of staff at the meeting

with the woman neither had mental health training nor were trained ACCT assessors. None of the mental health in-reach team were available over the weekend. This meant that it was more important than ever to make use of the resources that were available, such as the manager's advice. The clinical reviewer writes in her review that 'access to mental health advice may have assisted the decision making'.

168. I am concerned about the absence of proper 'out of hours' mental health advice and support at Send. The prison has thus far relied on the manager of the mental health In-reach team taking telephone calls on his days off. A proper support system would seem to be critical in a prison where ACCT documents are regularly opened and mental health issues are frequent and sometimes very serious amongst a troubled group of women. I make the following recommendation:

Surrey and Borders Partnership NHS Foundation Trust should review the provision of 'out of hours' mental health support at Send.

Potential ligatures in the cell

169. I have considered whether Senior Officer F could have removed obvious ligatures such as shoelaces and belts from the woman's cell when he took her back there in the early evening. He had checked for ligatures when he and his colleagues found her in her cell at the start of the day.

170. I recognise that the woman could have fashioned a ligature from sheets or other items in her cell, but it is unfortunate that she had specifically drawn attention to using shoelaces in the past. Her family have quite understandably asked why she was allowed to go back into her own cell with shoelaces at her disposal.

171. SO G expressed surprise to the investigator that Senior Officer F did not remove obvious ligatures from the cell. Given the woman's repeated attempts to wrap the escort chain around her neck at hospital, she said that she would have confiscated potential ligatures such as shoelaces, a belt or a dressing gown cord. (Although Senior Officer F escorted her back to her cell, he finished his duties at 6.00pm. When they responded to the advance disclosed copy of the draft report, Send pointed out that Senior Officer G was working evening duty and 'it would be her responsibility to check the cell as the senior officer in charge'.)

172. However, Senior Officer G also expressed sympathy with her colleague and acknowledged that prisoners typically use a bed sheet, curtain or such like in order to form a ligature. I agree that it is very difficult (without removing the prisoner to a special safer cell) to completely eliminate the possibility of a ligature.

173. Because he left the meeting with the opinion that ACCT monitoring was unnecessary, the duty governor told the investigator that he did not consider removing any ligatures from the woman's cell. Senior Officer F said that he felt that he would have been punishing her if he had stripped her cell of all potential ligatures (including sheets and curtains) and left her in a bare room. The orderly officer confirmed that he and his colleagues did not consider the possibility of removing potential ligatures from the cell.

Breakdowns in communication between the prison and the hospital

174. The doctor who reviewed the woman and discharged her from hospital wrote in her notes that she was at 'high risk of self harm' and required 'mental health input'. In accordance with the hospital's policy, her notes were not given to the escorting staff and did not return to Send with her. Copies of discharge letters are not routinely given to patients when they leave hospital. Patients are advised verbally if they require further treatment or need to take medication. A summary of their care in hospital and the outcome of their visit is sent in the post to the community general practitioner (in the case of members of the public) or to the prison healthcare team (in the case of prisoners).

175. During interview, the doctor remembered giving verbal instructions to the escorting officers. She had a conversation with Senior Officer F shortly before the woman was taken for her scan. She said that she would discharge her if the scan did not show any abnormalities. She told the SO that she had mental health problems, needed a psychiatric assessment and that there was a risk that she would harm herself.

176. The doctor recalled telling the SO that she was discharging the woman because she did not require 24 hour healthcare for a specific medical problem such as a brain injury. Nonetheless, she believes that she made it clear to him that she expected her to be kept under constant supervision back at Send (because of the risk of self harm) until she could undergo a mental health assessment. She remembered being reassured by the SO that measures to keep her safe would be put in place and that she would be kept under constant supervision. She felt that she had clearly communicated what should happen to her.

177. The scan showed no cause for concern and so the woman was duly discharged. The doctor's instructions are reflected in the letter she completed upon discharge (which would subsequently have been posted to the prison healthcare team). She wrote:

> 'Needs full mental health assessment & constant supervision … relayed to prison staff.'

178. Senior Officer F told the investigator that he and the doctor had a conversation before the woman was discharged, during which they discussed her attempts to strangle herself using the escort chain. He remembered reassuring the doctor that she would be subject to ACCT monitoring when she returned to Send. The SO could not recollect in interview whether the doctor mentioned the need for a mental health assessment.

179. During interview, the SO told the investigator that he did not communicate the doctor's comments about constant supervision and ACCT monitoring during the meeting back at Send because he thought that there was no need. He presumed that Senior Officer G had

already opened an ACCT document. The duty governor reached his decision not to proceed with self harm monitoring after he and the orderly officer had left him and the woman in the holding room. Hence the SO was unaware of the final decision about ACCT monitoring.

180. The discharge notes containing the doctor's advice were faxed across to the prison healthcare centre (which was locked up for the night) at 9.26pm that evening (after the woman had taken her own life). Nurse B told my investigator that she may well have requested the discharge notes for her (and the other woman also out at hospital on 21 August) from the hospital before she left for the day. She thought it very unlikely that hospital staff would fax the discharge notes across of their own accord.

181. The doctor told the investigator that she did not ask for the notes to be faxed to Send and that she left the hospital at about 6.00pm when her shift ended. She also confirmed that it is not standard practice to telephone a nurse at the prison if hospital staff have concerns about a prisoner they are discharging. The doctor expected the escort staff to communicate her advice to the prison management team.

182. Nurse B confirmed that the prison healthcare staff do not normally receive discharge letters from the hospital when a prisoner is returned to their care. She said that she wrote a letter to the hospital a few months before the woman died, asking for a discharge summary to accompany the prisoner. She expressed concern that prison nurses do not know what treatment and drugs the women have been given at the hospital, and that this can potentially be dangerous when healthcare staff then need to dispense further medication back in Send. (Indeed, the nurse refused to give the woman her antidepressant when she returned to Send for precisely this reason.)

183. When they met the woman to review her circumstances, none of the three members of staff had access to the doctor's written advice. Her verbal instructions to the SO were not clearly communicated. Even if the discharge letter had been handed to the escorting officers before they left the hospital, such documents have to be placed in a sealed 'Medical in confidence' envelope which only healthcare staff can open. Discipline staff are not allowed to read a prisoner's clinical record.

184. Although two nurses were still in the prison at the time, neither was asked to assess the woman in the reception area when she returned to Send shortly after 5.00pm. Nurse B told the investigator that she would normally have left Send by 5.30pm on a Saturday, but that she and her colleague had been delayed by the events of the day and were still dispensing medication on the wings at 6.00pm. Therefore, it was only by chance that there were any nurses at all remaining in Send around the time that she returned.

185. The lack of 24 hour nursing cover at Send can cause problems for prisoners like the woman who return from hospital as nursing staff are finishing their shift. Had any written information been sent by the hospital, the sealed envelope may not have been opened by a member of healthcare staff until the following day. The doctor was unaware whether nurses would still be on duty when she discharged her. She confirmed that Send had a mental health in-reach team but was not clear whether they worked during the weekend. I make the following recommendations:

The Governor, the Head of Healthcare and Surrey PCT should work together to improve procedures for discharging prisoners from hospital:

- **Written advice about immediate risk management should be prepared by the discharging doctor without breaching patient confidentiality.**
- **The form should be handed to escorting officers before they leave and passed to the duty governor upon their return to the prison.**
- **Hospital staff should communicate with healthcare staff at Send by telephone if they have serious concerns about a prisoner they are discharging and the ongoing risk she presents to herself.**

Surrey PCT should ensure that hospital staff avoid discharging patients with ongoing needs when there are no nurses on duty at Send to receive them.

The Head of Healthcare should ensure that, when a prisoner returns to Send from hospital, a nurse reviews her in the reception area.

186. I am also pleased that, following receipt of my investigator's initial findings, Send produced an action plan to address some of the problems that had been identified during the interview process. The prison provided the following response:

> 'The Primary Care Trust and Send Healthcare Department are in the process of reviewing a Memorandum of Understanding between HMP Send and the hospital. A simple pro forma will be drawn up for hospital staff that clearly indicates if the prisoner they have seen is a risk to herself or others. The information should be communicated directly with the Duty Governor or Orderly Officer so that the prison is aware of any risk management issues when a prisoner returns to Send.'

The woman's location in the prison

187. J wing is a quieter and more modern part of the prison. Sometimes, prisoners such as the woman may find it easier to cope there. Whereas A, B and C wings (where she stayed) are staffed by one officer (with assistance during busy periods from an operational support grade staff member), two officers work regularly on J wing. Senior Officer E told the investigator that he thought she might have benefited from being on J wing. The orderly officer said that the wing is viewed as a progression from the main block, where she had moved cells several times already.

188. Officer C told my investigator that there is a waiting list for prisoners who want to move to J wing. He recalled that the woman was moving up the list when she died and was aware of her progress. He said that she was "upbeat" about the prospect of the forthcoming move and had visited the unit already because she was helping one of the prisoners there with her 'Toe By Toe' reading course. The officer said that prisoners can occasionally be moved up the waiting list by a governor if they are judged to be a priority or to have greater need than others. However, she was progressing normally up the list.

189. Senior Officer B managed the woman's first two ACCT documents in June and July. He was very familiar with her and managed to build a rapport. He told the investigator that she was an ideal candidate for a move to J wing. He had considered this, but decided not to expedite the proposed move because of a difficult experience he had had with another prisoner. The other woman was also being bullied and struggled to cope. However, once she moved to J wing she caused a lot of problems. He reflected on that incident and decided to monitor her progress. He knew that she was on the waiting list for a move.

190. After the meeting with the woman late in the afternoon on 21 August, the duty governor agreed to move her to J wing on Monday 23 August, once a prisoner was discharged and a cell became vacant. She was anxious during the meeting that a further period of ACCT monitoring might hamper her progress to J wing. Although she was told that it would not, it is conceivable that she downplayed any negative feelings she was having in order to ensure that a move took place.

Response to the emergency

191. I am concerned about the way in which Senior Officer I (the night orderly officer) was obliged to administer CPR on her own for a prolonged period during the emergency. I commend her efforts. With no protection, she gave breaths and chest compressions. The process was particularly difficult because the woman was vomiting and this had to be cleaned away from her mouth after each set of breaths.

192. The SO's statement makes harrowing reading and I do not doubt that she was upset by the experience. I believe that she did everything she could, but I consider that she may have felt somewhat frustrated that none of her colleagues offered to assist her by giving the woman breaths or compressions until another mask was brought into the room. (The SO persevered without a mask after the first one was rendered unusable.)

193. I believe that the SO showed an admirable determination and I am pleased that she seems to be coping well. She told the investigator that she was very well supported on the night after the woman died and she decided to carry on working her shift in order to try to cope with events. She also said that she was offered excellent support in the weeks after she died.

194. The role of the night orderly officer is critical in these circumstances. They are the only member of discipline staff on duty overnight obliged to have full, up to date first aid training. He or she is the only senior member of staff in the prison once the day staff have gone home. They are supported by officers and operational support grade staff. Officer C (the assist night orderly officer on 21 August) told the investigator that he was not first aid trained.

195. I consider that it was unreasonable for Senior Officer I to have to take sole responsibility for CPR. As the only person with current first aid training, she was required to carry on unaided for between ten and 15 minutes with minimal life saving equipment available. There is no 24 hour nursing cover at Send. On Fridays, Saturdays and Sundays, there are no healthcare staff in the prison after about 6.30pm. I am concerned that there is then a gap of a couple of hours before the night orderly officer is due to begin their shift. I would ask the Governor to clarify who is expected to give CPR during this period. In this instance, the SO had only just arrived at Send for her shift.

<u>Access to emergency equipment</u>

196. The night staff do not have access to a defibrillator because the healthcare centre is locked and I understand that none are located on the wings. Even Senior Officer I has not received training to operate a defibrillator. However, they are relatively simple devices which

automatically guide the user through the process. They can be found in public places such as railway stations.

197. Senior Officer I's colleagues talked about their experiences on 21 August. Senior Officer G told the investigator that she did not feel confident about giving first aid because her training was not up to date. She said that she had last had training about five years ago.

198. Officer L said that he last received first aid training when he joined the Prison Service in 1997. He said that he did not feel able to join Senior Officer I's resuscitation efforts until a fresh mask was brought to afford him some protection whilst giving breaths. He expressed frustration about his lack of current first aid training. Although he remained with the SO and kept wiping the vomit away from the woman's mouth, he said that he felt powerless and inadequately equipped to deal with the emergency.

199. During interview, Officer L told the investigator that he was unhappy with the lack of healthcare provision overnight at Send. He ascribed the decision to financial considerations. He described how he had been temporarily promoted at Send in the spring of 2009 and asked to fill the role of night orderly officer for two or three months until a permanent replacement arrived. Although the night orderly officer is supposed to have up to date first aid training, he did not.

200. Senior Officer I expressed the view that, although her experience was upsetting, it is far more distressing for staff to be forced to stand by helplessly because they do not possess the correct training. The clinical reviewer recognises the SO's good practice and commends her efforts in very difficult circumstances. I echo her comments. Bearing in mind the difficulties which she experienced when she performed CPR single-handedly, I make the following recommendations:

The Governor should ensure that all night orderly officers and assist night orderly officers have current first aid training. They should also receive training to allow them to operate a defibrillator.

The Governor and the Head of Healthcare should locate defibrillators on each wing.

Surrey PCT should review the need for 24 hour nursing cover in Send.

The Governor and the Head of Healthcare should both personally commend SO I for her efforts to resuscitate the woman.

201. I am taking the unusual step of sending a copy of Senior Officer I's original statement to the Chief Executive Officer of NOMS. It is one of the most vivid accounts I have read of discipline staff trying to save a

prisoner's life. I think that it is important that those with ultimate responsibility at NOMS learn of the circumstances at Send which obliged the SO to deliver CPR alone.

202. The prison has already produced an action plan in response to the initial findings of the investigation. They provided the following response:

> 'A plan will be developed to implement an ongoing programme to deliver first aid training and maintain the number of staff who are first aid trained.'

203. Regrettably, following an inspection of Send in December 2010, some four months after the woman died, Her Majesty's Chief Inspector of Prisons made the following comments:

> 'The Prisons and Probation Ombudsman had not finalised the report into the most recent death in August 2010 but had supplied some initial feedback and the prison had subsequently produced an action plan. However, some of the responses detailed in the action plan did not fully address the concerns highlighted and the target date for completion of some action points did not ensure that the concerns were addressed with sufficient urgency. This included a concern raised about insufficient numbers of first aid-trained staff and the fact that no defibrillator was available in the prison overnight, to which the prison had stated it would develop a first aid training plan by 1 February 2011, with nothing to address the lack of defibrillators. None of the night staff during our night visit had attended full first aid training in the previous three years and only two had received basic 'heartstart' training in the same timeframe. None had been trained to use a defibrillator and no defibrillator was available.'

204. I am disappointed by the Chief Inspector's findings and trust that the prison's acceptance of my initial comments has now resulted in steps being taken.

Access to Listeners

205. There are somewhere in the region of 14 Listeners currently working in Send. The number fluctuates depending on whether any of the prisoners trained to be Listeners stay at Send or are either transferred or released. The Listeners work on a rolling rota. One Listener is available during the daytime and two at night. During the night, for reasons of safety, both Listeners have to be brought to sit in a suite with a prisoner who has asked to speak to them. Therefore, although there are two Listeners' suites at Send, only one can (at least according to the rota) be in use and only one woman can routinely be helped at any one time overnight.

206. The woman asked to speak to Listeners about 50 minutes before she was found hanged in her cell. Officer K checked and found that the Listeners' suite on B wing was occupied. He recalled during interview that it did not become free again before she died. The officer asked Senior Officer G and Senior Officer H for advice, and they agreed that she would wait until the Listeners and the suite became available.

207. I am satisfied that Officer K acted appropriately in checking with his managers. Senior Officer G volunteered during her interview that, because her request to speak to the Listeners indicated that the woman might be becoming more anxious, she and her colleagues might have considered increasing the frequency of ACCT observations from hourly intervals at this point.

208. Senior Officer D, the duty governor and Officer C all told the investigator that staff can informally arrange for two off-duty Listeners to sit with a prisoner in her cell if the need is pressing and the suite is occupied. This decision would depend on the relevant Cell Sharing Risk Assessment confirming that the woman will not present a risk of harm to the Listeners. The Listeners could then ask to leave the cell by pressing the cell bell. However, this option was not pursued on 21 August. Senior Officer G told the investigator that prisoners should only speak to Listeners in the designated suite once the women have been locked up for the night.

209. Officer C (who often works as the assist night orderly officer and did so on 21 August) told the investigator that, when he starts a night shift, he always obtains the names of two additional 'spare' Listeners (apart from the two officially on the rota) from the Listener Coordinator (who is a prisoner). He said that these two extra Listeners can then be called upon in the event of more than one woman being in distress at once.

210. During interview, Officer C said that he has previously used both Listeners' suites at the same time. He said that he escorted a prisoner who was asking to speak to Listeners to the opposite end of the prison, because the nearest Listeners' suite was occupied with another

prisoner and the allocated two Listeners on duty that night. He took that prisoner to J wing, put her in the other suite and asked two reserve off-duty Listeners to support her.

211. Senior Officer G expressed her opinion in interview that Send has insufficient Listeners' suites available to cope with intermittently high levels of demand from a population with prevalent mental health problems and a significant occurrence of self harm. There are currently two suites, one at each end of the prison. The orderly officer agreed that the main block at Send (where the woman stayed) could benefit from an additional suite. I draw staff members' comments to the Governor's attention.

212. The prison produced an action plan in response to the initial findings of the investigation. They provided the following response:

> 'The Listener Protocol will be amended to say that if staff consider a prisoner is *acutely distressed* and in a queue for the Listeners' suite then other off-duty Listeners should be asked to Listen and the prisoner's cell should be used as an option providing the Cell Sharing Risk Assessment level is appropriate. An acutely distressed prisoner should be given priority to see Listeners.'

Notifying the woman's family of her death

213. The woman's family told the investigator that they were disappointed with the prison's communication with them after she died. They felt the manner in which the news was broken to them, by telephone, was inappropriate. They were unhappy with the way information was provided. They said that they were not offered further opportunities to discuss their concerns.

214. The duty governor arrived at the hospital just after the woman's death was confirmed. Police officers attended the hospital and spoke to him. They asked him if her family had been informed of her death. They offered to ask the local police force to send officers in a car to the family home to tell her husband the news.

215. The duty governor declined their offer and telephoned the woman's husband from the hospital (about 20 minutes after she had been declared dead) to tell him of his wife's death. He made two separate calls to her husband and passed on the telephone number of the prison switchboard, in case he needed to speak to a member of staff again that night, after the initial shock of being told about his wife's death.

216. The woman's husband told the investigator that he tried this telephone number about once every hour for the rest of the night but could not get through to the prison. The woman's mother telephoned Send at about 7.00am the next morning. She was told that the duty governor would not be available until 7.30am. Her telephone call was not returned and she rang the prison again at 8.00am, whereupon she managed to speak to a governor. The family then made the decision to drive to Send.

217. The duty governor agreed during interview that it can be very difficult to contact the prison switchboard overnight, as he has tried to do so himself in the past. He confirmed that this is the only telephone number offered to bereaved families. I make the following recommendation:

The Governor should consider whether a unique emergency telephone number should be set up as a point of contact following a death in custody.

218. At interview, the duty governor told my investigator that he telephoned the woman's husband in the belief that he should be told about her death as soon as possible. He thought that his telephone call was preferable to the arrival of a police car outside the family home.

219. Prison Service Order (PSO) 2710 (concerning events following a death in custody) outlines the mandatory requirement to "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".

220. However, the PSO also stresses how important it is that the family be told face to face by a trained family liaison officer (FLO) from the prison and ideally a member of the chaplaincy. If this option is unavailable, the prison should arrange for the local police to visit the family home, or ask staff from another prison nearby to break the news.

221. The notification of the woman's family was not handled as it should have been. The investigator was told that the trained FLO at Send was on leave on 21 August. Until the following morning, the duty governor was unaware that the newly arrived deputy governor had the appropriate training. In the circumstances, I think that either the Anglican chaplain or the Catholic chaplain from the chaplaincy team (who had both known the woman) should have been asked to visit the family with a senior member of prison staff.

222. The duty governor told the investigator that he did not know of the advice contained in the PSO at the time. He accepts that he should have travelled to the family home with one of the chaplains. I once again draw the Governor's attention to my recommendation regarding the need for a rota of chaplaincy staff. In the event of a death in custody, the duty governor should be able to promptly locate one of the chaplains.

223. The Catholic chaplain confirmed that she was only told about the woman's death at 10.00am the following morning by the Anglican chaplain. She explained that the Anglican chaplain was very new in post and was not aware that, because the woman was a practising Catholic, she (as the Catholic chaplain) should have been told as soon as possible. In the event, she went to the prison on the Sunday morning after she was given the news and met the family.

224. The family live just over 50 miles from Send. During the summer months, when the weather is not adverse, I think that traveling such a distance to make a personal visit to the family should be an expectation. Although it was late in the evening, the duty governor could have contacted the local police for further information and assistance.

225. I think that the duty governor's decision to telephone the woman's husband to tell him of her death was regrettable. To then place him in a position where he was unable to obtain more information from the prison during the night was also unfortunate. I acknowledge that the duty governor was himself upset when he made his decision.

226. When the family arrived at Send the next day, the woman's mother was upset to see a Notice to Staff about her daughter's death displayed in

the gate lodge. She asked the investigator if such a notice could be placed away from public view.

227. I recognize that this situation was a result of prison staff following good practice. I am mindful that, following my investigation of a previous death at Send, I recommended that notices to staff telling them about a prisoner's death should be displayed as soon as was practicable. It is important that staff arriving for duty know about a death in custody immediately, in order to help other prisoners, some of whom may still be very distressed. My investigator has explained this requirement to the family and the woman's mother accepted the reasoning behind it.

228. If the procedures set out in PSO 2710 had been correctly followed, it is possible that the family would not have arrived at the prison in such a distraught state and their visit could have been more sensitively prepared for. I make the following recommendation:

The Governor should remind the management team at Send of the salient points contained in PSO 2710. The Governor should ensure that managers act in accordance with its directives. Particular attention should be paid to involving trained family liaison officers and the chaplaincy when a family needs to be told of a prisoner's death.

229. I am pleased that the prison has already produced an action plan in response to the initial findings of the investigation. They provided the following response:

> 'The correct procedure is to always conduct a face-to-face visit where a trained family liaison officer and a chaplain or governor visits the family to inform them of the death, even if this means that there is a delay in delivering the news. The death in custody contingency plans will be updated to reflect this and an up-to-date list of family liaison officers will be provided.'

Staffing matters

Support for staff

230. Officer L told the investigator that he did not feel that he received the support he needed after the woman died. Having witnessed Senior Officer I's resuscitation efforts and assisted her, he was very upset. He said that he took the next day off work but was not telephoned by a manager. He remembered that he was spoken to by a colleague on Monday 23 August in the car park outside the prison on his way into work. He was due to take the next day off and returned to work on Wednesday 25 August. He then received notice from the Coroner that he was due to give evidence at an inquest about the earlier death of another prisoner.

231. A senior officer apparently noticed that Officer L was struggling to cope and advised him to take the next day off work. He mistakenly returned to work on Friday 27 August to discover that he was not meant to be working. He went back home, but not before becoming involved in another less serious incident in Send. He did not receive any contact from the prison over the weekend. He telephoned colleagues on Tuesday 31 August to be told that he was needed the next day for an interview with the police. The officer was upset that nobody had given him prior notice of the interview. He visited his doctor, who told him to take a week off work.

232. The efforts of staff to resuscitate the woman were especially distressing. Officer L said that he found her death difficult to deal with partly because he had known her and talked to her. He said that he got in touch with the prison's care team himself and was satisfied with the support he received from them. I draw the Governor's attention to the officer's experiences.

233. Although the officer felt that support was lacking after the woman died, other members of staff have highlighted the way in which they helped each other. The orderly officer was keen to stress that he received excellent support from his colleagues.

Debriefing healthcare staff

234. The prison doctor expressed dissatisfaction to the investigator regarding the lack of opportunity for healthcare staff to learn from the circumstances of the woman's death. She said that she had not been invited to a full debrief meeting to discuss the lessons that could be taken from what happened. She thought that healthcare staff had missed out on any debrief that had taken place. She expressed her view that, in future, any healthcare staff who had worked with the prisoner should be invited (rather than just those who had attended the emergency). More generally, the doctor suggested the need for some sort of discussion forum following deaths in custody to allow staff the

opportunity to talk and reflect and plan for the future. I draw her comments to the attention of the Governor and the Head of Healthcare.

Training needs

235. Officer C mentioned that he had completed the Women Awareness Staff Programme (WASP) when he arrived at Send. This is a relatively new two day training course that has been piloted at Send about the specific needs of women prisoners. I gather that this programme is being introduced across the female prison estate. I would suggest that the Governor ensures that not only newly arrived staff complete the WASP training, but also existing staff at all grades, including governors. Governors are obliged to take important decisions about the care of vulnerable women who might be thinking about taking their own lives, and they should have received all possible training available.

Personal officer scheme

236. Each prisoner is allocated a personal officer to whom they can report problems or from whom they can seek advice. A consequence of the staff's willingness to move the woman to different cells and wings (in order to facilitate a fresh start, keep her safe and to try to resolve the bullying issues) was that the personal officer scheme failed to work as it is supposed to.

237. In two and a half months, the woman was allocated five different personal officers. This number meant that she never really got a chance to obtain long term or meaningful support from a personal officer. The scheme is cell based, which means that her personal officer changed not only when she moved wings, but also when she moved between cells.

238. An officer was allocated as the woman's personal officer when she moved to A wing in early August. However, because she was working nights, the officer had not had the opportunity to speak to her before she died. Officer G spoke to her on her behalf. (Staff do not have any regular meaningful interaction with prisoners overnight. They cannot go into cells and spend the night performing tasks such as responding to cell bells and checking prisoners subject to ACCT monitoring.)

239. I understand why the prison moved the woman and I recognize that a regrettable consequence was the loss of one particular officer with a long standing interest in her welfare. The prison produced an action plan in response to the initial findings of the investigation. They provided the following response:

> 'Consideration should be given to assigning victims of bullying a primary personal officer who remains involved with the prisoner despite change of location or other circumstance. This would ensure that they have a single point of contact until their issues have been resolved.'

Referral to the Enhanced Thinking Skills (ETS) programme

240. In June, staff suggested that the woman apply to join the ETS group work programme. (The ETS programme helps offenders to examine their behaviour and make changes to prevent them from taking poor decisions in the future.) She applied but the process did not go any further because staff running the course required a completed OASys assessment before determining her suitability for the programme. (OASys is a risk assessment tool completed electronically which uses information about a person's background to determine the likelihood of them committing further offences and the risk of harm they might present to the public.)

241. Officer L was the woman's offender supervisor. Programmes staff asked the officer to complete her OASys assessment. However, because she was serving a 12 month sentence, the officer told the investigator that he checked with his managers and was advised that he did not have to complete an OASys assessment. Because of the volume of OASys assessments pending, only prisoners serving sentences of more than 12 months were being assessed.

242. The woman did not have a history of long-term repeat offending. She had not committed any violent or harmful offences. I consider that it was a reasonable decision to omit an OASys assessment in this instance. Whilst this meant that her application to join the ETS programme could not proceed, both the officer and my investigator agreed that in any event she was unlikely to have met the criteria for the course.

243. Offenders attending cognitive behavioural programmes designed to address offending behaviour such as ETS would normally have to demonstrate a pattern of offending. In the woman's case, although she had served two prison sentences, she had only ever been arrested once by the police (for the original offences of fraud). Her likelihood of re-offending would have been assessed as low because of the lack of previous convictions.

244. Additionally, the course, including preparatory work and subsequent reviews, takes a couple of months to complete. It is unlikely, given that the woman was only serving half her sentence in Send, that there would realistically have been enough time for her to be placed on a waiting list, allocated to a group and complete the course prior to her release.

245. Officer L confirmed during interview that he advised the woman that she would not be put forward for the ETS programme for the reasons I have outlined. He recalled that she was satisfied with his explanation. There is no record of her complaining about the issue again in July or August.

Allegations made by a prisoner

246. One of the other prisoners gave a statement to my investigator several months after the investigation began. Most of the relevant staff had already been interviewed. This other prisoner was in the neighbouring cell to the woman when she died. She was also subject to ACCT monitoring. In her statement, she contradicted facts that my investigator had established both in documentary evidence and during interviews. My investigator therefore returned to Send to re-interview three members of staff about what the other prisoner had told him.

The prisoner's first allegation

247. The prisoner claimed that it was Officer L who had escorted the woman back to her cell after she returned to Send. (All the other evidence indicates that Senior Officer F walked her back from the meeting with the duty governor.) She claimed that the woman was still tearful and upset when the officer brought her back to the wing. (The SO, duty governor and orderly officer all recalled that she had calmed down by this stage.)

248. Officer L told my investigator that he saw the woman in the morning before she was taken to hospital. He said that he did not see her again until the emergency at 8.35pm. He confirmed that he did not walk her back to her cell and did not meet her when she initially returned from hospital. He recalled that he was working on a different wing at the time.

Her second allegation

249. The prisoner also said that, after about 6.30pm, she was not checked as part of the ACCT process until the woman was found hanging in her cell at 8.35pm. She claimed that the woman was not checked either during this two hour period. She said that she would have overheard her talking to staff during an ACCT check because she was next door. She did not remember hearing the woman ask for a Listener at 7.45pm.

250. The documentary evidence (in this case the ACCT documents for both women) shows that Officer K checked the woman at 6.00pm, 7.00pm, 7.45pm and then at 8.35pm. The prisoner's ACCT document shows that she was checked at 6.00pm and 7.45pm. The ACCT documents both contradict her version of events. My investigator re-interviewed Officer K, who confirmed that he made the checks as he had recorded them.

251. The officer pointed out that the checks made and recorded at 7.45pm took place during roll check. Thus the check took no extra effort on the part of the staff. Additionally, the information he recorded about the woman asking for a Listener (but then not being given access to one

before she died) seems an odd entry to make if an officer were fabricating observations. After all, the information does not reflect particularly well on staff.

Her third allegation

252. Finally, the prisoner claimed that, when the paramedics arrived on the wing, they asked an officer how long the woman had been on her own before being found hanging. The prisoner seemed to think that the paramedics were concerned that the woman had not been checked by staff for a longer period than the officers were claiming. When my investigator re-interviewed the officer she could not remember having a conversation with the paramedics before she got in the ambulance to accompany them to hospital.

253. I am satisfied that that the three members of staff have given good accounts of themselves and that the prisoner was mistaken in her version of events. There is no other evidence, either in the paperwork or given during interviews, which supports her claims.

CONCLUSION

254. My investigation has highlighted several examples of good practice. The way in which staff implemented and maintained ACCT monitoring on the first two occasions was largely excellent. The same case manager (Senior Officer B) was present at most reviews and the reviews were held regularly. The decisions by staff to take the woman to hospital on 12 July and 21 August demonstrated caution and compassion. The manner in which Senior Officer F managed to coax her from her unresponsive state at the hospital. Senior Officer I's (almost single-handed) attempt to resuscitate her showed perseverance and courage.

255. Unfortunately, all of this good work is overshadowed by what I can only describe as a catalogue of problems on 21 August:

- The assumption by hospital staff that the woman would receive a mental health assessment back at the prison.
- The absence of any written documentation to accompany her back to Send.
- The failure by prison managers to consult staff properly about events at hospital and to consider the doctor's verbal advice.
- The failure by the duty governor to look inside the ACCT document.
- The failure to involve nursing staff in the decisions about constant supervision and ACCT monitoring.
- The duty governor's rash decision that ACCT monitoring was not required.
- The failure to offer a Listener when she requested one.
- The reliance on one senior officer with no defibrillator to offer CPR during the emergency.
- The way in which the family were informed of her death.

256. In spite of my serious reservations about the decisions that were taken on the day the woman died, I bear in mind the limited resources which the duty governor was working with. The actions of staff must be placed in context. Throughout the day, events threatened to overwhelm the running of the prison. I am keen to draw attention to Senior Officer G, who had the foresight to begin ACCT monitoring and who insisted that this continued when her managers told her it was not required.

257. I echo the clinical reviewer's concerns about the lack of a psychiatric assessment whilst the woman was at Send. The failure to review her antidepressant medication is also notable. Whilst I am satisfied that her allegations of bullying were addressed, I think that more could probably have been done to monitor the situation after the anti-bullying investigation was completed. I consider that HMIP's comments about the way bullying is dealt with at Send are very relevant to her care.

258. The investigation also highlighted concerns about the woman's confiscation order. The order caused her anxiety and I hope that the report has given her family a better understanding of the way this type of order is administered.

THE FAMILY'S RESPONSE TO THE DRAFT REPORT

259. The woman's family were provided with a copy of my draft report. They responded to our findings through their solicitor. They wrote:

> '…we welcome all your recommendations and endorse in particular your plea that the PCT reviews the need for 24 hour nursing cover at HMP Send and for night prison staff to be first aid trained.'

260. However, the family thought that the prisoner's allegations could have been further investigated by speaking to the paramedic who attended on 21 August. They also thought that the investigator should have spoken to the chaplain and two other nurses. Whilst no further interviews have been carried out for this final report, it is important to reflect the family's opinion of the investigation.

261. In their letter, the family expressed their belief that staff at Eastwood Park should have begun ACCT monitoring. They also expressed concern that the woman's ACCT document did not accompany her to her mental health assessment at Send on 23 June. Although they suggest that the mental health nurse might have passed on useful information to the wing staff, we should stress that any such information would have been treated as 'medical in confidence'.

262. The family wrote about her potential move to J wing. Having read the draft report, they were worried that she might have been tempted to downplay her anxiety to bring an end to ACCT monitoring in the mistaken belief that this would secure her a place on the wing.

263. The family wrote about the woman's sentence:

> 'We share [the Ombudsman's] concerns regarding her sentence and note a copy of the report is to be sent to the court. We would like it known that following her conviction she entered into a voluntary arrangement with her previous employer to repay the money stolen over time.
>
> 'In your report you rightly emphasise the anxiety this sentence continued to cause her throughout her time in custody.'

264. The family thought that staff could have used Prison Service Order 4620 in order to properly inform her about the confiscation order and its consequences. They wrote:

> '[She] seemed unaware, for example, that she could not serve another sentence in respect of the sum due; only for accrued interest and if that was significant. That one piece of information may have made a huge difference to her.'

265. Regarding the woman's clinical care, her family commented:

> '[We] would like to see both prison and medical staff receive some kind of instruction about dissociative stupor so that they can identify and understand the condition if they come across it in the future.'

266. In their response to the draft report, the family expressed concern about her medication and asked whether she might have been able to hoard her antidepressants. They described the decision on 8 July to allow her to keep her medication 'in possession' as 'surprising'. They thought that the nursing staff should have had daily contact with her whilst her prescription for fluoxetine was reduced and escitalopram was introduced, to ensure that this process was managed appropriately.

267. The family expressed concern about how regularly she took her medication, and asked whether she might have been able to take both types of antidepressant at once. They questioned whether, if she stopped taking the drugs regularly, they would still have the desired effect. Her family expressed concern that she was able to stop taking her medication for several days at the beginning of August when she stayed in her room over the weekend. They were also worried that she was not given her antidepressant medication when she returned to Send in the late afternoon on 21 August.

268. With regard to the issue of bullying, the family wrote:

> 'Your report focuses on the staffing issues at the time rather than the substance of what was done to protect her.
>
> 'Sadly it is clear to us that the [bullying] investigation was ineffective with potentially devastating consequences.'

269. The family thought that the senior officer who carried out the bullying investigation did not have enough information available to him and did not have sufficient understanding of the ongoing nature of the bullying. The family felt that:

> '…a staged [anti-bullying] process should have been initiated, particularly so if other witnesses supported the threat.
>
> 'There is little evidence of the prison as a whole showing any willingness to deal with the bullying. She got moved numerous times (with the consequence for her of five new personal officers) yet there were no consequences for the bullies. It is no wonder that she felt scared, vulnerable and unprotected.'

270. With regard to the events of 21 August, the family wrote:

> ‘Your report does not adequately address the issue of the sedative that she was given in the hospital at about 2.25pm… This is important because the sedative was a strong one and had an almost immediate effect on her behaviour and continued to do so for some time… There is no reference in the records to anyone having known or thought about this and the potential impact upon her presentation at [the] time [she met the duty governor].’

271. The family commented on the emergency response when the woman was found in her cell. They found it ‘astonishing’ that SO I was the only officer qualified to administer cardiopulmonary resuscitation. They also expressed concern about the lack of trained staff in Send between the time that the nursing staff end their shift and the beginning of the night shift.

272. In their letter, the family asked whether the number of first aid trained staff in Send contravened Health and Safety Executive legislation. This is not a matter that I am able to address directly. However, I have shared the family’s comments with the Offender Safety, Rights and Responsibilities (OSRR) group at the National Offender Management Service. The OSRR group has agreed to respond directly to them about this specific concern.

273. The family expressed regret that she was not able to speak to a Listener very shortly before she died, despite making a request.

RECOMMENDATIONS

Recommendations for the Governor:

1. The Governor should remind ACCT case managers of the importance of referring prisoners to the mental health in-reach team when there are relevant concerns.

   The Governor accepted the recommendation and provided the following response:

   ‘All case managers, duty managers and healthcare staff to be reminded of the importance of referring those prisoners with relevant concerns to the mental health in reach team.’

2. The Governor should ensure that a rota detailing the availability of each chaplain and their whereabouts (whether at Send or Downview) is always available to the duty governor.

   The Governor accepted the recommendation and provided the following response:

   ‘All movements and telephone contact numbers will be left in the gate and with the duty Orderly Officer.’

3. The Governor should ensure that staff managing ACCT reviews take into account the prisoner’s current mood but also balance this against any evidence of recent and long standing behaviour.

   The Governor accepted the recommendation and provided the following response:

   ‘Case managers and duty managers who attend case reviews will be reminded that previous history of behaviour and self-harm must be considered as well as current moods when considering levels of support which must also be recorded in the ACCT document.’

4. The Governor should remind staff of the need to gradually reduce interaction with suicidal prisoners who have been closely monitored and the impact that sudden withdrawal of supervision can potentially have.

   The Governor accepted the recommendation and provided the following response:

   ‘All staff attending case reviews must carefully consider the impact of reducing observations and support to those prisoners who have been receiving high levels of support and observation. A gradual reduction in support / supervision will always be applied.’

5. The Governor should remind all managers to involve healthcare staff in ACCT decisions especially when constant supervision is being considered.

   The Governor accepted the recommendation and provided the following response:

   'Duty managers to be advised, wherever possible healthcare / mental health must be involved in decision where constant supervision is considered.'

6. The Governor should ensure that all night orderly officers and assist night orderly officers have current first aid training. They should also receive training to allow them to operate a defibrillator.

   The Governor accepted the recommendation and provided the following response:

   'Three staff are now trained in the delivery to staff for the first aid. Two courses have now been completed with 12 more staff from all area's trained with two more courses planned before the end of August. This training has been put onto the regular training programme.'

7. The Governor should consider whether a unique emergency telephone number should be set up as a point of contact following a death in custody.

   The Governor accepted the recommendation and provided the following response:

   'This is in the contingency plans for all Duty Mangers to immediately appoint a Family Liaison Officer (FLO) who has a direct line of contact.'

8. The Governor should remind the management team at Send of the salient points contained in PSO 2710. The Governor should ensure that managers act in accordance with its directives. Particular attention should be paid to involving trained family liaison officers and the chaplaincy when a family needs to be told of a prisoner's death.

   The Governor accepted the recommendation and provided the following response:

   'A review of the death in custody contingency plans to be carried out to ensure salient points from PSO 2710 are covered.

   'Duty managers to be reminded that contingency plans must be adhered to when dealing with incidents.'

Recommendations for the Head of Healthcare:

9. The Head of Healthcare should ensure that staff obtain previous clinical records relating to newly arrived prisoners, whether these be from other prisons or community treatment providers.

   The Head of Healthcare accepted the recommendation and provided the following response:

   'All Female establishments are now using Systm-One a universal medical record system that will ensure that clinical records for all new receptions are available to nursing staff at reception.

   'All new reception prisoners are now being asked to provide contact details for their GPs and any relevant external agencies.

   'Healthcare administration staff are now asking for information from the agencies.

   'A new system to enable the Department to search for Patient information from external NHS agencies using NHS Numbers is being developed.'

10. The Head of Healthcare should review the use of 'In-possession medication risk assessments' to ensure that staff take full account of women's mental health histories and any periods of ACCT monitoring.

    The Head of Healthcare accepted the recommendation and provided the following response:

    'In Possession medical risk assessment form is now electronic and running on the Systm-One medical system.

    'All clinical staff have now been trained in the use of the "in possession risk assessment tool.'

11. The Head of Healthcare should ensure that, when a prisoner returns to Send from hospital, a nurse reviews her in the reception area.

    'The Head of Healthcare accepted the recommendation and provided the following response:

    'The RSCH Management agreed to this arrangement.

    'The Head of Healthcare to monitor and report concerns to both Prison/ Hospital Management.

    'Escorting/ Reception Staff are now ensuring that returning patients from the hospital are seen by healthcare staff before returning to the wing.'

Recommendations for the Governor and the Head of Healthcare:

12. The Governor and the Head of Healthcare should review the channels of communication between discipline and healthcare staff to ensure that valuable information about prisoners is made available to all relevant parties.

    The Governor and the Head of Healthcare accepted the recommendation and provided the following response:

    'Lead Nurse linking Healthcare & Safer Custody is now in post

    'The multi-disciplinary team meeting is now established. First meeting is booked for the 11 July 2011.

    'A list of all Prisoners on ACCT Documents is now available for healthcare staff to pick at the Gate at the beginning of the day.

    'Email alerts are now being sent to wing nurses when new ACCT documents are opened.

    'All nursing staff are clear on the importance of retrieving "in possession" medication from prisoners on ACCT documents. Duty Lead Nurses are responsible for ensuring that this is followed.'

13. The Governor and the Head of Healthcare should locate defibrillators on each wing.

    'The Governor and the Head of Healthcare accepted the recommendation and provided the following response:

    'The Department now has three Defibrillators which are to be located:

    Main Healthcare (Covering Visiting room)

    'Main Block SO Office (Covering A, B, C & D Wings).

    'J Wing Discipline Officers Office (Covering J, E & F Wings)

    'Defibrillator Training arranged via the PCT. Training was scheduled for

    July 2011, rescheduled to the 4 August 2011 due to trainer availability.'

14. The Governor and the Head of Healthcare should both personally commend SO I for her efforts to resuscitate the woman.

    The Governor and the Head of Healthcare accepted the recommendation and provided the following response:

    'The SO was personally commended by both regarding her efforts to resuscitate the woman and the way she behaved throughout the whole incident.'

Recommendation for the Governor, the Head of Healthcare and the local Primary Care Trust (PCT):

15. The Governor, the Head of Healthcare and the local PCT should work together to improve procedures for discharging prisoners from hospital:

- Written advice about immediate risk management should be prepared by the discharging doctor without breaching patient confidentiality.
- The form should be handed to escorting officers before they leave and passed to the duty governor upon their return to the prison.
- Hospital staff should communicate with healthcare staff at Send by telephone if they have serious concerns about a prisoner they are discharging and the ongoing risk she presents to herself.

The Governor, the Head of Healthcare and the local Primary Care Trust accepted the recommendation and provided the following response:

'The Patient information tracker form detailing advice about immediate risk management prepared by the discharging doctor (without breaching patient confidentiality) has now been agreed and in circulation.

'The form should be handed to escorting officers before they leave and passed to the duty governor upon their return to the prison.

'The next audit is scheduled in the next quarter, September. A report will be provided to the Clinical Governance.

'Hospital management has agreed to make necessary arrangements to ensure that A&E staff communicate with the Duty Governor/ Senior Officer prior to discharging Patients during the "Healthcare out of Hours".

'1 July 2011 update: An analysis of discharges during the out of hours demonstrates that the arrangement is being followed.

'The Head of Healthcare is scheduled to a full audit of the system by 1 September 2011.'

Recommendations for the local Primary Care Trust (PCT):

16. The local PCT should ensure that accident and emergency staff understand the scope and availability of mental health in-reach provision in Send so that a prisoner's care can be managed accordingly. Accident and emergency staff should be able to offer a psychiatric assessment as necessary whenever mental health in-reach staff at Send are off-duty.

The local Primary Care Trust accepted the recommendation and provided the following response:

‘Information regarding the range of Healthcare Services available within HMP Send (Including Mental Health Services) has been discussed with the hospital management.

‘Information detailing the range and operating hours of the HMP Send Mental Health In-Reach Services is now contained in the Patient Information tracker form.’

17. The local PCT should ensure that hospital staff avoid discharging patients with ongoing needs when there are no nurses on duty at Send to receive them.

    The local Primary Care Trust accepted the recommendation and provided the following response:

    ‘A meeting has taken place between the Head of Healthcare and the hospital Clinical Governance Lead, Risk Manger and the Complaints Manager. The potential risks were discussed and remedial action were agreed and implemented.

    ‘The Hospital is currently reviewing the Memorandum of Understanding between the Hospital and the Prison.

    ‘A meeting between the Hospital Management and the Head of Healthcare is scheduled for the end of July 2011.

    ‘The Hospital agreed to ensure that during the “Healthcare out of Hours” the Hospital Staff would ring the Prison Duty Officer to confirm discharges from Hospital and in cases where further medical observation is needed, the Hospital would keep the Patient and only discharge when the Prison Healthcare Department is open.’

18. The local PCT should review the need for 24 hour nursing cover in Send.

    The local Primary Care Trust accepted the recommendation and provided the following response:

    ‘The recommendation has been discussed at both Clinical Governance and Partnership Board Levels and currently awaiting feedback from the local PCT commissioning.’

Recommendation for Surrey and Borders Partnership NHS Foundation Trust:

19. Surrey and Borders Partnership NHS Foundation Trust should review the provision of ‘out of hours’ mental health support at Send.

Surrey and Borders Partnership NHS Foundation Trust accepted the recommendation and provided the following response:

‘Service specification for HMP Send is currently under review.’