Investigation into the circumstances surrounding the death of a woman at Hospital in January 2008 whilst in the custody of HMP Styal

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of my investigation into the death of a woman who died in Hospital in January 2008, having harmed herself at HMP Styal four days earlier.

I would like to add my personal condolences to those already expressed to the woman's family by one my Family Liaison Officers. I regret that my report is delayed and apologise for any additional distress this may have caused the woman's family.

The investigation into the woman's death was undertaken by one of my investigators. I thank the Governor of HMP Styal and his staff for their participation. A clinical reviewer, from the Central and Eastern Cheshire Primary Care Trust, has undertaken a review of the woman's clinical care. I am also obliged to him for his assistance.

Since April 2004, I have investigated four self inflicted deaths at Styal and two natural cause deaths. Some of the issues I raised in those earlier reports are also touched upon in my report into the woman's death.

The woman was clearly a very vulnerable person who suffered from mental health and alcohol abuse problems. She first went to prison after assaulting a police officer who was providing assistance as a consequence of her having harmed herself. Whilst in prison, the woman harmed herself again and was treated in hospital. Six weeks after her release, the woman was back in prison. Staff at Styal duly recognised the risk that she posed to herself and located her on the specialist Keller Unit. Less than 48 hours later, the woman was discovered by staff having put a ligature around her neck. The woman never regained consciousness and died four days later in hospital.

My report highlights serious deficiencies in the care that the woman received whilst on the Keller Unit. The most worrying are that she was not formally assessed by a mental health nurse and was not observed for nearly an hour on the morning of the day she harmed herself. This was despite a requirement that she should be observed by staff five times an hour.

My report also looks at other issues and draws considerably on the clinical reviewer's review, in particular his views with regard to the suitability of the Keller Unit in holding particularly vulnerable women. I note with interest that HM Inspector of Prisons' report following her inspection of Styal in September 2008 confirms many of my own findings and those of the clinical reviewer. As a consequence I recommend that a strategic and operational review of the Keller Unit is undertaken.

I trust that my report helps to answer the questions that the woman's family have asked, and apologise once again for its delay.

Stephen Shaw
Prisons and Probation Ombudsman **August 2009**

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SUMMARY

The woman died in January 2008 at Hospital. She had been found four days earlier in her cell at HMP Styal with a ligature around her neck.

The woman's first period of custody at HMP Styal began in September 2007, and was as a consequence of assaulting a police officer who was assisting her after she had made an attempt to cut her own throat. On her arrival at the prison, staff opened an Assessment, Care in Custody and Teamwork (ACCT) document. (The ACCT document is used to assess, observe and support prisoners at risk of self harm.) During this process, the woman told staff that she suffered from borderline personality disorder and that she had regularly self harmed for a number of years. She was located on the Keller Unit, the unit at Styal that houses the most vulnerable of women.

On 10 October, the woman made a serious attempt at taking her life by tying a ligature to the curtain rail in her cell. Staff intervened, giving the woman cardio pulmonary resuscitation (CPR). When her breathing was stabilised, she was transferred to outside hospital for further treatment. On her return to Styal from hospital, the woman was again located on the Keller Unit. The woman was subsequently released from Styal on licence in November 2007.

The woman was remanded into custody at Styal for a second time in January 2008, having been charged with assault. Staff in reception recognised her from her previous sentence. During the reception process the woman told staff that she would harm herself again, and that this time she would not be found. Identifying the risk that the woman posed to herself, staff located her directly on to the Keller Unit rather than the First Night Centre.

That evening, staff opened an ACCT document which mandated that the woman should be checked at least five times every hour. The woman was seen by a nurse and the prison doctor who prescribed the same medication that she had received whilst in the community. The woman's first night at Styal was described by staff as quiet.

The woman was reviewed by another prison doctor that . He noted that she showed signs of alcohol dependence but denied other substance misuse. The doctor described the woman's mood as positive and thought that she displayed no signs of self harm. Later that morning, the woman went out for exercise before being served her lunch.

The woman's first ACCT review took place at 1.00pm but, although invited to attend, she refused. The officer completing the review noted that the woman was agitated and feeling unwell and made a referral for her to be assessed by the Keller Unit's mental health nurse. During the afternoon, the woman became argumentative and obstructive, making fun of some of the other women on the unit. Staff noted that she appeared to get "wound up by the smallest thing" and that her mood dipped during the afternoon. The woman joined the other prisoners for evening association and made a telephone call to her partner, leaving a short message, before being locked in her cell for the night.

The woman initially appeared cheerful on the morning of January. Later, she told one of the officers on the unit that she felt unwell and asked if she could clean her cell after lunch. The woman refused to attend her second review that morning, again stating that she felt unwell and wished to rest. Staff said that the woman was offered the opportunity to take a bath and exercise, but she refused to leave her cell.

One of the officers noted in the woman's record that she was issued with a warning for refusing to clean her cell. As a consequence of the warning, the woman was told that she would not be allowed on free association that afternoon but would be allowed to participate in the other unit activities. Although the woman's ACCT document stipulated that she should be observed five times an hour, closed circuit television (CCTV) footage shows that the woman was not observed by any members of staff between 11.15am and 12.14pm.

The woman was unlocked by staff and collected her lunch at 12.15pm. Over the lunch time period she was checked periodically and at 1.45pm her cell was unlocked and she was issued with her medication. Whilst this was happening one of the officers indicated to her colleague that the woman appeared to have a red mark to the right side of her neck. The woman was checked by one of the officers at 2.05pm. At 2.25pm, she was checked again, but this time the officer could not see the woman in her cell. Upon raising the alarm, the officer and colleagues immediately entered the woman's cell and found her hanging. CPR was initially administered by the officers before the arrival of nursing staff and paramedics. The woman's condition was stabilised and she was then transferred to the Hospital.

The woman's family was notified by prison staff that she had been taken to the Hospital, having harmed herself earlier in the afternoon. Over the following days the prison's Family Liaison Officer kept in contact with the woman's family. The woman remained in hospital and she died later in January, without regaining consciousness.

My report makes a number of recommendations, the most significant of which relate to the woman's referral to the prison's Mental Health In-Reach Team (MHIRT) and the level of nursing staff provided on the Keller Unit at weekends. I also draw attention to the disturbing fact that the woman was not checked for an hour in January despite her ACCT stipulating that she should be observed five times an hour. I also make reference in this report to the functions and purpose of the Keller Unit, as reported in the clinical reviewer's clinical review.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Styal late in January 2008 by one of my assistant ombudsmen. My assistant ombudsman met staff and was briefed with regard to the circumstances surrounding the woman's death. My assistant ombudsman took away relevant documentation for examination. Notices were distributed around the prison notifying staff and prisoners of the investigation and inviting anyone with information about the woman's death to contact the investigator who had been assigned the case.

2. The investigator reviewed all relevant prison records relating to the woman. They included her core prison record, medical records, statements by staff and other relevant documentation. My investigator visited Styal during the summer of 2008 to interview a number of staff with another of my investigators.

3. My investigator wrote to a prisoner who worked on the Keller Unit at Styal and had had contact with the woman in the hours before her death, asking her to participate in the investigation. Unfortunately, the prisoner who has since left Styal did not respond.

4. A review of the care afforded to the woman whilst in prison was commissioned by Central and Eastern Cheshire Primary Care Trust (PCT). The clinical reviewer, who is an Associate Director of Clinical Effectiveness at the PCT, carried out several joint interviews with my investigators.

5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. A copy of this report will be sent to the Coroner to assist in his enquiries into the woman's death.

6. My investigators also met a Detective Sergeant from Cheshire Constabulary. The Detective Sergeant provided my investigator with additional documentation including police statements and a copy of the CCTV footage taken on the Keller Unit on the day of attempted suicide in January 2009. (The CCTV timings have been used in this report between 11.00am and 3.00pm, other times quoted are those reported in staff statements and incident reports.)

7. One of my Family Liaison Officers contacted the woman's family. My Family Liaison Officer and my investigator subsequently met with members of the woman's family. The woman's family were given the opportunity to discuss the purpose of the investigation and to raise any concerns or questions they wished to be addressed. They asked a number of questions:

   - What medication was the woman being given whilst she was in custody?

   - Whether or not paramedics found it difficult to enter the prison and whether there was a delay before the ambulance left the prison?

- How the woman had been able to take her life, considering that she was on "suicide watch" and was being checked five times an hour?

- How staff had not noticed the woman preparing the ligature, given that she was subject to regular checks and the family had been told that it would have taken some time to have threaded the ligature through the television bracket. The woman's family said that prison staff had told them that she was "very clever/crafty and had been talking to them while doing this".

- They had been told by the prison that the woman "could have only been up there for two minutes". The family said the woman was described as having suffered from catastrophic brain injuries and they questioned how this could have happened within two minutes.

- Why was there a TV bracket in the cell since it could be used as a ligature point?

- The family said they had had trouble getting hold of the prison's family liaison officer.

- They questioned the time it took the prison to inform them that the woman had been admitted to the Hospital. When told the news of the woman's death, staff had asked for a name that no one in the family had.

8. The woman's family also told my Family Liaison Officer and my investigator of a number of other issues and concerns they had about the woman. The family provided additional documentation to assist with the investigation, including diaries, poems and drawings written and composed by the woman.

9. I have done my best to address the issues raised by the woman's family within my report. I hope it helps them better understand the events leading to her death.

   In response to the draft report the woman's family, represented by their Solicitor, made a number of comments. Although these comments have not led to changes in to the final report the woman's family has been provided with clarification of the points that they raised.

THE WOMAN

10. The woman was born in 1975. She had sisters and brothers. At the age of 13, the woman left home to live with a neighbour, moved schools frequently, and was seen by Social Services every week. The woman's education was further disrupted by a number of back operations and she left school early without qualifications.

11. The woman gave birth to a daughter when she was 16. The woman's family said that she idealised her daughter but found it hard to be a mother. The woman who had abused drugs for many years and been prescribed methadone (a heroin substitute). She also used alcohol to assist her withdrawal from heroin. However, it was whilst under the influence of alcohol that the woman's behaviour deteriorated and she would become aggressive, her behaviour often leading to violence. The woman began to self harm frequently from 2002 onwards. She was diagnosed as having borderline personality disorder in 2003. The woman continued to self harm and increasingly relied on alcohol.

12. The woman received her first custodial sentence in September 2007, and was sent to Styal prison. Staff described her behaviour as varying greatly, from being polite and compliant, and abiding by prison regimes, to being uncooperative and abusive to staff and prisoners. During this period of imprisonment, the woman made a serious attempt to self harm. Her actions resulted in an emergency transfer to outside hospital for treatment.

13. The woman's family said they strongly believed that for many years she had suffered from mental health problems that had gone undiagnosed. The woman's family felt that her story could best be told through the pictures and poems she had written, copies of which they gave to my investigator to assist in his investigation. The woman's sister described her as being "either up or down and there being no in-between".

14. The clinical reviewer describes the woman's medical history until 1993 as unremarkable. The clinical reviewer reports that in 1993 the first references to drug problems appear with the woman attending a Drug Dependency Clinic. As a consequence of the woman's intravenous drug use, she had frequent contact with drug detoxification services between 1996 and 2004. The woman was admitted to an in-patient detoxification unit for a second time in 2001, but was discharged for smoking cannabis.

15. From the late 1990s, the woman received a wide variety of medication including anti-depressants and anti-psychotics, both in and out of prison. The clinical reviewer notes that this was despite there being:

> " … no evidence of any psychotic symptoms in her medical record and most of her depression appears to be situational distress and anxiety around her chaotic lifestyle and often desperate situation. The most likely explanation for this prescribing is that the doctors involved with her care were trying to use these drugs to stabilise her mood swings and to dampen some of her more extreme impulsive behaviour. This view has been confirmed by one of the

prison GPs and by a Consultant Psychiatrist at the Cheshire & Wirral Partnership Trust."

16. From 2002 onwards, the woman frequently self harmed and had increasing contact with mental health services in the community. In 2005, the woman entered a more settled period, but her pattern of self harm resurfaced again in 2006. Between May of that year and September 2007, the clinical reviewer reports that four instances of accidental self poisoning and three incidents of self harm were recorded by her doctor. Although the woman's heroin addiction appeared to be under control at this time, she increasingly depended upon alcohol.

17. During this time the clinical reviewer says that assessments completed on the woman describe her as having a very chaotic lifestyle. Her progress in dealing with her problems was thwarted by frequent outbursts and highly impulsive and destructive behaviour. The clinical reviewer says that mental health and drug services in the community made considerable efforts to help the woman, but they were frustrated by her non-attendance and abusive behaviour.

18. Given the information available to him and with regard to the care the woman received in the community, the clinical reviewer describes the woman as a highly troubled woman who, since adolescence, " … had a history of disturbed behaviour including chronic substance misuse, severe personality disorder and impulsive behaviour with self-harming episodes." He concludes that, "By and large, the NHS had not been able to help her and at best achieved modest damage limitation." He says that the woman's condition was probably not treatable, and "although with age she may have become more willing to engage in therapy, at the time of her death it was proving difficult merely to contain her behaviour."

HMP STYAL

19. HMP Styal is one of England's largest women's prisons. Built as an orphanage in the 1890s, Styal became a women's prison in 1962 with the transfer of women prisoners from Strangeways prison in Manchester. In 1983, Styal admitted young offenders and in 1999 a new wing, Waite wing, was added following the closure of HMP Risley.

20. Styal is the only local prison for woman prisoners serving the North West and North Wales. It mainly holds short term sentence prisoners and those on remand and has an operational capacity of 460 women.

21. Styal is made up of two types of accommodation. There are 16 Victorian villas which hold up to 28 women and a purpose built conventional wing, Waite wing, which holds around 135 women in cellular accommodation. The prison also has the Keller Unit which is a specialist unit accommodating up to ten women. The prison also contains a specialist Mother and Baby Unit and a First Night Centre, which accommodates up to 25 women.

22. In her most recent inspectorate report HM Chief Inspector of Prisons reports that over a third of the women said they felt depressed or suicidal on arrival at Styal, with over half reporting drug problems and 40 per cent citing alcohol as a problem. Many of the women also present with high levels of self harm, physical and sexual abuse and mental health issues. Incidents of self harm at Styal remain high when compared with the rest of the women's estate. In the first half of 2008 alone, there were 1,335 recorded incidents of self harm, 71 per cent of these taking place on the Keller Unit. Four women on that unit accounted for 43 per cent of all the incidents. HM Inspector of Prisons reports that Styal's heavily substance dependent population was "extreme, complex and growing".

Keller Unit

23. The Care Support and Re-Integration Unit, formerly the Segregation Unit was re roled in September 2007 and renamed the Support and Intervention Unit, or Keller Unit. The Keller Unit's vision statement is: "To deliver an exceptional quality of care and increased support to prisoners with complex needs, and to achieve effective re-integration back into the prison community." The statement says the Keller Unit:

    " … aims to provide a safe, healthy and supportive environment which is conducive to the individual needs of the women, who have complex needs … The unit is aimed at adopting a more pro-active and interactive approach towards prisoners with complex needs without the use of segregation."

24. The ten cells on the unit are classified as normal residential accommodation and are subject to normal Prison Service standards. Cell five, the cell in which the woman was located, is a designated reduced risk/safer cell. (The Safer Custody and Offender Policy Group of the National Offender Management Service describes reduced risk/safer cells as designed to make acts of self harm as difficult as possible by reducing the obvious ligature points. The cells contain

anti-ligature fixtures and fittings which are an integral part of the cell fabric. Safer cells cannot be considered safe in their own right but do complement a regime providing care for at-risk prisoners.)

In response to the draft report the Prison Service said,

> "At the time of [the woman's] location on the Unit and death thee were no safer cells on Keller Unit. The specification for safer cells was altered in 2007 and none of the accommodation on Keller Unit met the new standard. All were designated normal accommodation."

However, during the investigation my investigator was told by staff that, although not a safer cell, the cell in which the woman was placed was a reduced risk cell. The cell contained some of the features of a safer cell, for example a built in bed and a sealed window which although could not be opened still allowed ventilation to the cell. The cell in which the woman was placed differed from other cells on the unit.

25. The Keller Unit has a central area where the women are able to associate and where intervention sessions take place. (Intervention sessions on the Keller Unit are designed to encourage the women to associate with one another and to participate in constructive, often group, activities. Such activities could include art work, board games and similar activities.) A PAT (pets as therapy) dog is a regular visitor to the Keller Unit.

26. The unit also houses a sensory room. (This is a room in which audio and visual distractions are introduced with the aim of promoting relaxation and contemplation.) During the investigation my staff viewed the sensory room. Some of the relaxation equipment was not working and the room was being used for storage. (I understand that the sensory room is now operational once more.)

27. The Keller Unit is not a medical unit and it is staffed predominantly by discipline staff. At the time of the woman's death the unit was staffed Monday to Friday by a senior officer and three officers during the day, with one officer leaving the unit at around 7.30pm leaving two officers working until 9.00pm. During the weekend a senior officer and two officers work on the unit. Each day one officer is required to assist with adjudications (disciplinary hearings at which charges against prisoners are heard), and which take part in other areas of the prison. An additional officer works Saturday mornings to assist with these duties. The unit is generally staffed by one Operational Support Grade overnight. This may be supplemented by additional officers or OSGs as required and at the discretion of the Night Orderly Officer.

28. The daily regime on the unit includes breakfast at 8.30am followed by administering medications, intervention sessions and access to other regimes and activities between 9.30am and 11.30am. Lunch is served between 11.30am and 12.30pm, with staff taking their lunch between 12.30pm and 1.30pm. Medications are given out again between 1.30pm and 2.00pm (2.30pm at weekends), which is followed by another period of intervention and association. Association also takes place between 6.15pm and 7.20pm, during which time

supper is served to the women.

29. In the process of completing his clinical review the clinical reviewer visited the Keller Unit. He says:

    "The unit consists of ten individual cells that have been made as safe as possible within the limitations of the building structure. The rooms are small and very shabby with old beds which themselves can be used as ligature points. There is a stainless steel toilet with no seat or lid and a television which is encased to minimise the possibility of self harm using the TV mount as a ligature point. All doors permit observation and some are largely transparent where a person is on continuous observation. Although the rooms have been improved they are still not fit for purpose. Prisoners admitted to the unit are seriously mentally ill and/or have a severe personality disorder and are likely to be in a highly volatile emotional state. Given this, putting highly disturbed prisoners into a cramped environment with little to do is likely to exacerbate problems."

Healthcare

30. Healthcare services at Styal are commissioned by Central and Eastern Cheshire Primary Care Trust (PCT), which also provides the primary healthcare facilities at the prison. Warrington PCT provides dental services, the Bolton, Salford and Trafford PCT provide consultant psychiatrists, and the Cheshire and Wirral Partnership Trust provides the Mental Health In-Reach Team (MHIRT). At the time of the woman's death the healthcare services at the prison were being re-tendered with the aim of having just one provider. The new contract was due to be awarded in October 2008, with the service to be delivered from April 2009.

31. A dual registered nurse, meaning a Registered Mental Health (RMN) and Registered General Nurse (RGN), works on the Keller Unit in order to respond to the physical and mental health needs of the women based there. The nurse works from Monday to Friday 8.30am to 4.30pm, and is assisted by a healthcare assistant. Although not formally trained, the healthcare assistant has experience in mental health and learning disabilities. There is no nurse on Keller Unit at weekends, although cover is provided from Waite wing to deal with emergencies and dispensing medication.

Mental Health In-Reach Team (MHIRT)

32. The MHIRT assesses the mental health of all the women received into custody. Most of these assessments take place in the First Night Centre (FNC). Nearly all the women spend their first night in the FNC, where interviews with healthcare staff and induction processes are completed. (On occasions, women may be located in another area of the prison straightaway and therefore bypass the FNC.) Additionally, the MHIRT liaises with visiting psychiatrists and other healthcare professionals.

33. Women transferred immediately to the Keller Unit are initially assessed by the resident mental health nurse and, if a need is identified, they are referred on to

the MHIRT. The Keller Unit RMN meets the MHIRT weekly each Tuesday to discuss referrals and caseloads.

34. In 2004, the healthcare manager introduced a standard whereby all women would have a mental health assessment within 24 hours of their arrival at the prison. The MHIRT arranged to provide cover on Saturdays so that this could happen. However, during the investigation into the woman's death my investigators were told that the MHIRT's actual target was to assess all the women within seven days, although they aimed to conduct the assessments more quickly, and if possible within 24 hours of their arrival at Styal.

35. Following the woman's death, MHIRT staff have resumed working in the prison on Saturdays. HM Chief Inspector of Prisons highlighted in her most recent report that all women were assessed by the MHIRT within 48 hours of arrival.

Assessment, Care in Custody and Teamwork (ACCT)

36. The Assessment, Care in Custody and Teamwork (ACCT) process operates in all prisons and aims to monitor and support prisoners who are assessed as at risk of suicide or self harm. Once an ACCT is opened, the prisoner is observed at pre-determined intervals according to their perceived level of risk. ACCT review meetings take place and the prisoner's progress and risk is reviewed by a multi-disciplinary team of staff who know the prisoner or are involved in their care.

37. The other women in the Keller Unit were also monitored under the ACCT arrangements. The observations were carried out by all the staff and no single member of staff was designated to monitor an individual prisoner. Any significant conversations should have been recorded in the ACCT document. As I have said, the unit is monitored by CCTV cameras and I have used the CCTV film to identify when the woman was observed by staff (although the film is not retained for this purpose).

Incentive and Earned Privileges (IEP) Warnings

38. Prisoners at Styal who commit minor acts of indiscipline, exhibit anti-social behaviour or fail to adhere to the expected standards of behaviour or performance can be issued with an Incentives and Earned Privilege (IEP) warning. IEP warnings are issued at the discretion of officers and are used as a tool to address prisoners' behaviour. The warning operates under a “tick/point system”. A prisoner receives nine points each week and these points can be added to or lost by the issue of positive (green) or negative (pink) warning slips. Prisoners can receive one or more ticks for each episode of indiscipline. If a woman receives three ticks on one or two warning slips she is given the loss of association for 24 hours from 4.00pm the following day. Women on the Keller Unit just lose their evening association, and continue to be allowed out of their cells for cell cleaning and other interventions.

    In response to the draft report the Prison Service said that,

> "The IEP policy is not designed to punish the women but rather is an attempt to encourage good pro-social behaviour and as such refers to the women 'not earning any association' if they receive three red ticks on red tickets. Any loss of association is in addition to the normal provision."

Listeners

39. Listeners are prisoners trained by the Samaritans to provide a listening ear to their peers. Like the Samaritans, Listeners do not offer counselling but are there to offer support, particularly to prisoners at risk of self harm. Their support is confidential. There are about 12 Listeners at Styal.

40. Around the time of the woman's death the Listener scheme at Styal had been suspended due to security issues and the consequent pressure this put upon the remaining Listeners in the prison. By the time of my investigation, the matter had been resolved and the Listener scheme was back in operation.

Previous Ombudsman reports into deaths in custody at HMP Styal

41. Before my office was given the responsibility of investigating all deaths in prison custody in April 2004, there had been a series of six self-inflicted deaths at Styal between August 2002 and August 2003. I personally investigated the last of these deaths and reviewed the others. Between April 2004 and the woman's death there had been two self inflicted deaths at Styal (and another occurred in January 2009). To date, my office has also investigated two natural cause deaths at the prison.

42. My report into the woman's death concludes with a number of recommendations that I had previously raised in other of my investigations at Styal. In particular these relate to the referral of prisoners to the MHIRT, staff confidence in the use of defibrillators, and issues surrounding the issuing of IEP warnings.

Her Majesty's Chief Inspector of Prisons' inspection – September 2008

43. HM Chief Inspector of Prisons .conducted a full announced inspection of Styal in September 2008. In her report, HM Inspector of Prisons said that the Keller Unit still resembled a segregation unit even though its aim was to provide a therapeutic environment. She observed that, " … the lack of a therapeutic lead and approach on Keller Unit for women who needed high levels of care was a particular concern." HM Inspector of Prisons concluded that, if the unit was to fulfil its stated purpose, it needed to be properly resourced and professionally led. She recommended that a more therapeutic response should be developed on the unit to counter the risk of suicide and self harm.

44. HM Inspector of Prisons reported that:

> "Few ACCT reviews were multi-disciplinary. Case managers arranged reviews and were required to invite relevant staff. Reviews were generally arranged at short notice, which made it difficult for others to attend and most took place with only the senior officer, landing officer and the prisoner.

Personal officers played little part in the process."

HM Inspector of Prisons went on to say that:

> "Although mental health in-reach nurses provided good support, they did not routinely attend ACCT reviews. A registered mental health nurse had been attached to the safer custody team, working mainly on the Keller Unit. At the time of the inspection, the post was vacant."

45. HM Inspector of Prisons found that there were no cells designed to current safe cell specifications and recommended that, "Safer cells in line with current guidance should be provided, with a protocol for their use." I repeat this recommendation in this report.

46. HM Inspector of Prisons also noted that, although officers treated some very difficult women in the Keller Unit with respect, they had not received training to develop skills to deal effectively with the complex problems caused by the prisoners' personality disorders. HM Inspector of Prisons said that, "There was no clinical manager to direct regime activities and no coordination to connect therapeutic intervention with the need for discipline and security." HM Inspector of Prisons went on to say that there were examples where staff had denied women aspects of the daily regime for petty infringements of unit rules for shouting and arguing with staff. Authorisation for such action was being given by the unit manager without consulting a governor or clinician. In the light of these findings, HM Inspector of Prisons recommended that, "Training for staff on Keller Unit should be provided to allow them to develop skills to deal better with complex problems and difficult behaviours."

47. HM Inspector of Prisons commented on the IEP behaviour warning slips issued to women. She said that staff were unsure of the system which led to some inconsistencies and there was no evidence of management checks to ensure consistency and fairness. HM Inspector of Prisons said that there were many examples where women had lost association due to a single negative behaviour. She made several recommendations with regard to the scheme, one of which was that: "Prisoners should not lose association or receive other unsanctioned punishments as a result of incentives and earned privileges warnings."

The Corston report

48. The Corston report was commissioned by the Government following my investigation into the series of deaths at Styal between August 2002 and August 2003. Baroness Corston's report was published in March 2007 and considered the particular vulnerabilities of women in the criminal justice system. Baroness Corston found that the factors leading women to harm themselves in prison included mental illness, drug addiction, persistent low-level offending and living chaotic lifestyles.

49. Baroness Corston observed that women had been marginalised within a system largely created by men for men, and identified a need for a "champion" to ensure that the needs of women were properly recognised and met. She concluded that

there needed to be a re-design of women's custody introduced alongside other gender specific measures.

50. In my report on the woman's death I have, where relevant, made reference to Baroness Corston's recommendations, which I believe are strengthened by the woman's own experience within the criminal justice system.

Independent Monitoring Board report

51. In their annual report for 2007/2008, the prison's Independent Monitoring Board (IMB) reported that there had been a reduction in self harm at Styal. This was due largely to the hard work of all staff, not least the safer prisons team, and the correct implementation of ACCT procedures.

52. The IMB reported their high regard for staff who worked on the Keller Unit, describing their daily routines as noisy, stressful, unpredictable and challenging. The board wrote of how staff often put themselves at risk of personal injury when coping with violent incidents.

53. As they had said in previous annual reports, the IMB commented that the Keller Unit continued to hold many women with psychiatric disorders who were not getting the mental health care that they required. They said that, "There continues to be a lack of sufficient resources to provide for the appropriate and specialist needs of these highly vulnerable women."

54. The IMB concluded:

> "Styal continues to have to many seriously mentally ill prisoners who, in the opinion of the Board, should be in alternative secure care. It often takes too long to get these women transferred out of the prison, which means resources are being stretched to the limit."

55. Members of the IMB also expressed their concern about the length of time it took for women to be screened by a member of the MHIRT, saying that the target to screen women had recently changed from seven days to two days. However, the inability of some prisoners to attend an appointment and the lack of subsequent follow-up by members of the MHIRT had resulted in several applications being made to the Board regarding inadequate care. The IMB added that healthcare had difficulty in recruiting and retaining nursing staff.

KEY FINDINGS

24 September to 29 November 2007 – the woman's first period in custody

56. In September 2007, whilst under the influence of alcohol, the woman became involved in an argument with her partner. During the argument the woman attempted to cut her throat and an ambulance was called. However, the woman refused assistance and became verbally and physically aggressive, spitting at one of the police officers who was trying to help her. In his clinical review, the clinical reviewer says that such actions are typical of those with a personality disorder, being performed impulsively and without thought. The woman received treatment at a Hospital, for superficial lacerations she had caused to herself while attempting to cut her throat.

57. The woman appeared at a Magistrates Court in September and was remanded into custody at HMP Styal. Staff at the prison noted that she had a long history of self harm, drank heavily and had suicidal intentions. The woman was placed on the Keller Unit. That evening staff opened an Assessment, Care in Custody and Teamwork document. The following day staff intervened in order to remove a ligature that the woman had made from a television aerial. During an ACCT assessment interview, the woman told staff how she had been harming herself for a number of years and had attempted to commit suicide four times before. The woman told staff that she suffered from borderline personality disorder and depression and was taking medication for both conditions.

58. On 26 September, staff intervened after seeing that the woman was again using a television aerial to prepare a ligature. The following day the woman continued to express suicidal ideas, telling staff that she saw herself hanging from the cell window. On 28 September, the woman denied any suicidal thoughts, saying that prison was a "wake up call". Whilst on the Keller Unit, the woman's risk of suicide reduced and staff took the decision that a transfer to normal location was appropriate. She continued to be monitored and supported under the ACCT arrangements.

59. Over the following weeks the woman continued to threaten to harm herself, although on occasions staff noted that she was positive. During one ACCT review the woman stated that she would not "do anything" as she needed to be strong for her daughter. However, during the same review, staff recorded that the woman was suffering from negative thoughts and hallucinations and finding it difficult to cope in prison.

60. During an ACCT review on 10 October, the reviewer noted that the woman was unsettled and expressed concern that she had been making a ligature that morning. The woman said that she was making curtains. She added that she believed she was "going crazy" and had "bad thoughts" in her head.

61. Later that evening, having barricaded her cell door with furniture, the woman committed a serious act of self harm by attaching a ligature to the curtain rail in her cell. Staff raised the alarm and nursing staff attended, giving cardio pulmonary resuscitation, that stabilised her breathing. Upon the arrival of

paramedics, the woman was immediately transferred to the Hospital for further emergency treatment. The woman's ACCT document remained open.

62. The woman's family visited her in hospital on 11 October. Staff recorded on the ACCT document that during the visit the woman voiced no thoughts of self harm. However, when her family left, the woman told staff several times that she still intended to take her life.

63. On her return to Styal on 12 October, the woman went back to the Keller Unit and she continued to express self harm ideas at an ACCT review on 13 October. The woman told staff that she had been admitted to hospital a few days earlier merely to have sutures (stitches) for a self inflicted cut to her arm removed. When informed that she had nearly died, the woman told staff that they must be talking about someone else. The woman denied attempting to harm herself and any thoughts of doing so.

64. During an ACCT review on 14 October, the woman told staff that if she was not given her medication she would again attempt to take her own life. At an ACCT review on 17 October, the woman said that she could not remember being in hospital and was described by staff as being "over excitable, hyper in mood", attempting to convince staff on the unit that she was okay. Staff on the Keller Unit were reminded to remain vigilant at all times as it was feared that she would make a further serious attempt to harm herself.

65. An undated report into the woman's actions on 10 October was completed (the author of the report is not identified). The woman was interviewed on 17 October and said that she could remember little about what had happened or about being taken to hospital. She said that she thought she had tried to kill herself due to her partner finishing their relationship, and was afraid she would never see her daughter again. She said that she had not planned to kill herself and expressed sorrow about how her daughter and partner would have felt if she had been successful. During the interview the woman was noted as inconsistent and taking a particular interest into the way she had attempted to take her life. Although a hot debrief of the incident was held, the report did not examine the issues surrounding the circumstances of the woman's self harm or the response by staff.

66. On 24 October, staff recorded that the woman had not self harmed that week. Her behaviour continued to improve over the following weeks. However, during an ACCT review on 8 November, it was recorded that the woman had again been found making a ligature and saying she was thinking of harming herself. The woman's mood stabilised the following day, and she told staff that she would talk with them if she felt low.

67. The woman went to court on 23 November expecting to be released, but she returned to Styal later that day. An ACCT review was held and the woman told staff that she had no thoughts of self harm. On 29 November, the woman was released from Styal on licence. In his clinical review, the clinical reviewer notes that the woman was discharged with a prescription for her medication and that a

letter was sent to her doctor to provide an update on her situation.

January 2008 – The woman's second period of custody

Thursday

68. The woman appeared at the Magistrates Court in January 2008, less than two months after her release on licence, after being charged with racially aggravated assault. She was interviewed by escort staff at court. They recorded that, although she was at risk of suicide/self harm, she said she had no thoughts of self harm at that time. At 11.30am the woman appeared in court, was refused bail and remanded into custody at Styal. She was due to appear at court again on 22 January.

69. At 2.45pm the woman left the Magistrates Court for transfer to Styal. The Escort Custody Officer recorded on the Prisoner Escort Record (PER) form that the woman was, "very distressed, states I need a fag". The woman told staff that she would not go on the escort van without a cigarette, but was persuaded to do so. (The PER form accompanies staff on all escorts. It provides a chronological record of the escort such as the meals served, journey times started etc, and also serves as a communication tool about risks on escort or transfer.) The Escort Custody Officer noted that, once on the van, the woman started to shout and became angry about the time it would take before she was able to have a cigarette. During her transfer to Styal the woman was observed every 15 minutes. She remained distressed and was tearing at her clothes. Shortly before her arrival at Styal, the woman was noted as being, "… a little calmer". The woman said she was alright when asked.

70. The woman arrived at Styal at 4.00pm and was seen in reception ten minutes later by the first officer. The first officer told my investigator that the woman was very angry and loud, demanding a cigarette and becoming quite abusive. At 4.30pm, the woman was issued with three strikes on an Incentives and Earned Privileges Warning Slip by the second officer for disobeying rules, being anti-social and for swearing.

71. A Personal Summary Sheet F2050 Page 1 was completed by the first officer. The woman's home address was recorded and she provided the name and address of her sister as her next of kin.

72. At 6.10pm the first officer opened an ACCT document. The officer wrote that the woman had attempted to take her life by tying a ligature during her last time in custody and was very up and down in mood. Although the woman had told staff she was fine, the first officer noted that she also said that, during this period of custody, staff would not find her and that she "will do it".

73. The first officer also began a Cell Sharing Risk Assessment (CSRA). (The CSRA is a form used to assess the risk that a prisoner would present to others when sharing a cell.) The officer recorded that the woman had tied a ligature during her last time in custody, was "up and down" in mood, and had threatened staff. The first nurse, a Registered General Nurse (RGN), continued the

assessment and noted that she had helped to resuscitate the woman after her act of self harm in October 2007. The first nurse wrote on the CSRA, "Last time the woman was here, she actually went into heart failure, due to ligature." In section four of the CSRA, a governor noted that the woman was, "High risk – historically a significant self harmer with difficulty in coping as well as unpredictable behaviour." The woman was highlighted as being a high risk to others and required a single cell.

74. The first officer also completed an Offender Management Record (a form designed to highlight prisoner's immediate needs). The first officer referred to the woman's previous time in custody. She noted that the woman's daughter was currently being cared for by her father, that the woman had overdosed a few weeks previously, but that at present she had no thoughts of self harm. A principal officer told my investigators that, due to the attempt the woman had previously made on her life, he considered the woman's risk would be better managed on the Keller Unit. He said that he discussed the situation with a governor and they decided that she should be placed there. The first officer noted on the follow up assessment that the woman would be located on the Keller Unit because of her suicide risk during her previous sentence.

75. The second officer, who worked on the Keller Unit and knew the woman from her previous period of custody, collected her from reception. In interview, he said that the woman appeared polite and chatted happily to him as he escorted her. The woman arrived on the unit at around 6.30pm. She was given tobacco and made a free telephone call to her boyfriend. The woman was placed in cell five on the unit, which is a reduced risk cell.

76. On the woman's arrival on the Keller Unit, the third officer undertook a further Cell Sharing Risk Review. The third officer concluded that the woman's risk of harming a cellmate was high. He also noted that the woman had made a serious attempt on her life during her previous time in custody. He wrote that the woman "… had known mental health issues which staff are aware of." On the back of the form it was recorded that the woman would need to be seen by a doctor for alcohol detoxification and that she had previously abused cocaine, heroin and crack.

77. The first senior officer opened a Keller Unit History Booklet on the woman. (The document is used to record daily events and observations of prisoners located on the unit.) The first senior officer recorded that the woman had been located on the Keller Unit due to her previous attempt to harm herself by tying a ligature. She noted that reception had been informed that the woman had not yet seen a doctor. The first senior officer told my investigator that she rang reception, asking for a doctor to attend Keller Unit in order that the woman could be assessed. At Annex B of the Keller Unit History Booklet, the principal officer wrote that the woman had a history of extreme self harm and that she had told staff that this time they would not be able to save her. The principal officer, as the Operational Manager on duty, formally authorised the woman's location on Keller Unit. The first nurse completed the healthcare safety screen section of the Keller Unit History Booklet. She wrote that the woman appeared calm at present, but was very unpredictable and noted the severity of her previous

attempt at suicide.

78. At 6.35pm, the first senior officer and two other officers met to agree an immediate ACCT action plan for the woman. They decided that the woman should be located in a single cell and observed five times an hour. One observation, involving a conversation, was to be recorded every hour, but the others were not required to be written down. It was also recorded that the woman should be able to access both the Samaritans and the Listeners when required. However, an unidentified hand has written, “when up and running again”.

79. The second officer completed the woman’s ACCT Assessment Interview at 7.10pm. He wrote that she appeared very positive in mood and was “chirpy” in appearance. He said that the woman talked of her time out of custody and asked what observations she would be on. He recorded that the woman had last self harmed by taking an overdose just before Christmas. She said that she had been sectioned around 12 January, due to an attempt on her own life, but currently she had no thoughts of self harm. The second officer decided that the woman should remain on five observations an hour. At 7.15pm, the second officer completed the assessment. He wrote in the ACCT ongoing record that, although the woman now appeared positive, she had not been so in reception.

80. The woman was given a meal at 8.00pm and staff noted that she continued to appear to be positive in mood.

81. In an entry at 8.19pm on the woman’s electronic medical record (EMIS), a prison medical officer wrote before actually seeing the woman:

    “Patient in Keller Unit not stable, police brought all medication labels with name recent issue, stat doses GP for confirmation.”

    The prison medical officer amended his entry a day after the woman harmed herself, adding:

    “The woman was seen in Keeler Unit by myself and …. [the first nurse], physical well however emotional unstable now. All medication to start from tonight and stat Librium as she has been recently abusing alcohol. Would require secondary assessment again in morning.”

    The prison medical officer explained to my investigators that he added to his original entry to record as much detail as possible, including the names of those who were present and details of the woman’s prescriptions. The prison medical officer told the clinical reviewer that the arrival of a large number of prisoners strained the ability of the health staff to provide an adequate risk assessment for every prisoner. The prison medical officer said that he had only been able to make a brief note at first due to the pressure of work. But given the woman’s death, he felt it was important to enter a full record of his contact with her.

82. The woman was prescribed Quetiapine, to treat psychosis, Valproic and Citalopram as a mood stabiliser for depression, Chlorpromazine for the treatment

of psychosis, and Chlordiazepoxide, used to assist with alcohol withdrawal. The woman was also prescribed Thiamine and a Vitamin B compound, nutritional supplements that are prescribed to people who are dependent on alcohol and who frequently have poor diets.

83. The first nurse assessed the woman by talking to her through the observation panel of her cell door. She wrote in the EMIS at 8.46pm in mid January:

> "The woman arrived at Styal this evening and was sent straight to the Keller Unit. The woman has brought her own medication in, which the prison medical officer wrote her PX [prescription] with medications she is prescribed from her GP. Appeared to be settled, no signs of shaking, clammy or upset. Difficult to assess as no officers to open cell door. The prison medical officer or …….[the second prison medical officer] to see the woman tomorrow. As the woman is a high risk prisoner and has a history of ligaturing (and almost succeeding suicide on one occasion), the woman is on an opened ACCT, 5 obs per hour, I am not happy that there is no MO [Medical Officer] tonight to see the woman, due to the amount of prisoners in tonight."

84. In a second entry made two minutes later at 8.48pm, the first nurse wrote on EMIS, "On leaving the woman tonight she appeared bright and in high spirits." The first nurse wrote at 8.51pm, "MO (that is the prison doctor) MUST!! See the woman tomorrow before coming onto the wing. Will hand over for the morning staff."

85. At 9.00pm it was noted in the ACCT ongoing record that a doctor was due to visit the woman on the Keller Unit. At 9.20pm, the prison medical officer, accompanied by the first nurse, arrived on the unit. The prison medical officer told my investigators that he had been asked by the first nurse to see the woman. The prison medical officer said that he sat and talked to the woman in her cell for around 20 to 30 minutes. He described her as agitated and not comfortable. No subsequent entry was made on EMIS that day by either the prison medical officer or the first nurse. (Although my investigator was unable to interview the first nurse, the clinical reviewer was able to do so. I understand that the first nurse although not remembering the exact times, confirmed that she and the prison medical officer saw the woman in her cell that evening.)

86. The ACCT ongoing record records that the woman had a quiet night, although she was disturbed by the noise of another prisoner in the early hours.

Friday

87. On the morning of this day in January, the woman was given her breakfast. The second nurse, a dual registered nurse based on the Keller Unit, saw the woman in passing whilst organising the transfer of another prisoner to hospital. He described her as being in good sprits and said she did not appear depressed. A note in the Keller Unit Daily Handover Log records that for the rest of that day the second nurse was out of the prison on escort duty. The mental health support worker was off sick and as a consequence no healthcare staff were based on the

Keller Unit that day.

88. The second prison medical officer saw the woman at 9.30am. He noted on EMIS that he saw the woman as part of the delayed first night reception screen. He recorded that she had been drinking heavily since her last sentence and showed signs of dependence, but denied other substance abuse. The second prison medical officer discussed with the woman her risk of self harm and various life choices. The doctor thought that the woman seemed receptive, but he believed that a lengthy sentence might alter her current guardedly positive mood. The second prison medical officer told my investigators that his half hour consultation with the woman was positive. They chatted about the woman's future and how she wanted to become the appropriate carer for her child. She displayed no signs of intending to harm herself.

89. At 10.30am, the woman was seen by a member of the Counselling, Assessment, Referral, Advice and Throughcare (CARATS) team. (The CARATS team specialise in the treatment of substance abuse and can run programmes, offer counselling to prisoners and offer support and referrals to rehabilitation centres on their release.) It was recorded that the woman:

> "… was concerned over confidentiality issues in relation to her substance misuse and getting custody back of her daughter. Declined to sign up to CARATS and walked off. However [the woman] did apologise for acting in this manner."

90. At 10.35am, the woman went out for exercise before returning to her cell. She was later seen lying on her bed writing. At 12.00 noon, the woman asked staff for a light but as lunch was being served, was told that she would have to wait. (Because of the risk that the woman posed to herself she was not allowed possession of her own cigarette lighter.) The woman reacted by kicking the cell door and saying that staff were winding her up.

91. At 1.00pm, the second senior officer, acting on her own, undertook the woman's first ACCT Case Review. She told my investigators that the woman refused to attend. In her absence, the second senior officer recorded that the woman had been up and down in mood all day and had been prescribed medication that morning by the doctor. The woman's previous comments about "not being found this time" were repeated. The second senior officer concluded that the woman remained at risk of self harm and so her observations remained at five per hour. The second senior officer noted on the ACCT Care Map, "No actions for care map at present due to her not feeling well and agitated" and scheduled the next review for 24 January. She recorded that the woman should be assessed by the second nurse (Keller Unit's mental health nurse), and completed a referral form, sending it to the MHIRT to process. My investigators were unable to establish what happened to the referral form and the MHIRT at Styal were unable to provide any evidence that it was received.

92. The third nurse, a RGN, dispensed the woman's medication at around lunchtime. In interview she recalled that the woman was demanding and wanted to ensure

that her medication had been prescribed correctly.

93. A member of Styal's probation team visited the woman at 2.30pm to conduct her first night interview. He noted in the woman's ACCT booklet that the woman had said that if she received a custodial sentence she would definitely kill herself. He also noted that the woman was very agitated.

94. The third officer told my investigators that, during an intervention session that afternoon, the woman was loud, argumentative and obstructive, making fun of the other women who were playing Scrabble. The third officer described the woman as manipulative, explaining that she would constantly say things like, "I won't be here in a week's time" or "I am going to kill myself." The third officer said that she challenged the woman's behaviour that afternoon.

95. An entry in the Keller Unit Daily Activity Log noted that:

> "The woman's behaviour is quite agitated at the moment and seems to get wound up by the smallest thing. Dipped in mood around 3.00pm (see ACCT). Had intervention and evening association. Not happy about what probation said about her expected sentence."

96. The second nurse returned from escort duties to the Keller Unit later that afternoon and saw the woman again. The woman appeared more "wound up" than she had done that morning, telling him that she had not received her dinner time medications. The second nurse told the woman that she would have to wait until the medication round was made at 5.30pm. However, because of her state, the second nurse gave the woman her Quetiapine early, making a note on EMIS that she was not to be given the drug that evening.

97. Later that afternoon, the woman returned to her cell until she was unlocked to collect her tea at around 5.30pm. Afterwards she joined the other prisoners on the unit for evening association. At 6.33pm, the woman rang her partner, leaving a short message on his answerphone about how she might get two years and that her medication had been increased. The woman was issued with her evening medication, and at around 7.30pm was locked in her cell. She remained in her cell that evening and was given her final medication at around midnight.

Saturday

98. During the early hours of Saturday**,** at 1.00am and 5.00am, the woman asked staff for a light. At 8.30am, she received her medication and breakfast and the fourth senior officer noted in her record that she appeared cheerful in mood.

99. At 9.30am, the second officer noted in the woman's ACCT, "[the woman] has stated that she feels poorly today and has asked to do her cell after lunch." The second officer wrote in an entry at 10.30am that the woman appeared to be asleep on her bed.

100. The fourth senior officer told my investigators that the woman was asked to attend her second ACCT review but refused, saying that she did not feel well and

wanted to rest. The fourth officer told my investigator that the woman refused to participate in any of the Keller Unit's regime, repeating that she did not feel well. The fourth officer said that she spoke to the woman periodically, offering her baths, asking that she clean her cell, and offering exercise. The fourth officer said that the woman refused to leave her cell.

101. Two references to the woman are made in the Keller Unit Daily Handover Log on 19 January. The first records that, "The woman was mythering for a risk assessment for lighter in possession. Told her wouldn't consider her today as she is too agitated. So we can see how she goes over the weekend." The other entry reads, "The woman – ACCT review required refused to do a review."

102. CCTV footage obtained from the Keller Unit provides a clear view of the corridor outside the woman's cell. Between 11.00am and 11.15am, a number of woman prisoners can be seen wandering around the unit. At 11.04am, the fourth senior officer walked onto the corridor and chatted to a number of the prisoners present, before walking out of the camera's view.

103. At 11.15am, the fourth officer approached the woman's cell with a piece of paper. She opened the hatch to the woman's cell and passed the paper through the cell door before walking out of view. The fourth officer told my investigator that she was unable to remember what she had passed the woman.

104. At 11.30am, the second officer wrote in the woman's ACCT, "The woman has been given three chances to clean her cell but has not done so. Issued with IEP warning slip." The second officer told police that the woman had been asked to leave her cell on a number of occasions but had refused. The second officer told my investigators that the woman was well aware of the unit's regime and that cells must be cleaned in the morning. As she had not cleaned her cell, he had issued her with an IEP warning slip. (The prison was unable to locate the warning slip and so it is unclear how many strikes or ticks were given as a consequence of the woman's refusal to clean her cell.) During interview, the fourth officer said that, although she could not recall issuing an IEP warning slip to the woman, she remembered her asking in the morning about coming out of her cell for association in the afternoon. The fourth officer said that she told the woman that she would not be allowed out for association that night because she had not complied with the unit's regime, but that she would be allowed out to participate in the afternoon interventions.

105. Between 11.15am and 12.14pm, the CCTV footage shows prisoners and officers moving around the corridor outside the woman's cell. However, during this time the woman's cell is not approached and there does not appear to be any interaction between either officers or prisoners and the woman.

106. The fourth officer wrote in the Keller Unit Daily Activity Log under "am", "the woman refused to comply to unit regime or to attend her ACCT review."

107. The fourth senior officer told my investigators that between 11.15am and 12.10pm she wrote up the woman's second ACCT Case Review, which the woman had earlier said she would not attend. The second officer was also

present at the review. The ACCT booklet shows that the review took place at 12.10pm. The fourth senior officer recorded in the review that:

> "The woman refused to attend her review, stating she was tired because of her medications. The woman has settled in mood but still presents a risk of deliberate self harm. Observations to remain at five per hour until next review. Hopefully at that point the woman will engage in the process. Staff to continue with support for the woman and record meaningful conversations or triggers."

The fourth senior officer made no further entries in the woman's care map. She noted that the woman's next review was scheduled to take place later that day, at a time to be advised.

108. When asked whether she was asked to go to the woman's ACCT review that morning, the fourth officer told my investigator that she did not remember. The fourth senior officer said that the ACCT review was the last thing she did before assisting the other officers to serve lunch. The CCTV footage shows the fourth senior officer arriving at the servery, which was opposite the woman's cell, at 12.11pm. The footage also shows the second officer arriving at the servery at 12.07pm, leaving at 12.10pm and returning less than a minute later also to help serve the lunches.

109. At 12.14pm, the fourth senior officer entered the servery and the fourth officer gestured to her colleagues that she was about to unlock the woman's cell. Soon after her door was unlocked, the woman left her cell and crossed the corridor to the serving hatch. The fourth officer told my investigators that this was the first time the woman had left her cell that morning. The woman appeared to communicate briefly with the fourth officer and the fourth senior officer before going back to her cell. Just a few seconds later the woman again approached the servery. The fourth officer told the police that she asked the woman how her trip to Thailand (planned when she was last in prison) had gone. The woman told her that she had not been able to go as the conditions of her release meant she had to stay in the UK. At 12.16pm, the woman carried her lunch back to her cell and shortly afterwards was locked in by the fourth officer.

110. The fourth senior officer, the fourth officer and the second officer went into the servery, where the Keller Unit's food is prepared, to collect their lunch at 12.20pm. The fourth senior officer was the last to leave at 12.26pm. The fourth officer explained to my investigators that she and the other officers would have eaten their lunch in the senior officer's office.

111. At 12.30pm, the fourth senior officer noted in the ACCT ongoing record that the woman, "Took lunch time meal. Not in a very good mood. Stated that she was tired due to her meds."

112. A prisoner, the wing orderly [a prisoner given the responsibility of cleaning and carrying out other minor duties on Keller Unit], looked through the hatch of the woman's cell. At 12.30pm she appears to be giving the woman a light for a cigarette. CCTV footage then shows the prisoner talking with the woman for

about 20 seconds before leaving and walking out of view. The third officer told my investigator that, although the wing orderly was not a trained Listener, the women on the unit often talked with her, telling her things that they would not disclose to officers. The officers said that the wing orderly would always approach staff if she had any concerns about any of the women on the unit.

113. The third officer, whilst walking past the woman's cell at 12.40pm, looked briefly through the observation hatch before walking out of view.

114. At 12.44pm, the woman rang her cell bell, illuminating the red light outside of the cell. A minute later the fourth officer walked up to the woman's cell and looked through the observation hatch, appearing to give her a light for a cigarette. The fourth officer remained at the cell for approximately 30 seconds before walking away.

115. At 12.51pm, the third officer also stopped at the woman's cell, looking briefly through the hatch before walking out of view. Approximately 40 seconds later, the third officer spoke with the woman through the observation hatch for about 15 seconds.

116. The third officer returned to the woman's cell at 1.00pm, opened the observation hatch and looked in. She walked away but then returned and talked to the woman through the door for around 20 seconds before leaving. The third officer's recollection of their conversation was that the woman told her she was feeling better and asked if she could have a bath that afternoon. The third officer said that she told the woman she would not be on duty that afternoon and advised her that it was something she should discuss with the other officers. The third officer learned later that the fourth officer had told the woman that she would be able to have a bath the following day.

117. The fourth officer told police that, in failing to comply with the regime by refusing to clean her cell, the woman would not have been allowed association later that day. The fourth officer told my investigators that she could not recall the exact time that the woman was told she would not be allowed out for association. She believed it to be some time after lunch and the woman had said it did not matter because she would not be there anyway. The fourth officer took no further action, telling my investigators that staff regularly heard such comments "day in and day out".

118. At 1.07pm, the woman rang her cell bell again, illuminating the light outside. The third officer answered the bell two minutes later. She opened the observation hatch and talked with the woman before turning the cell bell off. The third officer remained at the woman's cell for approximately 20 seconds.

119. The wing orderly can be seen speaking through the hatch of the woman's cell at 1.14pm. The wing orderly appears to issue the woman with a menu or canteen list, passing it under the cell door before giving the woman a light for a cigarette.

120. The third officer looked briefly through the hatch of The woman's cell again at 1.19pm.

121. The last entry in the woman's ACCT on-going record was made at 1.30pm. An entry at the bottom of one page, and written by the third officer says, "Has asked for a bath, however…" The entry, was completed by the fourth officer at the top of the following page and reads, "… she [The woman] has been advised that she can have one tomorrow". My investigators asked the fourth officer why she had finished the entry made by the third officer. The fourth officer said that she finished the entry as she knew what the third officer was going to say, namely that the woman had been told she could have a bath the next day, as it was she who had told the woman this. The third officer told my investigator that she believed that she did not finish the entry because she had run out of paper and became distracted.

122. At 1.34pm the third officer observed the woman once again through the cell hatch.

123. Having already dispensed the medicines that morning, the third nurse went back to Keller Unit to do so again in the afternoon. CCTV footage shows that at 1.44pm the third officer and the fourth officer went to the woman's cell. The fourth officer opened the cell door and the third nurse approached with the medication trolley. The fourth officer is seen talking with the woman through the open cell door. The third officer told my investigator that the fourth officer and the woman talked again about her being allowed to take a bath. The third officer said she left the fourth officer to deal with the issue as she herself was shortly going off duty.

124. CCTV images then show that the third officer leant forward and looked into the cell before stepping back. The third nurse walked to the cell door and talked with the woman before returning to the medication trolley and giving the woman her medication. The third nurse told my investigator that the woman was a lot calmer than she had been the previous day. The CCTV footage shows that the officers continued to talk with the woman before the third officer stepped back, out of the woman's sight, and kicked the fourth officer and made a cutting gesture across her own throat.

125. The third officer told my investigators that she kicked the fourth officer several times to get her attention to look at the woman's neck. She said that when the woman took her medication, throwing her neck back to do so, she had noticed a red mark to the right side of her neck. The third officer said that the fourth officer nodded yes, adding that she knew what she was indicating. The fourth officer told my investigators that the third officer, "… was asking me basically have I seen a red mark on The woman's neck and I acknowledged that yes I had seen the red mark." The woman's cell door was then locked by the fourth officer, and the officers and the nurse moved onto the next cell.

126. The third officer said that she could not recall talking about the red mark on the woman's neck with any of the officers again, adding that she may have said they had "better watch [the woman]". The officer said that no discussion took place

about making an entry in the ACCT document, assuming that a reference would be made in the woman's ACCT booklet at 2.30pm. The fourth officer told police that she did not record the red mark on the woman's ACCT document either.

127. The wing orderly approached the woman's cell at 1.49pm and gave something to her.

128. The CCTV footage shows that at 2.05pm the fourth officer looked briefly through the woman's cell hatch before moving away. She told my investigators that, when she looked in the cell, the woman looked up at her. She said that she thought something was not right as the woman had moved her mattress onto the floor behind the door. The fourth officer told my investigator that at this point the woman was not hurting herself and so she continued with her duties. The wing orderly cleaned the corridor outside the woman's cell for the next 15 minutes.

129. The fourth officer told police that, when the third officer went off duty at around 1.30pm to 1.45pm, she continued with the afternoon checks. She remembered that she gave the woman a light for her cigarette on a couple of occasions. Some time after giving the second light, she looked through the cell door and saw the woman sitting on her mattress close to the door. She said the woman looked up and seemed startled. The fourth officer told police that she returned to the woman's cell, observing the 15 minute checks and, looking through the hatch, was surprised that she could not see her.

130. The fourth officer told the police that she returned to the office, collecting the other officers, before returning and unlocking the cell door. The CCTV footage shows that at 2.24pm the fourth officer unlocked the cells adjacent to the woman's and several prisoners are seen coming onto the wing. At 2.25pm, the fourth officer looked through the hatch of the woman's cell, appearing to look down and to the right. The fourth officer then went to the office to summon help as she could not see the woman in the cell. She returned approximately 35 seconds later with the second officer and the fourth senior officer.

131. At 2.26pm, the fourth officer unlocked the woman's door but was unable to open it easily. The second and the fourth officers both pushed at the door before going inside. They found the woman hanging from the corner of the cell where the television was. The fourth senior officer made a call on her radio for urgent medical assistance, code blue on the Keller Unit, before checking on the other women on the unit. (A code blue is the emergency code used to alert staff of a serious incident involving a prisoner with breathing difficulties.)

132. An Operational Support Grade was working in the communications room that afternoon. She received a call from the fourth senior officer (Keller I) requesting urgent medical assistance. The Operational Support Grade asked whether the code was blue or red but said she received no response from the fourth senior officer. The Operational Support Grade immediately called Hotel 4, the emergency response nurse, who that afternoon was the third nurse. The Operational Support Grade requested that she go immediately to Keller Unit but advised her that the nature of the emergency was not yet known. The communication log records that at 2.30pm The Operational Support Grade called

for an ambulance and, whilst on the telephone to the emergency services, sought clarification from the Keller Unit as to the nature of the emergency.

133. On going into the cell, the second officer supported the woman's weight and called for an ambulance over his radio, while the fourth officer cut the ligature from around her neck. The woman was then placed on the bed. After checking for a pulse, the second and the fourth officers commenced cardio pulmonary resuscitation (CPR). At 2.27pm, the second officer ran from the woman's cell, returning 20 seconds later with a face mask. She then continued to assist the fourth officer with CPR. The fourth senior officer removed the mattress and bedding from the woman's cell.

134. The third nurse told my investigators that as Hotel 4 she received a radio message asking her to attend an urgent medical call on Keller Unit. Whilst making her way there, the third nurse asked for confirmation of the code being called and was told that it was a code blue. She said she did not take any emergency equipment with her as the necessary equipment was kept on the unit.

135. The third nurse reached the woman's cell just before 2.29pm. When she arrived the second officer was administering mouth to mouth resuscitation whilst the fourth officer was giving the woman chest compressions. The third nurse was unable to locate a pulse. The nurse radioed for further available medical assistance to attend Keller Unit, having confirmed that an ambulance had already been called. She asked the officers to continue CPR whilst she fetched the medical bag and the fourth senior officer collected the defibrillator from the office.

136. On her return to the cell seconds later, the third nurse and the officers continued with CPR. The third nurse inserted an airway and asked for the woman's top clothing to be cut to enable her to apply the defibrillator pads. The defibrillator advised the third nurse that compressions should be maintained but that no shock should be administered. At this point the third nurse began to give chest compressions to the woman herself.

137. At 2.33pm, the fourth nurse (RGN) arrived at the woman's cell, having been alerted to the emergency whilst she was working in the pharmacy on Waite Wing. On her arrival, the fourth nurse helped to ventilate the woman whilst the third nurse continued with chest compressions. Just after 2.34pm, the third and fourth officers left the cell. Approximately 20 seconds later the paramedics arrived, having reached the prison at 2.33pm. The paramedics took over CPR and the third and fourth nurses continued to assist. The fifth nurse (RGN) arrived at the cell at 2.35pm, shortly followed by the sixth nurse (RMN).

138. At 2.50pm, the woman was transferred by the paramedics from her cell to the waiting ambulance. Whilst she was in the ambulance, the paramedics and nurses continued to treat the woman. By this time she was responding to treatment and her condition was stabilised. The ambulance left the prison at 3.14pm.

139. The woman had hanged herself by threading bed sheets between the plastic casing surrounding her television set and the ceiling of her cell. The last entry about the woman in the Keller Unit Daily Activity Log was made by the fourth officer at 2.30pm. She wrote that the woman had hanged herself by using bedding tied to the television point.

140. Once the woman had been taken from the prison, a governor and he fifth officer attempted to contact her next of kin. The governor said:

> "This proved extremely difficult as the names listed did not match the addresses and although we tried four different names, none with contact numbers, we were unable to match the addresses with any numbers via directory enquiries. Before leaving the prison to go to the hospital I asked that the woman's GP be contacted to try and confirm a contact point for the family. From the hospital I phoned in and asked a second principal officer to contact the police, asking them to go to the family address and contact them as we could not raise the family any other way."

141. The woman's family were notified of her condition and arrived at the Hospital at around 7.30pm. The family met the prison's Family Liaison Officer as well as the other governors.. The woman's family were briefed by medical staff at the hospital. After their visit to the hospital, the prison arranged for a taxi to take her family back to their home at around 8.45pm. Over the following days, the prison Family Liaison Officer, who is of governorship grade, kept in contact with the woman's family.

142. The woman left two notes in her cell, one to her partner and another to her daughter, both expressing her love for them. A third note was written in large letters and reads, "……….. have a conscience."

143. Styal's deaths in custody contingency plans were implemented. A hot debrief took place later that evening, and staff who had had involvement with the woman that day attended. Reviews of those women on open ACCT booklets were undertaken. The prison care team were informed of the situation and made themselves known to those members of staff who had been involved.

144. Four days after the suicide attempt and, following a letter from the governing governor, the court granted unconditional bail to the woman.

145. The woman remained in the Hospital on a life support machine for four days. She did not regain consciousness and died at 2.30pm on the fourth day of the suicide attempt. The prison Family Liaison Officer spoke to the woman's family and expressed condolences on behalf of the Governor and staff. The prison Family Liaison Officer kept in regular contact with both branches of the woman's family. The governing governor and the prison Family Liaison Officer met members of the woman's family six days after the woman's death to discuss the circumstances of her death.

146. The prison Family Liaison Officer and another governor represented the Prison Service at the woman's funeral in February 2008. The prison met all the funeral

expenses. The prison Family Liaison Officer wrote to the woman's sister informing her that she would be on leave for three weeks and providing details of an alternative contact at the prison. A collection from staff and prisoners on Keller Unit raised £100.00. (The woman's family had asked what had happened to the money raised. My investigator has spoken to Styal and the prison has confirmed that the money raised has now been forwarded to the woman's family.)

Post Mortem

147. A post mortem was conducted on a day after the woman's death. The pathologist noted that there was a partly interrupted ligature mark around the woman's neck which was consistent with the results of hanging. Other features identified during the post mortem showed "typicality" of cardiac arrest following hanging. The pathologist reported no significant toxicological findings.

ISSUES CONSIDERED

Clinical Care

First Night Assessment

148. Because of the risk that the woman posed to herself it was decided that she should be taken directly to the Keller Unit. Although the woman was initially seen by the first nurse on her arrival and then by a prison medical officer several hours later, neither completed a First Night Reception Health Screen. (This is an immediate assessment by prison medical staff as to the medical requirements of a prisoner, normally completed in the First Night Centre.)

149. A mandatory requirement of Prison Service Order (PSO) 0500, Reception at section 6.2 is that:

> "An assessment of the healthcare needs of every prisoner must be undertaken on Reception, or before that day's final roll check of the establishment (lock up), by an appropriately trained member of the healthcare team to identify existing health problems and to plan any subsequent care."

150. The clinical reviewer concludes that:

> "As [the woman] was admitted direct to the Keller Unit, she by-passed the normal method of assessment at the First Night Centre; this meant that [the woman] was not properly assessed until the following day. Given the findings of the assessment on Friday 18 January 2008, this is not a contributory factor to the woman's death but in future prisoners should not be transferred to the Keller Unit unless a proper risk assessment has or will be performed."

151. I concur with the clinical reviewer's findings and make the following recommendation.

The Governor and Healthcare Manager should ensure that the First Night Reception Health Screen is completed for all new prisoners and before that day's final roll check.

Amendment of electronic medical records

152. In January, after the woman harmed herself and was taken to hospital, a prison medical officer amended his EMIS entry of four days earlier. The prison medical officer explained that, because of pressures of work, he was only able to enter a brief record of his contact with the woman on the night of the four days earlier. He said that he added to the original entry in order that as much detail as possible was recorded, the names of those who were present, and what had happened that night.

153. In his clinical review, the clinical reviewer concludes that it was understandable, given the pressures of a prison medical officer's work, that the original EMIS record was brief. However, he says that it is unacceptable practice to have added to the record after the woman's transfer to hospital.

154. However, having reviewed the amendments, the clinical reviewer is satisfied that the original brief record did not detract from the care that was given to the woman. The clinical reviewer reports that a prison medical officer is now aware that changes to the EMIS record should not be made. If any are made, the date of the modification and reason should be recorded.

The Healthcare Manager should remind all healthcare staff that any retrospective additions to EMIS entries must include the date and reason for amendment.

Mental Health In-Reach Team assessment

155. Because the woman was transferred directly to the Keller Unit and bypassed the First Night Reception Centre, she was not seen by a member of the MHIRT. It was explained to my investigators that, in such instances, women transferred straight to Keller Unit are given an initial review by the second nurse, the Keller Unit resident RMN. Any issues identified would be referred to a member of the MHIRT. However, even though the second nurse briefly saw the woman on 18 January, he was unable to carry out a detailed assessment that day as he was required to escort another prisoner to hospital.

156. Although the woman was not seen by the second nurse or a member of the MHIRT, she was seen by the second prison medical officer who did not identify any immediate mental health needs. During the woman's ACCT review later that day the second senior officer identified that the woman should be assessed by the second nurse and referred her to the MHIRT. However, despite making enquiries, my investigators were unable to locate the referral form nor were they able to obtain evidence that it was received and logged by the MHIRT.

157. Two of the MHIRT explained to my investigators that the woman should have been assessed by one of their team that Friday, but this did not happen due to a lack of time. One of the MHIRT volunteered to review the woman the following Monday during his regular visit to the Keller Unit.

158. The clinical reviewer says that, despite the referral, the woman was not seen as the MHIRT had already assigned reviews for that day and she was scheduled to be seen the following Monday. The clinical reviewer believes that the MHIRT also assumed that the second nurse would assess the woman and notify them if there was an urgent need for specialist intervention.

159. The clinical reviewer comments that, although the MHIRT should have seen the woman in mid January, it was highly unlikely that the omission would have led to her death. However, he notes that it was poor practice. He says that the MHIRT acknowledged that the procedures at the time were unsatisfactory. As a consequence, the MHIRT now work over six days and have refined their referral

process.

160. The clinical reviewer concludes that in future the PCT should monitor the performance of the MHIRT to ensure that high risk prisoners such as the woman are assessed within one working day of their arrival at the prison.

The Healthcare Manager, on behalf of the PCT, should monitor the performance of the MHIRT and ensure that high risk prisoners are assessed within one working day of their arrival at the prison.

161. I regret to say that I commented on similar matters surrounding the referral of women for mental health assessments by the MHIRT during my investigation into the death of a woman at Styal in May 2006. In that report I observed that there had been problems with regard to referrals to the MHIRT. In my report into the death of another woman in June 2007 (which has just been received at the prison), I also report on the restricted availability of the MHIRT at weekends. However, I am pleased to note that MHIRT staff now work on Saturdays.

Response and resuscitation

162. The clinical reviewer concludes that overall there appears to have been a prompt response to the request for urgent medical assistance. Although the communication officer said she had to seek further clarification of the nature of the emergency, the ambulance was called immediately whilst the details were sought. I note that in my report into the death of a woman at Styal in June 2007, which as explained the Governor has only recently had sight of, I recommended that the Governor should remind his staff of the correct emergency code calls to be used when requesting assistance. I have judged that I do not need to repeat that recommendation here.

163. The fourth nurse was one of the second response nurses and was working in the pharmacy on Waite Wing at the time. She was not carrying a radio and was alerted to the emergency by a colleague. The clinical reviewer notes that, although there might have been a short delay summoning additional emergency support, there were already two officers and one trained nurse providing resuscitation. For this reason, he concludes that the delay would not have affected the outcome either.

164. The clinical reviewer concludes that, as far as can be determined the resuscitation was carried out according to protocol and that there were no major issues. However he suggests that for future incidents the communications protocols should be checked. Although I make no recommendations with regard to this, I draw the Governor’s attention to these findings.

165. The woman’s family asked my investigator whether or not there was a delay in the ambulance arriving and leaving the prison. My investigator found no evidence to suggest that there was such a delay. Having arrived at the prison at 2.33pm, the paramedics were at the woman’s side within two minutes. The woman was transferred to the ambulance at 2.50pm. Paramedics continued to stabilise the woman before departing the prison at 3.14pm.

Injuries sustained by the woman

166. The woman's family said that they were told by staff at Styal that the woman had only been hanging for a couple of minutes before being found. They said that they could not understand how the woman could have suffered from such catastrophic brain injuries within just two minutes.

167. The CCTV footage clearly shows that the woman was last checked by the fourth officer at 2.05pm before being checked again at 2.25pm. Consequently, the woman could have taken the action that she did at any time during this 20 minute period and not within the two minutes that the family were told by prison staff.

168. In his clinical review, the clinical reviewer says that it is not certain how long the woman had been hanging from the ligature before being found, adding that any precise estimate would need a forensic pathologist to comment. However, the clinical reviewer says that, following discussions with an Accident and Emergency doctor, he believes that the woman, " … would need to have been suspended for at least five minutes and possibly ten for substantial brain damage to have occurred".

Staffing levels on Keller Unit during the weekend

169. The residential mental health nurse based on the Keller Unit works Monday to Friday, 8.30am to 4.30pm, and is assisted by a nursing assistant working similar hours. During weekends neither the nurse nor nursing assistant are present, leaving the unit reliant on nurses based on Waite Wing, the main residential wing in the prison.

170. In the mid January, the second nurse, the residential mental health nurse, was helping to transfer another prisoner to hospital, and his assistant had reported sick. As a result, there were no resident mental healthcare support staff available to the prisoners on the unit. The clinical reviewer reports that, although there was no evidence to suggest that the lack of healthcare staff in the mid January contributed to the woman's death, leaving the unit without mental health support was poor practice. He believes that steps must be taken by the Cheshire and Wirral Partnership NHS Trust, in conjunction with the PCT, to ensure that this does not happen again.

171. I agree with the clinical reviewer. Given the extremely vulnerable nature, and specific mental health needs, of the women located on the Keller Unit, I too believe it to have been poor practice to have left the unit without full time mental health nurse coverage on this day in mid January. Indeed, I would go further and suggest that, given the nature and specific and complex needs of the women located there, mental healthcare should not only be provided throughout the week but also during the weekends. It is evident that vulnerable women do not cease to be so at 4.30pm on a Friday afternoon and become so again at 8.30am on a Monday morning. I make the following recommendation:

The Governor and Chief Executive of Central and Eastern Cheshire PCT should review the level and scope of mental health nursing cover on the Keller Unit at weekends.

172. I make several similar observations with regard to the number of officers working on the Keller Unit. The unit is normally staffed from Monday to Friday during the day by a senior officer and three officers, and by a senior officer and two officers at weekends. Two officers are detailed to work in the evening, with two OSGs working at night, although I understand this is often supplemented dependending on the needs of the women in the unit. My investigators also established that one officer is taken away from the unit to assist with adjudications every day, which can be for several hours. An extra officer is detailed to work Saturday mornings to cover the adjudication duties.

173. I have already emphasised that the complex problems of the women on Keller Unit do not cease at weekends. The clinical reviewer says that:

> "The unit is not suitable for maintaining a high number of disturbed prisoners housed in individual cells unless well staffed with both health and disciplinary staff. A higher level of staffing at weekends might have prevented the self harming episode but this is speculation."

The clinical reviewer goes on to say that, "The low number of staff at night and at weekends represents a considerable risk especially in the absence of diversionary activities."

174. I fully appreciate the operational and budgetary restraints that have prevented the Governor from maintaining the same level of staff at weekends as during the week. However, in accommodating the most vulnerable women in the prison, the Keller Unit is different from the other units.

175. The clinical reviewer is correct when he says that it is pure speculation that a greater number of staff would have prevented the woman from self harming on Saturday afternoon. However, in order to provide the continuity of care afforded to the women by staff during the week the same staffing levels should be maintained during the weekend.

The Director of Offender Management and Governor should review the staffing of the Keller Unit and provide the same levels at the weekends as during the week.

176. The clinical reviewer concludes that staff at Styal correctly identified the woman as at risk of self harm. The clinical reviewer believes that the woman should ideally have been under constant supervision, but the nature of the Keller Unit makes this extremely difficult within existing prison resources. He comments that there are several areas where the provision of healthcare could be better but concludes none of this materially affected the final outcome with regard to the woman.

OTHER ISSUES

ACCT observations between 11.15am and 12.14pm

177. The first time that the woman left her cell on the day in mid January was at 12.14pm when she was unlocked by the fourth officer to collect her lunch. The CCTV footage taken of the Keller Unit shows that, in the preceding hour, no observations or interactions took place despite the woman's ACCT document stating that she was to be observed five times an hour. My investigator was unable to establish any reason why the woman was not observed during this time.

178. My investigator made enquiries about who was responsible for checking women who were subject to ACCT. The fourth officer explained that officers were assigned particular cells. However, all members of staff checked all of the cells of women on an open ACCT. The fourth officer said:

> "Generally on the Keller Unit what happens is every time you pass a door you check on it, or you'll ask other staff have you checked on such a body, then you'll know, and then it's recorded in the ACCT document … you just generally check them all the time."

179. The woman was subject to ACCT monitoring and should have been checked at least five times an hour. This was especially important as she had spoken of harming herself and her behaviour was disruptive during the morning. It is clearly unacceptable that a woman as vulnerable as the woman was not checked by staff. I am deeply concerned that, for whatever reason, this was allowed to happen. Women on the Keller Unit are there because, as the Keller Unit Local Policy Document states, the unit provides a:

> " … safe, healthy and supportive environment which is conducive to the individual needs of the women, who have complex needs, who would benefit from intensive work and intervention enabling the to be re-integrated back into the main prison population."

180. I have no reason to think that officers intentionally omitted to check on the woman. However, she was not checked and this should not have been allowed to have happened. It cannot be shown that this very poor practice had any direct bearing upon the woman's death which was at least two hours later. However, in light of my findings I make the following urgent recommendation.

The Governor should satisfy himself that women who are the subject of observations under the ACCT process are actually checked the required number of times.

ACCT reviews

181. The concerns above to one side, the ACCT document opened on the woman during her first stay at Styal was of a reasonable standard as was the second ACCT, given the woman's non-participation in the process. My investigators also

reviewed ACCTs open on other prisoners on the Keller Unit and Waite Wing and also found them to be reasonable.

182. The woman refused to attend both her ACCT reviews, saying that she was tired or feeling unwell. As a consequence, her reviews appear to be somewhat perfunctory, particularly her review on the morning of the last Saturday before she died. I must also highlight a discrepancy between the time that ACCT review was recorded as being written by the fourth senior officer and attended by the second officer (12.10pm) and the CCTV footage which records both officers at the servery at this time.

183. I must raise another major concern about the ACCT process. It is one that I first raised during my investigation into the death of a woman at Styal in May 2006. In that case, as with one of the woman's ACCT reviews, the review took place with just a senior officer present, and without a multi-disciplinary element or a member of healthcare staff. (either from the MHIRT or the resident unit nurse). I repeat the observation that I made in my previous report. The quality of any ACCT review is dependent upon a multi-disciplinary approach being taken. I note with interest and concern HM Inspector of Prisons Owers' finding that few ACCT reviews at Styal were multi-disciplinary. She found that reviews were arranged at short notice with often only the senior officer and an officer being present.

In response to the draft report the Prison Service said,

> "While it may inappropriate to conduct a case review with only the case manager and another member of discipline staff it should be pointed out that only those with an interest in an offender's care should be invited to contribute as opposed to a blanket multidisciplinary approach, whereby all departments are represented regardless of their input into the care of an individual."

The Governor should ensure that every ACCT review is multi-disciplinary and includes all the key personnel involved in the delivery of the prisoner's care.

184. During the issuing of medication the third officer observed a red mark on the woman's neck, drawing its attention to her colleague, the fourth officer. Given the woman's history of self harm and volatile behaviour, and the very fact that the third officer found the mark to be significant enough to draw it to the attention of the fourth officer, I am deeply concerned that no further action was taken.

185. The third officer said she did not recall mentioning the mark again or that any discussion took place about recording the observation in the ACCT booklet. She thought she might have told her colleagues that they "better watch the woman" and assumed that an entry would be made in the woman's ACCT at 2.30pm. The fourth officer also did not record the observation.

186. I appreciate that self-harming is very frequent on the Keller Unit. However, there is a great danger that as a consequence staff may regard it as almost 'normal'. Despite the regularity of attempts to self harm by women on the Keller Unit, it is

of the utmost importance that staff record and share significant events involving the women in their care.

187. I am unable to say what impact a note of the woman's actions might have made to the events that took place later that afternoon. However, I make the following recommendation:

The Governor should remind all staff of the need to record in the ACCT booklet all significant events relating to a prisoner and to share such information immediately with colleagues.

Incentives and Earned Privileges Warnings

188. Officers are permitted to issue women IEP warnings for acts of indiscipline and anti-social behaviour. The system works under a tick/points system, and a prisoner who receives three ticks on one warning slip loses association for the next 24 hours.

189. It is clear that the woman was distressed and in a volatile state when she arrived at Styal. Staff knew her previously and decided to place her on the Keller Unit. Nevertheless, in spite of her known vulnerability, the woman was issued with her first warning slip within minutes of arriving at Styal. This was despite a clear record on her Prisoner Escort Record (PER) that she was distressed and had been tearing her clothes during her transfer to prison.

190. The woman was issued with another slip two days later for refusing to clean her cell. Again this was despite the fact that the same officer had recorded two hours earlier that, "[The woman] has stated that she feels poorly today and has asked to do her cell after lunch." She told another officer that she did not want to attend her ACCT review that day as she felt unwell and wanted to rest. As a consequence of the second IEP slip, the woman was told that she would not be allowed out on association that evening.

191. During their investigation and interviews with staff, my investigators were presented with a confusing picture of how the IEP warning system operated. The third officer said that it was common for women on Keller Unit to receive IEP strikes and therefore lose their association. He added that as many as six women could lose their association at any time. The fifth officer explained that loss of association could start immediately for women on the Keller Unit, rather than losing it after 24 hours as is the case in other parts of the prison. The fourth senior officer confirmed this, telling my investigators that:

> "Sometimes on Keller Unit because of the prisoner we have located there; if they receive a red ticket they lose their association that night, because the day after they don't remember what it's for, they have difficulty in understanding the IEP system sometimes."

The first senior officer said that IEP warning slips would be recorded in the Keller Unit Daily Occurrence Activity Log.

192. HM Inspector of Prisons subsequent inspection of Styal also reports how women on the Keller Unit are denied aspects of their daily regime for petty infringements such as shouting and arguing with staff, she cites examples when women lost association due to a single negative act. HM Inspector of Prisons says that staff were unsure of the IEP system and that there was no evidence of management checks to ensure consistency. HM Inspector of Prisons concludes that prisoners should not lose association or receive other unsanctioned punishments as a result of IEP warnings.

193. As I have said previously in my report, I appreciate the difficulties that face staff on the Keller Unit every day. Nevertheless, women like the woman, located there as a consequence of their mental health and self harm vulnerabilities, should not be punished for behaviour which they may not be able to control. Indeed I am far from clear why the woman merited the two IEP slips. I am also concerned that the way the IEP system operates comes close to being a shadow system of punishments.

194. As I said in my earlier report into a woman's death at Styal in April 2008, staff should not be the subject of abusive or threatening behaviour. However, PSO 4000, Incentives and Earned Privileges, chapter 3 paragraph 3.22 says, "Governors should ensure that the local [IEP] scheme does not penalise behaviour which is the direct consequence of a disability, particular needs or age." In the light of my findings I make the following recommendation:

The Governor should urgently review the implementation of the IEP scheme in the Keller Unit.

Length of time staff have worked on the unit

195. My investigators established that a number of the officers working on the Keller Unit had done so for several years, and in some cases for as long as four years. Although I understand the expertise and knowledge that long serving members of staff can bring, I invite the Governor to consider whether he has achieved the best balance, given the pressures of working in such a volatile environment. Although I make no formal recommendation, the Governor might consider reviewing the length of time individual staff have worked on the Keller Unit.

Defibrillator training

196. My investigators learned that, despite the vulnerability of the women located on the Keller Unit, a number of staff had not been trained in the use of defibrillators. In my report into the death of a woman at Styal in May 2006, I also reported that a number of staff did not feel confident in the use of defibrillators and recommended that all healthcare staff should be aware of the location of defibrillators and be trained in their use.

197. The Healthcare Manager said that consideration was being given to the training of further staff in the use of defibrillators in particular, members of discipline staff based on the Keller Unit. Although I make no formal recommendation, I ask the Governor and Healthcare Manager to review the implementation of the training

proposal and consider whether it can be brought forward.

Safer cells

198. The woman took her life by suspending herself from the Perspex casing that surrounded the television in her cell. It appears that she managed to thread the ligature, which she made from sheets, between the Perspex casing and the ceiling of the cell.

199. I am pleased to report that my investigators were shown that the gap between the Perspex casing and the ceiling has now been filled in with a heavy duty sealant. However, I also note that HM Inspector of Prisons reports that, during her recent inspection, the prison has no cells designed to current safer cell specifications. HM Inspector of Prisons recommended that safer cells which meet current standards should be provided. I repeat her recommendation that:

Safer cells in line with current guidance should be provided, with a protocol for their use.

Mental health awareness training

200. My investigators established that, at the time of the woman's death, some staff on the Keller Unit had received little or no training regarding mental health issues. However, during their interviews it became clear that staff had received mental health awareness training after the woman's death. The third officer said that, although she had not been trained when the woman died, her experience was gleaned from working on the unit everyday. The second officer said that he had not received any training as it had been cancelled on a number of occasions. The fourth senior officer said that at the time of the woman's death she had not received mental health training but had done so subsequently. A sixth officer also said she had also received mental health training after the woman's death.

201. My investigators obtained records for mental health training from the Healthcare Manager. The records show that in 2004, 11 officers received three days of mental health training, 34 officers were trained in 2005, five in 2006, 56 in 2007 and 18 in 2008. Although the numbers trained rose significantly in 2007, only two hours of training was provided compared with three days the previous year. Apart from the fourth officer in February 2005, none of the other Keller Unit officers involved in the woman's care appear to have been trained. However, as noted above, many told my investigators that they had received some training since the woman's death.

202. I note with interest that until 2006 three days were provided for mental health training, but this was reduced to two hours in 2007. Although this is not an area in which I am personally expert, I am somewhat surprised that from one year to another the time given to such important training can be reduced by such a significant amount. However, I note that the prison has recognised the need for further training and I am pleased that since the woman's death, staff on the Keller Unit have received some additional training.

The Governor, Healthcare Manager and MHIRT Manager should jointly review the way in which mental health awareness training is delivered to ensure that sufficient time and resources are used to target the appropriate members of staff.

The Keller Unit

203. In his clinical review, the clinical reviewer points out how the ten cells on the unit have been made as safe as possible within the limitations of the buildings structure. He describes the rooms as small and shabby with old beds and a toilet with no seat or lid. The clinical reviewer concludes that:

> "The physical structure of the Keller Unit is unfit for any medical purpose and its functions are contradictory in attempting to be both a disciplinary and therapeutic environment."

The clinical reviewer says that, although the rooms have been improved, he believes them still not fit for purpose. He says that putting disturbed prisoners into such a cramped environment with little to do is likely to exacerbate their problems.

204. In her report, Baroness Corston says that prison is not the right place for managing women who have high levels of self harm which stem from deep-rooted long-term and complex life experiences such as violence, sexual abuse, lack of care and personality disorder. She says, "These are problems created within the community, which is where they should be addressed. The Prison Service cannot and should not be expected to solve social problems." Baroness Corston concludes that:

> "This vulnerable group of serious self harming women need a therapeutic environment with properly trained multi-disciplinary staff at an appropriate staffing level. Low-level offending women who self-harm should be diverted out of the route to prison into appropriate NHS services. The management and care for more serious offending self-harming women should be led by the NHS, either in an NHS resource or shared multi-disciplinary care in prison."

205. The clinical reviewer comments that:

> "At present, there are almost no units in the country that are designed to cope with such severe personality disorder in women and those units that do exist are generally designed with the expectation that the women are ready to engage with therapeutic services. Realistically, people such as the woman would take many years to rehabilitate and the main aim initially would be safe containment. Suitable facilities would not fit neatly into health or prison care. In the early stages they would be places of safety with a short term aim of stabilising behaviour, a medium term aim of teaching prisoners basic life skills and a long term aim of rehabilitation back into the community."

He goes on to explain that:

"Such a unit would provide a low stimulation, highly structured environment and would be a precursor to an active rehabilitation unit. It would need to straddle the boundaries of the prison, health and social care systems but would mainly cater for women serving custodial sentences who exhibited the most severe disturbed behaviours. The aim would be to break the cycle of self harming and anti-social behaviour and reduce the number of suicides in prison. Also by creaming off the most severely disturbed women it would reduce the strain on the Prison Service, enabling better care and rehabilitation for the remaining prisoners in the women's estate."

206. My own conclusions and those of the clinical reviewer are supported by the findings of HM Inspector of Prisons in her inspection conducted several months after the woman's death. In her report, HM Inspector of Prisons says that the atmosphere of the Keller Unit still resembled a segregation unit, despite the aim to provide a therapeutic environment. It was staffed by officers who, despite their best intentions and considerable knowledge of those in their charge, lacked the training, support and leadership to deal with women with complex mental health problems and who often exhibited prolific self harm. HM Inspector of Prisons judges that, " … the lack of a therapeutic lead and approach on Keller Unit for women who needed high levels of care was a particular concern." She concludes that, if the unit is to fulfil its stated purpose, it needs to be properly resourced and professionally led. HM Inspector of Prisons recommends that, "A more therapeutic response to dealing with women at risk of suicide or self harm on Keller Unit should be developed."

207. Given the clinical reviewer's conclusions and those of HM Chief Inspector, I make the following recommendation:

The Director of Offender Management, Governor and Healthcare Manager, together with safer custody, mental health and psychiatric services, should carry out a strategic and operational review of the Keller Unit.

CONCLUSION

208. The woman had a long history of substance misuse and mental health problems. She was leading a chaotic lifestyle with frequent outbursts and destructive behaviour, including a long history of harming herself. During her first period of custody, she made a serious attempt on her life. On her return to Styal for the second time, the woman was correctly identified as a vulnerable woman and properly located in the Keller Unit.

209. Her vulnerability was recognised and she was immediately made subject to ACCT monitoring. However, she was not properly assessed by nursing staff and, although referred to the MHIRT, was not reviewed by a member of their team. Although the clinical reviewer believes that these omissions were unlikely to have led to her death, it was poor practice as was leaving the unit without a mental health nurse on duty.

210. I am particularly concerned that, despite her ACCT document stipulating that the woman should be observed five times an hour, on the morning of her death, she was not checked. When marks were noticed on her neck, no action was taken and an ACCT review was not called. However, although my report is a very critical one, I cannot say with certainty that the significant concerns I have about her care contributed to the woman's death.

RECOMMENDATIONS

1. The Governor and Healthcare Manager should ensure that the First Night Reception Health Screen is completed for all new prisoners and before that day's final roll check.

   Accepted - There is now a system in place so that on the rare occasion that women are allocated to a Residential Unit bypassing the First Night Centre, that the healthcare screening is completed on the day of reception. The woman was seen by a number of Healthcare professionals in the small period of time she was at HMP/YOI Styal and some of these expressed concerns about her state of mind. Her quick location to the Keller Unit did not prevent her having access to these professionals or their expertise.

2. The Healthcare Manager should remind all healthcare staff that any retrospective additions to EMIS entries must include the date and reason for amendment.

   Accepted - The prison medical officer has been given advice and guidance regarding his additional entry on EMIS about the woman. Cheshire Eastern Community Health (CECH) have included guidance on additional EMIS entries in their good record keeping training to all staff.

3. The Healthcare Manager, on behalf of the PCT, should monitor the performance of the MHIRT and ensure that high risk prisoners are assessed within one working day of their arrival at the prison.

   Accepted - In April 2009 Manchester West became the new MHIR provider and the new contract contains key performance indicators that specify the need to complete assessments on prisoners within strict time scales. Performance against this standard is being monitored through the Healthcare Contract Performance Group, which comprises representatives from CECH, the PCT and the Deputy Governor

4. The Governor and Chief Executive of Central and Eastern Cheshire PCT should review the level and scope of mental health nursing cover on the Keller Unit at weekends.

   Accepted - As mentioned in recommendation three above there is a new contract in place for the delivery of MHIR in HMP/YOI Styal and this includes ensuring there is the appropriate level of mental health nursing cover on the Keller Unit each weekend. The MHIRT now provide cover all weekend and this cover and performance is being monitored by the Healthcare Contract Performance Group.

5. The Director of Offender Management and Governor should review the staffing of the Keller Unit and provide the same levels at the weekends as during the week.

   Partially Accepted (Subject to recommendation 12) - The staffing level on

Keller Unit on a weekend is often supplemented by additional Officers when the detail allows. This is at the discretion of the Orderly Officer and has become custom and practice.

6. The Governor should satisfy himself that women who are the subject of observations under the ACCT process are actually checked the required number of times.

   Accepted - In August 2009 a new function was created called Prisoner and Family Support and this incorporates all the safer custody standards and responsibilities at HMP Styal. There are now better systems in place to monitor the ACCT processes and this includes ensuring the required number of observations are being completed and recorded.

7. The Governor should ensure that every ACCT review is multi-disciplinary and includes all the key personnel involved in the delivery of the prisoner's care.

   Accepted - HMP Styal now have a more equitable approach to the allocation of ACCT Cases meaning that all Case Managers have less ACCT cases and therefore have the capacity to conduct more effective ACCT reviews. The inclusion of key personnel such as the MHIRT is being prioritised for the high-risk cases and the MHIRT are being performance managed as part of their contract on their attendance at these reviews when attendance is appropriate to need. Ensuring multi-disciplinary attendance at all ACCT reviews is more difficult to achieve when number of open ACCTs is high, however Styal are committed to achieving better attendance from all key personal and the Safer Custody Function will monitor this.

8. The Governor should remind all staff of the need to record in the ACCT booklet all significant events relating to a prisoner and to share such information immediately with colleagues.

   Accepted - HMP Styal have undergone substantial ACCT training programme over the last 12 months to ensure all staff receive the relevant input, and a refresher is provided where needed. Healthcare staff are included on this training programme and we have new systems in place to capture new staff when they start in the prison. Good record keeping and the sharing of significant information with colleagues is covered in this training. From January 2009 all new staff received ACCT Foundation training during their POELT course and the training provided by Styal is in addition to this.

9. The Governor should urgently review the implementation of the IEP scheme in the Keller Unit.

   Accepted - In May 2009 the Governor commissioned a comprehensive review of the IEP scheme across the whole of the establishment. This review is due to report back in July 2009.

10. Safer cells in line with current guidance should be provided, with a protocol for their use.

    Accepted - In September 2008 a bid was submitted for the creation of a total of 6 safer cells in HMP/YOI Styal, 4 on Waite Wing and 2 on the Keller Unit. The outcome of this is awaited. As an interim measure HMP Styal have begun a programme of improving the cells on the Keller Unit and installing fixed wooden beds in an attempt to reduce the risks the current metal ones pose. The installation of this furniture improves the environment and reduces some of the risks however the cells remain normal as normal accommodation.

11. The Governor, Healthcare Manager and MHIRT Manager should jointly review the way in which mental health awareness training is delivered to ensure that sufficient time and resources are used to target the appropriate members of staff.

    Accepted - As part of the new MHIR contract HMP Styal are currently negotiating with Manchester West HMT and Offender Health to deliver joint training on mental health awareness.

12. The Director of Offender Management, Governor and Healthcare Manager, together with safer custody, mental health and psychiatric services, should carry out a strategic and operational review of the Keller Unit.

    Accepted - The Governor is currently in the process of commissioning a strategic and operational review of the Keller Unit. This will be a joint commissioning process involving Offender Health, the PCT and Women's and Young People's Group. The terms of reference for the review have yet to be drafted.

ANNEXES

1. Clinical Review by a clinical reviewer, from the Central and Eastern Cheshire Primary Care Trust

2. Transcript of interviews

3. List of other documents considered but not included as an annex