Investigation into the circumstances surrounding the death of a woman at HMP Send in September 2007

Report by the Prisons and Probation Ombudsman for England and Wales

March 2009

This is the report of an investigation into the death of a life sentence prisoner at HMP Send on 11 September 2007. The woman was found hanging in the bathroom of her cell shortly after 5.00pm. She died at the Royal Surrey County Hospital at 11.15pm that night. At the time of her death, the woman was only 25 years old and was the mother of a young daughter.

The loss of a loved one is always distressing, all the more so in the circumstances described here. I would like to add my condolences to the woman's family and friends to those already expressed by my investigator and by one of my family liaison officers.

The investigation has been undertaken by one of my colleague.
I would like to thank the then Governor of Send and his staff for their participation and assistance. Particular thanks go to the Principal Officer who made all the practical arrangements.

A clinical review panel was chaired by the Quality and Clinical Governance Manager at Surrey Primary Care Trust. A Consultant Forensic Psychiatrist provided an independent clinical opinion on the woman's mental health. I must also thank them both for their reports.

Unusually, my final report identified many of the women who were prisoners with the woman and who were an important part of her life. I judged that this was better than making the story unreadable by anonymising them all at the time, especially since the Coroner will need to know who they were. Many of them were interviewed by my investigator, and I am grateful for the part they played in assisting the investigation.

My report is also unusual in that it discusses the intimate relationships that existed between these women prisoners. I have done so because this seems to have been a major element in the woman's distress. I also note that some prisoners at Send believe that the usual prison response on discovering such relationships is to separate the women from each other. Whether this perception is accurate or not it could be upsetting to those involved, and the inevitable effect might be to discourage prisoners from being open. As a result, when a relationship comes to an end, the impact may not be apparent to staff.

Following the issue of my draft report several comments were received by the family and friends of the woman and by the Prison Service. As a result some amendments were made to the report, one recommendation was removed and one new recommendation has been added. Several documents not originally released have been added as an annex to my report.

I make a total of 16 recommendations in this case. I also note one example of good practice at Send and one at HMP Bullwood Hall.

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

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SUMMARY

The woman died at Royal Surrey County Hospital at 11.15pm on Tuesday 11 September 2007. She had been found hanging in her cell at HMP Send earlier that day. The woman was a life sentence prisoner and just 25 years old.

At the age of 12, the woman had been referred to psychiatric services for the first time. Shortly afterwards she began taking drugs. A long history of substance misuse and acts of self-harm followed. The woman was bullied at school, and by a schoolmate when she joined the Royal Air Force Cadets which forced her to leave. When the woman was 21, her mother found her on two separate occasions with ligatures around her neck.

The woman had left school at the age of 15 and left home when she was 17. She lived with her boyfriend for a time and they had a daughter who was born in February 1999. The woman's boyfriend died in August 2003 from a drug overdose.

The woman was arrested in August 2001 and charged with murder. She was released on bail twice before being convicted and sentenced to life imprisonment in April 2003.

In March 2004, the woman was transferred to HMP Bullwood Hall where she appeared to make progress. She completed several courses and participated in one to one work with drug counsellors.

On 30 May 2006, the woman was transferred to Send to participate in the Therapeutic Community (TC). The transfer coincided with a change in function for Bullwood Hall from a female to a male establishment. As a result of this new role for Bullwood Hall, Send received an increase in prisoners serving life sentences.

When the woman arrived at Send she was subject to self-harm monitoring and support (ACCT) procedures. She had been subject to these procedures on no fewer than 13 occasions before she arrived at Send. In the ACCT document open when she transferred to Send, the woman described eight problems relating to her distress at that time.

The woman remained in the TC for less than six months and did not settle there. She ended therapy on 7 December 2006 and left the TC on 11 December. The summary report for prisoners who do not complete therapy said the woman found it difficult to engage, was often quiet, and lacked confidence to comment or respond to others. The report does not include an assessment of the woman's emotional state.

During her first few months at Send, the woman developed a relationship with another prisoner. The other prisoner was already in a relationship with a second prisoner at the time. Several prisoners interviewed by my investigator confirmed that the second prisoner and the woman did not get on and normally avoided each other.

In March 2007, a High Court Judge confirmed the woman's tariff as nine years less the 19 months and 18 days she had spent on remand. In July 2007, an amended notice was sent reducing the time spent on remand to 231 days. (An error had been

made when the time on remand was calculated as the woman had spent some time on bail.) This error meant that the woman would be in prison for almost a year longer than she had originally been told.

A third prisoner told my investigator that she was in a relationship with the woman between April and June 2007. She said the woman was worried that the prisoner she was currently having a relationship with would find out and that, if she did, the prisoner would end their own relationship. The woman told the third prisoner that if that happened she would kill herself.

An ACCT document was opened on 31 May 2007 and it was recorded that the woman said she had seriously thought about hanging herself. She felt down and, while she had no immediate plans to commit suicide, she accepted this remained a risk. The care map (part of the ACCT documentation) made no reference to management of the risk and the document was closed two weeks later on 13 June.

On 7 September 2007, the woman was told that the prisoner she was having a relationship with had slept with another prisoner, the fourth prisoner, who was an acquaintance of the woman. Later that day the woman had an argument with the second prisoner and difficult telephone conversations followed between the woman and her partner (who was now released). The second prisoner rang the woman's partner and left an answer phone message. The message contained threats directed at the woman.

On Tuesday 11 September, the fourth prisoner was due to transfer to HMP Downview. The transfer was cancelled at short notice and the fourth prisoner returned to the wing. She had a brief conversation with the woman. Some time in the early afternoon a further conversation took place between the woman and the fourth prisoner, following which the woman went to see another of her friends, a fifth prisoner. The woman was very upset and crying. She left the fifth prisoner's cell, saying that she needed to call her partner.

At 4.00pm, a prison officer discovered the woman in her cell. She had made superficial cuts to her wrist. The woman would not go into detail as to why she had self-harmed. She was escorted to the healthcare centre and a nurse ensured that the wound was appropriately dressed. She spoke to the woman at some length and offered support. The nurse returned the woman to her wing at about 4.30pm.

About half an hour later, the nurse returned to the woman's cell to see how she was. She did not receive a response. The cell door was opened and the woman was found hanging in her cell bathroom. CPR was attempted and an ambulance was called. The woman was taken to the Royal Surrey County Hospital. Later that evening the Governor collected the woman's family from their home. They were present when the woman died.

I recently published a report on the death of a woman at Eastwood Park who spent a period at Send in the TC. She had also finished therapy early and died less than three months afterwards. I am concerned that there are similarities with the case of the woman.

The woman's death was the third apparently self-inflicted death to have occurred at Send that I have investigated. The recommendations I have made in earlier reports are different from those I have made here. However, the bathroom door was used as a ligature point on each occasion.

THE INVESTIGATION PROCESS

1. My investigator made initial contact with the Acting Governor of HMP Send on 13 September 2007 and formally opened the investigation on 17 September. All available documents likely to be required for the investigation were collected or requested at this time.

2. Prior to my colleague arriving at Send, notices were issued to staff and prisoners. These announced the investigation and invited anyone who had information about the woman's death to make themself known. In the event, two prisoners and three staff members came forward.

3. My investigator carried out 23 interviews with staff and eight with prisoners. Interviews were either recorded or notes were taken. Copies of relevant recorded telephone conversations were obtained.

4. The clinical reviewer chaired an independent clinical review of the healthcare the woman received whilst in custody. The panel were asked to consider all clinical issues. In addition, a consultant forensic psychologist was asked to carry out a review of the woman's mental health. Following the issue of the draft report the family informed my investigator that the Psychiatric report contains inaccurate information. This relates to the date of birth of the woman's daughter and to which of the woman's family were diagnosed with breast cancer. I acknowledge that this may be inaccurate. The family also expressed concern that the review by Surrey PCT could not be considered independent.

5. My investigator obtained copies of recent reports on the prison by the Independent Monitoring Board (IMB) and Her Majesty's Chief Inspector of Prisons (HMCIP).

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

7. One of my family liaison officers contacted the woman's next-of-kin to offer the opportunity to participate in the investigation. My investigator and family liaison officer visited the woman's mother and her husband. At a later date they met the woman's partner. A number of concerns were raised by the woman's family and her partner. Many of these were not directly linked to my Terms of Reference. I have, however, addressed the concerns not previously covered in a separate section within this report. I hope my investigation has helped the family to understand better the events leading to the woman's death.

HMP SEND

8. HMP Send is a closed female training prison located near Woking in Surrey. The prison provides accommodation for female prisoners over the age of 18. The Certified Normal Accommodation (CNA) at the time of the woman's death was 218 with the same operational capacity. The prison has a 20 bed Addictive Treatment Unit (ATU), an 80 bed Resettlement Unit, and a Therapeutic Community (TC) with a capacity of 40, although only 24 places were available at the time of the woman's death. Send TC is the only one in the Prison Service that takes women.

9. Send changed from a men's to a women's prison in June 1998. The prison began taking a small number of life sentence prisoners in 2004 to participate on the TC. Numbers increased in 2006 when Send began taking life sentence prisoners from Bullwood Hall.

10. Send offers a variety of educational and vocational training courses. Prisoners on the resettlement unit have the opportunity to work outside the prison undertaking community work or education.

11. The latest report from the prison's Independent Monitoring Board (IMB) is for the year April 2006-March 2007. It noted that bullying complaints were not fully investigated. Of the 12 complaints submitted under the heading of diversity, nine related to bullying. The IMB felt more time should be allocated to anti-bullying issues.

12. A Prison Service Standards Audit in February 2007 noted that no in-patient facility was available at the prison so self-harm was managed on the wings.

13. A report of an inspection by HM Chief Inspector of Prisons in February 2006 found that Send was a relatively safe environment. Women at risk of self-harm were generally well supported and given good care.

14. The woman's was the third apparently self-inflicted death in custody at Send since I became responsible for investigating all such deaths in April 2004. The recommendations from those earlier cases are not relevant to the circumstances of the woman's death, although the bathroom door was used as a ligature point on each occasion

15. Healthcare provision at Send comprises a primary care service and visiting specialists. As mentioned above, there are no in-patient beds. On arrival at Send, prisoners are assessed by nursing staff to ensure they are suitable to be located in normal accommodation.

16. The prison has one gated cell located between C wing and the reception area. This is used when a constant watch on a prisoner is required. There is currently no safer cell furniture in any of the prison cells. Two cells on B wing are linked by an adjoining door. These cells are designated for use when a disabled prisoner requires assistance. At times when the cells are not used by disabled prisoners they may be occupied by any prisoner.

KEY FINDINGS

17. Following an incident at her home in August 2001, the woman was charged with murder. She was remanded into prison custody at HMP Eastwood Park. This was her first experience of prison. In September 2002, whilst at Eastwood Park, an F2052SH was opened. (The F2052SH was a form opened by staff if they were concerned that a prisoner was at risk of self-harm. The purpose of the form was to ensure as much help as possible was given to a prisoner during a difficult period when he/she may have self-harmed or been at risk of self-harm.)

18. The woman was released on bail twice before her trial in April 2003. On 15 April 2003, she was sentenced to life imprisonment. The Judge recommended she should serve a minimum period of nine years. An F2052SH form was opened on the woman at court and accompanied her into custody at HMP Holloway.

19. In August 2003, the woman's former boyfriend died following a drug overdose. The woman attended his funeral on 8 September. An F2052SH form was opened the next day. Comments entered on the form suggested she had taken his death badly.

20. On the day of the funeral, the woman met another prisoner in the reception area at Holloway. This prisoner became the woman's best friend and the two women wrote to each other when they moved from Holloway.

21. In March 2004, the woman was transferred to HMP Bullwood Hall. The transfer had been delayed so she could continue one to one psychotherapy work commenced at Holloway. The psychotherapist described the woman as a very intelligent and thoughtful young woman. She added that it seemed that the woman had never had a proper chance to show her qualities.

22. The woman made progress at Bullwood Hall, completing courses in Enhanced Thinking Skills (ETS), assertiveness training and domestic violence. She also undertook one to one work with drug counsellors. The woman developed a close friendship with another prisoner whilst at Bullwood Hall. The sixth prisoner subsequently transferred to HMP Send to take part in the Therapeutic Community (TC).

23. An F2052SH was opened on the woman on 14 May 2006. It was closed two days later and a different form opened. This form was of a new type called an Assessment, Care in Custody and Teamwork (ACCT) plan. (ACCT is a flexible, prisoner-centred, assessment and care planning system. It aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment. The ACCT form replaced the F2052SH.) Bullwood Hall changed to ACCT forms in May 2006. Send was one of the last prisons to change to ACCT and was still using the F2052SH until early 2007.

24. On 30 May 2006, the woman transferred from Bullwood Hall to Send. She was on an open ACCT document at the time. When the document was opened the woman was asked what she felt were the problems related to her current distress. She outlined eight different issues which caused her distress. These reflected long term abusive relationships, a bereavement, and her own post-natal depression.

25. Prison Service Order (PSO) 2400, Democratic Therapeutic Communities, describes the purpose of a TC. It says democratic TCs provide a long term, residential, offending behaviour intervention for prisoners who have a range of offending behaviour risk areas, including emotional and psychological needs. The PSO indicates that prisoners are expected to stay for at least 18 months in a TC to give sufficient time to learn from the experience and to embed new skills through practice. The TC aims to address offending behaviour and some of the emotional instability which underpins it. Whilst at Bullwood Hall, the woman applied to participate in therapy on the TC at Send.

26. The woman joined the TC after a brief induction period. She started on the new residents group on 8 June 2006, and began therapy on 13 July. She became reacquainted with her best friend and with the sixth prisoner, her friend from Bullwood Hall.

27. Numerous incidents involving the woman were reported during her time on the TC. In September 2006, a fellow prisoner on the TC accused the woman and her best friend of brewing hooch (illicit alcohol). They admitted that they had used the woman's best friend's fruit allowance for this purpose. In early October 2006, a prisoner claimed in a therapy session that the woman had put her medication in the hooch.

28. On 5 December 2006, the Security Department received information relating to the woman. Her inmate Intelligence Card (IIC) states information was received that if another prisoner on the TC, the seventh prisoner, was shown up by the woman in a session then the woman's family would "get it". (I should emphasise that an IIC contains a brief summary of information received, from staff or prisoners, about any security related matter. This information cannot always be confirmed as accurate. Prisoners are not normally made aware that information has been submitted about them.)

29. On 6 December, the woman alleged that the seventh prisoner had asked her to bring drugs into the prison. The prisoner admitted this but said she had asked the woman to test if she could be trusted. The Security Department received information on 10 December that the woman was upset and fearful of other TC prisoners. This was because she had disclosed in group that she was being pressured by the seventh prisoner to bring drugs into the prison. There are a total of 12 security issues relating to the woman during her six months on the TC. The woman ended therapy on 7 December 2006 and left the community a few days later.

30. In mid-February 2007, the woman's partner, was released from Send. They had begun their relationship whilst the woman's partner was in custody at

Send. The woman's partner said they kept it secret as she was seeing another prisoner, the second prisoner, at the same time. Shortly after her discharge the relationship with the second prisoner ended. The woman's partner's relationship with the woman then became common knowledge in the prison.

31. The woman received a letter from Her Majesty's Courts Service in March 2007. The letter informed her that her tariff would be set on 29 March. (The tariff is the punitive period that a life sentence prisoner must serve before they can be considered for release.) The woman was informed that the High Court Judge setting the tariff had agreed with the original trial Judge that she should serve a minimum of nine years. A total of 19 months and 18 days would be deducted for the time the woman had spent on remand before sentence. On 16 July 2007, an amended order was sent. This order reduced the time spent in custody on remand to 231 days, less than eight months.

32. The third prisoner moved into cell B1-19 on 12 April. Two days later the woman moved into cell B1-18. Cell B1-18 is normally used when a disabled prisoner requires support. At such times the adjoining door remains unlocked, allowing the prisoner next door have access. These are two of only eight cells in the prison that have an adjoining door. The third prisoner told my investigator in interview that she and the woman were in a secret relationship. She added that, following the death of another prisoner, they had managed to get the joining door left open by staff and it remained unlocked for almost six weeks. The third prisoner said they placed cell furniture against the adjoining door to avoid detection. The woman remained in this cell until 25 May 2007 when the cell was needed for a disabled prisoner. The woman was moved overnight to C wing. She moved to cell B2-01 on 26 May.

33. An ACCT document was opened on 31 May 2007. When asked about her current mental state, the woman had replied that overnight she had seriously thought about killing herself. The document was reviewed on 6 June and closed. A post closure review was scheduled for 13 June. It is recorded on the front of the ACCT that the document was re-opened on 13 June and then closed on 15 June. A post closure review was carried out on 22 June.

34. The woman was employed as a laundry orderly washing prisoners' clothing. She worked with the fifth prisoner who also became her friend. In mid-June, the woman complained that she was being bullied by a named prisoner to do extra laundry. On 2 July, the woman's best friend submitted a formal complaint saying that the woman was being bullied to do extra laundry.

35. At about 5.50pm on 7 September, the woman telephoned her partner. She called her again at about 6.10pm. On both occasions the woman used the prison pin-phone system which records calls for routine monitoring purposes. (Prisoners can purchase pin-phone credits through the weekly shopping system. The system is similar to that of a pay-as-you go mobile phone. Users are provided with a pin card which is inserted into a prison telephone. Telephones solely to be used as pin-phones are widely distributed throughout all prisons. Credit is used at a rate pre-set by British Telecom.)

36. The recordings from the above pin-phone conversations indicate that at some time during the day on 7 September the woman was told that her partner had slept with the fourth prisoner whilst the woman's partner was still in her relationship with the second prisoner. The second prisoner apparently became aware the same day. It is possible that the woman was told this information by the fourth prisoner herself. These matters were discussed at some length during the two conversations.

37. The second prisoner said in interview that at tea time on 7 September she and the woman had an argument. At about 7.25pm the same evening, the second prisoner attempted to call the woman's partner but there was no reply. An answer phone message was left. The message was for the woman's partner and the second prisoner was abusive and threatening towards the woman.

38. The woman telephoned her partner again during the morning of Saturday 8 September 2007. They discussed issues relating to the second prisoner. The woman's partner confirmed that she would visit the following Thursday to sort the fourth prisoner out. This was the last recorded contact between the woman and her partner.

39. The woman was visited by her mother, step-father and daughter later that day. This was one of the regular visits that family members made to the woman during her time in custody. The woman's mother said she seemed fine and quite happy, but that the woman was concerned about bullying by the second prisoner and the fourth prisoner.

40. On the evening of Sunday 9 September, a prisoner's cell was damaged by another prisoner. As a result, the main block of the prison was locked up. Although she was not directly involved in the incident, the fourth prisoner was moved from C wing to A wing the same evening.

41. During the morning of 10 September, the woman met with her Counselling, Assessment, Referral, Advice and Throughcare (CARAT) worker (drugs worker). This was a routine weekly session. The drug worker's written summary says that the woman was quite uneasy during the interview.

42. The lifer manager at Send, met the woman the same day after being unable to meet during the previous few days. She said the woman wanted to let her know what was happening with the dynamics of the groups that had formed. The lifer manager added that she believed the primary reason the woman wanted to see her was to distance herself from the fourth prisoner.

43. Later that day, the woman submitted a request to have an advance of pin-phone credit. The woman was told during the morning on Tuesday 11 September that the request had been denied.

44. The same morning, the fourth prisoner was moved to reception prior to a planned transfer to HMP Downview. This transfer was cancelled at short notice and the fourth prisoner was returned to her wing. The fourth prisoner spoke briefly to the woman as she returned from reception. The woman met her best

friend at lunch time and agreed to meet her again at tea. The fourth prisoner went to speak to the woman again shortly before 3.00pm.

45. The woman went to speak with the fifth prisoner in her cell at about 3.00pm. The woman was crying and very distressed. She left the cell shortly afterwards after telling the fifth prisoner she needed to get on the phone to her partner. A few minutes later, the prison officer found the woman sitting on the stairs with tears in her eyes. He arranged for the fifth prisoner to cover for the woman in the laundry and the woman returned to her cell.

46. The prison officer visited the woman's cell at about 4.00pm. The door was ajar and the woman was sitting on the floor with superficial scratches to her wrists. First aid was administered by a second officer. (He told my investigator he had been a qualified medic and worked for many years with St John's Ambulance Brigade. He was the senior first aider at a warehouse in Croydon before joining the Prison Service four years ago. His first aid qualification had since expired.) About 15 minutes later, the second officer accompanied the woman to the healthcare centre. The prison officer completed a F213SH form. (An F213SH is a self-harm/attempted suicide form completed when a prisoner deliberately harms herself. The cover page is in a check list format that describes the type of harm. This is normally completed by the member of staff who discovers the prisoner who has self-harmed.)

47. The nurse spoke to the woman and looked at the dressing. The nurse is an agency nurse who started working at Send in June 2007. During the conversation she removed a razor blade from the woman's clenched fist. She spoke at some length with the woman and offered to speak further when she did her medication rounds at about 5pm. (Medication rounds are carried out by healthcare staff and involve delivering prescribed medication to prisoners at various times of the day. A green and yellow card is pushed under the cell door by other prisoners who wish to speak to healthcare staff.)

48. The nurse returned the woman to her wing at about 4.30pm. A third officer said the nurse came to the office and told her that the woman was upset and felt that staff did not care about her relationship with the woman's partner. The third officer said she told the nurse that she would speak to the woman later that evening and let her know that staff were there for her. She would also offer support from a Listener and the Samaritans phone. The nurse told her the woman was back on the wing and needed to be locked up. The third officer told my investigator neither she nor the nurse were unduly concerned about the woman as she had self-harmed before when she was having difficulty with her relationships. The third officer then passed the information on to the first officer and left the wing for her tea time meal break.

49. The officer went to the woman's cell at about 4.45pm to lock her in her cell. He asked the woman if she was alright or if she wanted to speak to anyone. The woman replied that she was fine. The prison officer said he would see her later and the woman replied "okay". None of the staff who spoke to the woman felt she was suicidal at this time.

50. The first officer told my investigator that he returned to the wing office and completed the concern and keep safe section of an ACCT document at about 4.50pm. Once completed, the document should then be passed to the unit manager who completes the Immediate Action Plan.

51. At about 5.00pm, the nurse visited the woman's cell to check that she was alright. She was accompanied by the third officer. After looking through the cell observation panel and not receiving a response from the woman, they opened the cell. They discovered the woman hanging in the cell bathroom. She had used shoelaces as a ligature.

52. An ambulance was called at about 5.15pm and the paramedics arrived at 5.23pm. The nurse and the staff nurse attempted cardio pulmonary resuscitation (CPR). A second nurse also assisted with CPR. She went to collect the emergency response bag which contained oxygen and an electric defibrillator and used the equipment until the ambulance crew arrived. A member of the ambulance crew confirmed in his police statement that he saw the prison nurses giving CPR to The woman. Staff made every effort to resuscitate the woman and responded speedily and effectively.

53. The ambulance left the prison at about 5.45pm. The woman was taken to the Royal Surrey County Hospital in Guildford. The head of healthcare at Send, accompanied the woman and two officers in the ambulance. At 6.30pm, the head of healthcare contacted the Acting Governor and informed her that the woman was in a critical state. She believed the family should be informed. At about 8.25pm, the Acting Governor arrived at the hospital with the woman's family.

54. Although the woman was still alive, death in custody contingency plans were followed from about 9.00pm on the instructions of the Acting Governor. The duty governor arranged for the staff care and welfare team to be available if staff needed support.

55. The duty governor was informed at about 11.00pm that the woman had died. She was formally pronounced dead at 11.15pm by the doctor. (The doctor works in the Accident and Emergency unit at the hospital and was involved in the treatment of the woman.)

56. The following day (12 September), the fourth prisoner was transferred to Holloway and the second prisoner was transferred to HMP Bronzefield. On Monday 17 September, the woman's best friend was transferred to HMP Morton Hall.

57. Later on 12 September, an application form from the woman to move to the resettlement unit was handed to the duty governor by a residential officer. Applications are normally completed by prisoners and then submitted for processing the following day. It is possible that the woman submitted this application during the morning of the day she died.

58. The Acting Governor wrote a letter of condolence to the woman's family and published notices to staff and prisoners informing them of her death. In her letter to the woman's family, the Acting Governor informed them that the woman had used the sheet from her bed as a ligature. This was in fact not the case. The Acting Governor had been provided this information by the police on the night of the woman's death.

59. A post-mortem was carried out at Royal Surrey County Hospital on 14 September 2007 by a consultant forensic pathologist. The consultant concluded that the woman had died from hypoxic brain injury as a result of cardio respiratory arrest as a result of hanging.

FAMILY CONCERNS

60. Issues raised by the family or the woman's partner, not covered elsewhere in the report are outlined below followed by the relevant response.

61. **The family believe that the woman excelled at Bullwood Hall. They felt there were not the same numbers of staff at Send and therefore prisoners did not receive the same care and attention.**

    My investigator did not judge that staffing levels at Send are unsafe or that care and attention is lacking. Quite separately to this investigation, I have myself visited Send during the past couple of years and formed a favourable impression of staff-prisoner relationships. However, it is true that the number of staff experienced and trained to work with and manage life sentence prisoners may vary significantly between the prisons. The number of hours allocated to lifer work may also vary. (The issue of hours dedicated to lifer work is dealt with elsewhere in the report.)

62. **Why did the woman experience difficulty getting access to the lifer manager? Could they see the letter the woman wrote to the lifer manager?**

    The lifer manager said it was sometimes difficult to keep appointments due to her busy workload. She added that most appointments were made with the woman on a flexible basis as the woman worked close to her office and would often pop in. The lifer manager said she felt that the woman had more access to her than most prisoners. My investigator has been unable to obtain a copy of the letter written by the woman as it was not given to the lifer manager. The woman's best friend received the letter from the woman.

63. **Why did the woman have several shoelaces in her possession and how had she been able to collect these unnoticed? If the woman used a bed sheet why were sheets on her bed when the family visited the cell after her death?**

    The laces used by the woman to hang herself were unusually long and were taken from a pair of shoes sent in to her. It is normal practice to allow prisoners to have shoelaces in possession. There is no evidence that the woman had an excessive number of laces in her possession. Unfortunately, the Acting Governor was mistaken in writing that the woman had hanged herself using sheets from the bed. The principal officer told my investigator she made the bed shortly before the family visited to make the room look tidy.

64. **The family wanted to know why the prison did not inform them until 7.30pm when the woman self harmed at 5.00pm?**

    The head of healthcare, accompanied the woman to hospital. She contacted the Acting Governor during the evening and advised her that the woman might not survive. The Acting Governor decided to contact the family, collect them from their home and to go with them to the hospital. I believe this was an

example of good practice and that the Acting Governor is to be commended. There is in fact no current requirement for prisons to contact family members after an incident of self-harm or prior to the death of a relative in prison custody, although of course they should endeavour to do so unless the prisoner him or herself has asked that this not be done, or if there are other circumstances that make it unwise.

65. **The woman's partner asked why the woman was not encouraged to call either her or the woman's mother after she had self-harmed and before she hanged herself?**

There is no evidence that the woman asked to make a call to anyone before or after she self-harmed. The nurse said in interview that the woman told her she had no pin-phone credit and that she did not ask for a phone call. The nurse added that, if the woman had asked for a phone call, she would have refused because staff are not permitted to make telephone calls for prisoners. The Orderly Officer did not meet the woman to discuss her case before she hanged herself. It is impossible to say whether the matter would have been discussed if the meeting had taken place.

66. **The woman's partner felt staff should have picked up on the woman's previous self-harm history and put someone with her. Items that could be used for self-harm should have been removed. The ACCT should have been opened and actions put in place as a priority.**

The immediate action plan should take into account all relevant circumstances. In the woman's case the required meeting and completion of the document was not in place before her death. (I say more on this matter later in this report.)

ISSUES

Self-Harm monitoring documentation

67. The woman was the subject of self-harm monitoring 13 times before her arrival at Send. This number rose to over 20 before she died. Most of the documents were opened due to the woman self-harming by making superficial cuts to her wrists. The woman had extensive contact with psychiatric services both before and during her time in prison custody. She was first referred to psychiatric services at the age of 12 years old. The woman had numerous consultations with her GP about her misuse of drugs. At times she was also prescribed anti-depressants. The clinical review panel found that, in June 2000, the woman was referred to the local community mental health team but was assessed as not presenting with serious symptoms. It seems she was offered use of the duty system and referred to the family centre for a placement in a support group.

68. The consultant forensic psychiatrist notes in her independent psychiatric review that, after entering prison custody, the woman was seen by a number of different psychiatrists. She adds that the woman had difficulty building rapport with some of them. When the woman did develop a rapport, the therapy was terminated either by a change of psychiatrist or by the woman moving prisons. The consultant judges that the woman would have benefited from a longer period of involvement with psychiatric staff. The woman did not appear to be prepared to have contact with the mental health in-reach teams at either Bullwood Hall or Send. The consultant notes that the woman's case was closed to members of the in-reach teams at both Bullwood Hall and Send. It remained open to psychiatrists. The consultant thinks that this left the woman vulnerable to the changes in psychiatric care within those prisons. It would have been preferable for the woman to have been monitored by the full psychiatric team.

69. When the woman arrived at Send she was on an open ACCT form. Send closed the form and opened a F2052SH. The prison introduced ACCT in early 2007. The Send 2007 Suicide Prevention Policy document implemented in April 2007 and in place at the time of the woman's death still referred to F2052SH documents and not ACCT. I make no recommendation on this matter as it is now otiose. However, staff cannot work effectively with a policy if it refers to outdated policies and procedures.

70. During the assessment interview when the ACCT document was opened on 16 May 2006 at Bullwood Hall, the woman described her perception of problems related to her distress. She identified eight longstanding problems:

Death of her best friend's daughter in 1999
Birth of her daughter in 1999
Post-natal depression
Sleeping with her best friend's husband
Violent youth.

The other three points the woman identified were related to her family. As noted, the ACCT document was closed when the woman arrived at Send and was replaced by an F2052SH.

71. The woman went on to discuss her mental state and suicidal thoughts and intentions at the time. The problems causing the woman's distress are laid out clearly by staff at Bullwood Hall and are in a bullet format for easy reference. I consider this to be an example of good practice.

72. The F2052SH document opened to replace the ACCT made reference to the ACCT but did not address the problems identified. Subsequent forms follow a similar pattern. Several of the forms refer to short term solutions to problems, for example how to manage with low pin-phone credit. Few of the forms appear to pursue the woman's underlying issues. I believe numerous opportunities to help the woman were missed. In the ACCT opened on 31 May 2007, the woman said that overnight she had seriously thought about hanging herself. She added that she still felt down, had no immediate plans to commit suicide, but accepted that this remained a risk. The caremap made no reference to managing this risk and the document was closed two weeks later on 13 June. There are significant lessons here for HMP Send.

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

73. The entries made in the on-going record section of the ACCT document opened on 31 May follow the same pattern. In the period 31 May to 4 June, it is difficult to distinguish between routine observations and quality conversations. There are almost 60 recorded entries in a period of less than four days.

74. The on-going record section of the ACCT document is designed to provide a record of significant events, conversations linked to the caremap, and observations as described in the introduction to the section. Many of the woman's entries in this section are routine observations such as "appears asleep". This includes the older F2052SH forms. My investigator felt that the requirements in this section may cause confusion for staff. Including routine observations within this section means that there could be over 100 entries per day. It must surely become difficult for staff to identify key issues amongst so many routine entries. I believe the main purpose of this section is to provide significant contributions linked to the issues identified in the caremap. Some establishments have chosen to record regular checks elsewhere on a new "Observations" form. I do not make a formal recommendation on this matter, I simply bring it to the attention of the Governor.

75. HMP Send has limited options when considering cell locations for prisoners on open self-harm monitoring forms. Moving a prisoner who is feeling low or vulnerable into the gated cell in the reception area is only appropriate in extreme cases. The cells with access to adjoining cells are only available when not in use by other prisoners. However, my investigator was surprised to discover that there were no cells designated as safer cells at Send at the time

of the woman's death. (Although no cell can be described as completely safe, safer cells are designed so that the fabric and fittings offer reduced ligature points.)

76. When Send was a male category C prison there may have been little need for safer cell furniture. The need for safer cell furniture should have been considered when the prison re-roled to take female prisoners with a much higher incidence of self-harm. Indeed, the introduction of women serving life sentences ought to have been a further prompt for safer cell furniture to have been considered. In fact, my investigator found no evidence that Send considered submitting a bid for safer cells.

77. The woman's was the third death at Send since it began taking female prisoners. In each case, the bathroom door was used as a ligature point. Since the woman's death the prison has removed bathroom doors in all cells, but this does not remove the need for safer cells. I am aware that new accommodation has recently been built at the prison. My investigator was informed that this accommodation provided safer cell furniture for Send but even if this was the case this does not mean that they are safer cells. I am concerned that prisons that have been or may be re-roled may have insufficient safer cells to meet the needs of their new population.

The Prison Service should ensure that all prisons that are re-roled are assessed to ensure that there are sufficient safer cells to meet the needs of the new population.

78. Following the publication of my draft report I was informed that the new accommodation at Send did not in fact provide any safer cell furniture. I believe this is a serious oversight.

The Prison Service should ensure that sufficient safer cells are available at Send to meet the needs of the population.

Life sentence prisoners

79. The lifer manager at Send, said at interview that Bullwood Hall managed life sentence prisoners on one wing. The staff on that wing had experience in dealing with lifers; there were always two lifer trained officers on the wing. She added that life sentence prisoners from Bullwood Hall were happy there and did not want to be at Send. The lifer manager said a lot of time was spent settling lifers in at Send. Several lifers who transferred from Bullwood Hall moved onto the TC. She felt this was due, in part, to it being a separate unit. My own view is that prisoners serving life sentences may have very different needs to the general population. The woman might have benefited if more time had been spent with her by staff specifically trained to work with lifers.

80. The lifer manager said she had been to Bullwood Hall to look at their procedures as there is no formal training for lifer managers. She added that she had attended the Life in the 21st Century course, which is for all staff working with lifers, and a course designed for the life sentence prisoner

administration officer. I believe the role of lifer manager is an important one and cannot be carried out effectively without appropriate training.

The Governor should review the location policy for life sentence prisoners at Send and ensure that all staff working with them, including managers, receive the appropriate training.

The Prison Service should provide training for staff identified as lifer managers

81. The lifer manager said her role as lifer manager is combined with audit management and being the residential principal officer with responsibility for four wings. She estimated that only one fifth of her time was spent on lifer management. This may have been appropriate before the increase in numbers of life sentence prisoners following the re-role of Bullwood Hall. The hours may not be sufficient to meet the current needs.

The Governor should review the hours profiled for the role of lifer manager.

Send Therapeutic Community

82. The woman spent her first few months at Send on the TC. When she arrived at Send, her friendship with the sixth prisoner and the woman's best friend resumed as they were also on the TC. Following an incident in mid-June, the sixth prisoner claimed that the woman had assaulted her. The woman admitted that she had thrown a cup at the sixth prisoner and had later pulled her hair.

83. The incidents involving the woman during her time on the TC seem to suggest that she was a security concern to the prison. Significantly more information was submitted relating to her during her relatively brief spell on the TC than had been received in the past. Furthermore, the woman would have known that staff were aware of information concerning her as most issues were discussed in therapy sessions. This may well have had a significant effect on the woman.

84. The consultant who carried out the independent mental health review, found that there appeared to be little or no communication between the TC staff and healthcare. She believes it would have been helpful if there had been clear liaison with healthcare and the prison mental health in-reach team in respect of the woman's management within the TC and the difficulties encountered. I believe support from mental health staff during therapy could have been of significant help to the woman. Indeed, virtually all participants undergoing therapy in TCs might benefit from in reach support.

The Prison Service should consider providing mental health in reach support for all prisoners participating in therapy in Therapeutic Communities.

85. The woman ended therapy on 7 December 2006 and left the TC on 11 December. The summary report for prisoners not completing therapy said

therapy targets included family behaviour, relationships, trust, expression of anger, substance misuse and psychological distress. The report went on to say that the woman found it difficult to engage, was often quiet and lacked confidence to comment or respond to others. The report also said the woman admitted to brewing and using alcohol, and to saving medication and using it in conjunction with alcohol. It was felt that the woman was not ready to make the kind of changes expected of someone undergoing therapy. The woman chose to leave the TC rather than be voted off by her peers. This is of particular concern to the consultant as when the woman ended therapy she was returned into the ordinary prison population. The consultant feels support could have been offered over the issue of disengagement from the TC. The clinical review panel recommended that a process should be developed to enable information sharing between the TC and healthcare when a prisoner leaves the community. This has already been implemented by the Governor and healthcare at Send. I welcome this and therefore do not need to make a formal recommendation on this matter.

86. I recently issued a report on the death of a woman at Eastwood Park who spent a period at Send in the TC. She had finished therapy early and died less than three months afterwards. I am concerned that there are similarities with the circumstances surrounding the woman's death. In the earlier case the prisoner was transferred back to her sending establishment shortly after leaving the TC. I made a recommendation referring to Section 3 of Prison Service Order (PSO) 2400 which includes information on transfers from TCs before the end of therapy. It does not specifically cover prisoners who remain at the same prison that they have ended their participation in a TC. In the woman's case she did not transfer back to her sending prison as Bullwood Hall had been re-roled to hold male prisoners. PSO 2400 says that an end of therapy report must be completed. In The woman's case the report was completed by the senior psychologist on the TC. The report does not make reference to the effects that leaving the TC may have had on the woman. The senior psychologist said in interview that the report was written in collaboration with other TC staff. The senior psychologist offered ongoing support to the woman but this was refused.

87. Prisoners who do not complete therapy may have a wide range of needs. The consultant forensic psychiatrist feels that support should be offered from mental health in-reach teams, as has now been implemented at Send. I believe that needs should be identified and the appropriate intervention provided. In the woman's case she had a history of mental health referrals. Failing to complete therapy is likely to produce a number of difficult emotional issues for participants. These issues are likely to be heightened where a prisoner has mental health problems.

88. Section 3.4 of PSO 2400 outlines actions to be taken if prisoners are transferred following their dropping out of therapy. The section does not make any reference to the support individuals may need. Section 3.6 outlines the requirements when completing the end of therapy report. This report is required when an individual leaves a TC whether they have fully completed therapy or not. It says the report will detail work completed and outstanding

areas of risk/targets for further work. Again no reference is made to the impact the therapy may have had on the individual.

89. Section 2.1 gives an overview of the purpose of Democratic TCs. It says "Democratic TCs provide a long term, residential, offending behaviour intervention for prisoners who have a range of offending behaviour risk areas, including emotional and psychological needs." This is the only section my investigator could find in the PSO that mentions the emotional needs of participants. I do not believe the PSO places sufficient emphasis on the support individuals may need if they do not complete the full period in therapy.

The Prison Service should ensure that all prisoners with a history of mental illness, who do not complete therapy on a TC, are referred to healthcare and a full mental health assessment is carried out.

PSO 2400 should be reviewed in order to place a greater emphasis on identifying and managing the emotional and psychological needs of prisoners who do not complete a full period in therapy.

The woman's tariff

90. On 29 March 2007, a High Court Judge confirmed the woman's tariff as nine years less the 19 months and 18 days that she had spent in custody on remand. The lifer manager said in interview that the woman came to her at the time and said she was nervous and worried about the setting of her tariff. The lifer manager rang the court on the day of the hearing, was told the result, and informed the woman. She added that the woman was relieved and pleased at the result as she did not want the date to be higher than the nine years recommended by her trial Judge.

91. On 16 July 2007, an amended order was sent. This reduced the time spent in custody on remand to 231 days (less than eight months). The original document was incorrect in that it made no adjustment for days the woman spent on bail. This meant the woman's tariff would not expire until August 2011. This was almost a year longer than she had previously expected. This would also have been likely to have affected her speed of progress through the prison system. The lifer manager said the woman accepted that the revised tariff date was correct but was angry. I do not make a recommendation on this matter, but it should be noted that it may well have caused significant distress to the woman.

Bullying

92. The complaint submitted by the woman's best friend on 2 July 2007 that the woman was being bullied to do extra laundry was referred to the anti-bullying team the following day. It was investigated at the same time as the one submitted on 18 June. The woman was interviewed about the complaint and a response was provided the same day. However, it is dated 3 August more than six weeks from the date the original complaint had been submitted.

93. In the response the investigating officer notes that the woman's shifts in the laundry had been changed in order to avoid the prisoner who was bullying her. Nevertheless, the time delay in responding to the complaint was unacceptable. The way the complaint was handled, by changing the woman's shift, may not have resolved the conflict between the woman and the woman who was bullying her. I am aware that the prison is developing its violence reduction policy in line with PSO 2750 and so do not make a formal recommendation on this matter. However, it should be noted that the prison's failure to deal with this issue in a timely manner may have further contributed to the woman's distress.

Relationships between prisoners

94. When the woman's partner was discharged from Send in February she was still in a relationship with another prisoner, the second prisoner. As a result, the woman had kept her own relationship with her partner secret. The second prisoner said in interview that, shortly after the woman's partner's release, she had seen her visiting the woman at Send. The relationship between the second prisoner and the woman's partner ended at that time. The second prisoner told my investigator she had thought the woman's partner and the woman were just friends. The second prisoner added that she was not a friend of the woman's and had little contact with her. Several prisoners interviewed by my investigator confirmed that the second prisoner and the woman did not get on and normally avoided each other. This situation cannot have been easy to manage for any of the women involved.

95. The third prisoner told my investigator that the woman told her that she was in love with her partner and that if she ever found out about their relationship the woman's partner would leave her. The third prisoner added that she believed the woman's partner had treated the woman very badly. She gave several examples to demonstrate the point. She went on to say that the woman had told her, "If she leaves me I will kill myself". When asked if she was serious, the woman replied "yes".

96. The relationship between the woman and the third prisoner became difficult to hide when the woman had to move out of her cell next to the third prisoner. It may be significant that five days later the woman was at risk and placed on an ACCT document. No mention of any relationship with the third prisoner is recorded in the ACCT document, although there is a note in the ACCT ongoing record that the woman was seen talking to the third prisoner during the morning of 1 June 2007. The third prisoner said the relationship ended when rumours began to spread that the woman was in the relationship. The woman was concerned that her partner would find out. She added that the woman had told the fourth prisoner about the relationship when they were in the adjoining cells. Although the third prisoner did not see the woman again, she said that she was aware that the woman had spoken to the fourth prisoner on the day of her death. The third prisoner believed it was likely that the fourth prisoner threatened to tell the woman's partner about her own relationship with the woman if the fourth prisoner felt she herself was in trouble.

97. When the woman telephoned her partner at 5.50pm on 7 September she told her partner she felt prisoners were trying to break up the relationship between them. The woman's partner threatened to come up to the prison and knock the fourth prisoner out. She later said she would come on her visit on Thursday and "sort it out good and proper". The woman pleaded with her not to come. Again a heated discussion took place before the call ended amicably at about 6.20pm. Copies of transcripts of these conversations were attached to the report as annexes.

98. The following morning, the woman rang her partner again and during the conversation she described the previous day's row with the second prisoner. Her partner told the woman about the threatening answer phone message left by the second prisoner and added she had written what she described as a bad letter to the second prisoner. This upset the woman and they discussed the matter. The woman asked if her partner was still coming to visit on Thursday, and she replied that she was. The woman told her she did not want any trouble on the visit. The conversation ended with each of them saying they loved the other. This was the last recorded contact between them. The woman had used all her pin-phone credit and an application for additional credits submitted on 10 September was refused. It must have been very difficult for the woman to come to terms with all the issues relating to her relationship at this time. This could not have been helped by the fact that she could not talk to her partner openly or for a protracted period.

99. Family members visited the woman on Saturday 8 September. As noted earlier, the woman's mother said she seemed fine, but concerned about bullying by the second prisoner and the fourth prisoner. The woman's mother told my investigator that she felt something happened to the woman during the last few days of her life that pushed her over the edge.

100. A senior officer said in informal interview that the fourth prisoner may have been assaulted during the day on Sunday 9 September. There is, however, no documentary evidence to verify this. Later that evening the fourth prisoner was moved, at her own request, to A wing. Another prisoner told my investigator that the move was linked to relationships involving the second prisoner and three other prisoners. She added that they did not involve the woman.

101. On Monday 10 September, the woman attended a meeting with the drug worker. At the meeting the woman told the drug worker about a difficult phone call with her family at the weekend. The woman added she would not go into detail but it was upsetting. (It is likely that this related to a telephone conversation with her partner as the woman had not been in telephone contact with any family member that weekend). They discussed her relationship with her partner, and the triangle in which the woman felt she was playing the part of rescuer and ended up being the victim. The woman said she could see how she had been in similar relationships all her life.

102. Later that day, the woman met the lifer manager, who said she felt the woman would not want to be associated with the fourth prisoner as she had been involved in several recent incidents in the prison. In particular, the fourth

prisoner had been involved in the theft of a sum of money from the prison chaplain a few days earlier. (The money was returned later by the fourth prisoner.) The lifer manager said she had no evidence that the woman was linked to these incidents at all. The woman seemed satisfied that she did not think she was involved. During the meeting the woman also described disagreements she had with the second prisoner. The lifer manager told my investigator that the woman had not asked her to move the second prisoner or the fourth prisoner out of the prison. When the woman left the office, the lifer manager believed she was fine and had no concerns that she would self-harm.

103. Prisoners interviewed by my investigator gave a range of interpretations of events in the days leading up to the day of the woman's death. It is not possible to be absolutely certain which interpretation is the most accurate, nor is it particularly relevant. What is clear is that the events must have caused considerable distress to the woman. None of the prisons that held the woman seems to have done much to help resolve her ongoing history of self-harm. They appear to have had little or no written information about relationships between prisoners. These relationships clearly caused the woman a great deal of concern.

104. A fourth prison officer told my investigator that she had been friends with the woman. She described numerous examples of discussions with the woman. She spoke affectionately about the woman and was clearly upset at her death. But even she did not appear to have known the true facts surrounding the intricate prisoner relationships at Send.

105. Prison staff may have known bits of information; prisoners would certainly have known more. Only the woman knew all the information that, when it was put together, may have made her decide to take her own life. I do not believe any one individual should feel responsible for the woman's death. Nobody could have been aware of how any of their individual actions impacted on the woman and how this may have made her feel.

106. Nevertheless, I believe opportunities, identified in various self-harm documents, to work with the woman in order to get to the root of her problems may have been missed by staff during her time in custody. Self-harm documents may have been used to help the woman through her many crises, but there is no evidence that deep rooted issues were addressed. However, my investigator could not find any evidence that the staff at Send were aware of the complicated relationship issues affecting the woman in the days directly before she died.

107. Intimate relationships between women prisoners are not uncommon. The perception of some prisoners at Send is that the usual response from staff who discover the relationships is to separate the prisoners, this would inevitably cause distress to those involved. The effect may be to discourage prisoners from being open. As a result, when a relationship comes to an end, their distress may not be apparent to staff.

108. When relationships end it can also create animosity between ex-partners and all those associated with them. I do not believe any of the individuals involved in this case would have wished any harm to the woman. No one would have been fully aware of the effect of her actions on the woman or the cumulative effect of all their actions. The breakdown in relationships between prisoners can lead to bullying of the individuals concerned. Yet prison staff do not receive any in depth training on dealing with relationships in female prisons.

The Prison Service should consider training violence reduction co-ordinators in how to identify and manage bullying caused as a result of relationships between prisoners.

The events of Tuesday 11 September

109. On Tuesday 11 September, when the fourth prisoner's transfer was cancelled, she was returned to the wing. The fourth prisoner told my investigator she saw the woman who she thought would be pleased to see her. In fact, the woman walked past and appeared upset. It is possible that the woman believed the fourth prisoner's transfer would significantly reduce the stress on her. If, as the third prisoner said, the fourth prisoner was likely to tell the woman's partner about the woman's relationship with the third prisoner that likelihood would reduce if she transferred. If the fourth prisoner was involved in bullying the woman, her transfer would also relieve that problem. The woman's partner's visit to "sort the fourth prisoner out" would not be possible if the fourth prisoner was elsewhere. It is possible that the woman felt a lot of her problems would have gone away with the transfer of the fourth prisoner. This would explain why she would not be pleased to see the fourth prisoner return. The fourth prisoner may not have realised the effect she was having as she was surprised that the woman was not pleased to see her.

110. The woman's best friend said in interview that she met the woman at lunchtime and the woman gave her a letter containing details of things she wished to discuss with the lifer manager. The woman's best friend described the woman telling the lifer manager she was struggling and using drugs, and having told her how the drugs came into the prison. She said the woman asked the lifer manager to transfer the second prisoner and the fourth prisoner. This record of events conflicts with the description of the meeting given by the lifer manager. The woman's best friend said she agreed to meet the woman at tea time as the woman had more to tell her. She added that they discussed the woman's partner's planned visit on Thursday and the woman's best friend felt that everything would be okay. The woman's best friend said that at about 3.00pm the fourth prisoner told the woman that the woman's partner was going to end their relationship.

111. The fourth prisoner said she went to see the woman in the laundry that afternoon. The woman had told her that she knew the fourth prisoner's partner was coming to visit her on Thursday, when the woman's partner would also be in the visiting room. The fourth prisoner went on to say that it was thought that the second prisoner had rung the woman's partner to tell her that the woman was sleeping with the fourth prisoner. The fourth prisoner added that the

woman's partner was coming to end her relationship with the woman; her partner was coming to end their relationship at the same time. The fourth prisoner said she rang her partner after talking to the woman and discovered that this was not true. She said she did not have time to relay this to the woman. This version of events at the meeting cannot be confirmed.

112. If the woman believed that her partner was going to end their relationship, the comments made by the third prisoner to my investigator become very significant. The woman told the third prisoner that if her partner ended their relationship she would kill herself. It is unlikely the fourth prisoner was aware of this information or its significance. The woman's partner told my investigator that she had no intention of ending the relationship when she visited.

113. When the woman went to see the fifth prisoner that afternoon she was crying and very distressed. The fifth prisoner said that the previous week the fourth prisoner had told the woman that she had slept with her partner. She said that by the weekend the woman had come to terms with this. The fifth prisoner added that the woman said that the fourth prisoner spoke to her that morning in the laundry. The fourth prisoner had told the woman that the second prisoner had telephoned the woman's partner to tell her that the woman was causing trouble. At the second meeting the fourth prisoner said that the woman's partner was coming up on Thursday to confront the woman. The woman told the fifth prisoner, "I can't take this anymore". After a while, the woman calmed and said she needed to talk through the issue with the woman's partner. She left the cell hoping to get a phone call. The fifth prisoner said she did not think the woman would self-harm at that time.

114. Shortly after the woman left her cell, a prison officer asked the fifth prisoner to cover for the woman in the laundry. As the fifth prisoner left her cell she saw the woman sitting on the stairs. She said to the woman, "You know where I am if you need me." The fifth prisoner described the fourth prisoner as a game player, but not a malicious person. She said she blamed the woman's partner for the woman's death. She added, "[The woman's partner] played her games but had no idea how intensely vulnerable the woman was." It is possible that, when the woman realised the fourth prisoner was not being transferred, she told the fourth prisoner that the woman's partner was visiting on Thursday and she might confront her. If that was the case, the fourth prisoner could have responded by threatening to tell the woman's partner that the woman had slept with the third prisoner. This would have had a significant impact on the woman. None of this can be confirmed. However, it seems clear that the events of the previous few days would have been traumatic for the woman. She was already struggling to come to terms with numerous issues as well as the difficult relationship with the woman's partner. Her anxieties included the revised tariff, the recent anniversary of the death of her former partner, and the knowledge that her best friend would be transferred out of the prison the following week.

115. The prison officer said he saw the woman coming out of the fifth prisoner's cell shortly after 3.00pm. The woman sat on the stairs with tears in her eyes and would not say what was wrong. He asked the woman if she wanted to talk to someone. The woman replied "no". She said she could not go back in the

laundry, and the prison officer asked the fifth prisoner to cover the woman's shift. When he returned to the wing, the woman had gone. The prison officer said in interview that he thought the woman was quite stubborn. If she did not want to tell you something she would not do so and she would clam up. The prison officer said that it was not unusual for the woman to be upset and he felt it was normally due to difficulties with her relationship with the woman's partner. He added that he felt the woman just needed time away from the laundry to be alright. The prison officer told my investigator that the woman did not ask him for a phone call to her partner. The woman had no pin-phone credit and her recent application for additional credit had been refused. This meant that the woman had no means of contacting her partner.

116. At about 4.00pm, the prison officer found the woman sitting on the floor in her cell having made superficial scratches to her wrist. The prison officer said in interview that he asked the woman if she would be okay for two minutes. She replied yes. The prison officer left the cell and returned shortly afterwards with a second officer. The second officer said in interview that he went to the woman's cell when she self-harmed and spoke to the woman whilst he dressed her wounds. The second officer said the woman was tearful and not very talkative. She was upset. The second officer dressed the woman's wounds and escorted her to healthcare. The nurse assessed the dressing and decided not to disturb the wound. The second officer left the healthcare centre and returned to his normal duties. Following family concerns raised relating to assessing injuries I have reconsidered this issue. There is no evidence in this case that the woman's injuries were anything other than superficial. However, I believe that healthcare staff should see the wound in all cases of self-harm and ensure the appropriate cleaning and redressing of the wound takes place. This will not only ensure correct treatment of the wound but will allow the member of staff time to discuss the wound with the individual and assess the seriousness of the self harm attempt.

The Primary Care Trust should ensure that all injuries to prisoners are seen and the appropriate cleaning and dressing is carried out.

117. The prison officer collected a F213SH form and took it to healthcare. He added later in the interview that he filled out the F213SH when he returned to the wing and intended to hand it to the nurse when she visited the wings to carry out her medication rounds at around 5.00pm. The nurse said in interview that she could not recollect when she received the F213SH to complete her section of the form. She added it was often the case that forms did not accompany the prisoner to the healthcare centre. The date appears to have been changed on the F213SH that was completed by the nurse. It appears to have first been dated 12 September and then amended to 11 September. The nurse could not recollect why this was the case. The clinical reviewer cannot be certain when the F213SH was completed. I cannot be certain either.

The Governor should ensure that all staff are reminded of the importance of following procedures relating to the completion of F213SH forms.

The Primary Care Trust should ensure F213SH training is included during the induction of all new healthcare staff, including those provided by agencies.

118. The review of documentation undertaken by the consultant forensic psychiatrist highlights that self-harm incidents are recorded either on hard copy forms, or on the prisoner's computerised healthcare record, or on both. In the woman's case the information on the paper and computer record was not always consistent. The consultant forensic psychiatrist considers that if only one of the records was used to review a prisoner's level of self-harm the full extent of their needs might not be evident.

The Primary Care Trust should ensure that all incidents of self-harm are recorded on the healthcare computerised system. These records should be accessible to all healthcare staff and visiting specialists.

119. The section of the F213SH completed by the nurse does not include any written assessment of the woman's mental state. The consultant forensic psychiatrist has found that this was the case with most of the F213SH forms completed relating to the woman. In her opinion they focus primarily on the physical presentation of the self-harm incident. The F213SH should have accompanied the woman to healthcare when she self-harmed. The nurse should have completed her section whilst the woman was present. Had both these actions taken place it is unlikely that the comments on the form would have been different. I believe completion of the F213SH, in its current format, is of little use when considering the mental health of prisoners who self-harm.

120. I agree with the consultant forensic psychiatrist that the form should be revised. The ACCT form does not stipulate any time frames for completion of the "Immediate action plan". A significant period of time could elapse between a self-harm incident and the completion of the immediate action plan. In the woman's case, the section was not completed before she died. I believe a section should be added to the F213SH form that not only prompts healthcare staff to consider a prisoner's mental health but also requires them to complete an action plan for the individual's safety until the ACCT immediate action plan has been completed.

The Prison Service should review the F213SH form to include a section that requires healthcare staff to enquire about a prisoner's mental health and complete an action plan.

121. The clinical review panel considers that healthcare staff do not receive sufficient training in the management of prisoners with psychiatric difficulties. The mental health in-reach team and visiting psychiatrist provide psychiatric advice and support to prisoners during the day, Monday to Friday. At all other times, issues are dealt with by nursing staff. Healthcare staff should be equipped to undertake a risk assessment and develop a risk management plan for prisoners who have self-harmed. Any training should include the assessment of a prisoner's mental health following a self-harm incident. This should help to ensure the safety of prisoners following acts of deliberate self-

harm. In addition I believe it is not ideal to use agency staff on a regular basis. Permanent staff are more likely to have received appropriate training and should have a greater knowledge of the individual prisoners. Several comments were made by staff and prisoners relating to the poor relationships between prisoners and healthcare staff. As Send does not have an in-patient facility developing relationships is likely to be difficult. The use of more permanent staff may help. As recruitment of quality permanent staff is likely to be difficult I do not make a formal recommendation on this matter. I do however wish to bring it to the attention of the Governor and PCT.

The Primary Care Trust should provide training for staff in the presentation and management of deliberate self-harm. This training should be part of the induction process for new staff and bank/agency staff.

122. The clinical review panel considers that the general standard of record keeping was good. At times, however, some handwritten notes were difficult to decipher. The grade of the author was not always recorded. Management checks should be undertaken to ensure the standards are maintained.

The Primary Care Trust should ensure that all entries in clinical records are signed, dated and the signatories discipline clearly identified.

123. The nurse said in interview that the woman was escorted to healthcare by the second officer at about 4.00pm. She added that the woman was very upset and it took a while to calm her down before she could have a chat. The woman told the nurse that the second prisoner had been ringing her partner and shouting and yelling down the phone. The woman would not give details of what was said. The woman did say this had been going on for about a year. The nurse said she thought it was getting the woman down. During the conversation, the woman told the nurse that she had no pin-phone credit to talk to her partner. The nurse said the woman did not ask for a phone call but, if she had asked, it would have been refused. The nurse said the woman calmed down and she took a razor blade out of the woman's hand. The woman then asked to go back to her cell. Before the woman left healthcare, the nurse said to her, "If you want to have a chat then pop your card out under the door when I do the meds rounds about 5.00pm." The medical records confirm that the woman was not due to receive any prescribed medication at this time. The woman returned to her cell and the nurse spoke to the staff in the wing office.

124. The prison officer said he began to complete an ACCT document as soon as he returned to the wing office after leaving the woman's cell. He said that he completed the Concern And Keep Safe section of the ACCT form. The Concern And Keep Safe form says, "If you consider the risk of a suicide attempt to be imminent, or if the individual is acutely distressed, take action immediately and do not leave the person alone." There is no evidence that any staff who spoke to the woman believed she was suicidal or that she was acutely distressed when she left healthcare. When the Concern And Keep Safe section has been completed, the ACCT form should then be handed to the Orderly Officer who completes the Immediate Action Plan. The Orderly Officer

on 11 September 2007, said in interview that she saw the prison officer opening the document and intended to speak to the woman at about 5.30pm before tea was served. She would then have completed the Immediate Action Plan section of the ACCT document. The ACCT documentation in this case was not fully completed. However, there are no time limits relating to the completion of the Immediate Action Plan in PSO 2700.

125. If the ACCT document had been opened immediately and completed by the Orderly Officer, it is unlikely that the woman would have been placed on constant supervision as none of the staff felt she was suicidal. As the woman was seen at about 4.50pm and was discovered hanging about ten minutes later, placing her on frequent checks until the Immediate Action Plan had been completed might not have been sufficient to keep her alive. I believe the immediate completion of the ACCT process in this case would have made little practical difference and make no formal recommendation.

126. At about 6.30pm, the head of healthcare informed the Acting Governor that the woman was in a critical state. The Acting Governor informed the woman's mother and her husband and offered to collect them from their home and take them to the hospital to be with the woman. They accepted the offer. As I noted earlier, I believe this to have been an example of good practice.

127. Death in custody contingency plans were put into place before the woman died. I believe this was appropriate due to the woman's condition. Had the plans not been put in place, the family might not have been present when the woman passed away.

128. A hot debrief was carried out by the duty governor later on the evening of 11 September. Hot debriefs are primarily carried out to ensure staff have the opportunity to discuss emotive issues following serious events in prisons. Minutes are not normally taken at these meetings.

129. The Security Principal Officer told my investigator in interview that the second prisoner and the fourth prisoner were transferred on 12 September for their own safety. I could not find any documentary evidence to support the claim that the woman was being bullied by either the fourth prisoner or the second prisoner. The transcript of the pin-phone conversation between the second prisoner and the woman's partner was not available to staff until after the woman's death, although some prisoners were aware of the content of the call. The transfer followed the receipt of information that they might be at risk from other prisoners who believed they may have been partly responsible for the woman's death. There does not appear to be any documentation relating to the threats or the transfers. The second prisoner told my investigator that the prison told her she was moved for her own safety following the woman's death. The transfer of the fourth prisoner and the second prisoner may have been considered by some to have happened too late. However, my investigator could find little information available to the staff about the woman and these women. Staff were generally aware that the second prisoner had been the woman's partner's former partner. The reaction of prisoners after the woman's death seems to suggest that staff might have had less information than the

prisoners. The prison acted swiftly, and in my opinion appropriately, by transferring these two women for their own protection.

130. As was to be expected, the Acting Governor wrote to the woman's family offering the prison's condolences. Unfortunately, the Acting Governor had been informed that the woman had hanged herself using a sheet from her bed. She included this information in the letter. It was later confirmed by the police that this information was incorrect. As this appears to have been an innocent mistake by the Governor I do not make a formal recommendation relating to this matter. It must be noted that the misinformation caused confusion and distress to the family.

131. Several of the woman's friends believed she was using drugs in the days before she died. There are numerous entries relating to the woman's drug abuse in her prison records. Some believed that she was being supplied drugs by one of the women allegedly involved in bullying her. This investigation has found no evidence that the woman was using drugs at the time of her death. The post-mortem examination carried out did not find any traces of class A drugs. The analysis of the woman's hair did not reveal use of such drugs for a period of at least two months prior to her death.

132. It is clear from interviews and prison documents that the woman found it difficult to relate to some staff and prisoners. She clearly did not relate well to staff in healthcare. Time spent with the woman by the personal officer was scant. However the fourth officer appears to have been almost a friend to the woman and spent considerable time talking to her. The lifer officer had not seen the woman for some time as he had not been at work for some months. Cover should have been provided. Had the lifer manager been allocated more hours to carry out her role this issue may have been addressed and she herself may have been able to find more time to speak to the woman. Staff had very little knowledge of the issues surrounding the woman at the time of her death. Had they been aware of the issues it is possible that the actions taken following her self-harm may have been different.

133. I concur with the opinion of the clinical review panel that the woman received appropriate healthcare during her time at Send. They believe her death on 11 September was connected to a specific incident in her personal life that was not known fully to prison or healthcare staff.

134. Actions taken by the prison in the period directly following the woman's death appear to have been appropriate and in line with Prison Service policy. Many staff and prisoners were genuinely upset and concerned by the woman's passing. A ceremony was held in the prison grounds a few weeks afterwards that was attended by staff and many of the woman's prisoner friends. One of those friends told my investigator, "the woman did not mean to die forever. She was a dramatic person who probably needed a couple of days but she got stuck in the moment." It may well be that her friend's assessment was correct.

RECOMMENDATIONS

I make seven recommendations for the Prison Service:

- The Prison Service should ensure that all prisons that are re-roled are assessed to ensure that there are sufficient safer cells to meet the needs of the new population.

Prison Service response
Provisions already in place. PSO 2700 Chapter 10 refers.

- The Prison Service should ensure that sufficient safer cells are available at Send to meet the needs of the population.

Prison Service response
As this is a new recommendation the response has not yet been received.

- The Prison Service should provide training for staff identified as lifer managers.

Prison Service response
Recommendation accepted. A new course was introduced in April 2008 entitled Management of Indeterminate Sentence prisoners and Risk.

- The Prison Service should consider providing mental health in reach support for all prisoners participating in therapy in Therapeutic Communities.

Prison Service response
Partially accepted. A local working protocol needs to be developed outlining communication between the TC, healthcare and mental health in-reach services.

- The Prison Service should ensure that all prisoners with a history of mental illness, who do not complete therapy on a TC, are referred to healthcare and a full mental health assessment is carried out. PSO 2400 should be reviewed in order to place a greater emphasis on identifying and managing the emotional and psychological needs of prisoners who do not complete a full period in therapy,

Prison Service response
Partially accepted. PSO 2400 is currently under review and will need to include further guidance on the management of mental health needs for those de-selected from therapy.

- The Prison Service should consider reviewing the F213SH form to include a section that requires healthcare staff to enquire about a prisoner's mental health and complete an action plan.

Prison Service response
Not accepted. The ACCT process investigates mental health needs as required.

- The Prison Service should consider training violence reduction co-ordinators in how to identify and manage bullying caused as a result of relationships between prisoners.

Prison Service response
Accepted. A women's awareness staff programme is being piloted. This includes elements relating to prisoner relationships.

I make four recommendations for the Governor of HMP Send:

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

Governors response
Accepted. New procedures in place.

- The Governor should review the location policy for life sentence prisoners at Send and ensure that all staff working with them, including managers, receive the appropriate training.

Governors response
Accepted. Review completed. Location policy remains as per the current practice.

- The Governor should review the hours profiled for the role of lifer manager.

Governors response.
Accepted. Review completed. 16 hours per week now profiled for lifer manager work.

- The Governor should ensure that all staff are reminded of the importance of following procedures relating to the completion of F213SH forms.

Governors response
Accepted. A notice to staff was issued in October 2007 outlining the correct procedures to be followed when completing a F213SH.

I make five recommendations for the Primary Care Trust:

- The Primary Care Trust should ensure that all injuries to prisoners are seen and the appropriate cleaning and dressing is carried out.

Primary Care Trust response.
Partially accepted. Recommendation in place

- The Primary Care Trust should ensure F213SH training is included during the induction of all new healthcare staff, including those provided by agencies.

Primary Care Trust response.

Partially accepted. Recommendation in place

- The Primary Care Trust should ensure that all incidents of self-harm are recorded on the healthcare computerised system. These records should be accessible to all healthcare staff and visiting specialists.

Primary Care Trust response.
Partially accepted. Recommendation in place

- The Primary Care Trust should provide training for staff in the presentation and management of deliberate self-harm. This training should be part of the induction process for new staff and bank/agency staff.

Primary Care Trust response.
Partially accepted. Recommendation in place

- The Primary Care Trust should ensure that all entries in clinical records are signed, dated and the signatories discipline clearly identified.

Primary Care Trust response.
Partially accepted. Recommendation in place.

GOOD PRACTICE

The woman's problems are laid out clearly in the assessment interview section of an ACCT form completed at Bullwood Hall and are in a bullet format for easy reference. I consider this to be an example of good practice.

The Acting Governor at Send contacted the family personally, collected them and took them to the hospital to be with their daughter. I consider this to be an example of good practice.

(I should be grateful if my view of their good practice could be shared with Bullwood Hall and the Acting Governor respectively.)