The circumstances surrounding the death of a woman from HMP/YOI New Hall, at a hospital On 12 October 2004

Report by the Prisons and Probation Ombudsman for England and Wales

February 2006

This is the report of an investigation into the circumstances surrounding the death of a woman at a hospital on 12 October 2004. At the time of her death, the woman was serving a five month prison sentence at HM Prison and YOI New Hall, near Wakefield, West Yorkshire. A post mortem examination carried out on 13 October 2004 concluded that her death was caused by hanging.

The investigation was carried out on my behalf by my colleague. I also commissioned an independent clinical review of the management of the woman's health needs while she was at New Hall. This was conducted by a representative of the Wakefield West Primary Care Trust (PCT). I am grateful to the PCT for the thorough and comprehensive report he has written.

My thanks also go to the Governor and staff at New Hall for their help and co-operation during the investigation.

This was one of a number of deaths I have investigated at New Hall. As the report shows, a considerable number of the women at New Hall are either mentally ill, or have a history of drug abuse or, in some cases, a history of self-harm. It is no coincidence that those who have died at New Hall in recent years fit into at least one of those categories. Although I am critical of some crucial aspects of the management of this woman during her time at New Hall, I am nevertheless impressed by the commitment of the Governor and her staff to the challenging task of managing the needs of a difficult and vulnerable prisoner population.

At consultation stage, the Prison Service partially accepted one of my recommendations and fully accepted the remainder. The Service felt it was heartening that in the midst of this sad case, and despite the criticisms raised, I had recognised the difficulties caused by the imprisonment of so many mentally ill and vulnerable women and girls and the commitment of the Governor and her staff in catering for their needs. The Prison Service's plan of action to implement my recommendations is shown at the end of my report.

I hope that implementation of the recommendations I have made will help to reduce the risk of further tragedies at New Hall and elsewhere in the Prison Service.

Stephen Shaw CBE **February 2006**
Prisons and Probation Ombudsman

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1. Summary

In 2004, the woman spent two periods at New Hall. The first began in June of that year, when she was remanded by Bradford Magistrates' Court on a charge of criminal damage. The woman was released from custody by the same court in on 15 July. The second period began on 16 August, when she was again remanded by Bradford Magistrates' Court, this time for assault. This period ended with her death on 12 October. Throughout both periods, the woman was located in the Healthcare Centre.

During her first period at New Hall, a F2052SH (self-harm monitoring form) was raised. The document was opened on 12 June and closed on the last day of the month. Subsequently, the document was lost.

On 13 August 2004, the woman was arrested in Bradford for assaulting two Police Officers and a Detention Officer. On 16 August, she appeared before magistrates for those offences and was remanded in custody at New Hall. The court custody staff assessed her as being at risk of self-harm. They passed this information on to the Group 4 escort who took her to New Hall that day. In turn, the escort staff passed it on to reception staff in the prison.

During the reception procedures, the woman presented as elated and confused. She was assessed as being in need of urgent referral to a psychiatrist and was immediately admitted to the healthcare centre. The reception staff were not aware that, only six weeks earlier, the woman had been the subject of self-harm monitoring procedures at New Hall.

On 17 September, the woman returned to court and was sentenced to five months imprisonment. On her return to New Hall that day, she was again located in the healthcare centre. Thereafter, she experienced frequent mood swings and demonstrated abusive behaviour. She also expressed suicidal thoughts on a number of occasions. Although a nursing care plan was established and followed throughout her time at New Hall, no consideration was given to making her subject to formal self-harm monitoring procedures.

At about 1pm on 11 October 2004, the woman was found hanging from the door of her ward toilet by a member of the healthcare staff. The only other prisoner allocated to that ward with her had gone to court earlier that day.

Resuscitation attempts by New Hall staff and, later, by paramedics were sufficient to restore a weak pulse. The woman was therefore transferred to hospital at about 2pm. She survived the night but died at 4.20pm the next day.

I draw attention to the fact that, although the woman's medical care, diagnosis and treatment during her first period at New Hall in June and July 2004, were appropriate, there were some flaws in the way she was managed in the

healthcare centre during her second stay there between August and October 2004. I draw particular attention to the fact that she was not made subject to formal self-harm monitoring procedures during that second period at New Hall.

I also express my concern that so many vulnerable and mentally ill adult and young women are sent to prison where, all too often, their individual needs cannot be met. This is not a matter over which the Prison Service has any control. However, I will send a copy of this report to the Local Criminal Justice Board and the Office for Criminal Justice Reform.

I praise the efforts of healthcare staff at New Hall, and of the paramedics, who attended to the woman after she had been found hanging. They did so in very harrowing circumstances.

I make a number of recommendations about suicide prevention policy and practice at New Hall, as well as about a wide range of clinical governance issues that arose during the investigation.

I stress that none of the criticisms contained herein should take away from the commendable efforts made by the Governor and staff at New Hall, including those who work in the healthcare centre, in their management of a difficult and vulnerable prisoner population. The good practice found during the investigation, including the comprehensive care plan drawn up for the woman, testifies to those efforts.

2. Investigation methodology

The investigation was opened on 26 October 2004, when my investigator met with the Governor, and representatives of the Independent Monitoring Board and the local branch of the Prison Officers' Association respectively. On the same day, written notices were issued to staff and to prisoners explaining the nature and scope of the investigation and encouraging anyone who wished to submit information about the woman's death to make themselves known to my investigator.

An independent clinical review of the management of the woman's health needs was conducted by a representative of the Wakefield West Primary Care Trust.

A wide range of healthcare and other staff were interviewed. My investigator talked to a number of prisoners about the ethos of the prison and spoke to a close friend of the woman and to one of her cousins. My investigator also met with two representatives of the local branch of the Prison Officers' Association. He discussed their concerns relating to the high number of self-harm incidents with which staff at New Hall had to contend on a daily basis.

My investigator interviewed the woman's son at Wetherby Young Offender Institution.

During the course of the investigation, my investigator and one of my Family Liaison Officers met with the woman's mother. They explained to her the nature and scope of the investigation. She raised a number of concerns that she wanted the investigation to address. These have been addressed in the report.

3. The deceased woman

The woman was born in 1967. Her mother remembers her as a happy and boisterous child. The woman grew up in Halifax and settled with a man of 18 who was extremely violent towards her. She had a history of self-harm during her adulthood. The woman also had difficulties maintaining a stable life style and relationships. Indeed, her circumstances were often described as “chaotic” and problematic. She was diagnosed as having an emotionally unstable borderline personality disorder and had been in contact with mental health services for a considerable period. On occasions she was a psychiatric inpatient.

The woman left her first partner when she was 24. She married again at the age of 30. She met her second husband in Halifax and together they moved to Scarborough. They had a happy relationship but, tragically, her husband died seven years later in October 2003. The woman had eight children: three boys and two girls by her first husband, and one boy and two girls by her second husband.

The woman never gained long term employment. From June 2003, she had found herself before the courts for various charges of harassment, assault and criminal damage. Her offences were mainly alcohol related. Prior to her imprisonment in August 2004, she had been living in sheltered accommodation.

In prison, the woman’s behaviour was often unpredictable and violent, but she was nevertheless regarded by many as cheerful and amusing. She died three days before the first anniversary of her husband’s death.

4. HM Prison and YOI New Hall

Located near Wakefield in West Yorkshire, New Hall is a multi-purpose establishment that operates as a local and a training prison for adult and young women as well as for juveniles. The establishment can hold up to 426 prisoners.

At the time of the investigation, healthcare at New Hall was provided by the Prison Service. The healthcare centre provides 24 hour nursing and medical cover and has inpatient facilities for up to 19 prisoners.

In November 2003, Her Majesty's Chief Inspector of Prisons inspected New Hall. The report of that inspection was published in April 2004. It referred to the vulnerability and needs of many of the prisoners. The Chief Inspector commented on the high number of F2052SH forms open at the time of the inspection and on the fact that all the inpatients in the healthcare centre at that time were mentally ill.

Little had changed by the time the investigation into the death of the woman began in October 2004. My investigator was told that staff at New Hall were used to managing a very high number of self harm incidents every month. The following table shows the number of self-harm incidents that occurred at the establishment around the time the woman was there for the second time in 2004.

Type of self-harm	August 2004	September 2004	October 2004
Lacerations	31	61	62
Ligatures	15	35	31
Overdose,burns etc	8	9	18
Comments	10 prisoners account for 39 incidents	13 prisoners account for 94 incidents	18 prisoners account for 93 incidents

The Chief Inspector also wrote that there had been four self-inflicted deaths at New Hall in 2002 and 2003. In her introductory remarks, she said,

> "New Hall is holding women and girls who should not be there. They include those who are seriously mentally ill as well as some women and girls with levels of self-harm linked to abuse, including substance misuse. Staff at New Hall were doing their best to provide a stable and safe environment but were unable to do more than contain the level of need of some very damaged individuals.
>
> Prison was likely to increase their vulnerability and mental disorder, in some cases with tragic consequences, and caring for them meant that there was too little time to provide positive interventions

> for the less damaged women and girls. There is an urgent need to provide alternative therapeutic environments where appropriate treatment and support can be offered."

Between April and October 2004, three women, including this woman, died at New Hall. Each of them apparently took her own life. Two of them, including this woman, had long histories of self-harm prior to imprisonment.

5. Events during the woman's first period at New Hall: 9 June-16 July 2004

On 9 June 2004, the woman appeared at Bradford Magistrates' Court on a charge of criminal damage and was remanded in custody at New Hall. She was to reappear at court the next day.

The Prisoner Escort Report (PER) completed at court by Group 4 staff that day recorded that the woman was at risk of self-harm or suicide. A Court Custody Officer completed a self harm warning form in which she recorded that the woman had admitted self-harming during the preceding six months and that she currently seemed depressed. The Court Custody Officer recommended that the woman should be subject to intermittent observations during her journey to prison. The woman was escorted to New Hall after her court appearance and arrived at about 6.30pm.

The nurse on duty in reception at New Hall completed a proforma recording the details of the woman's first reception health screen. The nurse recorded that, prior to her admission to prison, the woman had been living at an address in Halifax and that she had been in custody at New Hall in 2003. A reference was also made to the suicide/self-harm warning raised by Group 4 staff on the PER. The woman admitted to the nurse that she had set fire to herself two weeks earlier, and that she had recently been discharged from a Psychiatric Hospital in Bradford. The nurse decided that the woman should be referred to a doctor for mental health screening and that she should be admitted to the healthcare centre.

A cell sharing risk assessment form was also completed on 9 June by another member of the reception staff who recorded that the woman's behaviour was unpredictable and who judged that her risk of assaulting other prisoners was high. It was therefore decided that the woman should be placed in single accommodation. This same member of staff also noted in the woman's file that she was prone to aggressive and violent behaviour and that she was currently not feeling suicidal. No F2052SH was opened.

On 10 June, a Staff Nurse followed up the note made on the woman's reception health screen proforma by asking for her to be seen either by a member of the mental health in-reach team, or by one of the prison doctors. The woman was seen by the mental health in-reach team on 16 June. Later on 10 June, the woman swore and spat at an officer as she was being escorted to reception on her way to court. When she arrived in reception, the woman became abusive to staff there too. Later that day and on the next day, she appeared at Bradford Magistrates' Court. She was further remanded in custody on both occasions. Her next court appearance was scheduled for 18 June. The PER completed for her journeys to and from court at this time noted a continuing risk of self-harm. No F2052SH was opened.

On 12 June, the woman underwent a mental health examination. A number of illegible entries relating to this examination were recorded in her prison medical record. The examination resulted in her referral to the mental health team.

On the same day, an entry was made in the woman's medical record showing that a F2052SH had been opened. The circumstances that led to the decision to open the F2052SH were not recorded. When my investigator asked to see the document, he was told that it could not be found. My investigator therefore talked to a number of staff who were involved in the woman's management at that time, but none could remember why the F2052SH had been raised, or the circumstances surrounding the decision to close it on 30 June. However, the medical record shows that at 3pm on 12 June, the woman was seen walking around her room in the healthcare centre responding to auditory hallucinations. A similar entry was made on 14 June.

On 15 June, the woman was seen by a psychiatrist. During the consultation, the woman explained that she felt anxious and in emotional pain all the time. She asked the doctor to give her an injection so that she could "go to sleep for ever and put an end to it all".

On the same day, the woman was seen by a locum consultant psychiatrist who wrote in the medical record,

> "Woman's hypomanic/mixed affective state
> - needs anti-psychotic and sedative in short term to lower mood elevation, agitation and get some sleep.
> - ideally would be on mood stabiliser and would benefit from MHA assessment if released.
> Continue with controlled unlock and 2052 at present.
> Prescription: chlorpromazine 25mg BD and 100mg nocte
> Amoxyllin 250g tds for teeth until seen
> Ideally urine/drug screen.''

On 16 June, a number of entries were made in the woman's medical record that show that her case was being considered by a member of the mental health in-reach team in conjunction with a doctor. It was also recorded that a urine sample taken from the woman had produced negative results, that she was showing a heightened response to hallucinations and that she was alluding to further thoughts of self-harm.

On 17 June, a representative of the mental health in reach team was due to see the woman but he found her in a very agitated and uncooperative mood. The representative therefore tried to speak to her through her cell door in the healthcare centre. She was so aggressive that he found it impossible to engage with her. The woman remained agitated and aggressive for the rest of that day. She slept badly that night and her fitness to return to court the following day was

questioned. However, she was more settled when she took breakfast on 18 June and appeared at court as scheduled. She was remanded in custody for a further week.

On 19 June, the woman superficially grazed her knuckles on the furniture in her cell. Her injuries were so slight that no treatment was deemed necessary, but a self-harm injury form (F213SH) was appropriately raised by staff. Entries made in the form drew attention to the fact that a F2052SH was already open. Further entries made in the medical record show that she remained in an agitated state for much of that day and for the following three days. She would go to sleep relatively early in the evening and would wake up in the middle of the night. Her medication was therefore adjusted in an attempt to stabilise her sleep pattern.

On 22 June, the following entry was made in the woman's medical record:

> "Cell entered after no response on checking. Ligature removed, colour good and conscious. Refused to talk. F213 completed.''

Beneath that entry appears an illegible signature against the words "wrong entry". No explanation for that entry was given to my investigator, other than it probably alluded to an incident involving another prisoner. As the F2052SH appertaining to that period was lost, my investigator was unable to confirm whether the remark did in fact refer to the woman.

On 25 June, the woman reappeared in court and was remanded in custody for a further week. On the same day, an entry was made in the medical record showing that a care plan review was to take place. No details of that review were recorded. The next day, she became abusive towards staff and she was placed on report for throwing a table at her cell door. The woman attended an adjudication (a disciplinary hearing) for this offence on 28 June and was given seven days forfeiture of her television as punishment.

On 29 June, the woman was seen again by a psychiatrist who recorded that her presentation over the previous two weeks was suggestive of hypermania. The psychiatrist decided to increase the woman's prescription of chlorpromazine (an anti-psychotic drug prescribed for the treatment of disorganised and psychotic thinking and to treat false perceptions) to 25mg twice daily and a further 150mg at 6pm each day. The psychiatrist noted that this dosage could be reduced during the day if the woman became drowsy.

On 30 June, an entry was made in the medical record by a Staff Nurse showing that a F2052SH case review had taken place, and that a decision had been made to close the document. As there are no other entries in the medical record relating to the case review and the F2052SH has been lost, it is not possible to ascertain the rationale behind this decision.

On 2 July, the woman returned to court and was remanded to reappear a week later. The escort record for her journey to and from court on this occasion noted that the F2052SH had been closed.

The medical record shows that on 4 July, the woman kept shouting at staff at lunchtime, but that she returned to her room of her own accord. The next day, she left her education class abruptly and asked to be allowed to stay in her room. The psychiatrist saw her again on 6 July and noted that she was much improved. He commented that she was due in court the following Friday and that if she was returned to the community, another psychiatrist would need to be told.

There is no available documentary evidence to show that the other psychiatrist was informed of the woman's discharge from prison or of her behaviour, mental state and clinical management whilst at New Hall.

Between 6 and 15 July, the woman continued to display episodes of unpredictable behaviour. On 16 July, she appeared again before Bradford magistrates and was given a conditional discharge from court.

6. Events during the woman's second period at New Hall: 16 August -11 October 2004

The woman's second period at New Hall in 2004 began only a month later on 16 August, when she was again remanded in custody by Bradford Magistrates' Court.

Events in police custody

The woman had this time been arrested at 2:20pm on 13 August, for assaulting two police officers and a detention officer in Bradford. She was seen in the police cells at 2:45am on 14 August by a police doctor who noted that she had been sniffing glue earlier that day, but that she was fit to be detained. The doctor recommended that she should be referred for mental health assessment. The woman was detained in police custody until her appearance before Bradford Magistrates' Court on 16 August. At that hearing she was remanded in custody to reappear at court on 23 August.

During the period of her detention in police cells, it was noted that the woman bore scars on her arms that were the result of recent self-harm incidents. The information was noted on the PER completed by Group 4 staff (later to become Global Solutions Ltd) when they escorted her to New Hall later that day. No evidence was available to show exactly when the self-harm incidents took place. However, a Prison Custody Officer raised a self-harm warning form on which she recorded that the woman had tried to slash her arms whilst in police custody.

Reception at New Hall

Upon her arrival at New Hall during the evening of 16 August, the woman underwent a first reception health screen, completed by a Staff Nurse who wrote on page 1 of the health screen proforma, *"F2052 warning."* During the screening process, the woman told the nurse that she had been at New Hall in July and that she had seen a doctor because of her mental health problems. The woman also told the nurse that she had recently sustained bruising on her legs and scratches on her arms. Guidance notes on the proforma completed by the nurse indicate that if a prisoner reveals evidence of injuries, the details should be recorded on a F213 (report of an injury to a prisoner). This was not done.

The woman admitted that she had recently suffered from manic depression and that she had been a psychiatric inpatient a week earlier. She also admitted that she had tried to harm herself in prison and in the community but denied scratching her arms. The woman told the nurse that she did not feel suicidal and that she would not harm herself as she felt safe at New Hall. She also told the nurse that she wanted to see a doctor. She was admitted to the healthcare centre primarily for mental health assessment. The nurse did not consider opening a F2052SH. There is no documentary evidence to indicate that any

attempt was made to obtain her medical records from the psychiatric hospital at which she had been an inpatient.

A cell-sharing risk assessment was completed on the same day. As the woman was judged as presenting a risk of harm to others, it was decided that she should be allocated single accommodation. She became violent during the reception process and punched a hole in the reception desk counter. She was later placed in a single room in the healthcare centre. No details of the woman's previous period of custody at New Hall were available during the reception process. The fact that she had been the subject of self-harm monitoring procedures at New Hall between 12 and 30 June 2004 was therefore overlooked. At Section 2 of the cell-share risk assessment form, it was recorded that there was no evidence that the woman had previously been the subject of a F2052SH.

The nurse wrote in the woman's medical record that she appeared "quite confused and elated in mood''. The nurse also recorded that the woman was to be admitted to the healthcare centre for urgent referral to a psychiatrist. This was organised through the Care Plan Approach (CPA) co-ordinator in the mental health in-reach team. He referred the woman to a visiting psychiatrist.

On 17 August, the woman appeared at a reception board taken by a Prison Officer. The interview had to be terminated because of the woman's bizarre behaviour. She continually spoke to other prisoners in the vicinity while the officer was trying to interview her, and kept telling the officer that her (the woman's) family was in danger. The checklist partially completed by the officer did, however, include a reference to the woman's self-harm history and to information included in her core record that told of her attempts to harm herself during and since childhood.

Consultation with the prison doctor

The woman was also seen by the prison doctor on the same day. The doctor wrote in the medical record that the woman was very agitated, argumentative and abrupt. As a result, the doctor terminated the interview and examination. At 11:05 am, CPA co-ordinator wrote in the medical record that he had "spoken to Probation who would like to organise a full psychiatric via the court''. The CPA co-ordinator wanted to plan a clinical appointment as soon as possible.

Between 17 and 22 August, a number of entries were made in the medical record showing that the woman was suffering from mood swings, hallucinations and paranoid ideation. She was prescribed chlorpromazine 150mg by night and 25mg twice daily.

Care plan

On 18 August, a personal care plan was opened. This identified four problems in respect of the woman together with a number of interventions designed to help her deal with them.

The first problem was recorded as mental health-psychosis. The interventions listed against this problem were:

- observe for signs of delusional ideas, especially paranoia focussed upon individual figures.
- observe for signs of auditory hallucinations, ie talking to self when alone.
- observe interaction with peers.
- refer to mental-health or doctor.

The second problem was the woman's aggression. The interventions listed for this were:

- to maintain a firm and consistent approach.
- to ignore undesirable behaviour.

The third problem related to the question of the woman's medication. The interventions were:

- to offer and maintain medication.
- to observe for EPS (extra-pyramidal side effects) and report same to MO.
- to offer sun-block when outdoors.

The fourth problem was the woman's need for a vaccination programme. She was to be given hepatitis B vaccinations on 10 September, 16 September and 14 October.

First care plan evaluation

The care plan set out a programme of weekly evaluations, the first of which took place on 21 August. On this occasion, the woman was described as hallucinatory, less aggressive and more manageable. She was to continue to take chlorpromazine.

Further appearances at court

On 23 August, the woman reappeared before magistrates and was remanded for a further day. The escort record completed for her journey to and from court indicated no risk of self-harm.

On 24 August, the woman was further remanded for three days. On 27 August, she was remanded to reappear for sentencing on 17 September.

Second care plan evaluation

On 28 August, the second weekly care plan evaluation took place. The following note was recorded:

> "Mental state more settled, encapsulated reasonably well when associating. Loses it when locked in. Responds to internal stimuli. Less aggressive tendencies. Uncomfortable with change."

Fluctuations in mental state

On 31 August, the woman lost her temper in an education class and kicked a teacher on the shin. The adjudication for this offence did not proceed as she was judged by the doctor to be unfit for both the hearing and any punishment that the Governor could give her.

On 2 September, the woman was again seen by a doctor. He found her very agitated. She told him that she was hearing voices that were talking about demons. The woman was clearly very upset and told the doctor that she did not want to live. The doctor did not consider opening a F2052SH. Neither did he or anyone else review the appropriateness of the woman's allocation to single accommodation or the frequency of observation she required. My investigator was told that all patients in the healthcare centre were routinely and automatically observed every 30 minutes irrespective of their medical status. However, the doctor did decide to increase the dosage of chlorpromazine from 25mg to 50mg twice daily.

Third care plan evaluation

On 4 September, the third care plan evaluation took place. The following record was made:

> "Mental state remains more stable. Able to encapsulate when associating, becomes distressed when locked in. 1/9/04 altercation with (another prisoner) - placed on report. Less aggressive tones overall noted."

Consultation with in-reach

On 7 September, the woman was seen by a representative of the mental health in-reach team to discuss her care plan. They talked about the woman's social, criminal and psychiatric background along with her current circumstances. During the interview, the woman said that on release from prison she wanted to move to a different area. The representative told her that he would liaise with

Shelter about finding her appropriate accommodation. He concluded his entry in the medical record with the comments:

> "Plan,
>
> 1. clinic
> 2. letter to doctor
> 3. liaise Probation
> 4. court 17/9/04''

The representative wrote to a psychiatrist in Bradford on 13 September as planned. In his letter, he asked the psychiatrist to visit the woman to plan her ongoing and post-discharge care.

Fourth care plan evaluation

The fourth weekly care plan evaluation took place on 12 September. The following record was made:

> "Mood appears slightly flat ? would benefit from mood stabilizer. Psychosis appears to be well encapsulated when on association but responds when alone. No aggression noted. Status elevated to enhanced (ie privilege level)"

Appearance in court for sentencing

On 14 September, the woman was allocated to a four-bed ward in the healthcare centre where she remained until 22 September. The records do not make clear how many other patients shared this ward with her during that brief period, or whether the decision to allow her to move into shared accommodation was based on a new cell sharing risk assessment.

On 14 September, the woman was distressed about the impending court appearance at which she knew she was due to be sentenced. She did not take her evening meal. The representative from the mental health in-reach team wrote in her medical record that he discussed this matter with a psychiatrist who agreed to review her case. However, the woman refused an interview with the psychiatrist after telling him that she did not want to see any more doctors because they did not help her. She said to him, "If you really want to help me, get me a rope.'' The psychiatrist did not consider opening a F2052SH.

On 15 September, the woman's mood deteriorated. She declined to attend the afternoon education period.

On 17 September, the woman appeared in court for sentencing. The escort record suggested that there was no known risk of self-harm. For this court

appearance, the woman's Probation Officer had prepared a pre-sentence report in which she commented that, in her opinion, the woman presented a significant risk of self-harm if sentenced to imprisonment. In the event, she was sentenced to five months imprisonment. The report was sent to New Hall after the court appearance and was delivered to the Sentence Planning Unit where prisoners' sentence plans are normally drawn up. As the woman was serving less than a year, it was not necessary for staff to complete a sentence plan for her. As a result, the comments made in the pre-sentence report did not trigger any fresh assessment of her risk of self-harm. However, as is pointed out in the Clinical Review, the CPA Co-ordinator was aware of the concerns expressed in the pre-sentence report and was able to a take account of this information and arranged medical follow up and assessment.

Upon her return to New Hall that day, the woman was located once again in the healthcare centre. No formal health screen took place following her change of status to that of a sentenced prisoner. However, the next day she attended a further reception board in the healthcare centre. A doctor commented in the medical record that she was low in mood and had a change of circumstances.

Fifth care plan evaluation

The next evaluation took place on 19 September. The following entry was made in the plan:

> "Mood continues to appear flat and is reluctant to engage with visiting psychiatrists. Is concerned she has nowhere to live. Result from court - 5 month sentence."

Psychiatric review

The medical record shows that a psychiatrist saw the woman again on 21 September, four days after she was sentenced. He included the following comments in his entry:

> "Sentenced on Friday 17/09 – 5 months. Will only serve 6 more weeks. Homeless at the moment. Was living in hostel accommodation. Feel terrible. Lost interest in activities. Don't want to do education, don't want to talk to people. Want to curl up and sleep and never wake up. Thought of hanging self - nowhere to do it - I've looked …
>
> … Can't see a future – feel doomed, nothing good - feel like I'm bad. ruminating all the time, past events. October 15th year since husband died ... Tearful often …

Feel worthless/useless ... I've failed. Unhappy all my life
Slashed my face when I was 17yrs old …''

The psychiatrist changed the woman's medication to 150 mg chlorpromazine at 10pm to improve her sleep. He also advised that she should be encouraged to attend education classes, to use distraction activities, and to engage with staff and counselling. He agreed to review her case after two weeks. He did not open a F2052SH. At interview, he said to my investigator, "Clearly I haven't documented that I suggested that a F2052SH would be opened but I was under the impression that a F2052SH was in operation."

Release planning

On 22 September, the CPA co-ordinator saw the woman again, this time to keep her informed of what was happening about her post-release accommodation. He reassured her that he was in touch with Shelter and that he was trying to find her a new GP.

Change of cell

On the same day, the woman was relocated to a five - bed room in the healthcare centre. Her cellmate was a mentally ill woman. There is no record of any cell sharing risk assessment having been completed.

Induction employment

On 24 September, it was decided that the woman should be given an opportunity to engage in some form of employment in the prison. She was therefore to commence an employment induction programme during the week commencing 27 September.

On 30 September, the woman returned from the induction workshop in distress. My investigator was told that she found it difficult to remain in the company of relatively large numbers of prisoners in an open area such as a workshop, and that this may have contributed to her distress. It was agreed that she should attend for work during the mornings only, until she felt better.

Further mental health deterioration

On 1 October, the woman declined to attend her education class. During the day, her mood deteriorated. She complained that she was frustrated with her cellmate. Staff responded swiftly and sympathetically by allowing her to relocate to the four-bed ward in the healthcare centre which she shared with only one other prisoner.

On 5 October, the woman was very emotional. Her mood was described by a nursing assistant as “quite low”. The nursing assistant talked to her and reassured her.

Sixth and last care plan evaluation

The only other record of a care plan evaluation presented to my investigator related to that which took place on 10 October, three weeks after the previous evaluation. The following entry was made in the plan:

> “Her MH [mental health] continues to improve although presently does appear worried regards prospect of t/ex [short for time expired or release from prison] and no accommodation. ? depressive element. Continue involvement with CPA.”

7. Events on and after 11 October 2004

At 8.30am on 11 October, the woman should have been given her medication of chlorpromazine, but this was not administered. My investigator was unable to establish the reason for this. The woman went straight to work but, at about 11am, she returned early because she experienced what staff described as a panic attack. She told a nurse that she was worried about her accommodation on release and whether she would be able to cope on her own. She was also anxious about seeing her Probation Officer later that day. The nurse reassured her and suggested to her that it would be inappropriate for her to return to work. The nurse made a note to that effect in the medical record. The woman did not go back to work. Instead, she remained in her ward in the healthcare centre. The other prisoner who shared the ward with her had gone to court earlier that day.

At midday, the woman took lunch and was then locked into the ward. The healthcare staff then took their lunch break in the nearby rest room.

The staff office has a large window, abutted onto one side of the ward, giving staff clear visual contact with those women located in the five-bed ward. There is also a toilet recess area in the ward. In order to prevent prisoners in the ward seeing confidential documents used by the healthcare staff in the office, the blinds over the window were drawn. The staff were therefore unable to observe the woman's activities in the ward.

At about 1pm, as part of her routine checks of prisoners, a Staff Nurse looked through the observation panel of the door that led into the ward. She saw the woman hanging from the toilet door which was partly opened. The nurse called for assistance. Four nurses who were in the rest room responded immediately. One was asked to fetch the emergency equipment. Two others took the woman's weight while another cut the ligature. At this stage there were no obvious signs of life. The woman was placed on the floor so that cardiopulmonary resuscitation (CPR) could commence. One of the nurses applied oxygen while another gave chest compressions. Both members of staff noted that the woman was not breathing and had no pulse. At about 1.05pm, an ambulance was called.

After about three minutes, a nurse telephoned the prison doctor who, at the time, was taking his lunch break in the mess just outside the prison, and asked him to attend. The nurse also fetched a resuscitation bag, emergency drugs and a pulse oximetry machine. Meanwhile further attempts were made by two other nurses to revive the woman.

At 1.21pm an ambulance operational supervisor arrived at the prison gate, followed by a full paramedic team at 1.24pm.

At about the same time, the prison doctor arrived to attend to the woman. He examined her and, although her breathing had not been established and her pupils were fixed, he detected a slight pulse. Resuscitation techniques therefore continued.

At about 1:35pm, the paramedics applied a defibrillator and gave further oxygen. At 1:51pm, the woman was transferred to a nearby hospital. The ambulance arrived at the hospital at 2:08pm.

The establishment's contingency plan log shows that at 3:15pm the Prison Service Press Office was informed of what had happened up to that point.

At 3:55pm, the woman was admitted to the Intensive Care Unit and placed on a ventilator. At 4pm a member of the prison chaplaincy team visited her.

At 6pm, one of the senior managers at New Hall telephoned the woman's mother to let her know what had happened to her daughter. Arrangements were made for a taxi to take her to see her daughter at the hospital. The cost of the taxi was to be met by the establishment. At about 8:15pm, the senior manager met the woman's mother at the hospital and talked to her at length about the events that had taken place earlier that day. As the senior manager retired shortly after the woman's death, it has not been possible to clarify why there was such a delay in contacting the mother.

At 11:15pm, the woman's mother decided to stay in the hospital overnight. A short while later, other family members arrived at the hospital to see the woman. All of them remained at the hospital overnight. The woman's condition remained unchanged that night.

12 October

The records show that at about 9:25am on 12 October, the woman's mother was awaiting advice from a doctor as to whether her daughter's ventilator could be switched off to allow her to breathe unaided. At 11:10am, it was confirmed that the ventilator had been switched off, and the woman was breathing unaided. The records show that, if the woman's condition deteriorated, she would be re-ventilated, but only for 24 hours.

Just after midday, a decision was made to withdraw the prison escorting staff. The woman was effectively on temporary release from custody. Members of the woman's family remained at her bedside.

During the morning, the woman's son, who at the time was also in prison locally, was escorted to the hospital to see his mother. He was escorted in handcuffs. Other members of the woman's family arrived at the hospital during the course of the morning. Both the Chaplain and the senior manager spent some time with

them. The record of communications between representatives of New Hall and the family indicate that the mother did not want her daughter to be revived if further difficulties arose. At 4:10pm, the woman passed away. The establishment's contingency plan log does not show if or when the Prison Service Press Office was informed of her death.

Support for the woman's family after her death

The next day, the Governor of New Hall spoke to the woman's mother on the telephone to express her condolences and to offer support, including financial support for the funeral arrangements. During the conversation, the mother expressed her concern that there had been a media announcement of her daughter's death in spite of the fact that she had asked that there should be no publicity and that she had not been able to inform other close members of her family beforehand. She was also concerned that her grandson had appeared in the hospital handcuffed.

Between 13 and 26 October, the Chaplaincy team at New Hall kept in touch with the woman's mother to ensure that she felt supported following her daughter's death and in preparing for the funeral. She was reassured that the full funeral costs would be paid for by the prison. The mother was offered the opportunity to visit the prison, but she declined. She also requested that no prison staff should attend the funeral. This request was honoured, but the Governor arranged for a bouquet of flowers to be sent from the establishment to the undertakers.

The woman's funeral took place on 27 October 2004.

8. Consideration of issues arising from the investigation

The following issues arose during the investigation:

- the absence of suicide prevention measures applied to the woman.
- the general level of care given to her.
- concerns expressed by the woman's family:
  - the nature of the medication prescribed for her
  - the level of observations made on her
  - the manner in which the news of her death was handled
  - the escorting of her son to visit her in hospital in handcuffs
- the failure to administer the woman's medication on 11 October
- issues raised by the Prison Officers' Association.

The absence of suicide prevention measures applied to the woman

Loss of F2052SH 12-30 June 2004

The woman was made subject to self-harm monitoring procedures between 12 and 30 June during her first period in custody at New Hall in 2004. The F2052SH that was used during that period was subsequently lost. It should have been stored with her core and medical records following her release from custody on 30 June 2004. It is an important document that should have been available to staff when she returned to New Hall in August.

As a consequence of the loss of the F2052SH, my investigator was unable to ascertain what specific circumstances led to the decision to place the woman on self-harm monitoring procedures on 12 June. Neither was he able to judge how well the woman was managed during the three-week period that the document was open, nor to judge the appropriateness of the decision to close it.

The Governor should ensure that adequate arrangements are in place for the safe storage of documents both whilst they are in use and after they have been closed.

Absence of self-harm monitoring procedures: August to October 2004

I am concerned that at no stage during the woman's second period of custody at New Hall in 2004, was she made subject to formal self-harm monitoring procedures.

The suicide prevention policy document in place at New Hall at the time of the investigation lists a number of self-harm risk indicators, including the following:

- history of self harm
- pessimism about the future

- impending release.

These indicators were evident in the woman's case: she had set fire to herself prior to her imprisonment and had tried to slash her wrists whilst in police custody. She was worried about where she was going to live once released from prison and how she was going to cope in the community.

A pre-sentence report, prepared by her Probation Officer at the time of her court appearance in September 2004, stressed that the woman would present a significant risk of self-harm if imprisoned.

A few days after her court appearance, the woman told a psychiatrist that she wanted to "curl up and sleep and never wake up". She also said that she had thought of hanging herself but that there was nowhere to do it because she had looked. The psychiatrist thought that the woman was already on a F2052SH.

I believe that more careful consideration could have been given to the assessment of the woman's risk of self-harm and of the need to make her subject to formal self-harm monitoring procedures. The nursing care plan drawn up for her was comprehensive, but lacked any reference to the management of her risk.

The Governor and PCT jointly should review the extent to which the establishment's suicide prevention policy is appropriately applied by healthcare staff, particularly in respect of those prisoners who, like the woman, manifest symptoms suggestive of their being at risk of self-harm or suicide.

The general level of care given to the woman

The Clinical Review assesses the management of the woman's health needs while she was in custody at New Hall on both occasions in 2004. In respect of her first period of custody, the report concludes that her medical care, diagnosis, treatment and review were thorough and appropriate.

However, the author of the Clinical Review draws attention to a number of flaws in the management of the woman's health needs during her second period of custody. He makes a number of recommendations about:

- clinical governance, management and accountability.
- training in risk assessment and documentation.
- aspects of FACE (a tool by which the risk to self and others can be assessed) and Care Plan Approach (CPA) documentation.
- clinical supervision.
- the physical environment of the healthcare centre, including the capacity of staff to observe patients and the ligature points available in the centre.
- the need for visible leadership within the healthcare team.

- the administration of prescribed medication.
- the system for the restricted unlocking of prisoners.

I agree with the author's findings and support the recommendations he has made. These have been integrated with my own recommendations at the end of my report.

Concerns expressed by the woman's family

The woman's mother asked my investigator to examine the following points:

- what medication was prescribed for her daughter and was her medication changed at any time?
- why was she not observed more closely?
- why was her death announced by the media before her mother could inform other close members of her family and when she had asked that there should be no publicity?
- why was it necessary for her daughter's son to be brought to his mother's bedside and to the funeral in handcuffs? Was the decision to do so based on a risk assessment?

What medication was prescribed for the woman and was that medication changed at any time?

Very shortly after her admission to New Hall in August 2004, the woman was assessed as suffering from mood swings, hallucinations and paranoid ideation. She was therefore prescribed chlorpromazine, an anti-psychotic drug for the treatment of disorganised and psychotic thinking. This prescription was maintained throughout her stay at New Hall, but the dosage was adjusted from time to time according to the signs and symptoms that she presented. The author of the Clinical Review raises no criticism about the prescription of chlorpromazine or about the dosage.

However, the investigation found that the woman did not receive her medication at about 8:30am on 11 October. At paragraph 6.3 of the Clinical Review, the author comments as follows:

> "I asked a consultant forensic psychiatrist, to provide an independent medical opinion as to the difference the failure to administer chlorpromazine on the morning of the woman's death would have made. He agreed that the absence of the drug on this occasion would have had nothing more than a marginal effect on her mood in the time-scale involved. However, there are clear duty of care issues that need to be considered. Additionally, had this been a different drug being administered, the effect on the individual could have been far more significant."

The following further comments are made in the concluding section of the paragraph:

> "The woman was in a hospital setting, she was receiving prescribed medication and this medication was a key element of her treatment at the time. The failure to administer the medication was not followed up by any action, e.g. the workplace was not alerted and colleagues there were not asked to monitor her/report any undue effect, there was no discussion with senior colleagues or medical staff nor any other action taken.
>
> There are no systems or management checks in place for ensuring medication has been administered appropriately before a patient leaves the centre.
>
> This situation therefore is most unsatisfactory and requires measures to be put in place which place more vigilance on the administration and monitoring of medications.
>
> It is recommended that as a minimum:
>
> 1. There is a more robust unit medication policy in place that clearly stipulates the arrangements for the administration of medicines by registered nurses (as per South West Yorkshire NHS Mental Health Trust policy).
>
> 2. There is a regular audit cycle established, administered by the local Drugs & Therapeutic Committee, specifically focused on the efficacy of the administration of medicines within the Health Care Centre."

I endorse these recommendations.

Why was the woman not observed more closely?

My investigator was told that patients in the healthcare centre are routinely observed by staff every 30 minutes, but that staff are not required to record details of these observations unless the patient is subject to F2052SH procedures. I have already made the comment that more careful consideration could have been given to the assessment of the woman's risk of self-harm and of the need to make her subject to formal self-harm monitoring procedures. Had she been subject to those procedures, the approach to her observation might have been more structured and more responsive to her mental state.
The Clinical Review also comments on this matter. At paragraph 6.4 of the review, the author comments as follows:

> "In this particular case, the observation arrangements did not directly fail. The woman was not on a F2052SH ... and therefore the service requirement was for her to be monitored only on a 30 minute basis. However, the arrangements for the management and oversight of someone who was not on a F2052SH appear weak: there is no procedural system in place to regulate this activity and there are physical problems in the actual observation process currently which need to be resolved."

The physical problems to which the author refers relate to the presence and use of blinds against the window which forms part of the partition between the ward in which the woman was found hanging and the adjoining staff office. The blind was in the closed position at the time the woman was discovered, thereby preventing effective observation into the ward by staff. My investigator was told that blinds were used to prevent prisoners looking at confidential papers in use in the office.

In his review, the author comments,

> "This particular issue poses a need to strike a balance between confidentiality of records/documentation, access to observation and patient dignity (the female prisoners are fully visible through the glass window). Historically, the window has not been regarded as having a primary function in terms of observation but in the light of this incident a review and decision on the matter would be advised."

I agree.

The Clinical Review goes on to make the following recommendations about the physical arrangements for observing prisoners within the healthcare centre and about observation policy in general:

> **"1. The Health Care Centre should review the physical arrangements for observation within the unit, in particular the use of the dividing glass window.**
>
> **An observation/supervision policy be established (and audited) that stipulates:**
>
> - **the level of observation**
> - **how observations are to be carried out**
> - **recording and reporting arrangements**
> - **monitoring and management arrangements**
>
> **(South West Yorkshire NHS Mental Health Trust have recently introduced a Supervision Policy which may be of assistance)."**

Included with these recommendations is a further suggestion, linked to the physical problems to which the Clinical Review refers, that there should be a "ligature review" to consider the proliferation of ligature points available in the healthcare centre and ways in which these can be reduced. The author recommends that this should be undertaken in partnership with the Safer Custody Group (now part of the National Offender Management Service).

At the time of the investigation, the establishment's suicide prevention policy set out the procedures to be followed, including observation procedures, for prisoners for whom a F2052SH is considered necessary. However, the policy did not legislate for those prisoners, who, like the woman, find themselves in the 'grey' area in the Healthcare Centre: i.e. subject to a nursing care plan but not subject to formal self-harm monitoring procedures.

It is within this context that I endorse the author's recommendations.

Why was the woman's death announced by the media before her mother could inform other close members of the family and after requesting that there should be no publicity?

My investigator was unable to ascertain the precise chronology of the events concerning the handling of information in the woman's case.

The establishment's contingency plan log shows that at 3.15pm on 11 October, the Prison Service Press Office was informed of the events regarding the woman up to that point. There is no record of when the Press Office was informed of her death. However, my investigator was told by the Press Office that the establishment reported the death during the evening of 12 October. It is most likely that, given the presence of some of the family members at the woman's bedside prior to, and at the point of, her death, an understandable assumption was made by New Hall staff that the next of kin were fully aware of the developing situation and that informing the Prison Service Press Office of the woman's prognosis at 3:15pm on 11 October was appropriate. It is unfortunate that the log does not show when the Press Office was informed of the woman's actual death.

I understand the concerns expressed by the woman's mother on this point, but in the circumstances it would be unfair to criticise the establishment beyond this recommendation:

The Governor should make sure that clear instructions are set out for the handling of information to families and the Prison Service Press Office in the event of the admission of a prisoner to hospital and after a prisoner's death. The Governor should also ensure that an accurate record is kept of any communication made to the Press Office about such matters.

Why was it necessary for the woman's son to be brought to her bedside and to the funeral in handcuffs? Was the decision to do so based on a risk assessment?

At the time of the discovery of the woman hanging at New Hall on 11 October 2004, her son was in prison at HMYOI Wetherby. Arrangements were made between New Hall and Wetherby for the son to be taken to see his mother in hospital. When he arrived he was in handcuffs.

My investigator interviewed the son and the manager at Wetherby responsible for security. The son confirmed that he resented having to remain in handcuffs during his visit with his mother, but was grateful for being allowed to see her. The manager confirmed that a risk assessment had been completed at Wetherby before permission was given by the Governor for the son to be taken to see his mother. My investigator was shown the paperwork relating to the risk assessment. He was not shown any paperwork relating to the risk assessment undertaken for the funeral escort.

As much as I understand the concerns expressed by the woman's mother, I am satisfied that the decision to escort her grandson in handcuffs was based on a full assessment of the security risk he presented and that the decision that he should remain in handcuffs was justified.

Concerns expressed by the Prison Officers' Association (POA)

The local branch of the POA raised the following matters with my investigator:

- They felt that, following the closure of mental institutions, many people who would formerly have been sent to them were instead sent to prison. The Prison Service's healthcare resources were, therefore, having to cope with a disproportionate number of mentally ill prisoners. The attention that had to be afforded to such prisoners had the effect of reducing the amount of time staff could spend with others. The POA considered that at New Hall the Healthcare Centre was so full of mentally ill prisoners that it had effectively become a no-go area for prisoners with other types of illness, or for prisoners who simply needed a period of respite.

- The POA believed that there were so many prisoners subject to F2052SH monitoring procedures at any given time that staff could not offer the level of care each individual required. The level of observation required in each case was too high for staff to be able to cater properly for individual needs. The greater the number of F2052SH checks that had to be completed, the poorer the quality each check became.

- They suggested that prisoners were frequently at the highest risk of self-harm at weekends when staffing levels were at their lowest and when there was often a reduction in the regime.

- Finally, the POA said that prisoners should be able to spend more time out of their cells, not least because they could then be more easily observed.

My investigator asked the Governor to comment on the POA's concerns.

- The Governor did not wish to comment on the claim made by the POA that, following closure of mental institutions, many people who would formerly have been sent to them were instead sent to prison.

- The Governor agreed that the inpatient unit at New Hall does, in the main, cater for mentally ill women. However, she pointed out that the unit also caters for women who have acute physical illness, if they cannot be cared for on normal location. The Governor disagreed with the assertion that the inpatient unit had become a 'no go' area for those women requiring admission for acute physical conditions. The Governor stressed that the inpatient unit criteria for clinical admission did not include admission for women who need a period of respite. However, managers had co-operated to facilitate that type of service as and when it was required, and when it could be accommodated.

- The Governor pointed out that, during October 2004, there were 78 F2052SH documents opened. Seventy F2052SH documents were also closed. There was a total of 111 reported incidents of self harm during October 2004. The year to date (31 October, 2004) figure of self-harm incidents indicated some 873 acts of self harm at HMP/YOI New Hall. During the same period for 2003, there were 1,181 recorded incidents of self-harm. The Governor noted that this showed a reduction of some 308 incidents of self-harm from the previous year.

- The Governor had some difficulty in commenting on the POA's assertion that the level of observations required in each case was too high for staff to be able to cater properly for individuals needs, as these observation levels were set by a multi disciplinary team of staff who had gathered to assess/manage individual case reviews of those prisoners who were deemed to be at risk at the time. The Governor pointed out that this was in line with the Local Suicide & Self Harm Prevention Policy Document, as the establishment promoted a "holistic" whole prison approach to the management of those prisoners identified as being at risk of suicide and self-harm.

- The Governor stressed that she was aware of the fact that the number of prisoners subject to F2052SH monitoring at the time of the woman's death

was slightly higher than the figure recorded the previous month. However, she stressed that, although there were 111 acts of self-harm reported in October 2004, only a small number of prisoners were responsible for a high proportion of these incidents.

- In response to the POA's assertion that prisoners were frequently at the highest risk of self-harm at weekends, when staffing levels were at their lowest, or when there was a reduction in the regime, the Governor reported that 62 per cent of the incidents that occurred in October 2004 happened during weekdays and only 38 per cent occurred at weekends. The times during which the incidents occurred were:

  8am – 12 noon, 16 incidents (14.5%)

  12 noon – 8pm, 65 incidents (58.5%)

  8pm – 8am, 30 incidents (27%)

  The Governor also provided similar statistics for incidents that took place in the healthcare centre in the same month. Fourteen incidents of self-harm were recorded for the month, involving only four prisoners. Of these 14 incidents, nine took place between Monday and Friday. The remainder took place at weekends.

- In response to the POA's concern about the length of time prisoners were able to spend out of their cells, the Governor presented statistics showing out of cell activity hours for the Healthcare Centre for the whole of 2004. These showed that the yearly out of cell activity time was 7.91 hours of purposeful activity per prisoner per day. The monthly figure recorded for eleven of the twelve months was eight hours per prisoner per day. This was against the prison's Key Performance Target of ten hours. The Governor felt that the hours achieved in the Healthcare Centre were realistic, given the difficulties presented by a difficult and challenging client group.

During the course of the investigation, my investigator was impressed by the personal commitment shown by the Governor to the enormously challenging task of catering for the individual and collective needs of those in her charge. My investigator was no less impressed by the sincerity and determination shown by the staff at New Hall in facing up to their responsibilities for the care of prisoners. The representations made to the investigation by the Prison Officers' Association are, I believe, an expression of the genuine concern felt generally at New Hall about the difficulties imposed on the institution by the imprisonment of so many mentally ill and vulnerable young and adult women. The statistical information presented to my investigator in respect of the number of self-harm incidents and the number of F2052SH documents opened and closed at New Hall around the

time the woman died are testimony to the very serious problems faced on a daily basis by the Governor and her staff.

Her Majesty's Chief Inspector of Prisons has drawn attention to these problems in her reports on women's prisons, including New Hall. In my description of the establishment earlier, I have referred to the report of an inspection of New Hall by the Chief Inspector in November 2003 in which she commented that the prison was holding women and girls who should not be there. I echo her words. The woman was, in my view, typical of those damaged and vulnerable women whose needs cannot be met in prison.

9. Recommendations

(These recommendations are derived both from the Ombudsman's report and the Clinical Review.)

1. Suicide prevention

- The Governor should ensure that adequate arrangements are in place for the safe storage of self-harm forms both whilst they are in use and after they have been closed.

- The Governor and PCT jointly should review the extent to which the establishment's suicide prevention policy is appropriately applied by healthcare staff, particularly in respect of those prisoners who, like the woman, manifest symptoms suggestive of their being at risk of self-harm or suicide.

- The Governor should ensure that a clear policy is put in place in the Healthcare Centre for the monitoring of inpatients, especially in respect of those who are considered to be at risk of self-harm or suicide. The policy should stipulate:

    - the level of observation
    - how observations are to be carried out
    - recording and reporting arrangements
    - monitoring and management arrangements, including audit (South West Yorkshire NHS Mental Health Trust have recently introduced a Supervision Policy which may be of assistance.)

- The Governor should review the physical arrangements for observation of inpatients in the Healthcare Centre, especially where the window dividing ward H2.01 and the staff office is concerned.

- The Governor should carry out a review of the current ligature points in the Healthcare Centre.

2. Information to next of kin

- The Governor should make sure that clear instructions are set out for the timely handling of information to families and the Prison Service Press Office in the event of the admission of a prisoner to hospital and after a prisoner's death. The Governor should also ensure that an accurate record is kept of any communication made to the Press Office about such matters.

3 . Clinical governance

In conjunction with the Wakefield West Primary Care Trust, the Governor should:

- urgently review and agree clinical governance management and accountability arrangements.

- review the arrangements for risk assessment and risk management to ensure a co-ordinated process that brings together all risk assessment activity.

- establish a prioritised training and development plan for relevant nursing staff that includes risk assessment, management of deliberate self-harm and suicide, and documentation standards.

- review the arrangements for the operation of the integrated FACE/CPA documentation process to ensure that appropriate summarised background and other relevant information is included within this assessment process.

- review the arrangements for clinical supervision and ensure that systems are put in place to help staff maintain and develop their standards of professional knowledge and competence (consistent with Nursing & Midwifery Council Code of Professional Conduct requirements).

- implement the recommendations from the “In Patients Risk Management Profile 2003” and the report by Dr Louisa Snow: “Overview of Suicide and Self Harm Prevention at HMP New Hall, 2004”.

- undertake a NHS Patient Environment Team Assessment (PEAT) specifically for the inpatient facility in the healthcare centre, in respect of its physical care environment, with the aim of providing an appropriate therapeutic milieu for patient care (e.g. standards of decoration, furniture, fitments).

- ensure that there is visible leadership within the Healthcare Centre in support of staff and to promote and maintain standards (the siting of a nurse manager’s office within the unit may assist in this process).

- ensure that a clear medication policy is put in place in the Healthcare Centre that stipulates the arrangements for the administration of medicines by registered nurses (as per South West Yorkshire NHS Mental Health Trust policy).

- ensure that a regular audit cycle is established, administered by the local Drugs & Therapeutic Committee and specifically focused on the efficacy of the administration of medicines within the healthcare centre.

- ensure that the present “restricted unlock” system that operates within the healthcare centre is made subject to a procedural process.

Annex A

PRISON SERVICE PLAN OF ACTION FOR IMPLEMENTATION OF RECOMMENDATIONS

No	Recommendation	Accepted /Partially accepted/ Not accepted	*Response*	Target date for completion
1	The Governor should ensure that adequate arrangements are in place for the safe storage of self-harm forms both whilst they are in use and after they have been closed.	Accept	Since the Implementation of ACCT at New Hall (March 05), all closed ACCT Documents are returned to the Safer Custody Office to be filed securely. Local Notice to staff to be issued to remind staff of this process.	28th February 2006
2	The Governor and PCT jointly should review the extent to which the establishment's suicide prevention policy is appropriately applied by healthcare staff, particularly in respect of those prisoners who, like the woman, manifest symptoms suggestive of their being at risk of self-harm or suicide.	Accept	The Current Policy dated April 2005 has recently been reviewed and the first draft is due to go out to consultation to the Suicide Prevention Committee, members of SMT, POA and Y&H Area Safer Custody Advisor by 28th Feb 2006. The Suicide Prevention Policy & Procedures document was reviewed as a result of a previous PPO recommendation. Once this has been accepted, it can be discussed with PCT, and review the extent to which it is applied by Healthcare staff at New Hall	31st March 2006
3	The Governor should ensure that a clear policy is put in place in the Healthcare Centre for the monitoring of inpatients, especially in respect of those who are considered to be at risk of self-harm or suicide. The policy should stipulate: • the level of observation • how observations are to be carried out • recording and reporting arrangements monitoring and	Accept	The Current Suicide Prevention Policy Document identifies the minimum number of entries that are required within an open ACCT Document on a daily basis. These must be qualitative entries, which demonstrate interaction (a conversation) has taken place with the prisoner subject to ACCT procedures. The level of observation a prisoner is on will be considered on an individual basis, and will be set by a local Case Management Review. A new Inpatient Policy will be formulated in partnership with	31st March 2006 30th April 2006

	management arrangements, including audit (South West Yorkshire NHS Mental Health Trust have recently introduced a Supervision Policy which may be of assistance.)		South West Yorkshire Mental Health Trust which will cover all areas identified within the Clinical Review.	
4	The Governor should review the physical arrangements for observation of inpatients in the Healthcare Centre, especially where the window dividing ward H2.01 and the staff office is concerned.	Accept	Y&H Area Safer Custody Advisor has agreed to look at this recommendation in relation to the observation of In patients as part of his visit to review ligature points within the Healthcare Centre at HMP/YOI New Hall (As per Recommendation 5) and include in his report to the Head of Safer Custody. The long-term plan for the 5 bed ward area is that it will become a day care facility. This is due to be implemented in January 2007. In the short term levels of observations for this facility will be covered in the revised in patient policy document as per recommendation 3.	31st March 2006
5	The Governor should carry out a review of the current ligature points in the Healthcare Centre.	Accept	As per Recommendation 4	31st March 2006
6	The Governor should make sure that clear instructions are set out for the timely handling of information to families and the Prison Service Press Office in the event of the admission of a prisoner to hospital and after a prisoner's death. The Governor should also ensure that an accurate record is kept of any communication made to the Press Office about such matters.	Accept	HMP/YOI New Hall has trained and appointed two Family Liaison Officers. Part of their role is to deal with the timely handling of information to families. Death In Custody Contingency Plans highlight the need to record the time we contact the press office in relation to any Death In Custody. HMP/YOI New Hall to formalise a local Protocol which identifies a formal risk assessment procedure and strategy for working with bereaved families. Consideration will be given to allowing the Family Liaison Officer to attend the Media Liaison Officers Course.	30th April 2006
7	In conjunction with the Wakefield West Primary Care Trust, the Governor should:	Accept	Carry out a review of the current Clinical Governance Management & Accountability	August 2006

	urgently review and agree clinical governance management and accountability arrangements.		arrangements in line with the findings contained within the Clinical Review as part of this PPO Report. A project team will be established to develop joint Clinical Governance arrangements across the 3 service providers.	
8	Review the arrangements for risk assessment and risk management to ensure a co-ordinated process that brings together all risk assessment activity.	Accept	FACE Risk Assessment, Cell Sharing Risk Assessment, reception screening and finally ACCT Document where appropriate are all completed for prisoners who are admitted to the In patient Unit. This information will be shared on a need to know basis with other disciplines with the patients consent. All three documents will be discussed at the weekly multi-disciplinary ward round. The Inpatient manager will be responsible for the process.	Completed
9	Establish a prioritised training and development plan for relevant nursing staff that includes risk assessment, management of deliberate self-harm and suicide, and documentation standards.	Accept	Clinical Training and a Training Plan will be formulated for the Mental Health team, which will include Risk Assessment and Management of Self Harm, in partnership with South West Yorkshire Mental Health Trust.	August 2006
10	Review the arrangements for the operation of the integrated FACE/CPA documentation process to ensure that appropriate summarised background and other relevant information is included within this assessment process.	Accept	FACE & CPA is now in place within the In-patient facility. Every prisoner admitted as an in patient has a FACE document completed and placed within the CPA folder on the P Drive to allow all Healthcare staff access.	Completed
11	Review the arrangements for clinical supervision and ensure that systems are put in place to help staff maintain and develop their standards of professional knowledge and competence (consistent with Nursing & Midwifery Council Code of Professional Conduct requirements).	Accept	Carryout a Full Review of the current Clinical Supervision Procedures in operation at New Hall and make recommendations in line with the findings of the Clinical Review as part of this PPO Report.	August 2006
12	Implement the recommendations from the "In Patients Risk	Partially accept	Most if not all of the recommendations made by Dr Louisa Snow in her report	30th December 2006

	Management Profile 2003" and the report by Dr Louisa Snow: "Overview of Suicide and Self Harm Prevention at HMP New Hall, 2004".		"Overview of Suicide and Self Harm Prevention at HMP New Hall 2004" have been implemented. These recommendations shall be reviewed in consultation with Dr Louisa Snow. A full review of current service provision will take place, which will systematically look at Risk Management, Workforce Issues and Service Delivery, which will supersede the Risk Management Profile 2003 document.	
13	Undertake a NHS Patient Environment Team Assessment (PEAT) specifically for the inpatient facility in the healthcare centre, in respect of its physical care environment; with the aim of providing an appropriate therapeutic milieu for patient care (e.g. standards of decoration, furniture and fitments).	Accept	PEAT Assessment completed in September 2005, and Action Plan completed as part of this assessment. All of the recommendations from PEAT Assessment have now been completed with the exception of a civilian cleaner and pictures for the walls of the In Patient Unit.	By End of Feb 2006
14	Ensure that there is visible leadership within the healthcare centre in support of staff and to promote and maintain standards (the siting of a nurse manager's office within the unit may assist in this process).	Accept	The Operational Capacity of the In Patient Unit has been reduced from 19 to a 10 Bed Facility. This allows for the conversion of one cell into an In Patient Unit Managers office once funding has been secured. Bid for funding for conversion to be completed and submitted. The interim measure has a SHCO as inpatient manager, who has completed the first year of his RMN, supported by Head of Healthcare who is RMN, and Mental health Project manager SWYMHT will appoint a band 6 mental health lead who will based on inpatients, and line managed by a band 7 who will have overall responsibility for clinical leadership.	By 30th April 2006
15	Ensure that a clear medication policy is put in place in the healthcare centre that stipulates the arrangements for the administration of medicines	Accept	Medication Policy will be formulated in partnership with South West Yorkshire Mental Health Trust	30th April 2006

	by registered nurses (as per South West Yorkshire NHS Mental Health Trust policy).			
16	Ensure that a regular audit cycle is established, administered by the local Drugs & Therapeutic Committee and specifically focused on the efficacy of the administration of medicines within the healthcare centre.	Accept	This will be reviewed by the Medicines Management Committee and any appropriate action taken	30th April 2006
17	Ensure that the present "restricted unlock" system that operates within the healthcare centre is made subject to a procedural process.	Accept	A full review of the Restricted Unlock system in operation within the Inpatient Unit, has been carried out and a written Policy and Procedures document for the Use of Restricted Unlock status within the In patient Unit has been produced and implemented.	Completed