INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING

THE DEATH OF A WOMAN AT

HMP/YOI BROCKHILL IN OCTOBER 2004

Report by the Prisons and Probation Ombudsman for England and Wales

September 2006

This is a report of an investigation into the circumstances of the death of a woman at HMP/YOI Brockhill in October 2004. The young woman was found hanged in her cell. She was 19 years old and in prison for the first time.

This investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which ran from 1 April 2004 to 30 November 2004. The Governor of HMP Swinfen Hall, assisted by other members of Prison Service staff, undertook the investigative work. A clinical review was carried out by the Acting Director of Public Health at the Redditch and Bromsgrove Primary Care Trust. An investigator from my office liaised with all members of the team. I am extremely grateful to them all for their work. I am also grateful to the West Mercia Police for their co-operation, having carried out a very detailed investigation of their own, and to the staff and prisoners at Brockhill.

One of my family liaison officers accompanied by the investigator visited the woman's mother. The young woman's mother raised a number of issues that I hope my investigation has answered. I would like to take this opportunity to express my condolences to the woman's parents, brother and other family members, and to all those touched by her loss.

The young woman had been identified as being at risk of self-harm following her arrival into Brockhill on 25 August 2004. She was supported throughout the early stages of her remand, but the formal procedures were closed on 4 October when the risks appeared to have reduced and she seemed more positive. My report identifies a number of procedural deficiencies and I make 11 recommendations.

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PRISONS AND PROBATION OMBUDSMAN **April 2006**

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Summary

The woman appeared at the Magistrates' Court in August 2004 and was remanded in custody to appear at the Crown Court on 2 September. Upon her arrival at HMP Brockhill, she was assessed as suffering from depression, for which she was taking anti-depressant medication, and as having previously self-harmed. The assessment also identified that she was regularly consuming excessive amounts of alcohol.

As a young offender, the woman was located onto D Wing. This was her first time in custody.

During an assessment the following day with the Substance Misuse Manager and a doctor, she stated that "I'd rather be dead then in here". As a result it was decided to place her on an F2052SH self-harm and suicide monitoring booklet.

She remained on the F2052SH for a period of 39 days, during which time she was reviewed 11 times. During this period, it was recorded that she self-harmed on a number of occasions and her observations were altered as a result.

During her time in custody, she was also offered the support of a Registered Mental Nurse and psychiatric services and counselling. At the review on 4 October 2004, it was decided to take her off the F2052SH procedures. It was recorded that she presented more positively, had gained enhanced status on the Incentives and Earned Privileges (IEP) scheme and had secured employment on the internal gardens party. All of these things suggested to staff that her risk of self-harm had reduced.

The woman was located in cell D214 on 13 September, following an episode of self-harm. This cell was on the main corridor and close to the staff office on D wing. The cell is not up to full 'safer cell' specification but has benefited from some modifications to the lights and windows to minimise ligature points. Once removed from the F2052SH procedures, she requested a cell change and was allocated to cell D204. This cell is a normal cell (not a safer cell), but as part of a prison-wide project has been fitted with anti-ligature windows.

At 7:00 am, on the morning of 15 October, the young woman was found suspended by a ligature which had been attached to the conduit running from the cell light fitting. She did not show any signs of life and it appeared that she had been dead for some time. The ambulance was called at 07:05am and paramedics attended at 07:25.

She was declared dead five minutes later by the police surgeon. She had left a suicide note.

The investigation focussed on her treatment whilst in custody, the assessment of risk, specifically the management of her vulnerability and how this was communicated amongst prison staff, specialists and external agencies.

My report makes 11 recommendations.

Matters raised by the woman's family

When my colleagues met with the young woman's mother, she raised a number of issues that she wanted the investigation to look into. These were the young woman's use of anti-depressants, her diagnosis of manic depression and her use of a reflective notebook used at the recommendation of the psychologist. The clinical review comments in detail on these issues.

The mother last visited her daughter on the afternoon of 14 October, the day before the young woman was found. The mother recalled that the young woman had appeared fine at the visit, but had expressed some worry that she had recently heard that Brockhill was going to become a prison for males rather that females and she felt rather unsettled by this.

On 26 August, her father wrote to the young woman's solicitor raising his concerns about his daughter's vulnerability. He outlined her family history, her psychiatric history including her self-harming, the impact of her recent failed relationship and the impact of the prolonged divorce between her parents. It was the view of her father that his daughter was vulnerable and that there was a significant risk of self-harm or suicide. The letter was received at the prison on 31 August 2004, at which point the young woman had already been placed on the F2052SH procedures.

A draft version of this report was sent to the young woman's family and the Prison Service. In response to the recommendations, the Prison Service provided an action plan.

The young woman's mother accepted the recommendations. In addition, she made a number of factual corrections, and asked that the report highlighted that her daughter was allowed to make telephone calls to her on the days that she could not visit. The mother had found this very helpful.

Events leading to the young woman's death

The woman appeared at the Magistrates' Court in August 2004, charged with attempted murder. She was remanded in custody and was to return to the Crown Court on 2 September 2004. She arrived at HMP Brockhill at 5.30 pm.

Reception procedures at Brockhill require staff to carry out three assessments. The first is an assessment of how the prisoner presents in light of the information contained on the prisoner escort (PER) form; the second is completion of a Cell Sharing Risk Assessment (CSRA) form; the third is a Reception First Health Screen (RFHS) assessment.

The Prisoner Escort Record form, which accompanied her into the prison had been ticked in both the 'no known risk' box and the no issues in relation to 'suicide/self-harm' box. However, under the 'further information about risk' section of the PER form, which had been completed at the police station, was recorded: 'depression. Just sinking in about the sentence she could get.' Part B of the PER recorded that she was being observed every ten minutes whilst in the court cells. The PER also recorded that she had been administered Fluoxetine (Prozac) that morning on her arrival into court custody. The investigation team discovered that in the early morning of 24 August, whilst in police custody, she had been placed on constant watch until she was handed over to court services on the morning of 25 August. They placed her on a 15 minute watch. None of this information was transferred onto the PER and therefore was not known to prison staff during her reception. This was a significant omission.

The Cell Sharing Risk Assessment is a form used by the Prison Service to assess the risk that a prisoner may pose to another if they were to share a cell, and it briefly asks about the risk of self-harm. Section 2 of the CSRA, which was completed by an officer in reception, recorded alcohol/drug abuse and dependency, that the young woman requested a single cell, and that it was her first time in prison. The completing officer indicated they had seen the PER form. Section 3 of the CSRA was completed by the duty nurse and records 'first time in custody, but appears ok'. The section 'Following the self-harm assessment have any concerns been raised?' was left blank.

The duty nurse also completed the First Reception Health Screen. It is not clear from this interview if the nurse had seen a copy of the PER form. During the interview, the young woman openly and clearly gave information about her previous physical and mental health problems. She also disclosed that she was currently taking anti-depressants (Prozac 20mg). She did not identify any other issues in relation to her physical well being. In relation to substance use, it was recorded that she was drinking 10 pints a day plus shorts. (If more than 14 units are being consumed per day, or there are signs of withdrawal, there should be a referral to a doctor for a further assessment. This was initiated and she saw the doctor the next day.) Routine urine samples proved negative for heroin, methadone, amphetamines, cocaine and crack but were positive for benzodiazepines. The young woman denied any illegal drug use. As part of the initial mental health assessment, it was disclosed that she had

previously been seen by a psychiatrist as a result of depression and self harm. Although she was not currently receiving any psychiatric follow up, she had been seen by the community psychiatric nurse two years previously. She said her last self-harm incident had been approximately one year before. She was described as appearing calm and not disturbed by the prison environment.

The following day (26 August), the young woman was seen by the Substance Misuse Manager, and the prison doctor. Due to her history of depression, previous self-harming, and the fact that it was her first time in custody and there was the prospect of a long sentence, it was decided to place her on suicide prevention (F2052SH) procedures and hourly observations were started. The Inmate Medical Record (IMR) recorded that she was prescribed medication for depression and her alcohol detoxification was started.

The Mental Health Manager at Brockhill, saw her on 27 August for a mental health screening. She recalled the young woman being very angry and frustrated at not killing her victim. She refused the help offered but the mental health manager recommended she go on the Registered Mental Nurse (RMN) case load for support and monitoring. She appointed an RMN, as the young woman's key worker. The mental health manager referred her to the GP in relation to her Prozac prescription. Her 2052SH was reviewed and the hourly observations continued.

The young woman's solicitor wrote to her on 26 August and it is assumed she received the letter at some point in the following days. The letter included information concerning the possible length of sentence – 'The maximum sentence that you could receive in respect of this allegation is a life sentence. The sentence that you will receive, assuming that you are either convicted or plead guilty to the offence, is likely to be one of a substantial period of imprisonment. At this stage it is rather too early to estimate exactly how long it will be.' The solicitor said he had subsequent discussions with her regarding sentence and the possibility of reducing the charge to a section 18 assault, which he suggested might attract a sentence of between three and five years.

On 30 August, the young woman made cuts to her arm using a screw. On 1 September, she was seen following another incident of deliberate self-harm (DSH) to her wrist using a staple. During that day, there were three reported incidents of DSH. She stated that she was worried about her court appearance the following day. At 3.31 pm, her watch was increased to half hourly. Despite this, there are no entries in the watch record between 07.45 am and 1.50 pm.

On 2 September, she appeared at the Crown Court where she was again remanded into custody. Whilst waiting in reception prior to leaving the establishment, she was assaulted by another prisoner. It was alleged that the other prisoner demanded a cigarette/roll up and when she did not comply she was punched in the face causing bruising to her right eye and cheek. The prisoner was charged with assault, which was referred to the police. The

young woman was photographed and the police attended the prison and interviewed the prisoner on 8 September. Her alcohol detoxification finished on 2 September.

On 3 September, following an F2052SH review, the level of observations was reduced to 24 daily. She stated that she felt better now that she had been to court and that she got stressed prior to her court appearances. On 4 September, her observations were changed to 24 daily and 48 nightly, following a further act of self-harm.

On 6 September, she saw a consultant clinical psychologist, for the first time. The clinical review indicates that this would appear to have been a brief psychological assessment and the outcome was that he would see her again if she requested it. The same day a trainee psychologist and qualified counsellor saw the young woman. In interview, the psychologist stated that a prison officer had originally referred the young woman to her for counselling. She reported that the young woman was cutting herself quite a lot during the early stages of her time in custody and that she had said that this was a release. The psychologist stated that, during counselling, the young woman said that she had actually tried to commit suicide several times when she was 12 years old. She stated that the young woman had said it was at this point that her self-harming began.

The psychologist recalled that the young woman had told her she liked writing poetry and drawing, and that this helped to prevent self-harming. She suggested to her that she keep a journal to log events and her feelings. The young woman agreed but did not wish to share the contents with her. During these counselling sessions, the psychologist worked with her on developing relaxation techniques.

On the morning of 7 September, she had a further F2052SH review. Notes made by the mental health manager, stated that the woman participated very well and that she expressed some anxieties about the length of sentence she might receive. Her observations remained at hourly during the day and half hourly at night. Notes from the review state that the woman was feeling very good that day and that she had good eye contact. Later that day, she had a RMN assessment. Records indicate that during this session she described herself as low in mood and had poor eye contact.

On 13 September, she self-harmed twice by reopening cuts to her wrists with her nails. A review of her F2052SH was undertaken and she stated that her solicitor had informed her that she would get a long sentence. Her observations were increased to 96 daily. Later that day, she was told to move from cell D206 to cell D214 which was located nearer the staff office and had fewer ligature points. (It should be noted that this cell was not a full specification safer cell as identified by the Prison Service Safer Custody Group. The cell had been fitted with anti-ligature windows and the lighting had been encased in coving. Both these arrangements reduced ligature point attachments.)

On 14 September, she re-opened existing wounds on two occasions causing significant blood loss. A review was carried out and it was decided to maintain the current level of observations at 96 daily. On 15 September, following a further review, it was decided to reduce the level of observations to 48 daily but 96 (every 15 minutes) during patrol state (when prisoners are locked in their cells and officers patrol the wings). It is recorded that she was feeling much better and was aware of the triggers to her self-harming.

On 16 September, the mental health manager made a note in her medical notes that she was concerned about her mental health and felt that the anti-depressants were not working. The manager wrote that she would refer her to the GP. An F2052SH review took place on 17 September and it was recorded that the young woman was sleeping better, had no thoughts of self-harming, and had had a visit from her mother the day before. The level of observations was reduced to 48 daily. The on-going support plan recorded that she should aim to get a job on the gardens. (At this time, the perception of staff was that prisoners who were on open F2052SHs could not work on the gardens party.)

On 18 September, the young woman made an application:

> 'Can someone review my medication please? I don't think my prozac is working anymore. Some days I'm high as a kite, others I want to kill myself.'

On 19 September, she reported as part of her mental health review that she was having visual hallucinations. Initially, she thought this was a result of her detoxification from alcohol but these had continued post detoxification and she reported feeling frightened by them.

On 20 September, she saw the psychologist for the second time. At this clinical session she was said to have quite a low mood. She reported being up and down most of the week and described having experienced hallucinations. There was some detail about what these images were. The night of the alleged crime was also discussed. She reported concerns regarding her case and was anxious that she might get a life sentence. She also described how she was feeling upset with her father.

During this contact, it was evident that her anxieties had increased. She described sleep disturbances, lack of concentration, restlessness and fidgeting. Once again, coping strategies were discussed. She felt that writing in the journals helped and that she was going to the gym, which helped her feel good whilst she was there. Relaxation techniques were also discussed.

At about 10:00 am on 21 September, she made a superficial small incision wound to her wrist with a staple. Later that day, she was seen by the duty GP. He reported her as having mood swings and referred to the visual hallucinations. The plan was for a referral to the psychiatrist in view of her young age and her mood swings. He also queried whether she would in future need mood stabilisers.

A further F2052SH review took place on September 22. Her watch was maintained at twice hourly. There is an entry in the wing observation book and a security report that the young woman was amongst a number of prisoners found smoking cannabis in a cell.

She had her first appointment with a consultant forensic psychiatrist, on 23 September. A full clinical history was taken and they discussed stopping her Prozac. Following this consultation, the plan was to stop taking Prozac and to review in three weeks time. There was also a discussion about whether she would benefit from mood stabilisers but she wanted to try without any medication. This was the last day that she took Prozac.

On 26 September, she stubbed her big toe on the wall in her cell and her nail came off (this may have been an act of deliberate self-harm but was not recorded as one). This is the last report of any injury by her. The psychologist saw her for the last time on 27 September. The young woman stated that she had had a good week. She said that she still had ups and downs, but the ups lasted longer. She said she had not made any cuts in the preceding week and had not thought about suicide for three days. A further review took place on 28 September and her observations were reduced to 24 daily. She reported that she was 'fine' and able to talk about her problems.

During October, her mood appeared to improve. There were no further incidents of self-harm. Following a review of her F2052SH on 4 October, her monitoring form was closed. She was reported to be 100 per cent better than she had been; she had gained the enhanced level of privileges and stated that she had no thoughts of self-harm. Under the support plan section of the F2052SH booklet is the word 'close'. There was no on-going support plan. Two appointments were arranged during October with the psychologist but neither of these was kept, as the young woman was unavailable as a result of a legal visit and then being in work.

Following the closure of her F2052SH, she requested a cell change and was moved from cell D214 to cell D204. On 7 October, she started to work for the gardens party. On 13 October, she was again seen by the psychiatrist. She was described as euthymic (normal mood), having stopped her Prozac. She was sleeping well and feeling better, although her eating was reported as being out of control. This seemed to be associated with her trying very hard to reduce her DSH. Although she was not self harming, the urge was very strong for her to do so. The plan following this consultation was for her to have her weight checked regularly, to continue on the RMN case load, and for the psychiatrist to see her again if she was asked to. But no regular follow up was arranged.

Whilst in custody, the young woman made regular phone calls, the majority of which were to a man with whom she had started a relationship a few days prior to coming into prison. On 13 October, she indicated on the phone that she wanted to end their relationship and that she wanted him to stop visiting her. A few days prior to this call, the man had told her that he had been

involved in an altercation with her ex-boyfriend and the alleged victim of the assault. One of her friends in prison said in interview that she had been worried that she might face further charges in relation to this incident. (This was the only mention of this found during the investigation.)

The RMN stated that the young woman had an upsetting phone call in the last few days before her death, although she was unsure of what it was in relation to. The RMN also believed that the young woman had received her depositions from her legal advisors the day before her death, although my investigation is unable to confirm whether this was the case.

14 October 2004

A prison officer recalled that, on the morning of 14 October, the young woman was ready for work when the garden party instructor, came to collect her from the wing. The officer recalled seeing her during the day when she was preparing a hanging basket. She seemed to be in quite a cheery mood. The garden instructor also said that on the morning of 14 October the young woman seemed to be her normal happy self. In the afternoon, she had a visit; the garden instructor saw her afterwards and said that she had said she had enjoyed a good visit and that she would see the garden instructor at work tomorrow.

The visit was from her mother. The mother said that the young woman had appeared to be fine at the visit, but had expressed some worry that she had recently heard that Brockhill was going to become a prison for males rather than females, and that she felt rather unsettled by this.

Another prison officer stated that the evening of 14 October was a normal evening duty with no incidents or concerns. She was regularly checking on another prisoner who was on an open F2052SH and recalled seeing the young woman in a cell with either one or two other prisoners. During her time in custody, the young woman spent time with a number of prisoners, two of whom were prolific self-harmers and had spent most of their time in custody on open F2052SHs. One of these woman said in interview that the young woman had told her she was going to kill herself that night. She did not bring this to the attention of prison staff because the young woman tried to laugh it off and she was preoccupied with another prisoner who had been self-harming all that day.

The prison officer recalled locking the young woman's cell door at approximately 8.15pm. She was sitting on the bed and the officer said 'good night' and 'I'll see you tomorrow', but could not recall her response. He stated that her mood appeared to be normal.

The wing night officer was briefed by the day staff at the commencement of his night shift on 14 October. The Officer Support Grade (OSG) was also allocated to D Wing for his night duty. The wing night officer recalled that he was specifically asked to keep a special eye on a prisoner on an F2052SH. The wing night officer and the OSG did not recall any problems during their tour of duty.

CCTV monitoring of the wing showed her exiting her cell on three occasions during the night: at 21.35 to 21.39 (4 minutes), at 22.21 to 22.25 (3 minutes), and at 22.51 to 22.52 (1 minute). (At night the prison operates an automatic unlock SAN system which allows prisoners out one at time to go to the bathroom within a set time.) The police took possession of the CCTV coverage for the night of 14 October but found nothing of note in relation to her death.

Finding the woman

The morning duty officer started her duty at approximately 6:45 am on the morning of 15 October. On arriving on D Wing, the officer began the morning roll check. At cell D204, she looked through the observation panel in the cell door and saw the young woman hanging from a ligature attached to the ceiling. She immediately requested assistance by announcing a 'Code Blue' over the radio network. (A Code Blue is an emergency request for assistance to a prisoner who has breathing difficulties or attempted death through strangulation.) Such a request specifically alerts medical staff by raising their awareness to the type of equipment that may be needed (eg resuscitation equipment). A Code Blue will also alert all staff of the need to provide immediate assistance. The officer recalled shouting along the landing to wing night officer who was at the time in the staff kitchen area on the wing.

The morning duty officer then entered the woman's cell and immediately went behind her and took her weight until assistance arrived. The night SAN log records the cell door being opened at 6.59 am. On entering the cell, the officer recalled kicking a chair away that was next to the body. The wing night officer entered the cell within seconds of the duty officer and removed the ligature. The duty officer stated that the wing night officer placed the duvet from the bed onto the floor and they then laid her body onto the duvet. The duty officer said that the young woman was cold and stiff, and that her nose and lips were blue.

The substance misuse manager responded to the Code Blue call for assistance. She said that, on her arrival at cell D204, the woman's body had already been placed on a sheet on the floor. She said in her opinion there was evidence of rigor mortis. The duty officer left the cell at this point. The duty nurse and another wing officer had also arrived. It was clear that the woman had been dead for some time and therefore no attempt at resuscitation was made. The orderly officer had the cell door locked to preserve evidence at 7.05 am. At this time, the ambulance service and police surgeon were called. The young woman was pronounced dead at 7:35 am by the police surgeon.

The young woman left a note in her cell.

The young woman regularly corresponded with family and friends. Following her death, four letters were found in her cell, all stamped ready for posting. The letters were not dated. These other letters contained nothing of significance in relation to this enquiry and no indications that she would take her own life.

Contact with the woman's family

The police broke the news of her death to her mother. Following their visit, the mother was distressed at the haste with which the media had been informed of her daughter's death, especially as she only became aware of this when a friend called to say that she had heard about the young woman's

death on the television. The Governor wrote a long letter to the young woman's mother on 15 October and specifically mentioned that she would be taking this further with the Home Office press office. The letter also offered help with the funeral costs.

The mother visited the prison on 21 October.

Two members of staff attended the young woman's funeral. When my colleagues visited her mother, she said that she had found the staff at the prison to be very helpful and kind.

Issues considered during the investigation

F2052SH procedures

The PER form, which travelled with the young woman's from court to prison, did not indicate that she was a risk to herself. However, whilst in police custody she had been on a permanent watch, and in the court cells she had been subject to a 15 minute watch. That this was not accurately recorded on the PER form is of serious concern. On her second day at Brockhill, a F2052SH was opened and it remained open for 39 days. During this time her case was reviewed 11 times. She self-harmed on a number of occasions and her observations were altered accordingly during this time. On 4 October, her F2052SH was reviewed and it was closed. No on-going support plan was put in place. An SO stated that there is no local policy with regard to putting in place post F2052SH closure support plans. The RMN stated that, although on-going support was often discussed, it was rarely recorded within the F2052SH.

A comprehensive post closure support plan should be put in place for all prisoners. This should take place at the final review meeting and prior to the closure of the F2052SH/ACCT booklet. The Suicide Prevention Co-ordinator (SPC), along with wing staff, should monitor and follow up each plan.

The SO who chaired her final F2052SH review, had not been involved in any of the previous ten reviews. The two nurses who attended her final F2052SH review, had not attended any of the previous reviews either. The RMN who was the appointed key worker under the establishment's RMN referral scheme, had not attended any of the young woman's F2052SH reviews.

HMP Brockhill should review its F2052SH/ACCT review procedures so membership wherever possible includes the allocated key worker under the establishment's RMN referral scheme and that continuity of other review staff is maintained where it can be.

At the time of the young woman's death, 25 per cent of all unified staff were trained in Suicide Prevention. Some senior officers who chaired F2052SH review boards had not received suicide prevention training.

The Governor should reviewed suicide and self-harm prevention training requirements across the staff team.

Gardens Party

A nurse stated that the young woman had told her she was keen to get off her F2052SH so that she could get a job on the gardens party. A fellow prisoner said that had told her she had stopped self-harming to get a job on the gardens party. The majority of those interviewed who were asked specific questions with regard to those on F2052SH being allowed to work on the

gardens were of the view that the prisoner must come off the procedures before being given the job.

The majority of staff interviewed stated that prisoners who were on open F2052SH booklets could not work on the gardens party. The gardens party instructor stated that in the past there had been occasions when such prisoners were allowed to carry out this work. The wing night officer said the young woman had met with the gardens party instructor previously and that she had been informed that, if she could get her watch down (the level of observations), she could get a job on the gardens. The wing night officer had been told this by the young woman but the instructor did not recall this on interview. The general view that prisoners either needed to be taken off the F2052SH procedures or, at the very least, a reduced level of observation, indicates that this decision was delayed until her F2052SH had been closed. On 6 October, she was placed on the enhanced level of the IEP scheme, and on the following day she started work on the gardens party.

Prisoners on F2052SH/ACCT booklets should not automatically be excluded from working on the gardens party and other such work parties or positions within the prison.

Cell D204

Following the closure of her F2052SH, she requested a cell move from cell D214. Cell D214 is one of a number of cells located closer to the staff office. The cells have fewer ligature points due to a coving arrangement which covers the light fittings, but these are not cells which have been fitted out to full 'safer cell' specification. The cells are smaller and generally used for those prisoners who require an increased level of observation. It is quite normal for someone who has come off a F2052SH to request a move out of such a cell. The decision to allow such moves is taken following discussion amongst the staff. Consideration is mainly dependent on the prisoner's perceived level of vulnerability and cell vacancies. Prisoners may suggest the cell they wish to be moved to (often to be close to friends, a better view or a quieter position). In interview, the movements' officer recalled discussing her cell move request with the SO, stating that she did not specifically request a move to cell D204 or any other cell. She stated that she just wanted to move out of cell D214 as it was one of the smaller cells.

In interview, a prisoner stated that she was aware of the ligature point in cell D204. She said that she had previously used the ligature point in an attempt to hang herself. This prisoner's F2052SH recorded that on 22 August she attempted to strangle herself and made superficial cuts to her arms. The incident happened at night and the night patrol, an OSG attended. The OSG stated in interview that the other prisoner had tied a ligature to her bed head. The prisoner said she had used the same ligature point as the deceased. In interview she did not mention attaching the ligature to the bed frame. She also stated that the ligature had snapped and that the material used was hanging from the fitting and that staff saw this. The prisoner said the attachment point was a gap between conduit and the ceiling, at a point where

the conduit joined the light fitting. The OSG stated that there were some strips of fabric, possibly ligatures, but these were underneath a chair in the cell and not underneath the light fitting, which was central in the cell. A former prisoner, informed her solicitor when released from custody that the wing night officer had been aware of the ligature point in cell D204 as she had personally informed the officer of this. The former prisoner also stated that the wing night officer was aware that the other prisoner had previously used the attachment point on 22 August. The wing night officer denied both having any prior knowledge of the ligature attachment point and that she saw the ligature hanging from the attachment point on the night of 22 August. The officer does not recall ever having previously attended such an incident in cell D204.

The prisoner said that the young woman was aware of the ligature attachment point in cell D204 and that she specifically requested a move to that cell. Another prisoner stated that the young woman had asked the officer to move specifically to cell D204. The officer denied this. The prisoner also stated that the prisoner who attempted to hang herself had told her and other prisoners that she had dug out the resin between the ceiling and the conduit with a spoon when she was in D204. However, in interview, the prisoner that tried to hang herself stated that the gap was there when she moved in and that, following her tying of a ligature on 22 August, she was moved out of the cell because staff were aware of the ligature point. Records indicate that this prisoner remained in cell D204 for a further five days after 22 August and there is no mention of the ligature point at that stage and no record of the prisoner ever using it.

There are many conflicting accounts with regard to how and when the ligature point was or was not made. There is no clear evidence to suggest that the young woman specifically requested a move to cell D204 and no clear evidence to suggest that the ligature point was there prior to her moving in to the cell. I therefore conclude that it was reasonable for her to have been moved out of cell D214 after her F2052SH was closed.

Accommodation Fabric Checks

All cells are checked on a daily basis to ensure that windows, door and fittings have not been tampered with and the results are recorded on the Accommodation Fabric Check (AFC). The officer carrying out these checks either records that all is correct or reports any damage or faults and signs to that effect in the wing daily diary, thus creating an audit trail. These checks are often used to check the cleanliness of the cell, which is fed back to the prisoner and sometimes linked to the Incentives and Earned Privileges Scheme (IEPS). The AFC procedures are essentially a security check aimed at preventing escape. All staff interviewed at Brockhill were asked if the AFC procedures are also use to identify potential ligature points. The majority of staff, but not all, thought that there was a requirement to do this as part of the AFC procedures. On checking daily diaries, there is evidence to suggest this may well be the case as there are frequent entries relating to damage or faults that are clearly not security related. There has also been a minor repairs reporting system in place, which had previously been the methodology that

wing staff would use to request a repair from the establishment's estates department. (It was not possible to find evidence that repairs to potential ligature points were made as the entries were not specific.) During this investigation, the estates department stated they would have responded to such a request immediately. At the time of the investigation, a system had been put in place that all requests were now made to a dedicated answer phone. However, an emergency request could still be made on an individual basis and these would be dealt with immediately.

The PO stated that two years previously all cells in the establishment had had the gap between the ceiling and the conduit filled with resin. This action was taken after an attempted hanging in cell D204. At this time, there was no filling and ligature attachments which could be made along the whole length of the conduit (some two to three foot in length). Although there is no firm evidence, it is suggested that the conduit in the communal bathrooms/toilets were also filled around this time. This action clearly identified the potential use of such points and raised staff's awareness to this, although there is no evidence to suggest this was reiterated to staff during the following two years. There is also no evidence to suggest the need to make good any gaps during the interim period. There is, however, a minor repair request for repairs to a flickering light in cell D204 on 25 September 2004. The electrician did not notice, or report, any resin missing from the gap between the ceiling and the conduit. The only possible reference to such repairs were following the young woman's death.

In interview, the senior officer stated that all cells are checked prior to a new occupant moving in and any potential ligature points would be identified and repaired at this stage. The wing night officer stated that any tampering by prisoners to the cell fabrication would be reported as part of the AFC checks. A prison officer stated that it would have been highly unlikely that the prisoner who attempted to hang herself had previously (some 54 days earlier) removed the resin from the gap as this would have been picked up during AFCs. Although the three officers all indicated that AFC procedures should and would identify such potential ligature attachment points, this was not the case for all staff. When interviewed, a wing officer was not sure whether the reporting of ligature attachment points was or should be part of the AFC procedures. Several other staff interviewed were unable to answer this question in an informed and positive manner. They were clear on the main purpose of the checks being predominately security based but many seemed unsure as to whether they should report potential attachment points. Most said they would, although the majority indicated they had not previously.

The Governor should clarify the purpose of the daily Accommodation Fabric Checks (AFCs). Specific reference should be made as to whether they are to include a check on potential ligature points.

The Governor should ensure staff are aware of the emergency reporting procedures to ensure that potential ligature attachment points are repaired.

Safer cells

There is confusion amongst the staff at Brockhill as to what are ‘Safer Cells’ as defined by the Prison Service. There are a range of different types of cell at Brockhill, some of which have had alterations that reduce the potential for ligature attachments. There are only two single occupancy cells that meet the full Safer Cell specification and these are in the segregation unit.

The NOMS Safer Custody Group should consider carrying out a review of safer cell accommodation at Brockhill and submit their findings to the Area Manager and Governor.

The Governor should remind staff that only two cells in the segregation unit are currently designated as ‘safer cells’

The Clinical Review

The clinical review examined the young woman’s care whilst at HMP Brockhill in line with Redditch and Bromsgrove Primary Care Trust’s Significant Incident Investigation Policy. In addition, the reviewer looked at the woman’s use of anti-depressant medication, her diagnosis of manic depression and her use of the reflective notebook - issues raised specifically by her mother.

The review concluded that there were some process issues that could be improved within HMP Brockhill, but these in themselves were very unlikely to have contributed to this death. According to the reviewer, the visiting psychiatrist considered the young woman to have a borderline personality disorder. However, the degree of disorder was not such as to have been recognised in a community setting and almost certainly would not have been formally treated.

Most of the recommendations in the clinical review have already been highlighted in my investigation. However, the reviewer makes an additional four, three of which I endorse. (The second recommendation states that a F2052SH should have been opened on her first night in custody. This may well have been the case, but the nurse conducting the health screen was not interviewed and therefore I do not believe it is possible to draw any conclusions from her actions.)

It is good practice to request previous medical records, particularly if there is a record of psychiatric involvement and prescribed medication.

A F2052SH should have been commenced on the night that the young woman was detained in custody

Transfer forms such as the PER should be available to the nurse at reception; the inmate medical record should confirm whether this form has been seen or not.

The psychologist records were not kept with the IMR and it is not apparent that there was any formal communication between the Nursing/medical team and the psychologist. Records should be stored together and where appropriate multi disciplinary health meetings should take place.

Conclusions

The young woman was placed on a F2052SH on 26 August. The level of care given to her in terms of her physical and mental health was excellent. The clinical review provides detailed information.

Her F2052SH was closed on 4 October. No post closure support plan was put in place. This is contrary to Prison Service Order 2700.

The decision to take her off the F2052SH procedures on 4 October was made by staff who had not been involved in any of the ten previous reviews, nor did they have all the relevant information available to them.

The young woman had self-harmed for many years and had spoken of previous suicide attempts when younger. In addition, being in prison for the first time presented its own difficulties and increased her vulnerability. A letter from her legal advisors, dated 26 August, indicated that she could receive the maximum of a life sentence and that she should expect to serve a lengthy period in custody. Subsequent contact suggested that the charge might be reduced and alter the likely sentence. However, in September she self-harmed the day before going to court and frequently talked about her worries over the sentence she might receive. The day before her death she expressed some concern having heard that Brockhill was going to be re-roled into a male prison. She was unsettled by this as she believed that she would be serving her sentence there. (This would not have been the case, and she would have relocated to a different prison following sentence.)

Two days before her death, she stopped contact with a man with whom she had become involved and she seemed upset by this. She also spoke to a fellow prisoner about the man's involvement in an altercation with her former boyfriend (her alleged victim) and she thought this might in turn harm her own case.

On the night of 14 October, she was not on an open F2052SH and therefore there were no formal observations carried out by the night staff. The night sanitation report records that she came out of her cell on three occasions. There is no record of her being observed during the night or of her exiting her cell after 10:52 pm.

The young woman was found in her cell at 06:59 am on the morning of 15 October by the wing night officer. The action taken by the officer and those staff who attended the call for assistance was appropriate. It was clear that she had been dead for some time and therefore no attempt was made at resuscitation.

There was some confusion amongst staff about the purpose and or potential of the daily Accommodation Fabric Checks (AFCs) in the identification of ligature points.

There was also confusion with regard to the classification of cells with regard to their level of safety. The only full specification 'safer cells' are in the segregation unit. Some cells have modifications to the light fittings that reduces the potential for ligature points, but the majority of cells (including cell D204) have several ligature points including internal door handles, wall mounted wardrobes, picture boards and bed frames. HMP Brockhill had recently had all cell windows replaced with anti-ligature windows, and some staff were not sure whether these modifications made them 'safer cells'.

Only 21 (of 115) uniformed staff and three nurses were trained in Suicide and Self Harm (SASH) between 9 December 2003 and 28 September 2004 (there was no further training between this date and the woman's death). Some of those senior officers who were responsible for chairing F2052SH review boards had not been trained. At the time of the woman's death, there were only 20 per cent of uniformed staff recorded as being SASH trained. Guidance issued by the NOMS Safer Custody Group states that refresher training will need to appropriate to the level of risk within the establishment. HMP Brockhill often has a significant number of prisoners detoxifying from opiate addiction and regularly has over 20 prisoners on open F2052SHs. In the circumstances, it is felt that the number of staff undertaking refresher training is insufficient for a whole prison approach to the management of the vulnerable. However, there is no suggestion that a lack of trained staff is directly linked to this death.

There is no clear evidence to suggest that the young woman specifically requested a move to cell D204, and no clear evidence to suggest that the ligature point was there prior to her moving into the cell.

Recommendations

1. A comprehensive post closure support plan should be put in place for all prisoners. This should take place at the final review meeting and prior to the closure of the F2052SH/ACCT booklet. The Suicide Prevention Co-ordinator (SPC), along with wing staff, should monitor and follow up each plan.

2. HMP Brockhill should review its F2052SH/ACCT review procedures so membership wherever possible includes the allocated key worker under the establishment's RMN referral scheme and that continuity of other review staff is maintained where it can be.

3. The Governor should review suicide and self-harm prevention training requirements across the staff team.

4. Prisoners on F2052SH/ACCT booklets should not automatically be excluded from working on the gardens party and other such work parties or positions within the prison.

5. The Governor should clarify the purpose of the daily Accommodation Fabric Checks (AFCs). Specific reference should be made as to whether they are to include a check on potential ligature points.

6. The Governor should ensure staff are aware of the emergency reporting procedures to ensure that potential ligature attachment points are repaired.

7. The NOMS Safer Custody Group should consider carrying out a review of safer cell accommodation at Brockhill and submit their findings to the Area Manager and Governor.

8. The Governor should remind staff that only two cells in the segregation unit are currently designated as 'safer cells'

Additional recommendations from the clinical review:

9. It is good practice to request previous medical records, particularly if there is a record of psychiatric involvement and prescribed medication.

10. Transfer forms such as the PER should be available to the nurse at reception; the inmate medical record should confirm whether this form has been seen or not.

11. The psychologist records were not kept with the IMR and it is not apparent that there was any formal communication between the Nursing/medical team and the psychologist. Records should be stored together and where appropriate multi disciplinary health meetings should take place.